



Agenda

Mangum City Hospital Authority

March 24, 2026 at 5:30 PM

City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on March 24, 2026, at 5:30 PM, in the City Administration Building at 130 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Trustees.

CALL TO ORDER

ROLL CALL AND DECLARATION OF A QUORUM

CONSENT AGENDA

The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

1. Approve February 24, 2026, regular meeting minutes as present.
2. Approve February 2026 Medical Staff Meeting Minutes
3. Approve February 2026 Clinic Report.
4. Approve February 2026 Quality Meeting Minutes
5. Approve February 2026 CCO Report
6. Approve February 2026 CEO Report
7. Discussion related to HIM Delinquencies-none to report

FURTHER DISCUSSION

REMARKS

Remarks or inquiries by the audience not pertaining to any item on the agenda.

REPORTS

8. Financial Report for February 2026

OTHER ITEMS

9. Discussion and Possible Action to Approve the MRMC and BlueCross BlueShield of Oklahoma-Health Care Services Corporation Agreement for Acute Care Hospitals (Critical Access)
10. Discussion and Possible Action to Approve the MRMC and BlueCross BlueShield Medicare Advantage Network Participation Agreement for Hospital.

- [11.](#) Discussion and Possible Action to Approve the renewal agreement between MRMC and Stericycle for regulated waste disposal.
- [12.](#) Discussion and Possible Action to Approve the renewal agreement between MRMC and Stericycle for Pharmaceutical Waste Disposal
- [13.](#) Discussion and Possible Action to Approve the MRMC MedPro renewal quote providing general liability, professional liability insurance, and employee benefits liability.
- [14.](#) Discussion and Possible Action to Approve the DA Engineering, LLC-engineering services proposal for Lab Renovation
- [15.](#) Discussion and Possible Action to Approve the CNA insurance quote for Directors and Officers and Entity Liability Coverage Part Employment Practices Liability Coverage Part
- [16.](#) Discussion and Possible Action to Approve the MRMC and CommuniCare Technology, Inc. dba Pulsara BAA
- [17.](#) Discussion and Possible Action to Approve the Termination Letter for Tyto Care Telehealth Services
18. Discussion and Possible Action to Approve April Summerlin as the MRMC Infection Preventionist.
19. Discussion and Possible Action to Approve declaring both non-functional autoclaves as scrap
20. Discussion and Possible Action to Approve to the auction of 4 eye beds/stretchers
21. Discussion and Possible Action to Approve the auction of 1 anesthesia machine.

EXECUTIVE SESSION

22. Discussion and possible action to enter into executive session for the review and approval of medical staff privileges/credentials/contracts for the following providers pursuant to 25 O.S. § 307(B)(1):
 - Credentialing
 - Ryan Sand, APRN-CNP-Allied Health Professional-Temporary Privileges
 - Ashley Rae Lindsey, APRN-CNP-Allied Health Professional-Temporary Privileges
 - Re-Credentialing
 - Nelson Ogembo, APRN-CNP, Allied Health Professional-Courtesy Privileges

OPEN SESSION

23. Discussion and possible action in regard to executive session.

STAFF AND BOARD REMARKS

Remarks or inquiries by the governing body members, Hospital CEO, City Attorney or Hospital Employees

NEW BUSINESS

Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

ADJOURN

Motion to Adjourn

Duly filed and posted at 3:00 p.m. on the 20th day of March 2026, by the Secretary of the Mangum City Hospital Authority.

Brittany McClintock Secretary



Minutes
Mangum City Hospital Authority Session
February 24, 2026 at 5:30 PM
City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on February 24, 2026, at 5:30 PM, in the City Administration Building at 130 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Trustees.

CALL TO ORDER

Chairman Vanzant called the meeting to order at 5:30 p.m.

ROLL CALL AND DECLARATION OF A QUORUM

PRESENT

- Trustee Michelle Ford
- Trustee Carson Vanzant
- Trustee Lisa Hopper
- Trustee Ronnie Webb

ABSENT

- Trustee Cheryl Lively

ALSO PRESENT

- Kelley Martinez
- Nick Walker
- Leslie Faye
- Adrian Brownen

VIA PHONE

- Chee Her
- Dennis Boyd
- Cindy Tillman
- Salvador Viagas Martinez

CONSENT AGENDA

The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

Motion to approve consent agenda as presented.

Motion made by Trustee Vanzant, Seconded by Trustee Hopper.

Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

1. Approve January 27, 2026, regular meeting minutes as present.
2. Approve January 2026 Medical Staff Meeting Minutes
3. Approve January 2026 Clinic Report.
4. Approve January 2026 Quality Meeting Minutes
5. Approve January 2026 CCO Report.
6. Approve January 2026 CEO Report.
7. Discussion related to HIM Delinquencies-none to report.

FURTHER DISCUSSION

No further discussion

REMARKS

Remarks or inquiries by the audience not pertaining to any item on the agenda.

No remarks

REPORTS

8. Financial Report for January 2026

The average daily census for the month was 10.52. This is up one day from December and down one day from the year-to-date monthly average. The acute payer mix for January was 85% for Medicare and Medicare Managed Care with the prior month being 85% as well. The swing bed payer mix for December was 67% for Medicare and 33% for Medicare Managed care. The year-to-date for Medicare is 80% and Medicare Managed Care is 20%. The operating margin was \$10,000, which is up \$121,000 from December. The year-to-date operating margin monthly average was a loss of \$36,000. Net patient revenue was \$1.57 million for the month, an increase of \$203,000 from last month and a increase of \$142,000 from the year-to-date monthly average. 340B revenue was \$22,000 for January and expenses were \$14,000. Operating expenses were at \$1.58 million for January, which is up \$71,000 from the prior month and \$95,000 from the year-to-date monthly average. Patient days for December were at 326. That's up 58 days from December. Cash receipts for the month were \$1.35 million. That's a decrease of \$243,000 from the year-to-date monthly average and a decrease of \$59,000 from December. Cash disbursements were at \$1.49 million. Cash balance at the January month end was \$1.01 million giving us about 19.9 days of cash on hand. The clinic average daily visits were 14. The revenue for the clinic is \$67,000. Operating expenses were \$78,000, which is a loss of \$11,000.

OTHER ITEMS

9. Discussion and Possible Action to approve the Heartland Pathology Consultants, PC-Agreement for Anatomic Pathology Services for Medical Director Services

Motion to approve.

Motion made by Trustee Webb, Seconded by Trustee Ford.

Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

10. Discussion and Possible Action to Approve Meghan Smith as the MRMC Compliance Officer

Motion to approve.

Motion made by Trustee Webb, Seconded by Trustee Vanzant.
Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

11. Discussion and Possible Action to Approve Meghan Smith as the MRMC Risk Manager

Motion to approve.

Motion made by Trustee Hopper, Seconded by Trustee Vanzant.
Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

EXECUTIVE SESSION

12. Discussion and possible action to enter into executive session for the review and approval of medical staff privileges/credentials/contracts for the following providers pursuant to 25 O.S. § 307(B)(1):

- Credentialing
 - DIA Schedule 1 List of Providers 02/2026

- Re-Credentialing
 - Dr. Laura Gilmore, MD-Courtesy Privileges

Motion to enter into executive session at 5:35 p.m.

Motion made by Trustee Vanzant, Seconded by Trustee Ford.
Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

OPEN SESSION

Motion to enter into open session at 5:38 p.m.

Motion made by Trustee Vanzant, Seconded by Trustee Hopper.
Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

13. Discussion and possible action in regard to executive session.

Motion to approve credentialing and re-credentialing.

Motion made by Trustee Vanzant, Seconded by Trustee Hopper.
Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

STAFF AND BOARD REMARKS

Remarks or inquiries by the governing body members, Hospital CEO, City Attorney or Hospital Employees

No remarks.

NEW BUSINESS

Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

ADJOURN

Motion to Adjourn

Motion to adjourn at 5:39 p.m.

Motion made by Trustee Vanzant, Seconded by Trustee Webb.

Voting Yea: Trustee Ford, Trustee Vanzant, Trustee Hopper, Trustee Webb

Duly filed and posted at 3:30 p.m. on the 20th day of February 2026, by the Secretary of the Mangum City Hospital Authority.

Carson Vanzant, Chairman

Brittany McClintock, Secretary

Mangum Regional Medical Center
Medical Staff Meeting
Thursday
February 19, 2026

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Laura Gilmore, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT

Mary Barnes, APRN-CNP
David Arles, APRN-CNP

NON-MEMBERS PRESENT:

Kelley Martinez, RN, CEO
Chelsea Church, PharmD
Nick Walker, RN, CCO
Meghan Smith, RN – Infection Control
Chasity Howell, RN – Utilization Review
Denise Shaw, RN – Quality
Lynda James, LPN – Drug Tech

1. Call to order
 - a. The meeting was called to order at 12:24 pm by Dr. John Chiaffitelli, Medical Director.
2. Acceptance of minutes
 - a. The minutes of the January 22, 2026, Medical Staff Meeting were reviewed.
i.Action: Dr.Chiaffitelli, Medical Director, made a motion to approve the minutes.
3. Unfinished Business
 - a. None.
4. Report from the Chief Executive Officer
 - o Operations Overview -
 - o We have hired a new IT employee.

- Looking at clinic collections for January, we collected a total of \$443.74 up from \$416.44 at time of service.
 - Hospital upfront collections were at \$1,205.64 for the month of January up from \$621.25 in December.
 - Swing Bed rounds three times a week are going very well. We hope to see continued great patient and staff satisfaction.
 - We are continually looking for new service lines to provide our community at the hospital and the clinic.
 - We continue to work towards a strategic plan for the hospital and the clinic.
 - We are also looking at doing a provider driven Facebook post where they talk briefly about the current month's health focus.
 - We continue to work towards moving our lab into the facility. Please see electrical engineer agreements.
 - We continue to try to find a contractor that will give us two more quotes for the lab building repair.
- Written report remains in the minutes.

5. Committee / Departmental Reports

a. Medical Records –

1. January – ER – 3 ER Note needed out of 132 – Completed
 OBS – 0BS out of 4
 Acute – 1 H&P in Acute note need out of 15 – Completed
 SWB – 0 SWB out of 27

b. Nursing

Patient Care

- MRMC Education included:
 1. Nursing documentation updates are communicated to nursing staff weekly.
 2. Nurse meeting was held January 21st..
- MRMC Emergency Department reports 0 patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports 0 contaminated blood culture set(s).
- MRMC Infection Prevention reports 1 CAUTI.
- MRMC Infection Prevention report 0 CLABSI.
- MRMC Infection Prevention reports 0 HAI, and 0 MDRO for the month of January, 2026.

Client Service

- Total Patient Days for January 2026 were 327. This represents an average daily census of 11.

- January 2026 COVID-19 statistics at MRMC: Swabs (0 PCR & 36 Antigen) with 1 positive.

Preserve Rural Jobs and Culture Development

- One-PM House Supervisor RN position is open.
- Patients continue to voice their praise and appreciation for the care received at MRMC. We continue to strive for excellence and improving patient/community relations.

Written report remains in minutes.

c. Infection Control –

- Old Business
 - a. None
 - New Business
 - a. N/A
 - Data:
 - a. N/A
 - Policy & Procedures Review:
 - a. Completed July, 2024
 - Education/In Services
 - a. N/A
 - Updates: None at this time.
 - N95 Fit Tests – 0: N95 Fit Test
Annual Items:
 - a. Construction Risk Assessment - ICRA completed for OR to Lab conversion. Submitted to state by K. Martinez, CEO. No start date on this project at this time. Roof has been completed. ICRA for June 2024 completed.
 - b. Linen Services – No issues reported with new linen company.
- Written report remains in minutes.

d. Environment of Care and Safety Report

- i. Evaluation and Approval of Annual Plans
 - i.i. Old Business - -
 - a. Chrome pipe needs cleaned and escutcheons replaced on hopper in ER – could not replace escutcheons due to corroded piping in wall – capped off leaking pipe under the floor to stop leak – hopper will be covered – remodel postponed.—Talked to contractor 10-4-2025 about cover for hopper – contractor measured and is making quote for cover.
 - b. ER Provider office flooring needing replaced. Tile is onsite.- remodel is postponed.
 - c. Stained ceiling tile throughout facility from leaking roof – Replacement Started 9-15-2025. Need more tile.
 - d. Damaged ceiling in OR2 due to leaking roof.

- e. New Hope Roof – Leak in Physical Therapy office after hail storm – City approved vendor to repair.
- f. Remove Velcro strips from data drops and replace with zip ties. Started 11-13-2025. Complete 11-21-2026.
- g. Regulator on reserve oxygen manifold has small leak and needs replaced - - Apex scheduled for repairs - - Complete 12-16-2026
- h. Main entry has slight rise between ramp and sidewalk creating a possible trip hazard. Contractor preparing quote to repair.
- i. Blanket warmer log not current – Nick will follow up.
- j. Need light installed for parking lot at New Hope - - Contractor preparing quote.
- i.i.i. New Business
 - a. Appoint Safety Officer for 2026 - - Mark Chapman was appointed 2026 Safety Officer 1-14-2026.
Written report remains in the minutes.
- e. Laboratory
 - i. Tissue Report – Approved
 - i.i. Transfusion Report – Approved
Written report remains in minutes.
- f. Radiology
 - i. There was a total of – 205 X-Rays/CT/US
 - i.i. Matters for approval
 - o Nothing up for approval
 - i.i.i. Updates:
 - o No Updates
 Written report remains in minutes.
- g. Pharmacy
 - i. Verbal Report by Clinical Pharmacist
 - i.i. P & T Committee Meeting –
The P&T Committee Meeting will be held next month.
 - i.i.i. Lorazepam injectable is available for order.
Demerol IV is unavailable.
 - i.v. Reviewing Policies & Procedures to be presented at a later date.
Written report remains in the minutes.
- h. Physical Therapy
 - i. No report.
- i. Emergency Department
 - i. No report
- j. Quality Assessment Performance Improvement
 - Risk Management
 - o Grievance – 0

- Fall with no injury – 2
 - Fall with minor injury – 1
 - Fall with major injury – 0
 - Death – 3
 - AMA/LWBS – 1-In Pt – 0- ER AMA -
OBS – SWB
 - Quality – Minutes are in the minutes of Medical Staff Meeting.
 - HIM – ED discharge instructions - Compliance
100% - D/C Note Compliance
100% - Progress Notes
96% - ED DC Instructions
100% - ED Provider Dx
 - Med event – 2
 - After hours access was – 48
- Written report remains in the minutes.

k. Utilization Review

- i. Total Patient days for December: 265
 - i.i. Total Medicare days for December: 241
 - i.i.i. Total Medicaid days for December: 6
 - iv. Total Swing Bed days for December: 208
 - v. Total Medicare Swing Bed days for December: 204
- Written report remains in the minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports for January, 2026.

6. New Business

- a. Review & Consideration of Approval of Appointment: MRMC: –
Appointment 2026 – Risk Manager – Meghan Smith
i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve the MRMC:
Appointment 2026 – Risk Manager – Meghan Smith.
 - b.Review & Consideration of Approval of Appointment: MRMC Appointment
- 2026 MRMC Compliance Officer – Meghan Smith
i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve the
Appointment – 2026 MRMC Compliance Officer – Meghan Smith.
 - c.Discussion over Order Sets: Discussion was held over Order Sets.
 - d.Discussion over Order Pre-Albumin on all new admits Discussion was held over Order
Pre-Albumin on all new admits.
 - f.Discussion over PDMP. Discussion was held over PDMP.
- f. Discussion over Discharge, Admit and Transfer Orders. Discussion was held over Discharge, Admit and Transfer Orders.

7, Adjourn

a, Dr Chiaffitelli made a motion to adjourn the meeting at 12:52 pm

Medical Director/Chief of Staff

Date



Clinic Operations Report

Mangum Family Clinic

February 2026

Monthly Stats	February 2025	February 2026
Total Visits	183	169
Provider Prod	156	168
RHC Visits	176	154
Nurse Visits	2	0
Televisit	0	0
Swingbed		101

Provider Numbers	RHC	TH	SB
Ogembo	137		
Sanda	32		
Other			101

Payor Mix	
Medicare	33
Medicaid	75
Self	11
Private	50

Visits per Geography	
Mangum	134
Granite	27
Willow	3
Duke	5

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Visits	167	169											

Clinic Operations:

- Clinic short staffed without an LPN for 3 weeks.
- Dr. Sanda's medical assistant, who started on 2/25/2026, will be working full-time.
- Job posting for LPN is current.
- Nelson on PTO for 2/27/2026.

Quality Report:

Improvement Measure	Actual	Goal	Comments
Reg Deficiencies	10	0	10- Insurance Verification Errors
Patient Satisfaction	0	5	
New Patients	15	10	Impressive
No Show	6.70%	<12%	Impressive
Expired Medications	0	0	None noted.

Outreach:

- Nothing specific to report. Clinic continues to support the community by providing compassionate quality care.

Summary :

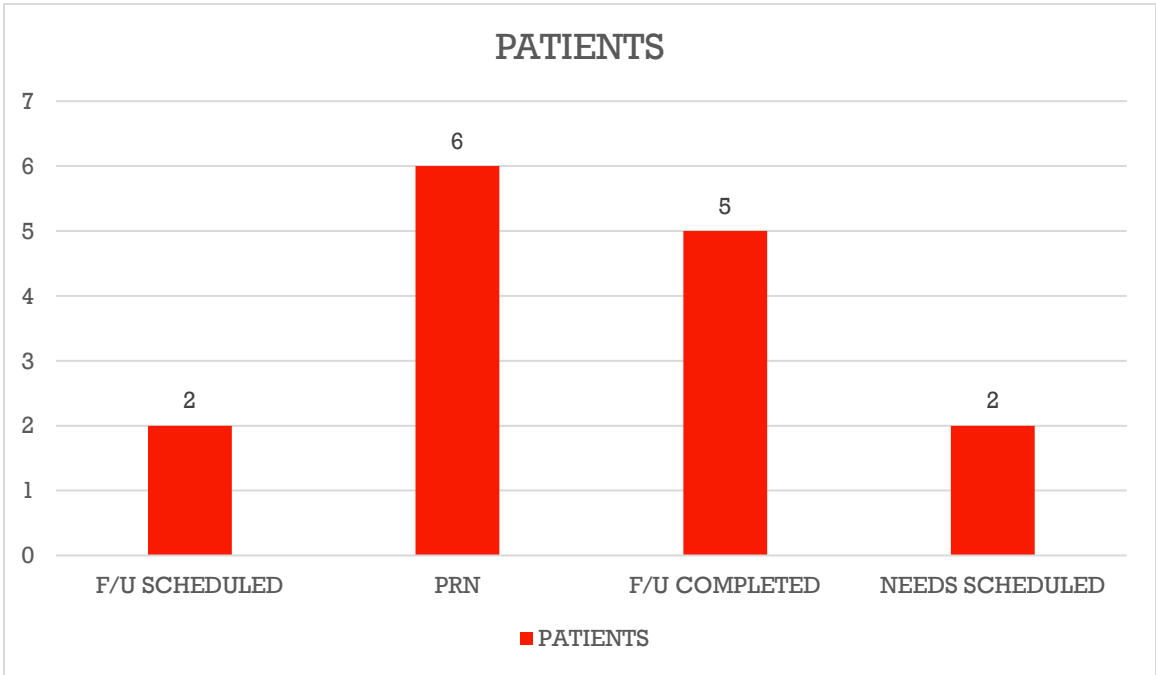
Mangum Clinic continues to stand strong in serving the community. The month of February the clinic saw a decrease in no show appointments.

"You love, you serve, and you show people you care. It's the simplest, most powerful, greatest, success model of all time." Joe Gordon.

MANGUM FAMILY CLINIC

NEW PATIENT TRACKING

FEBRUARY



**Mangum Regional Medical Center
Quality and Patient Safety Committee
Meeting
February 2026 Meeting Agenda**

Meeting Location: OR	Reporting Period: Jan 2026	
Chairperson: Dr Gilmore	Meeting Date: 02/11/2026	Meeting Time: 14:00
Medical Representative: Dr Gilmore	Actual Start Time: 1400	Actual Finish Time: 1455
Hospital Administrator/CEO: Kelley Martinez	Next Meeting Date/Time: tentatively 03/12/26	

Mission: To provide our Mangum community and surrounding counties with convenient, gold-standard “dependable and repeatable” patient care, while assisting and supporting all their medical healthcare needs.

** Items in blue italics denote an item requiring a vote*

I. CALL TO ORDER				
Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. Call to Order	QM	1 min	Called to order at 1400	Approval: First – Kelley Martinez Second– Stephanie Hughes
II. COMMITTEE MEETING REPORTS & APPROVAL OF MINUTES				
Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. Quality and Patient Safety Committee <i>1. Approval of Meeting Minutes</i>	Meghan Smith	2 min	Meeting minutes – Jan 2026	Approval: First – Stephanie Hughes Second – Kelley Martinez
B. Environment of Care (EOC) Committee <i>1. Approval of Meeting Minutes</i>	Mark Chapman	2 min	Meeting minutes – Jan 2026	Approval: First – Nick Walker Second – Stephanie Hughes
C. Infection Control Committee <i>1. Approval of Meeting Minutes</i>	Meghan Smith	2 min	Meeting minutes – N/A	IP to complete 2 months of meeting minutes March 2026
D. Pharmacy & Therapeutics (P&T) Committee <i>1. Approval of Meeting Minutes</i>	Chelsea Church/ Lynda James	2 min	Meeting minutes – None Next P&T –	Next P&T scheduled for March 2026
E. Health Information Management (HIM)/Credentialing Committee	Jessica Pineda/ Kaye Hamilton	2 min	Meeting Min – Jan 2026	1.) Approval: First Stephanie Hughes Second Nick Walker

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

<i>1. Approval of Meeting Minutes</i>				
D. Utilization Review (UR) Committee <i>1. Approval of Meeting Minutes</i>	Chasity Howell	2 min	Meeting Minutes – January 2026	Approval: First – Jessica Pineda, Second – Stephanie Hughes
III. DEPARTMENT REPORTS				
Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. Nursing/Emergency Department	Nick Walker	5 min	Blood utilization – 2 Code Blue – 1 Restraint – 1 Emergent Intubations: 1	Every Monday CCO will validate crash cart checks to insure nursing has checked the crash cart. Binder in CCO office to be keep Monday checklist and monthly crash cart checklists.
B. Radiology	Pam Esparza	2 min	5/12 repeats	0 Contrast reactions 1/1 Critical Test reporting
C. Laboratory	Tonya Bowan	8 min	41 – repeated labs, all critical repeats	1 AMT license review Competency completed with x2 employees 0 Contaminated blood cultures
D. Respiratory Care	Heather Larson	2 min	0 vent day neb changes	Director out
E. Therapy		2 min	Total # of Sessions Performed 147 -PT SWG 23 OP PT 136 -OT 25-ST Improved Standard Assessment Scores: - PT - OT - ST	Director out
F. Materials Management	Cory Ross	2 min	Back Orders 0 Late Orders 2 Recalls 0	Cory Ross is the new Materials Manager for MRMC

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

G. Business Office	Desarae Clinesmith	2 min	DL – 100% Cost Share – 68%	BO manager reports that attempts to collect are being made but patients have just not been willing to pay or set up payment plan.
H. Human Resources	Stephanie Hughes	2 min		59 employees at the end of the month
I. Environmental Services	Mark Chapman	2 min	100% terminal room cleans	
J. Facility/Plant Operations	Mark Chapman	2 min	24 extinguishers checked 1 boiler checks 1 generator/transfer switch inspection 15 – filter checks 1 egress inspections	
K. Dietary	Treva Derr	2 min	Daily meal count – 100%	Stove repairs still pending. Attempts to order replacement parts The health inspector came to evaluate the dietary department. No deficiencies noted.
L. Information Technology	Hank Hunt	2 min	Director out –	
M. Strong Minds	Brittany Nelms/Brittany Niles	2 min	1 active patient	

IV. OLD BUSINESS

V. NEW BUSINESS

Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. New Business	QM	2 min	MRMC Risk Manager appointment – Meghan Smith MRMC Compliance officer	

VI. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT DASHBOARD REPORT

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. Volume & Utilization	CM	5 min	1) AMA- Patient seen in ED on 1/8/26. Chief complaint back pain and new onset weakness. Patient received prompt evaluation. ED Provider recommended that the patient needed to transfer to a higher level of care for neurology/neurosurgical evaluation. Patient declined transfer stating he had too much to do to be transferred.	
B. Case Management	CM	8 min	CAH readmits – Patient was admitted from 01/07-01/13 with dx: UTI, AKI, Hypokalemia. Patient completed IV antibiotics and requested discharge to home with home health of choice. Patient readmitted acute inpatient and then changed to observation due to United Healthcare Medicare advantage denial for acute IP stay dates from 01/20-01/23 and patient approved for SWB stay dates from 01/23-02/03. Patient completed IV antibiotics and requested discharge to home. United Healthcare provided "Notice of Medicare Noncoverage" for this patient with last covered day of 02/05. Patient did not wish to appeal the decision from United Healthcare. Patient requested discharge on 02/03 with Lifesprings Home Health.	
C. Risk Management	QM	10 min	Deaths - 3	

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

		<p>1.) Inpatient: Patient admitted from ER for unresponsiveness. Patient had a DNR in place. Due to poor prognosis, patient's daughter (POA) elected to keep patient at MRMC for comfort care. Patient expired the next day.</p> <p>2.) Inpatient: Patient admitted from another facility for UTI, debility, malnutrition. Patient had a DNR on file with facility. Due to patients continued decline, family chose to make patient comfort care. Patient expired three days later.</p> <p>3.) ER: Patient arrived to ED via EMS. Pt reportedly had upset stomach the night before. Was found to be unresponsive and had vomited blood. Upon arrival patient had no pulse and no spontaneous respirations. Code Blue was initiated in ED. Resuscitation attempts unsuccessful.</p> <p>Complaints – 0</p> <p>Grievances – 0</p> <p>Workplace Violence Events - 0</p> <p>Falls - 3</p> <p>Falls w/o injury -</p> <p>1.) Patient was found sitting on the floor next to the bed, pt was in the chair at prior check. Attempted to go to the restroom and fell. No injuries noted. Fall precautions in place prior to fall – chair/bed alarm, non-skid socks, call</p>	<p>Other - 1.) pt was assisted to the bathroom and shut the door, when attempting to open the bathroom door, it was found to have been locked from the inside and pt was not able to unlock it.</p> <p>Skin tear (2)</p> <p>1.) Pt found to have skin tear to left arm, found arm blankets were moved and gown was over patient arm. Pt is not able to recall events. 2.) Pt spouse found pt to have skin tear upon their arrival to patient room. RN noted pt to have skin tear to arm. Spouse reports patient arm fell off the bed and hit a hook like area on the side of the chair.</p> <p>Bodily Injury:</p> <p>1.) Pt was found with right leg between the seat and foot rest of the garichair, pt not able to free leg. Nursing assisted patient in freeing leg with noted approx 15 cm skin tear to right shin.</p>
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**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

			<p>light within reach, frequent rounding and room free obstructions. Risk factors - >60 years, impaired cognition, physical impairment, hx of falls</p> <p>2.) Outpatient being transported for outpatient services, when unloading patients who were ready to exit the van, driver noted the lift gait would not go completely down due to the curb. Patient remain standing while the van was being moved up to be able to lower the lift gait completely, patient was not able to hold on to the handrails while moving the van and fell over hitting the other patient. Both patients fell on the floor. Patient declined any injuries or the need to be evaluated in the ER.</p> <p>3.) Outpatient being transported for outpatient services, when unloading patients who were ready to exit the van, driver noted the lift gait would not go completely down due to the curb. Patient remained standing while the van was being moved up to be able to lower the lift gait completely, second patient fell knocking over this patient. Both patients fell on the floor. Patient declined any injuries or the need to be evaluated in the ER</p> <p>Delay in Care 1 Pt arrived via EMS unresponsive, no spontaneous respirations, no palpable pulse. CPR and Code blue initiated. No adult ambu bag found on the crash cart. Floor staff sent to locate an adult ambu bag. Leading to delay in ventilation. After the code was completed, it was found that there were no adult ambu</p>	
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**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

			bags in central stores. Per RT an order request was made to previous materials manager 1 month prior to this incident.	
D. Nursing	CCO	2 min	Med reconciliation – 100% Preferred Pharmacy – 100% Hospital Formulary – 100%	
E. Emergency Department	CCO/QM	5 min	1.) ER log compliance – 100% 2.) EDTC Data 88% 3.) LWBS – 0	EDTC data: 1 transfer chart did not include signed nurses note.
F. Pharmacy & Therapeutics (P&T)	Pharmacy	2 min	Next P&T – March 2026 After hours access - ADR - 0 Med errors – 1 Dose omissions –	Med errors - 1.) missed Vancomycin dose. No trends noted with nurse. CCO did 1:1 with the nurse
G. Respiratory Care	RT	2 min	0 unplanned decannulation 100% resp assessments 100% on Chart checks	
H. Wound Care	WC	2 min	1 wound	1 hospital acquired wound. Patient treated by the wound care team.
I. Radiology	RAD	2 min	Pt site verification - 100%	
J. Laboratory	LAB	5 min	0 – Blood culture contaminates	
K. Infection Control/Employee Health	IC/EH	5 min	1 – Inpt HAIs 0 – MRDO 0 – VAE 0– Cdiff 1 – CAUTI	1 CAUTI. Patient admitted after a fall at home. During patients stay the patient required an indwelling foley due to urinary retention. On 1/31/2026, the patient developed a fever of 100.9. Urinalysis was

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

			0 - CLASBI	<p>ordered and patient was started on Rocephin 1gm IV q 24hr. Urine culture pending. Patient remained febrile on 2/1/26 and antibiotic switched to Levaquin 750mg IVPB q 24hr. Patient met NSHN criteria for CAUTI due to temperature greater than 100.4.</p> <p>Contributing factors: Patient’s age, history of urinary retention, foley catheter use, prolonged stay in hospital, weakened immune system, and dementia.</p> <p>Outcome: Patient was started on antibiotic therapy. Urine culture resulted pseudomonas aeruginosa which is sensitive to Levaquin. No fever documented after</p>
L. Health Information Management (HIM)	HIM	2 min	<p>100% - D/C Note Compliance</p> <p>100% - Progress Notes</p> <p>100% - ED DC Instructions</p> <p>100% - ED provider Dx</p>	
M. Dietary	Dietary	2 min	100% - daily meal count	
N. Therapy	Therapy	2 min	Gait belt usage – 100%	
O. Human Resources (HR)	HR	2 min	<p>90 day evals – 100%</p> <p>Annual evals – 100%</p>	
P. Business Office	BOM	2 min	<p>Cost Share Collections – 68%</p> <p>Med Necessity Verification – 100%</p> <p>Drivers Licenses – 100%</p>	
Q. Environmental Services	EVS	2 min	10/10 on room cleans	

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

R. Materials Management	MM	2 min	Electronic Requisitions – 100%	
S. Life Safety	PO	2 min	Fire extinguisher Inspections -100% Egress checks – 100%	
T. Emergency Preparedness	EP	2 min	None for the reporting period	
U. Information Technology	IT	2 min	Director out – will defer	
V. Outpatient Services	Therapy	2 min	Temp logs – 100%	
W. Strong Minds	SM	2 min	Continuing outreach to boost patient numbers	
VII. POLICIES & PROCEDURES				
Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. Review and <i>Approve</i>	QM	10 min	<ul style="list-style-type: none"> 1) Compliance Officer Appointment 2) Risk Manger Appointment 	<ul style="list-style-type: none"> 1. Approval: First – K. Martinez , Second– S. Hughes 2. Approval: First –, K. Martinez Second– S. Hughes

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

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VIII. PERFORMANCE IMPROVEMENT PROJECTS

IX. OTHER

X. ADJOURNMENT

Agenda Item	Presenter	Time Allotted	Discussion/Conclusions	Decision/Action Items
A. Adjournment	QM	1 min	There being no further business, meeting adjourned at 1455 by K. Martinez seconded by C. Howell	

MEMBERS & INVITED GUESTS

Voting MEMBERS				
Kelley Martinez CEO	Nick Walker CCO	Dr Gilmore (Teams)	Treva Derr Dietary Manager	Lynda James DRS
Chasity Howell CM	Desarae Clinesmith BO Manger	Cory Ross Materials Management	Pam Esparza Radiology Manger	Mark Chapman Plant Ops
Tonya Bowen Lab Director	Stephanie Hughes HR	Brittany Niles Strong Minds	Kaye Hamilton	Jessica Pineda HIM
Non-Voting MEMBERS				
Meghan Smith QM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Mangum Regional Medical Center
Quality and Patient Safety Committee Meeting
February 2026 Meeting Minutes**

Sign-In Sheet
Date of Meeting: 02/12/2026

Title	Print Name	Signature
Chairman		
Administrator		
CCO		
Quality Manager		
Respiratory Care		
Drug Room Supervisor		
Physical Therapy		
Dietary		
Case Management		
HIM		
Business Office		
Infection Control		
Radiology		
Plant Operations		
Materials Management		
Environmental Services		
Laboratory		
Human Resources		
Strong Minds		
Other		



Chief Clinical Officer Report February 2026

Patient Care

- MRMC Education included:
 1. Nursing documentation updates are communicated to nursing staff weekly.
 2. Nurse meeting scheduled for March 4th.

- MRMC Emergency Department reports that there are 1 patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports 0 contaminated blood culture set(s).
- MRMC Infection Prevention reports 1 CAUTI.
- MRMC Infection Prevention report 0 CLABSI.
- MRMC Infection Prevention reports 3 HAI and 0 MDRO for the month of February.

Client Service

- Total Patient Days for February 2026 were 264. This represents an average daily census of 9.
- February 2026 COVID-19 statistics at MRMC: Swabs (0 PCR & 38 Antigen) with 5 Positive.

Mangum Regional Medical Center												
Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Inpatient acute	14	12										
Swing Bed	17	9										
Observation	3	1										
Emergency Room	130	122										
Lab Completed	2018	1973										
Rad Completed	205	193										
Ventilator Days	0	0										

Preserve Rural Jobs and Culture Development

- One- PM House Supervisor RN position is open.
- Patients continue to voice their praise and appreciation for the care received at MRMC. We continue to strive for excellence and improving patient/community relations.



Chief Executive Officer Report February 2026

Operations Overview

- Looking at clinic collections for February, we collected a total of \$717.06 up from \$443.74 at time of service.
- Hospital upfront collections were at \$273.40 for the month of February down from \$1,205.64 in January.
- We are continually looking for new service lines to provide our community at the hospital and the clinic.
- One of our strategies from our strategic plans for the facility for 2026 is to focus on getting more patients in the clinic. We are going to do this by doing advertising outside our area. Offering more services lines to our community and surrounding areas.
- Another strategic plan for our facility is to inform our community of services the hospital has to offer. This is going to be done through testimonials and informative posts on social media.
- Our last objective for our strategic plan is to increase knowledge of our Strong Minds program.
- We have received all quotes needed for the Lab repair and awaiting approval from the insurance company to begin work.
- We continue to get all staff more involved during patient rounds with providers.
- We continue small improvements within the facility such as sign rejuvenation and yard maintenance.
- We held a Manager Education in the month of February focusing on our Strategic Plan.

Mangum Board Meeting Financial Reports

February 28, 2026

REPORT TITLE	
1	Financial Summary (Overview)
2	Cash Receipts - Cash Disbursements - NET
3	Financial Update (page 1)
4	Financial Update (page 2)
5	Stats
6	Balance Sheet Trend
7	Cash Collections Trend
8	Medicare Payables (Receivables)
9	Current Month Income Statement
10	Income Statement Trend
11	RHC YTD Income Statement
12	AP Aging Summary

Mangum Regional Medical Center
 Financial Summary
 February 28, 2026

	Current Month	Feb-26 Year-to-Date	Mthly Avg Prior Year	Variance
ADC (Average Daily Census)	9.43	10.00	9.73	-0.30
Payer Mix % (Acute):				
MCR	64.86%	56.94%	54.62%	10.24%
MCR Mgd Care	16.22%	26.39%	22.34%	-6.12%
All Others	18.92%	16.67%	23.04%	-4.12%
Total	100.00%	100.00%	100.00%	0.00%
Payer Mix % (SWB):				
MCR	82.82%	74.13%	79.71%	3.11%
MCR Mgd Care	17.18%	25.87%	19.35%	-2.17%
All Others	0.00%	0.00%	0.94%	-0.94%
Total	100.00%	100.00%	100.00%	0.00%
Operating margin	184,594	195,061	(435,422)	
<i>Operating Margin (monthly average)</i>	184,594	97,530	(36,285)	133,816
NPR (Net Patient Revenue)	1,576,362	3,148,629	17,161,266	
<i>NPR (monthly average)</i>	1,576,362	1,574,315	1,430,106	144,209
Operating Expenses	1,405,219	2,992,499	17,902,547	
<i>Operating Expense (monthly average)</i>	1,405,219	1,496,250	1,491,879	4,371
NPR % of Oper Exp	112.2%	105.2%	95.9%	
Patient Days	264	590	3,550	(3,286)
Oper Exp / PPD	\$ 5,323	\$ 5,072	\$ 5,043	\$ 29
# of Months	1	2	12	
Cash Receipts (rnd)	1,530,505	2,878,917	19,097,911	
<i>Cash Receipts (monthly average)</i>	1,530,505	1,439,458	1,591,493	(152,034)
Cash as a % of NPR (s/b 100% min)	97.1%	91.4%	111.3%	
Days Cash-On-Hand (Net of MCR Pay / Restrictions):				
Calendar Days	28	59	365	
Operating Exp / Day	\$ 50,186	\$ 50,720	\$ 49,048	\$ 1,138
Cash - (unrestricted)	1,242,632	1,242,632	1,161,872	80,760
Days Cash-On-Hand	24.8	24.5	23.7	
Days Cash-On-Hand: Minimum during month	10.1	10.1	12.6	(2.4)
MCR Rec (Pay) - "as stated - but to be adjusted"	187,362	187,362	92,857	94,505
AP & Accrued Liab	16,443,404	16,443,404	16,244,681	198,723
Accounts Receivable (at net)	1,518,902	1,518,902	1,192,826	326,076
Per AP aging schedule (incl. accruals)	Feb-26	Feb-26	Prior FYE	Net Change
Account Payable - Cohesive	14,315,203	14,315,203	14,084,830	230,373
Account Payable - Other	1,235,477	1,235,477	1,267,128	(31,650)
Total	15,550,680	15,550,680	15,351,958	198,723
Cohesive Loan	4,466,413	4,466,413	4,528,447	(62,034)

Mangum Regional Medical Center
 Cash Receipts - Cash Disbursements Summary
 2/28/26

	Current Month	COVID	Total Less COVID
Cash Receipts	\$ 1,530,505	\$ -	\$ 1,530,505
Cash Disbursements	\$ 1,308,184	\$ -	\$ 1,308,184
NET	\$ 222,321	\$ -	\$ 222,321

	Year-To-Date	COVID	Year-To-Date Less COVID
Cash Receipts	\$ 2,878,917	\$ -	\$ 2,878,917
Cash Disbursements	\$ 2,799,193	\$ -	\$ 2,799,193
NET	\$ 79,724	\$ -	\$ 79,724

	Prior Month	COVID	Total Less COVID
Cash Receipts	\$ 1,348,412	\$ -	\$ 1,348,412
Cash Disbursements	\$ 1,491,009	\$ -	\$ 1,491,009
NET	\$ (142,597)	\$ -	\$ (142,597)

	Prior Month YTD	COVID	Prior Month YTD Less COVID
Cash Receipts	\$ 1,348,412	\$ -	\$ 1,348,412
Cash Disbursements	\$ 1,491,009	\$ -	\$ 1,491,009
NET	\$ (142,597)	\$ -	\$ (142,597)



**Board of Directors
Mangum Regional Medical Center**

March 24, 2026

February 2026 Financial Statement Overview

- **Statistics**
 - The average daily census (ADC) for February 2026 was **9.43**– (PY fiscal year end of **9.73**).
 - Year-To-Date Acute payer mix was approximately **81%** MCR/MCR Managed Care combined.
 - Year-To-Date Swing Bed payer mix was **83%** MCR & **17%** MCR Managed Care. For the prior year end those percentages were **80% & 20%**, respectively.

- **Balance Sheet Highlights**
 - The cash balance as of February 28, 2026, inclusive of both operating & reserves, was **\$1.24M**. This increased **\$223K** from January 31, 2026.
 - Days cash on hand, inclusive of reserves, was **24.8** based on February expenses.
 - Net AR decreased by **\$32K** from January.
 - Payments of approximately **\$1.31M** were made on AP (prior 3-month avg was **\$1.75M**).
 - Cash receipts were **\$182K** more than in the previous month (**\$1.35M vs \$1.53M**).
 - The Medicare principal balance was completely paid off in the month of August 2024.



- Income Statement Highlights

- Net patient revenue for February 2026 was **\$1.58M**, which is approximately an increase of **\$4K** from the prior month.
- Operating expenses, exclusive of interest & depreciation, were **\$1.41M**.
- 340B revenue was **\$10K** in February, this is a decrease of **\$11K** from the prior month.

- Clinic (RHC) Income Statement Highlights - actual & projected (includes swing bed rounding):

- Current month's average visits per day = **13.0**
- YTD Operating revenues = **\$129K**
- YTD Operating expenses = **\$155K**
- YTD Operating loss = **-\$26K**

MANGUM REGIONAL MEDICAL CENTER**Admissions, Discharges & Days of Care****Fiscal Year 2026****12/31/2026**

	January	February	YTD
Admissions			
Inpatient	14	12	26
Swingbed	17	9	26
Observation	4		4
	<u>35</u>	<u>21</u>	<u>56</u>
Discharges			
Inpatient	13	11	24
Swingbed	18	9	27
Observation	4		4
	<u>35</u>	<u>20</u>	<u>55</u>
Days of Care			
Inpatient-Medicare	17	24	41
Inpatient-Medicare Managed Care	13	6	19
Inpatient-Other	5	7	12
Swingbed-Medicare	196	188	384
Swingbed-Medicare Managed Care	95	39	134
Swingbed-Other	0	0	0
Observation	6	2	8
	<u>332</u>	<u>266</u>	<u>598</u>
Calendar days	31	28	59
ADC - (incl OBS)	10.71	9.50	10.14
ADC	10.52	9.43	10.00
ER	132	121	253
Outpatient	130	144	274
RHC	291	253	544

MANGUM REGIONAL MEDICAL CENTER
Comparative Balance Sheet - Unaudited
Fiscal Year 2025

Item 8.

	January	February	12/31/25
Cash And Cash Equivalents	1,019,825	1,242,632	1,161,872
Patient Accounts Receivable, Net	1,551,232	1,518,902	1,192,826
Due From Medicare	123,029	187,043	92,538
Inventory	233,694	236,070	230,865
Prepays And Other Assets	1,554,966	1,535,715	1,570,019
Capital Assets, Net	1,449,909	1,421,726	1,454,496
Total Assets	5,932,655	6,142,086	5,702,615
Accounts Payable	15,461,240	15,550,680	15,351,958
AHSO Related AP	892,724	892,724	892,724
Deferred Revenue	141,879	108,872	0
Due To Medicare	(319)	(319)	(319)
Covid Grant Funds	-	-	0
Due To Cohesive - PPP Loans	-	-	0
Notes Payable - Cohesive	4,497,430	4,466,413	4,528,447
Notes Payable - Other	17,948	17,948	17,948
Alliantz Line Of Credit	-	-	0
Leases Payable	250,514	249,937	251,087
Total Liabilities	21,261,416	21,286,254	21,041,844
Net Assets	(15,328,762)	(15,144,168)	(15,339,229)
Total Liabilities and Net Assets	5,932,655	6,142,086	5,702,615

**Mangum Regional Medical Center
Cash Receipts & Disbursements by Month**

2024			2025			2026		
Month	Receipts	Disbursements	Month	Receipts	Disbursements	Month	Receipts	Disbursements
Jan-24	1,187,504	1,150,522	Jan-25	1,105,099	996,372	Jan-26	1,348,412	1,491,009
Feb-24	708,816	995,157	Feb-25	1,184,447	1,231,249	Feb-26	1,530,505	1,308,184
Mar-24	1,236,158	1,073,824	Mar-25	1,289,275	1,250,266	Mar-26		
Apr-24	1,645,373	1,483,022	Apr-25	1,225,184	1,060,130	Apr-26		
May-24	1,273,007	1,062,762	May-25	1,481,774	1,044,123	May-26		
Jun-24	950,928	1,216,556	Jun-25	1,530,626	1,607,511	Jun-26		
Jul-24	1,344,607	1,562,407	Jul-25	2,452,132	1,209,562	Jul-26		
Aug-24	2,089,281	2,176,381	Aug-25	1,271,486	2,373,927	Aug-26		
Sep-24	1,183,508	1,322,228	Sep-25	1,837,975	2,032,771	Sep-26		
Oct-24	1,779,690	1,154,658	Oct-25	2,266,799	1,772,799	Oct-26		
Nov-24	770,820	1,370,620	Nov-25	2,045,662	1,298,783	Nov-26		
Dec-24	888,776	1,027,058	Dec-25	1,407,450	2,482,755	Dec-26		
	<u>15,058,468</u>			<u>19,097,911</u>			<u>2,878,917</u>	
Subtotal FY 2024	<u><u>15,058,468</u></u>		Subtotal FY 2025	<u><u>19,097,911</u></u>		Subtotal FY 2026	<u><u>2,878,917</u></u>	

**Mangum Regional Medical Center
Medicare Payables by Year**

	Original Balance	Balance as of 02/28/26	Total Interest Paid as of 02/28/26
2016 C/R Settlement	1,397,906.00	-	205,415.96
2017 Interim Rate Review - 1st	723,483.00	-	149,425.59
2017 Interim Rate Review - 2nd	122,295.00	-	20,332.88
2017 6/30/17-C/R Settlement	1,614,760.00	-	7,053.79
2017 12/31/17-C/R Settlement	(535,974.00)	(318.61)	269,191.14
2017 C/R Settlement Overpayment	3,539,982.21	-	-
2018 C/R Settlement	1,870,870.00	-	241,040.31
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	-	1,802,867.00	-
2019 C/R Settlement	(967,967.00)	-	-
2020 C/R Settlement	(3,145,438.00)	-	-
FY21 MCR pay (rec) estimate	(1,631,036.00)	-	-
FY22 MCR pay (rec) estimate	(318,445.36)	-	-
2016 C/R Audit - Bad Debt Adj	348,895.00	-	16,927.31
2018 MCR pay (rec) Audit est.	-	(34,322.00)	-
2019 MCR pay (rec) Audit est.	(40,612.00)	-	-
2020 MCR pay (rec) Audit	(74,956.00)	-	-
FY23 (8-month IRR)	-	95,225.46	-
FY23 (8-month IRR) L4315599	1,918,398.00	-	155,799.09
FY23 MCR pay (rec) remaining estimate	-	-	-
FY24 MCR pay (rec) estimate	-	(176,300.00)	-
FY25 MCR pay (rec) estimate	-	83,762.00	-
FY26 MCR pay (rec) estimate	-	(94,505.00)	-
Total	7,009,696.31	(187,361.61)	1,355,350.56

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended February 28, 2026
Unaudited

Item 8.

MTD					YTD			
Actual	Budget	Variance	% Change		Actual	Budget	Variance	% Change
235,271	279,432	(44,161)	-16%	Inpatient revenue	468,579	591,356	(122,777)	-21%
1,132,789	1,038,768	94,021	9%	Swing Bed revenue	2,373,215	2,189,472	183,743	8%
606,237	639,779	(33,542)	-5%	Outpatient revenue	1,236,355	1,347,580	(111,225)	-8%
125,414	159,683	(34,269)	-21%	Professional revenue	271,006	337,467	(66,461)	-20%
2,099,711	2,117,662	(17,951)	-1%	Total patient revenue	4,349,156	4,465,876	(116,720)	-3%
658,651	578,200	80,450	14%	Contractual adjustments	1,486,260	1,294,601	191,659	15%
(64,014)	-	(64,014)	#DIV/0!	Contractual adjustments: MCR Settlement	(94,505)	-	(94,505)	#DIV/0!
(108,872)	(93,473)	(15,399)	16%	SHOPP revenue	(217,743)	(186,945)	(30,798)	16%
37,583	54,611	(17,028)	-31%	Bad debts	26,515	109,222	(82,707)	-76%
523,349	726,284	(15,990)	-2%	Total deductions from revenue	1,200,527	1,590,768	(16,351)	-1%
1,576,362	1,391,378	184,985	13%	Net patient revenue	3,148,629	2,875,108	273,521	10%
3,245	5,441	(2,196)	-40%	Other operating revenue	7,117	10,893	(3,776)	-35%
10,205	19,957	(9,752)	-49%	340B REVENUES	31,814	41,022	(9,208)	-22%
1,589,812	1,416,776	173,037	12%	Total operating revenue	3,187,560	2,927,024	260,537	9%
				Expenses				
400,592	411,240	(10,649)	-3%	Salaries and benefits	859,697	863,487	(3,790)	0%
83,267	82,303	963	1%	Professional Fees	155,012	167,228	(12,216)	-7%
404,584	402,544	2,041	1%	Contract labor	929,097	847,532	81,564	10%
118,752	124,375	(5,623)	-5%	Purchased/Contract services	226,289	248,798	(22,508)	-9%
225,000	225,000	-	0%	Management expense	450,000	450,000	-	0%
66,482	74,759	(8,277)	-11%	Supplies expense	150,453	157,623	(7,170)	-5%
18,104	16,403	1,701	10%	Rental expense	37,454	32,806	4,648	14%
11,001	13,139	(2,138)	-16%	Utilities	25,052	26,278	(1,226)	-5%
891	1,286	(395)	-31%	Travel & Meals	1,218	2,590	(1,372)	-53%
9,273	13,460	(4,187)	-31%	Repairs and Maintenance	17,401	26,921	(9,520)	-35%
19,509	13,720	5,789	42%	Insurance expense	36,173	27,441	8,733	32%
10,320	13,263	(2,943)	-22%	Other Expense	24,183	26,529	(2,346)	-9%
9,193	15,107	(5,914)	-39%	340B EXPENSES	22,852	30,498	(7,646)	-25%
1,376,967	1,406,599	(29,632)	-2%	Total expense	2,934,881	2,907,730	27,152	1%
212,846	10,177	202,669	1991%	EBIDA	252,679	19,294	233,385	1210%
13.4%	0.7%	12.67%		EBIDA as percent of net revenue	7.9%	0.7%	7.27%	
69	100	(31)	-31%	Interest	188	100	88	87%
28,183	28,257	(74)	0%	Depreciation	57,430	28,257	29,173	103%
184,594	(18,181)	202,774	-1115%	Operating margin	195,061	(9,063)	204,124	-2252%
-	-	-		Other	-	-	-	
-	-	-		Total other nonoperating income	-	-	-	
184,594	(18,181)	202,774	-1115%	Excess (Deficiency) of Revenue Over Expenses	195,061	(9,063)	204,124	-2252%
11.61%	-1.28%	12.89%		Operating Margin %	6.12%	-0.31%	6.43%	

MANGUM REGIONAL MEDICAL CENTER

Statement of Revenue and Expense Trend - Unaudited

Fiscal Year 2026

Item 8.

	January	February	YTD
Inpatient revenue	233,308	235,271	468,579
Swing Bed revenue	1,240,427	1,132,789	2,373,215
Outpatient revenue	630,118	606,237	1,236,355
Professional revenue	145,592	125,414	271,006
Total patient revenue	2,249,445	2,099,711	4,349,156
Contractual adjustments	827,609	658,651	1,486,260
Contractual adjustments: MCR Settlement	(30,491)	(64,014)	(94,505)
SHOPP Revenue	(108,872)	(108,872)	(217,743)
Bad debts	(11,068)	37,583	26,515
Total deductions from revenue	677,178	523,349	1,200,527
Net patient revenue	1,572,267	1,576,362	3,148,629
Other operating revenue	3,872	3,245	7,117
340B REVENUES	21,609	10,205	31,814
Total operating revenue	1,597,748	1,589,812	3,187,560
	99.1%	112.2%	105.2%
Expenses			
Salaries and benefits	459,105	400,592	859,697
Professional Fees	71,745	83,267	155,012
Contract labor	524,512	404,584	929,097
Purchased/Contract services	107,537	118,752	226,289
Management expense	225,000	225,000	450,000
Supplies expense	83,971	66,482	150,453
Rental expense	19,350	18,104	37,454
Utilities	14,051	11,001	25,052
Travel & Meals	328	891	1,218
Repairs and Maintenance	8,128	9,273	17,401
Insurance expense	16,664	19,509	36,173
Other	13,863	10,320	24,183
340B EXPENSES	13,660	9,193	22,852
Total expense	1,557,914	1,376,967	2,934,881
EBIDA	\$ 39,834	\$ 212,846	\$ 252,679
EBIDA as percent of net revenue	2.5%	13.4%	7.9%
Interest	119	69	188
Depreciation	29,247	28,183	57,430
Operating margin	\$ 10,467	\$ 184,594	\$ 195,061
Other	-	-	-
Total other nonoperating income	\$ -	\$ -	\$ -
Excess (Deficiency) of Revenue Over Expenses	10,467	184,594	195,061

Mangum Family Clinic
For the Month Ended and Year To Date February 28, 2026

	Current			Last FYE	Net Change
	Month	Year-To-Date	12-Month Projected		
Gross Patient Revenue	38,675	69,042	414,254	342,640	71,615
Less: Revenue deductions	22,651	59,829	358,971	254,389	104,583
Net Patient Revenue	61,326	128,871	773,226	597,028	176,197
Other Income (if any)	-	-	-	-	-
Operating revenue	61,326	128,871	773,226	597,028	176,197
Operating Expenses:					
Leased Salaries	14,312	36,547	219,284	238,089	(18,805)
Contract labor	4,447	4,503	27,017	1,969	25,048
Benefits	3,885	8,611	51,667	44,085	7,581
Provider Fees	8,472	14,953	89,719	88,636	1,083
Purchased/Contract services	7,551	13,318	79,909	67,107	12,802
Management expense	11,250	22,500	135,000	135,000	-
Supplies expense	-	157	944	7,708	(6,764)
Rental expense	1,801	3,551	21,305	21,444	(139)
Utilities	448	830	4,980	7,335	(2,355)
Repairs and Maintenance	-	333	1,998	868	1,131
Insurance expense	248	495	2,971	2,845	126
Other expense	404	882	5,289	4,591	698
CAH Overhead Allocation	24,154	48,308	289,848	289,847	1
Total Operating Expenses	76,972	154,988	929,931	910,335	19,595
Net Income (loss)	(15,646)	(26,118)	(156,705)	(313,307)	156,602
340B					
Gross revenues	10,205.02	31,814	190,885	191,188	(302)
Operating expenses	9,192.71	22,852	137,114	149,534	(12,420)
Profit (loss)	1,012	8,962	53,772	41,654	12,118
Net Income (loss) with 340B	(14,633)	(17,156)	(102,933)	(271,653)	168,720
Stats					
Onsite Visits	169	335	2,010	2,268	(258)
Swing Bed Visits	84	209	1,254	379	875
Telehealth, CCM, Nurse Visits	0	0	-	-	-
Total Visits	253	544	3264	2647	617
Payor Mix based on Total Visits					
Medicare		37%	37%	34%	4%
Managed Medicare		15%	15%	6%	9%
Medicaid / Managed Medicaid		20%	20%	23%	-3%
Commercial/Other		27%	27%	37%	-9%
Total		100%	100%	100%	0%
Clinic Days	19	41	246	246	-
Average Visit Per Day	13	13	13	11	3
Cost Per Visit	\$ 304.24	\$ 284.91	\$ 284.91	\$ 343.91	\$ (59.01)
Medicare Visit Cap		\$ 292.54	\$ 292.54	\$ 282.65	
Over (Under) Cap		\$ (7.63)	\$ (7.63)	\$ 61.26	

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	2/28/2026	1/31/2026	12/31/2025	11/30/2025	10/31/2025
AMERISOURCE RECEIVABLES (ARFC)	Pharmacy Supplies	10,759.15	-	-	-	10,759.15	7,543.78	4,641.12	2,445.89	14,501.84
AT&T	Fax Service	(794.71)	-	-	-	(794.71)	-	2,284.32	3,153.09	3,275.87
BADGE BUDDIES LLC	Office Supplies	-	-	-	-	-	-	-	-	127.97
BIO-RAD LABORATORIES INC	Lab Supplies	2,638.52	-	-	-	2,638.52	-	-	1,429.68	-
BRIAN SHIDELER	Repairs/maintenance	-	-	-	-	-	4,558.55	-	-	-
CARDINAL HEALTH 110, LLC	Patient Supplies	-	-	-	(144.30)	(144.30)	(144.30)	(144.30)	(144.30)	(144.30)
CAREFUSION	Rental Equipment	-	-	-	-	-	4,449.00	-	4,449.00	4,449.00
careLearning	Training	-	-	-	-	-	3,442.50	-	-	-
CARLOS MENDOZA	Education/Training	-	-	-	-	-	750.00	-	-	-
CITY OF MANGUM	Utilities	-	-	-	-	-	5,606.15	-	-	6,400.66
CLEAN THE UNIFORM HOLDING COMP	Linen Services	4,132.87	-	-	-	4,132.87	4,217.87	1,201.29	2,800.58	4,229.87
CLIA LABORATORY PROGRAM	Lab Services	3,840.00	-	-	-	3,840.00	-	-	-	-
CLIFFORD POWER SYSTEMS INC	Repair and Maintenance	-	-	-	-	-	-	3,465.00	-	-
COHESIVE HEALTHCARE MGMT	Mgmt Fees	229,766.66	230,554.16	231,476.66	2,491,640.33	3,183,437.81	2,984,517.31	2,990,836.47	3,213,012.76	3,198,246.10
COHESIVE MEDIRYDE LLC	Patient Transportation Service	-	-	-	-	-	-	-	-	2,950.00
COHESIVE STAFFING SOLUTIONS	Agency Staffing Service	524,672.57	1,102,083.94	593,768.42	8,911,239.81	11,131,764.74	11,117,477.91	11,093,993.51	11,812,352.51	11,816,997.33
COMMERCIAL MEDICAL ELECTRONICS	Quarterly Maintenance	-	-	-	-	-	-	1,750.00	-	-
CONVATEC, INC	Patient Supplies	4,921.00	-	-	-	4,921.00	3,426.00	-	-	-
COONTZ ROOFING, INC.	Repair and Maintenance	-	-	-	-	-	-	8,500.00	-	-
CRITICAL ALERT	Software license	-	-	-	-	-	-	-	-	2,060.72
DAN'S HEATING & AIR CONDITIONI	Repairs/maintenance	-	-	-	-	-	-	-	1,434.09	-
DIAGNOSTIC IMAGING ASSOCIATES	Radiology Purch Svs	2,150.00	-	-	-	2,150.00	2,150.00	2,150.00	2,150.00	2,150.00
DIRECTV	Cable service	-	-	-	-	-	-	297.60	297.60	297.60
DOYLE HOPPER	Repair and Maintenance	125.00	-	-	-	125.00	-	-	-	-
DP MEDICAL SERVICES	Rental	-	-	-	-	-	1,750.00	-	-	-
DTG MEDICAL ELECTRONICS	Patient Supplies	-	-	-	-	-	-	822.89	964.89	-
DYNAMIC ACCESS	Vascular Consultant	3,607.08	-	-	-	3,607.08	1,591.36	795.67	-	-
EARTHSAFE CHEMICAL ALTERNATIVE	Patient Supplies	-	-	-	-	-	838.36	-	-	-
eCLINICAL WORKS, LLC	RHC EHR	-	-	-	-	-	-	3,427.66	3,170.94	-
FEDEX	Shipping	17.39	-	-	-	17.39	17.92	-	32.17	78.82
FIRST DIGITAL COMMUNICATIONS	IT Support Services	-	-	-	-	-	-	-	-	(22.32)
FOX BUILDING SUPPLY	Repairs/maintenance	-	-	-	-	-	837.83	-	-	111.92
FUCHA RADIO, LLC	Advertising	110.00	-	-	-	110.00	110.00	110.00	-	-
GEORGE BROS TERMITE & PEST CON	Pest Control Service	200.00	-	-	-	200.00	-	-	-	200.00
GE PRECISION HEALTHCARE LLC	Patient Supplies	-	606.40	-	-	606.40	-	-	-	-
GRAINGER	Maintenance Supplies	700.91	-	-	-	700.91	193.41	661.56	-	508.49
GREER COUNTY TREASURER	Insurance	-	-	-	4,680.00	4,680.00	4,680.00	9,360.00	-	-
HAC INC	Dietary Supplies	50.74	-	-	-	50.74	82.81	62.46	25.70	101.90
HENRY SCHEIN	Lab Supplies	-	-	-	-	-	-	-	1,307.35	-
HEWLETT-PACKARD FINANCIAL SERV	Computer Services	307.10	-	-	-	307.10	307.10	-	307.10	307.10
HSI	Materials Purch svs	-	-	-	-	-	-	-	-	3,150.00
IN BLOOM FLOWERS AND GIFTS, LL	Supplies	-	-	-	-	-	-	65.00	-	-
INTEGO SOFTWARE, LLC	Software license	-	-	-	-	-	-	153.49	3,906.00	-
KELLEY MARTINEZ	Expense Reimbursement	-	-	-	-	-	-	-	-	613.16
LANDAUER	Radiology Purch Svs	-	-	-	-	-	-	1,847.40	-	-
LG PRINT CO	Advertising	-	-	-	-	-	-	165.00	-	-
LOCKE SUPPLY	Plant Ops supplies	-	-	-	-	-	223.23	-	-	1,737.20
LOWES	Patient Supplies	-	-	-	-	-	-	737.95	677.02	-
MCKESSON - 340 B	Pharmacy Supplies	-	-	-	-	-	-	937.45	937.45	937.45
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	-	-	-	-	-	4,962.07	1,976.82	102.14	1,938.40
MEDLINE INDUSTRIES	Patient Care/Lab Supplies	17,312.04	856.95	-	-	18,168.99	31,582.03	27,675.83	13,782.29	23,914.09
MYHEALTH ACCESS NETWORK, INC	Compliance purch svs	758.95	-	-	-	758.95	758.95	758.95	758.95	758.95
NUANCE COMMUNICATIONS INC	RHC purch svs	123.00	123.00	-	-	246.00	123.00	-	123.00	123.00
OFMQ	Quality purch svs	360.00	-	-	-	360.00	360.00	360.00	-	-
OK STATE DEPT OF HEALTH	License	180.00	-	-	-	180.00	-	-	-	-
OKLAHOMA BLOOD INSTITUTE	Blood Bank	-	-	-	-	-	-	(332.90)	-	-
OKLAHOMA HOSPITAL ASSOCIATION	License	-	-	-	-	-	2,199.00	16,103.00	-	-
PHARMACY CONSULTANTS, INC.	PHARMACY CONSULTANTS, INC.	2,770.00	-	-	-	2,770.00	3,426.84	2,950.00	2,700.00	3,987.93
PHILADELPHIA INSURANCE COMPANY	OHA Insurance	3,215.58	-	-	-	3,215.58	-	3,215.58	3,215.58	3,215.58
PM BIOMEDICAL INC.	Repair and Maintenance	595.00	-	-	-	595.00	-	395.00	-	-
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance	35.00	-	-	-	35.00	-	35.00	1,118.80	-

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	2/28/2026	1/31/2026	12/31/2025	11/30/2025	10/31/2025
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract	-	-	-	-	-	1,067.39	-	28.58	-
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	1,735.00	-	-	-	1,735.00	1,735.00	-	1,735.00	1,735.00
SPACELABS HEALTHCARE LLC	Telemetry Supplies	-	-	-	-	-	-	-	635.00	-
SPARKLIGHT BUSINESS	Cable service	149.43	-	-	-	149.43	141.43	-	-	-
STANDLEY SYSTEMS LLC	Printer lease	2,509.69	-	-	-	2,509.69	4,855.19	-	-	2,509.69
STAPLES ADVANTAGE	Office Supplies	-	-	-	-	-	-	-	2,234.22	949.59
STAPLES, INC.	Office Supplies	72.59	-	-	-	72.59	703.74	627.41	-	-
STERICYCLE / SHRED-IT	Waste Disposal Service	766.00	-	-	-	766.00	1,350.49	-	158.79	1,607.39
SUMMIT UTILITIES	Utilities	3,524.47	-	-	-	3,524.47	3,236.07	2,664.57	175.26	138.65
SYSMEX AMERICA INC	Repair and Maintenance	-	-	-	-	-	-	-	9,282.90	-
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	2,133.23	-	-	-	2,133.23	-	-	2,902.03	-
TELEFLEX	Patient Supplies	-	-	-	-	-	-	-	-	900.00
TOPIJET SALES, INC	Software license	225.50	-	-	-	225.50	-	-	-	-
TRIOSE INC	Freight	-	-	-	-	-	-	182.24	388.61	531.99
TRUBRIDGE	Software license	-	-	-	-	-	-	-	459.70	-
T & S LAWN SERVICES	Repairs/maintenance	1,200.00	-	-	-	1,200.00	-	-	-	-
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	4,246.29	-	-	-	4,246.29	459.73	3,150.57	3,781.29	632.93
Grand Total		829,116.05	1,334,224.45	825,245.08	11,407,415.84	14,396,001.42	14,205,587.72	14,187,883.61	15,098,291.66	15,106,209.57
					Conversion Variance	13,340.32	13,340.32	13,340.32	13,340.32	13,340.32
					AP Control	14,744,742.67	14,551,232.53	14,533,513.95	15,443,922.00	15,451,839.91
					Accrued AP	1,698,661.12	1,802,731.61	1,711,167.31	1,749,463.93	1,656,409.73
					AHSO Related AP	(892,723.76)	(892,723.76)	(892,723.76)	(892,723.76)	(892,723.76)
					TOTAL AP	15,550,680.03	15,461,240.38	15,351,957.50	16,300,662.17	16,215,525.88
						15,550,680.03	15,461,240.38	15,351,957.50	16,300,662.17	16,215,525.88
						-	-	-	-	-

Hospital Vendor Contract Summary Sheet

1. Existing Vendor New Vendor
2. **Name of Contract:** Blue Cross Blue Shield
3. **Contract Parties:** MRMC/Blue Cross Blue Shield
4. **Contract Type Services:** Insurance
5. **Impacted Hospital Departments:** Hospital Patient Care
6. **Contract Summary:** Provides an agreement with BCBS for the to be able to provide services to Blue Cross Blue Shield members.
7. **Cost:** No Cost
8. **Prior Cost:** None
9. **Term:** 3 years- then renews automatically for 1-year intervals
10. **Termination Clause:** 180 day written notice prior to expiration of initial term or any renewal term
11. **Other:**



**HEALTH CARE SERVICE CORPORATION
AGREEMENT FOR ACUTE CARE HOSPITALS (CRITICAL ACCESS)**

This Agreement for Acute Care Hospitals (“Agreement”) is by and between Blue Cross and Blue Shield of Oklahoma (“BCBS”), a Division of Health Care Service Corporation (“HCSC”), a Mutual Legal Reserve Company and an Independent Licensee of the Blue Cross and Blue Shield Association, and the undersigned acute care hospital, licensed and in good standing under Oklahoma Law to provide Health Care Services (“Facility”), (collectively, “Parties”).

Incorporation. The following Attachments are incorporated herein by reference as of the Effective Date:

Attachment A: Provider Networks

- A-1: Blue TraditionalSM
- A-2: Blue Choice PPOSM
- A-3: Blue Preferred PPOSM
- A-4: Blue Advantage PPOSM
- A-5: BlueLincs HMOSM
- A-6: BlueLincs HMOSM
- A-7: NativeBlueSM
- A-8: Blue Plan65 Select

Attachment B: Requirements for Acute Care Hospitals

Attachment C: Reimbursement for Acute Care Hospitals

- C-1: MS-DRG Weights, Day Thresholds & Per Diems Weight Version 38
- C-2: Weight Table Version 3.12 (CAH)
- C-3: Discount Percentage Matrix Version 3.12
- C-4: Consolidation Logic Version 3.12
- C-5: Ancillary Packaging List Version 3.12
- C-6: CPT-4/HCPSC Mapping Version 3.12
- C-7: ICD-10 CM Diagnosis Mapping Version 3.12
- C-8: Revenue Codes Requiring CPT-4/HCPSC Codes Effective 01/01/17
- C-9: Recurring Services Version 3.12

Attachment D: Locations and Ancillary Entities

- D-1: Ambulance
- D-2: Dialysis
- D-3: DME/O&P
- D-4: Home Health
- D-5: Hospice
- D-6: Infusion
- D-7: Laboratory
- D-8: Skilled Nursing
- D-9: Swing Bed

Attachment E: Hospital Performance Program

Written Notice given pursuant to the terms and provisions of this Agreement must be sent as follows:

BCBS.

Vice President, Provider Network Operations
Blue Cross and Blue Shield of Oklahoma
1400 South Boston Avenue, Tulsa, OK 74119

Facility.

Name/Title: Mangum Regional Medical Center, Attn: Administrator
Address: PO Box 280, Mangum, OK 73554
Email: kmartinez@chmcok.com

In Witness Whereof, the undersigned Parties hereby agree to the terms and conditions contained in this Agreement, to be effective April 1, 2026. The authorized BCBS signature below binds GHS Health Maintenance Organization, Inc., d/b/a BlueLincs HMO (“BlueLincs HMO”), a Subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association to this Agreement for purposes of the BlueLincs HMO Attachment.

BLUE CROSS AND BLUE SHIELD OF
OKLAHOMA, A DIVISION OF HEALTH CARE
SERVICE CORPORATION, A MUTUAL LEGAL
RESERVE COMPANY

MANGUM CITY HOSPITAL AUTHORITY D/B/A
MANGUM REGIONAL MEDICAL CENTER

Authorized Signature

Rick Kelly

Name of Signatory

Vice President, Provider Network Operations

Title of Signatory

Date Signed

Authorized Signature

Name of Signatory

Title of Signatory

Date Signed

RECITALS

WHEREAS, Facility provides Health Care Services; and

WHEREAS, BCBS arranges for access to Covered Services for Covered Persons pursuant to the terms of Coverage Agreements; and

WHEREAS, this Agreement is intended to memorialize the arrangement whereby Facility will provide Covered Services to Covered Persons as a Participating Provider.

NOW THEREFORE, in consideration of the mutual covenants and agreements herein contained, the receipt and sufficiency of which the Parties hereby attest, and for their mutual reliance, the Parties mutually agree as set forth in this Agreement.

ARTICLE I DEFINITIONS

- 1.0 **Affiliate** means any corporation, firm, limited liability company, partnership or other legal entity that directly or indirectly controls, or is controlled by, or is under common control with, a Party, which may include subsidiaries, parent entities and sister companies. As used in this definition, “control” means (i) ownership of fifty percent (50%) or more of the shares of stock entitled to vote for the election of directors, in the case of a corporation; or (ii) any ownership of fifty percent (50%) or more of the equity interests in the case of any other type of legal entity; or (iii) status as a general partner in any partnership; or (iv) any other arrangement whereby a Party legally controls, or has the right to legally control, the governing body of a corporation or other legal entity.
- 1.1 **AMA** refers to the American Medical Association.
- 1.2 **Administrative Services Only (“ASO”) Group** means an employer, union trust fund, or other legal entity with which BCBS has contracted to provide such entity only with administrative services that are, in whole or in part, related to a benefit Plan that is not underwritten by BCBS, or associated with the employer or entity’s self-funded or otherwise funded (other than by BCBS), Product(s).
- 1.3 **Blue Cross and Blue Shield Association or BCBSA** means the association of independent Blue Cross and Blue Shield Plans.
- 1.4 **BlueCard® Program** means an agreement among participating BCBSA-related Plans pursuant to which Covered Persons participating in a Product of any one such Plan may access the Provider Network and financial terms of other such Plans for Covered Services, when such Covered Persons are away from their primary home Plan state.
- 1.5 **Change of Control** means (i) the merger, consolidation, acquisition, or other transaction or series of transactions of (a) Facility or (b) any direct or indirect parent Person of Facility (“Parent”), in each case with, by or into another Person; (ii) the sale of all or substantially all the assets or business of Facility; (iii) any change in the ownership of more than fifty percent (50%) of the voting equity interests of (a) Facility or (b) any Parent, in each case in one or more related transactions; (iv) if Facility and/or Parent is a not-for-profit entity, any change of the member or parent of (a) Facility or (b) any Parent; or (v) the change in composition of more than fifty percent (50%) of the board of directors or other governing body of (a) Facility or (b) any Parent, in each case in one or more related transactions.
- 1.6 **Claim** means an itemized statement of Facility’s charges for Health Care Services provided by Facility to a particular Covered Person.
- 1.7 **Clean Claim** means unless State law imposes a distinct requirement(s), an itemized statement of billed charges submitted to BCBS by Facility for Covered Services performed at a Facility location

included in this Agreement, which has no defect, impropriety or special circumstance, including incomplete documentation (including incomplete Medical Records (as defined in Section 2.5.0, *Medical Records*)), coding or marking, that delays adjudication by BCBS, and which consists of the UB04 or CMS 1500 data set, or its successor form, with entries stated as mandatory by the National Uniform Billing Committee or its successor, and with respect to electronic Claims, in the format and with the data content and data conditions consistent with HIPAA, as amended from time to time, or as required by other Law. A Claim that does not include all the required information, or for which BCBS will request additional information (for example, properly authenticated Medical Records (as defined in Section 2.5.0, *Medical Records*), other coverage information, or subrogation information) is not a Clean Claim until BCBS receives the required additional information.

- 1.8 **CMS** refers to the Centers for Medicare & Medicaid Services.
- 1.9 **Codes** means the types of codes typically and commonly used in Claims and Clean Claims, which codes change from time to time, including, but not limited to, Diagnosis Related Group (“DRG”), Current Procedural Terminology (“CPT”), revenue codes, and International Classification of Disease (“ICD”) codes which are published, authored, created or assigned by various third-parties, including, but not limited to, CMS, the AMA, or other agencies and their successors.
- 1.10 **Coordination of Benefits (“COB”)** means coordination of health care benefits in accordance with Section 2.9, *Coordination of Benefits (“COB”)*.
- 1.11 **Cost Share** means that portion of Facility’s payment for a Covered Service for which a Covered Person is responsible, including, but not limited to, co-payments, co-insurance, deductibles, reduction of benefits, and any other applicable financial responsibility of the Covered Person, pursuant to his or her Coverage Agreement.
- 1.12 **Coverage Agreement** means any policy, contract, Plan document, or certificate entered into or issued by a Plan, which entitles Covered Persons to receive benefits for Covered Services, and which identifies the Covered Services that the Plan, or the Plan’s or the ASO Group’s designee, has agreed to adjudicate, and, to the extent appropriate, pay for, on behalf of Covered Persons. A Coverage Agreement can be pursuant to an insurance arrangement, an administrative services arrangement, or an arrangement whereby a Plan contracts with BCBS to utilize Participating Providers. The Coverage Agreement explains the benefits, limitations, exclusions, terms, and conditions of a Covered Person’s health coverage.
- 1.13 **Covered Person** means any person entitled to receive Covered Services pursuant to: (i) the terms of a Coverage Agreement, and (ii) the Provider Networks covered under the terms of this Agreement, at the time Health Care Service(s) are furnished.
- 1.14 **Covered Services** means Health Care Services that are specified as benefits covered under a Coverage Agreement and are provided by Facility to Covered Persons pursuant to the terms of this Agreement.
- 1.15 **Credentialing and Recredentialing.** means a process to validate the credentials of and approve Facility and its employed or affiliated Health Care Providers, as applicable, for participation in a BCBS Provider Network.
- 1.16 **Debarment** means the prohibition of a Health Care Provider from receiving compensation for services provided under any federal health benefit plan or program, including, without limiting the foregoing, Medicare, Medicaid, and the FEP, as reported by the federal OPM, OIG, CMS, OFAC, or any other applicable governmental agency.
- 1.17 **Designees** means a Party’s vendors and independent contractors that assist a Party in the performance of its obligations under this Agreement but excluding a Party’s employees.

- 1.18 **Emergency Medical Condition** means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
- 1.19 **Erroneous Payments** means any overpayment, underpayment, or any other improper payment of a Claim, but does not include any upward and downward adjustments made as part of a retrospective reconciliation performed by BCBS.
- 1.20 **Experimental, Investigational or Unproven** means a drug, device, biological product, or medical treatment or procedure is Experimental, Investigational, or Unproven if BCBS determines that:
- 1.20.0 The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or
 - 1.20.1 The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
 - 1.20.2 The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- 1.21 **FEP** refers to the Federal Employees Health Benefits Plan.
- 1.22 **Financial Records** has the meaning set forth in Section 2.5.1, *Financial Records*.
- 1.23 **Health Care Provider** means any provider, appropriately licensed, certified or otherwise authorized to render Health Care Services under Oklahoma law.
- 1.24 **Health Care Service(s)** means health care related services, items, treatments, testing, drugs, supplies, procedures, investigation or observation for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- 1.25 **HHS** refers to the United States Department of Health and Human Services.
- 1.26 **HIPAA** means the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and their implementing regulations, as amended from time to time.
- 1.27 **HMO** means an entity licensed as a Health Maintenance Organization under State Law.
- 1.28 **In-Network Services** means Covered Services provided to Covered Persons in accordance with the Coverage Agreements' requirements for in-network benefits as set forth in the applicable Coverage Agreement.
- 1.29 **Law(s)** means all applicable State and federal laws, rules, regulations, guidance, licensing requirements, common and case law, local ordinances and any other applicable authority of a tribunal or governmental entity (including, but not limited to, State Departments of Insurance), and including, but not limited to, court orders.

- 1.30 **Maximum Reimbursement Allowance** means the amount established by BCBS as the maximum allowed amount for Covered Services rendered to the Covered Person as set forth on Attachment C.
- 1.31 **Medical Director** means a physician designated by BCBS, or such physician's designee who, where required by Law, will also be a physician.
- 1.32 **Medically Necessary** or **Medical Necessity** means Health Care Services that a Health Care Provider, exercising prudent clinical judgment, would provide to a Covered Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- 1.32.0 in accordance with generally accepted standards of medical practice;
 - 1.32.1 clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Person's illness, injury or disease; and
 - 1.32.2 not primarily for the convenience of the Covered Person, physician, or other Health Care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
- 1.33 **Non-Covered Services** means those Health Care Services that are not Covered Services.
- 1.34 **Notice** means a notification required by this Agreement or Law, that is not a required Written Notice, but is a notification to one Party by the other Party: (i) via U.S. mail, which will be deemed received on the third business day after it is postmarked; or (ii) via email, which will be deemed received on the date it is sent; or (iii) from BCBS to Facility only, via provider newsletter or website, which will be deemed received on the date that the newsletter is sent or website update is posted by BCBS.
- 1.35 **OFAC** refers to the Office of Foreign Assets Control.
- 1.36 **OIG** refers to the Office of the Inspector General.
- 1.37 **OPM** refers to the federal Office of Personnel Management.
- 1.38 **Participating Provider** means those Health Care Providers, appropriately licensed, certified, or otherwise authorized to render Health Care Services under Oklahoma law, that have an agreement with BCBS to provide In-Network Services to Covered Persons according to the terms of their Coverage Agreements, Plan direction and this Agreement.
- 1.39 **Penalty** means a fee or other monetary charge to Facility.
- 1.40 **Person** means any individual, corporation, limited liability company, limited or general partnership, joint venture, association, joint-stock company, trust, unincorporated organization, government or any agency or political subdivisions thereof.
- 1.41 **Plan** means BCBS, ASO Group, or any other HCSC Plan, Blue Cross and/or Blue Shield Plan licensed by BCBSA and a subsidiary of such Plan, or any other BCBS Affiliate, or employer, with respect to which BCBS has contracted to provide access to Participating Providers.

- 1.42 **Policies and Procedures** means the Provider Manual and any other policies, programs, rules, guidelines, protocols, and administrative procedures adopted by BCBS that relate to, without limitation, Credentialing and Recredentialing processes, medical policies, Utilization Management and care management processes, quality improvement, peer review, Covered Person grievance, concurrent review, or any other BCBS programs.
- 1.43 **PPO** means a Preferred Provider Organization.
- 1.44 **Prior Authorization** means BCBS's or its UM Agent's qualified prior approval of the Medical Necessity of certain Health Care Services provided to Covered Persons under the terms of their Coverage Agreement.
- 1.45 **Products** means those products, services, items, programs, arrangements, or Plans offered to Covered Persons pursuant to a Coverage Agreement.
- 1.46 **Provider Manual** means the BCBS document(s) located in a manual or on a BCBS website that describe(s) requirements applicable to Facility for the provision of Covered Services to Covered Persons.
- 1.47 **Provider Network** means a network of Participating Providers which has contracted with BCBS to provide Health Care Services to Covered Persons on certain terms and conditions related to the applicable network(s) and Products covered under this Agreement.
- 1.48 **Service Area** means the area served by BCBS with respect to the Product in which the Covered Person is enrolled.
- 1.49 **State** means the state of Oklahoma.
- 1.50 **UM Agent** means an entity that is a licensed Utilization Review agent under Law and is designated to perform Utilization Management in connection with the care of Covered Persons, which is usually indicated on the Covered Person's identification card. The administrator of the applicable Plan may designate Plan, BCBS or another licensed Utilization Review agent to act as UM Agent for purposes of this Agreement and may designate one or more UM Agents to perform various Utilization Management activities. To the extent that BCBS has been designated as the UM Agent, BCBS may delegate any of BCBS's obligations to perform Utilization Management to any other entity licensed or otherwise permitted, in accordance with Law, to perform Utilization Management.
- 1.51 **Utilization Management or Utilization Review** means the evaluation by BCBS, or its authorized agent, vendor or subcontractor, or an ASO Group, or its UM Agent, as applicable, of the Medical Necessity, appropriateness and efficiency of the use of Health Care Services, in accordance with the provisions of the applicable Covered Person's Coverage Agreement, this Agreement, and Policies and Procedures, including, but not limited to, for purposes of Prior Authorization for benefits, concurrent review, and retrospective review.
- 1.52 **Written Notice** means a type of written notification required by this Agreement (other than Notice) which is sent by either Party: (i) via U.S. mail, which will be deemed received on the third business day after it is postmarked, or (ii) via email, which will be deemed received on the date it was sent.

ARTICLE II OBLIGATIONS OF FACILITY

- 2.0 **Provision of Covered Services.** Facility will (i) provide, or arrange for the provision of, Covered Services to Covered Persons in the same manner and of the same quality that Facility customarily and usually provides to other patients in a similar situation and in accordance with generally accepted standards of medical practice and the scope of its license, certifications, registrations, or other appropriate legal authorization under Law, applicable Coverage Agreements, accreditation

organization(s), the terms and conditions of this Agreement, the Provider Manual, and Policies and Procedures, (ii) require all employed or affiliated Health Care Providers to comply with the terms and conditions of this Agreement and Policies and Procedures, (iii) participate in Utilization Review activities in accordance with Section 2.13, *Utilization Management and Quality Improvement*, and the Utilization Management Policies and Procedures, and (iv) provide Covered Services to Covered Persons only at Facility locations included under this Agreement, as further described on Attachment B.

2.0.0 Responsibility for Medical Treatment. Facility acknowledges and agrees that Facility, not BCBS, is solely responsible for arranging or providing Covered Services to Covered Persons under this Agreement. All decisions regarding the treatment and care of Covered Persons are the sole responsibility of Facility, and such decisions are neither directed nor controlled in any way by BCBS. Facility will continually monitor and evaluate the quality and appropriateness of patient care and/or services, including the performance of Facility employees and all other individuals and entities who furnish services under arrangements with Facility, including, but not limited to identifying and implementing:

2.0.0.0 Required quality improvement activities;

2.0.0.1 Methods to identify incidents or patterns;

2.0.0.2 Mechanisms for taking follow-up action; and

2.0.0.3 Methods for implementing the monitoring and evaluation activities, for reporting the results, and for monitoring corrective action.

2.0.1 Credentialing. Facility acknowledges and agrees that Facility will cooperate with and participate in BCBS's Credentialing and Recredentialing programs as described in the Policies and Procedures and will provide in a timely manner to BCBS all Credentialing and Recredentialing information requested by BCBS, including evidence of licensure and accreditation. Facility will obtain all necessary releases from employed or affiliated Health Care Providers, as applicable, to release Credentialing and Recredentialing files to BCBS, and BCBS is entitled to presume that such releases have been obtained by Facility. Acceptance of this Agreement by BCBS is conditioned upon approval by BCBS's Credentialing committee. Facility's failure to meet Credentialing and Recredentialing criteria is considered to be a breach of this Agreement and may result in immediate termination of this Agreement by BCBS.

2.0.2 Subcontractors and Designees.

2.0.2.0 Subcontract Agreements. Facility may not enter into a subcontract agreement with any third-party pursuant to which such third-party assumes responsibility for the delivery of any Covered Services that are the responsibility of Facility under this Agreement.

2.0.2.1 Designees. BCBS has the right to disapprove, at any time, any and all Designees. Upon request, Facility agrees to provide BCBS with a list of Designees, if any, as of the Effective Date and will provide BCBS at least thirty (30) calendar days' prior Notice of any Designees engaged after the Effective Date. In the event that BCBS disapproves of a particular Designee, BCBS will provide Notice to Facility of such disapproval, and Facility will remove such entity or individual as a Designee within ten (10) business days after Facility's receipt of Notice from BCBS that such Designee is to be removed. In the event that there is a reasonable possibility, pursuant to BCBS's sole determination, that a Designee is likely to cause imminent harm to any Covered Persons, Facility will immediately terminate or otherwise remove from service such Designee to the extent necessary to prevent such

imminent harm from occurring. Moreover, Facility will immediately terminate or otherwise remove from service any Designee that is terminated, suspended (other than a temporary short-term suspension for non-medical reasons), restricted, or otherwise loses medical staff membership privileges or affiliated or allied health professional staff membership or privileges at any hospital.

- 2.0.3 **Nondiscrimination.** In providing or arranging for Covered Services pursuant to this Agreement, Facility will not discriminate against any Covered Persons on the basis of membership in a Product, source of payment, sex, age, race, color, religion, health status, disability, gender, ethnicity, sexual orientation, or any other basis forbidden by Law. Facility will provide Covered Services to a Covered Person without regard to such Covered Person's enrollment in a particular Product, as a private purchaser or as a participant in any financed or otherwise insured program of Health Care Services, unless Facility should not render a Health Care Service because of its lack of training, experience, or skill or because of restrictions on Facility's licensure.
- 2.0.4 **Accessibility.** Facility will assure that its Covered Services are readily available, accessible and provided to Covered Persons in a prompt and efficient manner that is at all times in accordance with Facility's scope of practice, applicable community standards, and as set forth in the Provider Manual. Facility will provide such Covered Services in the same manner, in accordance with the same standards, and within the same time availability as such services are provided to other patients without regard to the degree or frequency of utilization of such Covered Services by Covered Persons or the Product in which such individual is enrolled.
- 2.0.5 **Culturally Competent.** Facility will ensure that it provides information regarding treatment options in a culturally competent manner, including, without limitation, the option of no treatment and ensure that each Covered Person with disabilities or who speaks or understands only languages other than English has an effective means of communication with Health Care Providers in making decisions regarding treatment options.
- 2.0.6 **Facilities, Equipment and Staff.** Facility will provide and maintain facilities and/or equipment that are of adequate capacity, clean, and safe, are readily accessible to Covered Persons and, where appropriate, properly licensed, certified, or registered. Facility will assure the appropriate supervision of, licensure of, certification of, and insurance coverage in accordance with Section 2.11, *Insurance*, for all Facility employees and Designees. If any Facility employee or Designee violates any of the provisions of Law or the Policies and Procedures or commits any act or engages in any conduct for which their license and/or certification may be revoked or suspended (whether or not such license and/or certification is revoked or suspended) or is otherwise disciplined by such licensing authority or any professional organization having authority over such Facility employee or Designee, BCBS may immediately require Facility to direct such Facility employee or Designee to cease providing Covered Services to Covered Persons under this Agreement and/or may immediately terminate this Agreement upon Written Notice of such termination.
- 2.0.7 **Covered Persons.** Facility agrees that BCBS has no obligation to guarantee that any minimum number of Covered Persons will be provided any Covered Services by Facility. Facility will accept all patients who are Covered Persons. In the event that Facility believes that a Covered Person poses a threat of imminent harm to other individuals, Facility shall contact the appropriate authorities (e.g. local police) and not BCBS to resolve the issue.
- 2.0.8 **Administrative Services.** Facility will perform or contract with permitted Designees for all administrative and support services necessary for Facility to perform its obligations under this Agreement.

- 2.0.9 **Eligibility Verification.** Facility is responsible for verifying in advance the identity, eligibility and coverage for each Covered Person for which Facility submits a Claim to BCBS for coverage of Health Care Services. BCBS may adjust amounts paid to Facility under this Agreement based on updated enrollment information received by BCBS after Health Care Services are provided by Facility. BCBS and ASO Groups have no obligation under this Agreement to pay for Health Care Services provided by Facility to individuals who were not Covered Persons at the time such Health Care Services were provided. Facility understands and agrees that Claims may be denied by BCBS, or, if BCBS pays for Health Care Services in error, BCBS may recoup such payment pursuant to its right to recovery under this Agreement.
- 2.1 **Payment.** For Covered Services provided to Covered Persons that are documented on a Clean Claim and otherwise meet the standards for payment under this Agreement, Facility will accept, through: (i) Cost Share and (ii) payment from BCBS, the amounts set forth in this Agreement as full reimbursement for arranging and providing Covered Services to Covered Persons, in accordance with the terms of this Agreement and its applicable Attachments, Policies and Procedures, and the Coverage Agreement. To qualify for payment of a Claim under this Agreement, Facility will submit such Claims in the format, time frame, and manner set forth in this Agreement and Policies and Procedures. Facility agrees BCBS may make adjustments to amounts previously paid to Facility in accordance with the terms of this Agreement. Facility agrees and understands that BCBS will not pay for Non-Covered Services. Facility agrees that only Clean Claims for Covered Services that are performed at a location included in this Agreement are eligible for reimbursement.
- 2.2 **Provider Networks.** Facility agrees to be a Participating Provider in the Provider Networks as set forth in this Agreement and such other Provider Networks added pursuant to the terms of this Agreement. Facility will not be a Participating Provider in any other Provider Network.
- 2.3 **BCBS Policies and Procedures.** Facility will comply with all Policies and Procedures which are hereby incorporated, and made a part of, this Agreement. Electronic access to the Policies and Procedures will be provided to Facility. The Policies and Procedures are subject to change at any time with Notice, including, but not limited to, all BCBS medical policies. In the event of a conflict between the terms of this Agreement and the terms of the Policies and Procedures, the terms of this Agreement will govern.
- 2.4 **Cooperation.** Facility will cooperate with BCBS in facilitating cost-effective, quality-driven Covered Services for Covered Persons, including, but not limited to, cooperation and participation in programs such as pre-service review. Facility will use commercially reasonable efforts to do business with BCBS electronically when such electronic business opportunity is made available by BCBS, or its Designee, including electronically checking eligibility status and Claims status, receiving Electronic Remittance Advices, Provider Remittance Advice or Provider Claims Summary documents (or their equivalent), and submitting requests for Claims adjustments for Covered Persons. Facility will use BCBS's website, as applicable, for additional functionalities after BCBS notifies Facility that such functionalities are available.
- 2.5 **Medical and Financial Records.**
- 2.5.0 **Medical Records.** Facility will establish and maintain an accurate medical record, which may include an electronic record, for each Covered Person with whom Facility has had an encounter that, at a minimum, will (i) include such information about the Covered Person and a description of all services rendered to the Covered Person as dictated by generally accepted practices and standards, (ii) be maintained for the period of time required by Laws, and (iii) be established and maintained in all instances as required by the Policies and Procedures ("Medical Records"). Facility and each Health Care Provider will ensure that a Covered Person's Medical Records are legible, complete, dated, timed, and authenticated.

- 2.5.1 **Financial Records.** Facility will maintain accurate financial books and records, including electronic records, concerning Covered Services provided to each Covered Person, including any charges to, and payments received from, the Covered Person by Facility (“Financial Records”). All Financial Records must be submitted in accordance with requirements as outlined in the Provider Manual.
- 2.6 **Use of Participating Providers.** Facility shall use best efforts to ensure that all Health Care Providers who provide Health Care Services to Covered Persons at a location covered under this Agreement are Participating Providers. Notwithstanding the foregoing, Facility shall notify a Covered Person in advance if a Health Care Provider is not a Participating Provider, and a Covered Person may elect in writing to utilize such a Health Care Provider at a Facility location.
- 2.7 **BCBS Insurance Cards.** Facility will use reasonable efforts to cross-reference the applicable Covered Person’s BCBS insurance card with his or her driver’s license, passport or State identification card, or other acceptable form of identification, and, if necessary, contact BCBS to confirm that the person presenting the BCBS insurance card is the Covered Person listed on the insurance card. Facility will verify the identity, eligibility and coverage of each Covered Person prior to furnishing Covered Services to such Covered Person and from time to time throughout the course of such Covered Person’s treatment. If Facility does not verify the identity, eligibility and coverage of the Covered Person, Facility agrees that the Claim may be denied by BCBS. If BCBS makes an Erroneous Payment under this Section, Facility agrees that BCBS is entitled to recovery of such Erroneous Payment.
- 2.8 **Collection of Cost Share.** Facility agrees to diligently pursue and collect from Covered Persons all applicable Cost Share amounts at the time and in the manner described in the applicable Coverage Agreement and in accordance with the Policies and Procedures. In no event will Facility offer, advertise or otherwise publicize any waiver or other reduction of any Cost Share amount.
- 2.9 **Coordination of Benefits (“COB”).** When the Covered Person has another source of healthcare benefits, the following Coordination of Benefits rules shall apply in a manner consistent with Section 2.0 on Attachment C, *Accept Reimbursement*:
- 2.9.0 **Primary Responsibility.** When BCBS is primary, BCBS shall pay benefits as if the other payer did not provide benefits.
- 2.9.1 **Non-Primary Responsibility.** When BCBS is secondary, unless otherwise provided by the Covered Person’s Coverage Agreement or state law, the following provisions shall apply:
- 2.9.1.0 BCBS’s benefits will be determined after those of the other payer and may be reduced because of the other payer’s benefits, including cost containment reductions;
- 2.9.1.1 reimbursement will not be made for any amount for which the Covered Person is contractually held harmless by either payer;
- 2.9.1.2 reimbursement will be determined using the lesser of BCBS’s Maximum Reimbursement Allowance had BCBS been primary, or the maximum reimbursement allowed by the other payer.
- 2.9.2 **Secondary to Medicare.** If Medicare is primary and BCBS is secondary, reimbursement will be based upon the Medicare allowable. If Medicare is primary and there is no allowed reimbursement, then reimbursement will be based on BCBS’s allowable.

2.10 Covered Person Hold Harmless.

2.10.0 **Covered Person Hold Harmless.** Facility agrees that, except for the amount of applicable Cost Share for Covered Services, in no event, including, but not limited to, nonpayment by BCBS of amounts due Facility under this Agreement, insolvency of BCBS, or any breach of this Agreement by BCBS, will Facility or its Designees have a right to seek any type of payment, compensation, or other remuneration from, bill, charge, collect a deposit from, or have any recourse against (i) a Covered Person, (ii) a person acting on the Covered Person's behalf (other than BCBS), or (iii) ASO Groups, for any and all Covered Services provided pursuant to this Agreement. In such cases, Facility may pursue remedies under this Agreement against BCBS but will still hold the Covered Person harmless. As stated above, Facility will accept as payment in full for Covered Services provided to Covered Persons pursuant to this Agreement, the amounts set forth in this Agreement. This Section supersedes any oral or written agreement now existing or hereafter entered into between (i) Facility or a Health Care Provider and a Covered Person, (ii) between Facility or a Health Care Provider and persons acting on the Covered Person's behalf (other than BCBS), or (iii) between Facility or a Health Care Provider and any other person or entity, including, but not limited to, an ASO Group. This obligation to refrain from billing Covered Persons applies even in those cases in which Facility believes that BCBS has made an incorrect determination. Covered Persons, the persons acting on the Covered Person's behalf (other than BCBS) and ASO Groups will be third-party beneficiaries of this clause.

2.10.1 **Charges for Non-Covered Services.** The provisions of this Section do not prohibit Facility from collecting charges from a Covered Person for Non-Covered Services, so long as Facility obtains written consent from such Covered Person or such Covered Person's legal representative or designee, in advance of providing the Health Care Services, on a Non-Covered Service waiver form containing an acknowledgement from the Covered Person that: (1) the Health Care Services are Non-Covered Services; (2) BCBS will not be responsible for payment of such Non-Covered Services; and (3) the Covered Person will be financially responsible to the Facility for such Non-Covered Services. Notwithstanding the foregoing, Health Care Services which are not separately reimbursable by BCBS due to bundling or other Claim edits may not be billed to or collected from Covered Persons, even if the Covered Person has agreed in writing to be responsible for paying any of the charges for such Health Care Services, as such Health Care Services are Covered Services, but are not separately payable by BCBS; and, Health Care Services which require Prior Authorization, but for which Prior Authorization was not obtained, as further described in Section 2.13.2, *Prior Authorization*, may not be billed to or collected from Covered Persons, even if the Covered Person has agreed in writing to be responsible for payment any of the charges for such Health Care Services. Such Health Care Services are Covered Services but are not separately payable by BCBS.

2.10.2 **Amounts in Excess of Cost-Sharing.** Facility may not charge Covered Persons any amounts in excess of the applicable Cost Sharing for Covered Services, including any access fees for "concierge" services or any other additional charges as a condition of accessing Facility's services.

2.10.3 **Survival.** This Section shall survive termination of this Agreement for any and all Health Care Services rendered prior to such termination, regardless of the cause of such termination.

2.11 **Insurance.** At all times during the Term of this Agreement and for at least two (2) years after termination of this Agreement, Facility will obtain and maintain the following insurance coverages for itself, its Health Care Providers, Designees, agents, and employees:

2.11.0 Coverages.

2.11.0.0 **Medical Malpractice Insurance.** Facility, at its sole expense, agrees to maintain insurance coverage for professional liability risk as required by BCBS Policies and Procedures at all times while this Agreement is in effect. In the event Facility's liability coverage is through a self-funded arrangement, Facility must provide coverage certificates and attestations requested by BCBS for such self-funding arrangement to be accepted by BCBS's credentialing committee.

2.11.0.1 **Commercial General Liability.** Facility, at its sole expense, agrees to maintain insurance coverage for commercial general liability risk as required by BCBS Policies and Procedures. General liability insurance will be on Insurance Services Office ("ISO") form or equivalent and include operations, contractual liability and personal injury. The limits of such insurance may be satisfied with umbrella policies. Policy will name HCSC and its shareholders, directors, officers, employees, representatives and agents as additional insureds. The policy will be primary and non-contributing to any insurance carried by HCSC and will contain a waiver of subrogation and rights of recovery in favor of HCSC.

2.11.0.2 **Government Agency or Political Subdivision.** If Facility is an agency or political subdivision of the federal or state government (as defined under a state Governmental Tort Claims Act or the Federal Tort Claims Act) and provided evidence of that fact satisfactory to BCBS, Facility will not have to provide the required liability insurance coverage. However, Facility must demonstrate that it carries professional liability and comprehensive general insurance sufficient to cover any claims for which it can be liable under Law. Should Facility's status as an agency or political subdivision of the federal or state government change during the Term of this Agreement, Facility must provide Written Notice to BCBS and provide, within thirty (30) days of such change, evidence that Facility has obtained the required liability insurance coverage.

2.11.1 **Termination for Loss of Insurance Coverage.** Failure to maintain any of the insurance coverages required in accordance with this Section will be grounds for termination of this Agreement. Facility will indemnify BCBS for any loss incurred as a result of Facility's failure to maintain such coverage, which obligation to indemnify will survive the termination of this Agreement.

2.11.2 **Survival.** This Section shall survive termination of this Agreement for a period of two (2) years from the date of termination.

2.12 **Insurance Specifications and Requirements.** The following specifications and requirements will be conditions for all insurance identified in Section 2.11, *Insurance*:

2.12.0 **Responsibility for Deductibles and Self-Insurance.** Facility will be responsible for its own deductibles and self-insurance retentions, and such costs will not be the responsibility or liability of BCBS.

2.12.1 **Certificates of Insurance and Cancellation.** Facility will furnish, or cause to be furnished, certificates of insurance, Association for Cooperative Operations Research and Development form or equivalent, evidencing the required coverages. Facility will also furnish renewal certificates to BCBS upon reasonable request of BCBS. Further, Facility will provide BCBS with Written Notice at least fifteen (15) calendar days in advance of any cancellation, in whole or in part, non-renewal, or any material change in the terms of any such policy. Receipt of each certificate of insurance or other documentation of insurance by BCBS or by any of its representatives which indicate less coverage than required will not constitute a waiver of Facility's obligations to fulfill the insurance requirements. Facility

is solely responsible for obtaining and paying for any additional insurance or any increase of limits of liability not described above which are required by Law.

2.12.2 **No Limitation of Liability, Surplus and Reserves.** Nothing contained in Section 2.11, *Insurance*, or this Section as it relates to Facility will be construed in any way to limit the extent of Facility's responsibility, liability or payment of monies or damages under any other provision in this Agreement. Facility waives rights of subrogation and rights of recovery and will not seek contribution from BCBS under any circumstance. Facility will maintain monetary resources to ensure Facility's ability to meet its obligations under this Agreement and to comply with Law.

2.12.3 **Survival.** This Section shall survive termination of this Agreement.

2.13 Utilization Management and Quality Improvement.

2.13.0 **Utilization Management.** Facility will cooperate, participate and comply with all required Utilization Management, medical management, and quality improvement activities of BCBS, or ASO Groups, related to Covered Services, including, but not limited to, Utilization Management processes required by BCBS or its designee, ASO Groups, Blue Cross and/or Blue Shield Plans, BCBSA, BCBS's related managed care programs, or Law. The BCBS Utilization Management program may consist of various review methodologies, including but not limited to, case management, review of referrals, internal peer review, and prospective, concurrent, and retrospective review. Facility acknowledges and agrees that BCBS's Utilization Management and quality improvement activities may change from time to time in the sole discretion of BCBS upon prior Notice to Facility. Facility acknowledges and agrees that Claims may not be reimbursed by BCBS if Utilization Management requirements are not followed by Facility, and Facility may not balance bill the Covered Person if such Claims are not reimbursed by BCBS. Facility also agrees to provide all Medical Records required for Utilization Management, medical management, and quality improvement activities of BCBS, or ASO Groups, or their Designees, at no charge.

2.13.1 **Performance Quality Measurement Programs.** Facility shall fully comply and cooperate with and participate in BCBS's Quality Improvement Programs, as applicable. Facility agrees to furnish BCBS with Facility performance data for quality improvement activities and allow BCBS to compile and compare the performance data to meet BCBS's regulatory and Accrediting Agency requirements. Information requested must be readily available and shall be requested within a reasonable time frame.

2.13.2 **Prior Authorization.** Except for emergency services or where not required by applicable Laws, this Agreement or the Policies and Procedures, Facility must obtain Prior Authorization for Covered Services in accordance with this Agreement and the Policies and Procedures before providing Covered Services to Covered Persons. Except where not permitted by Laws, BCBS may apply a Penalty or deny payment for Covered Services where the Facility fails to meet BCBS's requirements for Prior Authorization. Facility may not bill or collect payment from a Covered Person for any Penalty applied by BCBS or any amounts denied or not paid under this Agreement due to Facility's failure to comply with BCBS's Prior Authorization requirements (see also *Hold Harmless* in Article II). This obligation to refrain from billing a Covered Person applies even in those instances in which Facility believes that BCBS has made an incorrect determination. Prior Authorization of Covered Services does not constitute a guarantee of payment to Facility. BCBS may revoke, limit, condition, or restrict a Prior Authorization or deny, reduce or delay payment for a Health Care Service provided by the Participating Provider pursuant to a Prior Authorization, only to the extent allowed by Laws.

2.14 **Third-Party Payment Assistance.** BCBS allows premium payments or Cost Share assistance for Covered Persons only from (i) Covered Persons and their families; (ii) required third-party entities identified in 45 C.F.R. § 156.1250, as it may be amended from time to time, and (iii) not-for-profit foundations whose payment assistance programs (1) meet certain nondiscrimination and full coverage period commitment, and other related criteria, as outlined under federal regulatory guidance and determined by BCBS in its sole discretion, and (2) make premium or Cost-Share assistance available to a Covered Person (a) regardless of the Covered Person's health status, and (b) for the entire coverage period of the Covered Person's Coverage Agreement. BCBS does not accept payments from other third-party entities, including, but not limited to, Facility or other Health Care Providers.

2.14.0 **Violations.** Payments for premiums made by a third-party in violation of this Section may not be credited by BCBS to a Covered Person's BCBS account, and, in the event Facility makes, requires, or cooperates in the making of requests, or instructs the making of payments to cover a Covered Person's premium or Cost Share in violation of this Section, BCBS may terminate this Agreement immediately upon providing Written Notice. In the case that Facility makes unauthorized premium payments, BCBS may non-renew, cancel or terminate the Covered Person's Coverage Agreement where permitted under the terms of such Coverage Agreement.

2.14.1 **Offsets.** If BCBS discovers that any premium payments were provided directly by, or at the request of, or instruction from, Facility or by a Health Care Provider with the knowledge of Facility, on behalf of any Covered Person in violation of this Section, BCBS may also apply a Penalty under this Agreement equal to the amount of such premium assistance.

2.14.2 **Survival.** This Section shall survive termination of this Agreement.

2.15 **Third-Party Billing Requirements and Covered Person Waivers.**

2.15.0 **Third-Party Billing Requirements.** Facility is required to submit to BCBS all Claims for Covered Services rendered to BCBS Covered Persons whether or not the costs for such Claims may be the responsibility of a third-party (e.g. an auto carrier when a person is injured in an auto accident). When Facility submits a Claim to BCBS seeking payment under the terms of this Agreement, all terms of this Agreement are applicable, and Facility must accept BCBS reimbursement as full and final payment for services rendered, excluding any applicable Cost Share. If it is later determined that another person or entity is liable to the Covered Person, Facility cannot refund the payment to BCBS and seek full billed charges from the liable person or entity. Notwithstanding the above, Facility will cooperate with BCBS in the collection on BCBS's behalf of third-party payments including workers' compensation, third-party liens and other third-party liability according to the procedures set forth in the Policies and Procedures.

2.15.1 **Covered Person Waivers.** However, if a Covered Person voluntarily chooses to waive his or her benefits and agrees to provide a signed, written document to Facility, waiving his or her insurance benefits with BCBS for a particular Claim(s) ("Waiver"), and allowing Facility to seek payment only from the Covered Person or one or more third-parties (collectively, "Third-Party"), BCBS will honor the Covered Person's decision to waive his or her insurance benefits and Facility may bill the Covered Person or a Third-Party for Covered Services rendered. The Waiver must specifically state that the Covered Person: (i) is voluntarily and knowingly waiving his or her health benefits with BCBS, and (ii) is aware that Facility is intending to seek payment from the Covered Person or a Third-Party, which may include a recovery from the Covered Person's potential or actual settlement dollars or award from such Third-Party, regardless of whether the Third-Party denies or admits liability for the Covered Person's injury or illness, and (iii) is aware that the Facility will seek his/her/its full billed charges (or, if applicable, some other specifically identified amount) from the Covered Person or a Third-Party, instead of Facility's discounted rate with BCBS,

and (iv) may rescind the Waiver at any time, however, such retraction of the Waiver may not be retroactive, and (v) understands that BCBS will have no responsibility for payment of any Health Care Services covered by the Waiver which, but for the Waiver, would have been considered eligible for benefits and/or payable by BCBS under the Covered Person's Coverage Agreement, even if no Third-Party is determined to be liable for the payment.

- 2.15.2 **No Impact on Claims Related Policies or COB.** Nothing in this Section changes, waives or amends any Policies and Procedures relating to Claims, Claims submission to BCBS (including, but not limited to, format and timely filing requirements) or subrogation. These third-party billing and waiver requirements do not affect in any way COB where the Covered Person has health benefit coverage under more than one Product. All BCBS Coverage Agreements remain in force and effect.
- 2.16 **Communication of Treatment Options.** The Parties agree that BCBS does not provide medical treatment or Health Care Services to Covered Persons. Facility agrees that BCBS does not dictate or direct Facility in the practice of medicine, nor the exercise of medical judgment, nor making Health Care Service treatment decisions. Facility acknowledges and agrees that BCBS decisions, policies, and procedures regarding the provision of Covered Services to Covered Persons apply solely to Facility's right to payment, and will not be construed as interference with, direction of, or substitution for the professional judgment of Health Care Providers, staff and employees in the provision of Health Care Services. Nothing contained in this Agreement is intended to prohibit or discourage Facility from discussing with or communicating in good faith to a current, prospective, or former patient, or patient's legal representative or designee, information or opinions regarding (i) the patient's health care, including but not limited to the patient's medical condition or treatment options, including alternative medications or medication treatment options, regardless of BCBS coverage limitations, or (ii) the Policies and Procedures.
- 2.17 **Representations and Warranties.** Facility hereby represents and warrants to BCBS that at all times during the Term of this Agreement the statements set forth below in this Section are true. Facility will provide BCBS with immediate Written Notice upon any occurrence that contravenes any of its representations and warranties under this Section, and agrees that any such change is grounds for immediate termination of this Agreement with Written Notice to Facility by BCBS. Facility further acknowledges and agrees that any misrepresentation of Facility's status or any change in Facility's status at any time during the Term of this Agreement may be grounds for immediate termination of this Agreement by BCBS at the sole discretion of BCBS:
- 2.17.0 Facility is in compliance with Laws;
- 2.17.1 Facility will maintain all requisite licenses, certifications, registrations, credentials and/or accreditations required by Laws or this Agreement;
- 2.17.2 Within the three (3) year period preceding the Effective Date of this Agreement, Facility has not had any public transactions (federal, state, or local) terminated for cause or default;
- 2.17.3 Within the three (3) year period preceding the Effective Date of this Agreement, Facility has not been charged with a criminal offense in connection with obtaining, or attempting to obtain, or performing of a public (federal, state, or local) contract or subcontract;
- 2.17.4 Facility meets, at a minimum, or exceeds all current BCBS participation and Credentialing and Recredentialing criteria as set forth in the applicable Policies and Procedures;
- 2.17.5 Facility has the authority to, and will, bind all Facility employees and Designees to the terms and conditions of this Agreement;
- 2.17.6 Facility has given no commissions, payments, rebates, kickbacks, or other unauthorized inducements to any employee or agent of BCBS in connection with this Agreement;

- 2.17.7 Facility has not given any commissions, payments, rebates, kickbacks, or other unauthorized inducements to any Health Care Provider in connection with Covered Services performed or rendered by Facility;
- 2.17.8 Neither Facility, nor any Facility employees or Designees, are knowingly involved in any illegal activities, or any activity that would reasonably create the appearance that it is illegal;
- 2.17.9 Neither Facility, nor its employees, or Designees have been (i) charged with a criminal offense involving any State or Federal government programs, including, but not limited to, Medicare and Medicaid, or (ii) proposed for Debarment or suspended from State or Federal government programs, including, but not limited to, Medicare or Medicaid;
- 2.17.10 Facility will only submit Claims for Covered Services provided to Covered Persons by Facility at a location covered under this Agreement; and
- 2.17.11 Neither Facility, nor its employees or Designees, have been convicted of or had a civil judgment rendered against it regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property.

2.18 Notices.

- 2.18.0 **Change in Information.** Facility will notify BCBS at least thirty (30) calendar days in advance of a change in Facility's business address, telephone numbers, hours of operations, tax identification number, billing information, or the scope of services provided by Facility.
- 2.18.1 **Notification Regarding Covered Persons.** Facility will promptly provide BCBS with Written Notice if it becomes aware that a Covered Person:
- 2.18.1.0 has any insurance coverage which differs from health coverage information provided by BCBS to Facility;
 - 2.18.1.1 has committed acts of physical or verbal abuse that pose a threat to Facility's staff or another Covered Person; or,
 - 2.18.1.2 has allowed another individual to use the Covered Person's insurance identification card to obtain Health Care Services.
- 2.18.2 **Placement of Staff in Offsite Locations.** Facility will provide thirty (30) days Written Notice to BCBS prior to placement of individuals in physician or other Health Care Provider locations, whether as direct employees or under another arrangement, that will be responsible for direction of specimens, images, or tests of any type that may be sent to Facility. For avoidance of doubt, staff responsibility for the direction of specimens includes any act in directing the specimen even if Facility has an agreement with the physician or other Health Care Provider that the physician is responsible. Placement includes not only direct employment arrangements but also agreements whereby Facility contributes in any way to the staffing for the physician or other Health Care Provider.
- 2.18.3 **Change in Facility's Status.** Facility will give Written Notice to BCBS within five (5) business days after Facility learns of any of the following:
- 2.18.3.0 Facility's or any Facility employees' or Designees' applicable license or certification or registration to provide Health Care Services or Drug Enforcement Agency registration or accreditation is suspended, revoked, terminated or

subject to terms of probation or other restriction (whether or not such action is stayed);

- 2.18.3.1 Facility or any Facility employee or Designee, becomes the subject of any disciplinary proceeding, Debarment or action before an applicable governmental supervisory board or agency in any state, or the inclusion of Facility or any Facility employee or Designee in the OFAC/OIG/GSA/OPM list;
- 2.18.3.2 Facility or any Facility employee or Designee, is charged with or indicted for, or convicted of, fraud or a felony, such as regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property;
- 2.18.3.3 An act of nature or any event occurs which substantially interrupts all or a portion of Facility's business or practice or which has a materially adverse effect on Facility's ability to perform Facility's obligations under this Agreement;
- 2.18.3.4 Facility learns of any malpractice action or other lawsuit, arbitration, or other legal action brought against Facility or any Facility employee or Designee, or becomes aware of a malpractice judgment or settlement against Facility or any Facility employee or Designee; and/or;
- 2.18.3.5 Any other occurrence or situation that could reasonably be expected to materially affect the ability of Facility to carry out Facility's obligations under this Agreement or, if true, could subject Covered Persons to potential harm.

2.18.4 **Change in Operations.** Facility will give one hundred and eighty (180) days Written Notice to BCBS prior to a Substantial Change in Operations. For purposes of this provision, a "Substantial Change in Operations" shall mean any change in Facility's operations that could be anticipated to result in a shift in Facility's volume of Covered Services of more than ten percent (10%) or where a primary service accounts for less than fifteen percent (15%) of Facility's billing volume (e.g., a hospital having less than ten percent (10%) of billings attributable to inpatient services or a long term care facility operating with a minimal number of beds).

2.19 **Appeals and Grievance Procedures.** Facility will cooperate with BCBS's Policies and Procedures related to the appeals and grievance process, including, but not limited to, furnishing all relevant information to BCBS, in resolving any grievance or appeal related to the provision of Health Care Services furnished to Covered Persons under this Agreement. Facility will forward to BCBS any Medical Records related to any grievance or appeal at Facility's expense within ten (10) days of BCBS's request unless a grievance or appeal is expedited, in which case Facility will immediately provide the Medical Records to BCBS. Facility will comply and cooperate with BCBS's adjudication process for any grievance or appeal. Any Covered Person complaints or grievances received by Facility related to BCBS will be forwarded to BCBS within ten (10) days of Facility's receipt of such complaint(s) or grievance(s). Prior to initiating any dispute under Article VI related to either whether a Health Care Service provided by Facility is a Covered Service or the amount of compensation due Facility under this Agreement for providing a Covered Service, Facility must exhaust any applicable BCBS internal appeal process as set forth in Policies and Procedures, or as otherwise communicated by BCBS to Facility.

2.20 **Audit/Access to Records.**

2.20.0 **Access to Records.** Subject to compliance with Law regarding the confidentiality of Medical Records, and at no charge to BCBS, Facility will:

2.20.0.0 Provide BCBS, its designee, or any applicable regulatory agency responsible for oversight of BCBS or Facility, upon request, copies of records related to Health Care Services provided to Covered Persons that are in the custody of Facility; and,

2.20.0.1 Upon three (3) business days' advance Notice or such shorter Notice as may be required by the circumstances or by Law, allow BCBS, its designee, or any applicable regulatory agency responsible for oversight of BCBS or Facility to inspect and copy Medical Records on Facility's premises during regular business hours; and

2.20.0.2 Allow BCBS to conduct any coding or Claim audit during reasonable business hours; and

2.20.0.3 Transmit information from Covered Persons' Medical Records, including by telephone, to BCBS, its designee, or any applicable regulatory agency responsible for oversight of BCBS or Facility for purposes of Prior Authorization or other Utilization Management or quality improvement activities; and

2.20.0.4 Provide copies of a Covered Person's Medical Records, upon reasonable request, to any other Health Care Provider treating such Covered Person.

2.20.1 **Audit.** BCBS's review of records under this Section may be undertaken to, among other things, verify BCBS's reimbursement was made in accordance with the provisions of this Agreement, comply with Medical Loss Ratio ("MLR") reporting requirements, verify that Health Care Services provided by Facility were Medically Necessary, and identify cases for potential COB, workers' compensation, and other third-party liability. Should BCBS not receive the Medical and Financial Records requested within sixty (60) days of the original request, BCBS will continue with its audit which may include a request for Facility to refund amounts previously paid by BCBS. Facility shall continue to provide such requested information to BCBS for a period of two (2) years after the termination of this Agreement (or for such other period as may be required by network accreditation organizations as applicable).

2.20.2 **Regulatory Compliance.** Facility will maintain and provide access to such Medical and Financial Records to BCBS or any applicable regulatory agency with oversight of BCBS or Facility, as may be necessary for compliance by BCBS with Law during the Term of this Agreement and for a period of at least ten (10) years after termination of this Agreement. All records, books and papers of Facility pertaining to Covered Services provided to Covered Persons will be open to inspection during regular business hours by BCBS and by state and federal authorities at no charge to BCBS.

2.20.3 **Survival.** This Section shall survive termination of this Agreement.

ARTICLE III OBLIGATIONS OF BCBS

3.0 **Compensation.** For Covered Services provided to Covered Persons that are documented on a Clean Claim and otherwise meet the standards for payment under this Agreement, BCBS will make payment to Facility in the amounts set forth in this Agreement, minus any applicable Cost Share and COB, as full reimbursement for Facility arranging and providing Covered Services to Covered

Persons. BCBS may make adjustments to amounts previously paid to Facility consistent with the terms of this Agreement. BCBS will not pay for Non-Covered Services.

3.1 **Applicability of Agreement.**

3.1.0 **ASO Groups.** With respect to Covered Services provided by Facility to an ASO Group's Covered Persons, Facility acknowledges and agrees that payment for Covered Services will be made solely from funds received by BCBS from the ASO Group, and Facility acknowledges and agrees that BCBS has no liability for the financial capacity of such ASO Group to satisfy Facility's Claims. Facility acknowledges that BCBS's sole function relative to such a Coverage Agreement and Product will be to provide administrative services as agreed upon by BCBS and the applicable ASO Group. The ASO Groups, and not BCBS, have sole financial responsibility for all Covered Services provided to ASO Groups' Covered Persons. From time to time with ASO Groups, BCBS may agree to process Claims for dates of service prior to the employer group's effective date. In such cases, the terms of this Agreement and all Attachments will apply.

3.1.1 **BlueCard.** Facility acknowledges and agrees that, pursuant to BCBS's BlueCard Program, Facility will provide Covered Services to Covered Persons under the BlueCard Program while such Covered Persons are in the BCBS Service Area subject to the same terms and conditions of this Agreement as are applicable to the provision of Covered Services to other Covered Persons and subject to the BlueCard Program requirements set forth in the Provider Manual.

3.2 **Covered Person Identification.** BCBS or the Covered Person's ASO Group, as applicable, will provide appropriate insurance card identification to Covered Persons identifying them as Covered Persons under Coverage Agreements. BCBS will make available to Facility electronic eligibility information regarding Covered Persons.

3.3 **Credentialing.** With Facility's cooperation in accordance with Facility's responsibility under Section 2.0.1, *Credentialing*, BCBS or its delegate will maintain Credentialing and Recredentialing and peer review processes for determining the eligibility of Facility to participate in BCBS's network. BCBS will Credential and Recredential and review the qualifications of Facility at least every three (3) years. BCBS may amend its Credentialing and Recredentialing Policies and Procedures at any time, at its discretion and upon Notice to Facility. BCBS retains the right to approve, deny, suspend or terminate any Health Care Provider's participation with BCBS based on its Credentialing and Recredentialing review.

3.4 **Complaints.** BCBS will maintain a complaint procedure as required by Law and the Policies and Procedures.

3.5 **Provider Status.** For those Provider Networks in which Facility has agreed to be a Participating Provider pursuant to an Attachment to this Agreement, consistent with Plan terms and Coverage Agreements accessing those Provider Networks, BCBS may identify Facility as a BCBS participating Facility to BCBS employees and independent contractors, as well as certain third-parties, including, but not limited to, ASO Groups and Covered Persons. Facility acknowledges and agrees that Facility will be a non-Participating Provider in all other Provider Networks unless otherwise provided for under the terms of this Agreement.

3.6 **Advisory Panels.** BCBS may establish one or more health services delivery advisory review panels to advise BCBS on a variety of issues. Facility may be requested from time to time by BCBS to serve as a member on such panels.

ARTICLE IV CONFIDENTIALITY

4.0 Confidential Information Definitions.

4.0.0 **“Representatives”** of a Party, for purposes of this Article only, means the respective officers, directors, trustees, employees, agents, consultants and Designees of a Party, and its Affiliates.

4.0.1 **“Confidential Information”** means this Agreement, and the related discussions and negotiations, as well as information of either Party, whether oral, written, electronic, or in any other form or format, provided or made available by one Party to the other Party, including but not limited to the following: information pertaining to business operations, employees, staff, financial information, fee schedules, technology, suppliers, customers, Product administration and management, business practices, trade secrets, Policies and Procedures, compliance with standards from accreditation and certifying boards, or other information, documents, agreements, project work product, data, any oral discussions or negotiations of the Parties, analyses, compilations, studies or other documents or information prepared by the other Party or its Representatives (as defined in Section 4.0.0, *Representatives*) containing or based in whole or in part on any information furnished by another Party or its Affiliates. The Parties acknowledge and agree that Claims and Clean Claims submitted to BCBS are owned by BCBS. Confidential Information does not include Protected Health Information (“PHI”), which is subject to the protections in Section 4.6, *HIPAA/HITECH Compliance*.

4.0.2 **“Unauthorized Access or Disclosure”** means the access or disclosure, by or to, any unauthorized individual(s) or entity(ies), of any (i) Confidential Information received by the Recipient Party (as defined in Section 4.2.0, *Receipt and Disclosure of Confidential Information*) or (ii) PHI. The access or disclosure will be considered unauthorized without respect to whether the access or disclosure is the result of any criminal, intentional or negligent act or omission by any individual(s) or entity(s), including, but not limited to, the Parties to this Agreement.

4.1 Information Excluded from Definition of Confidential Information. Confidential Information will not include information that:

4.1.0 is or becomes generally available to the public other than as a result of a voluntary disclosure or release by a Recipient Party or its Representatives;

4.1.1 was available to a Recipient Party on a non-confidential basis prior to the disclosure in connection with this Agreement;

4.1.2 is lawfully obtained by the Recipient Party from a third-party under no duty of confidentiality to the Disclosing Party; or

4.1.3 is independently developed by the Recipient Party.

4.2 Confidentiality Requirements.

4.2.0 **Receipt and Disclosure of Confidential Information.** Each Party agrees that the Confidential Information of the other Party disclosed under this Agreement is confidential and that any use, disclosure or release of the Confidential Information that is not permitted under this Agreement would injure the other Party. To the fullest extent permitted by Laws, the Party receiving Confidential Information under this Agreement (the “Recipient Party”) and its Affiliates will, and will cause its Representatives, to maintain and hold such Confidential Information confidential, and not use, disclose or release to any person or

entity, any Confidential Information disclosed by the other Party (the “Disclosing Party”) or its Affiliates in connection with this Agreement, except as permitted under Section 4.2.2, *Restricted Disclosures*, Section 4.3, *Required Disclosures by Law(s)*, Section 4.4, *Disclosures to Regulators*, and Section 4.8, *Release of Information*. Both Parties agree to comply with any and all Laws related to obtaining, maintaining, analyzing, securing, safeguarding, storing or transmitting Confidential Information, or reporting of unauthorized disclosures of Confidential Information.

- 4.2.1 **Care and Ownership of Confidential Information.** Recipient Party and its Representatives and Affiliates will use at least the same degree of care to use, maintain, store, and protect the Confidential Information as it employs in using, maintaining, storing, and protecting its own Confidential Information, but always with at least a reasonable degree of care. The Disclosing Party will be and remain the sole and exclusive owner of any and all Confidential Information it provides to the Recipient Party.
- 4.2.2 **Restricted Disclosures.** Recipient Party and its Representatives and Affiliates may only use Confidential Information solely for purposes of implementing this Agreement and will restrict disclosure of Confidential Information to those of its Representatives that have a “need to know” the Confidential Information for purposes of performing under this Agreement. Recipient Party and its Affiliates will take all necessary steps to inform each of its Representatives of, and to cause each of its Representatives to comply with, these obligations, including restrictions on use, protection, safeguarding, and disclosure of Confidential Information, as set forth herein. For purposes of clarity, Facility and its Representatives may not use Confidential Information to coordinate, collaborate, or in any way act in concert with another to either avoid or utilize this Agreement in a manner inconsistent with the intent of this Agreement to provide Covered Services solely to Covered Persons at Facility unless otherwise permissible by this Agreement.
- 4.3 **Required Disclosures by Law(s).** If Recipient Party or its Affiliates or Representatives becomes legally compelled by Laws, process or order of any court or governmental agency to disclose any Confidential Information of the other Party except when disclosed pursuant to Section 4.4, *Disclosures to Regulators*, such Party will give the Disclosing Party maximum practical advance Written Notice thereof to permit the Disclosing Party, or as appropriate, the Recipient Party, to seek a protective order or to take any other appropriate action to protect the Confidential Information. In addition, the Recipient Party will provide reasonable cooperation to the Disclosing Party to protect the Confidential Information to the greatest extent possible under Laws, and the Disclosing Party will request maximum protection and confidential treatment of such disclosure as may be afforded by Laws, including pursuant to any available protective legal mechanism, such as a confidentiality agreement. So long as the aforementioned terms and requirements of this Article have been met, a Party will be relieved of its confidentiality obligations under this Article to the extent that it becomes legally compelled by a court of competent jurisdiction or governmental agency to disclose Confidential Information, subject to protective orders or other restrictions imposed on or granted by the court or governmental agency.
- 4.4 **Disclosures to Regulators.** Each Party agrees to keep all terms of this Agreement confidential in accordance with this Article, except that a Party will be relieved of its confidentiality obligations under this Article for purposes of disclosure of the terms of this Agreement in response to a lawful request from any regulator or governmental agency with valid jurisdiction over BCBS or Facility or that regulator’s or agency’s official designee(s), such as an auditor.
- 4.5 **Breach of Confidentiality.** The Parties agree that any breach (or anticipatory breach) of the confidentiality obligations set forth in this Article will result in irreparable damage to the Disclosing Party for which it will have no adequate remedy at Law. Therefore, it is agreed (and as the sole exception to the dispute resolution provisions described in Article VI of this Agreement that a Disclosing Party may seek equitable relief to prevent unauthorized use or disclosure by the Recipient Party, including, but not limited to, an injunction enjoining any such breach or anticipatory

breach, and Recipient Party will pay all attorneys' fees and court costs incurred by the Disclosing Party to secure such equitable relief. Such equitable relief will be without prejudice to any other right or remedy to which the Disclosing Party may be entitled, including but not limited to any damages resulting from a Party's breach of the confidentiality obligations under this Article. Any failure or delay in exercising any right, power or privilege hereunder will not operate as a waiver thereof, nor will any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege hereunder.

- 4.6 **HIPAA/HITECH Compliance.** All PHI used or disclosed by either Party under this Agreement is subject to various state and federal statutory privacy standards and Laws, including HIPAA and HITECH. The Parties will use, maintain, store, safeguard, and protect all PHI at all times in accordance with HIPAA, HITECH and other Laws.
- 4.7 **Cybersecurity and Data Breach Cooperation.** Facility will notify BCBS within forty-eight (48) hours of its knowledge of any event, act or omission that has resulted, or may have resulted, in the Unauthorized Access or Disclosure, regardless of the source of such event, act or omission.
- 4.8 **Release of Information.** Notwithstanding anything else in this Agreement, Facility authorizes BCBS to publicly release general cost, utilization and other performance information and data concerning Facility or Facility's provision of Covered Services, or data in Claims or Clean Claims, as BCBS deems appropriate, consistent with BCBS's existing or future consumer transparency programs, tools and initiatives, as permissible by Law.
- 4.9 **Return or Destruction of Confidential Information.** Facility will use best efforts to return or destroy all Confidential Information provided to it by BCBS in accordance with Policies and Procedures, together with all copies thereof, whether in electronic or tangible form, within fifteen (15) calendar days following a request from BCBS or termination of this Agreement. At such time, Facility agrees to certify by a signed declaration provided to BCBS that all BCBS Confidential Information has been returned or destroyed.
- 4.10 **Survival.** The covenants and obligations of the Parties and their Affiliates and Representatives set forth in this Article IV shall survive termination of this Agreement.

ARTICLE V TERM AND TERMINATION

5.0 Term and Termination.

5.0.0 **Agreement.** This Agreement will commence on the Effective Date and continue in effect for three (3) years (the "Initial Term"). Thereafter, the Agreement will automatically renew for successive one (1) year terms (each, a "Renewal Term," and together with the "Initial Term," the "Term") unless:

5.0.0.0 a Party sends a Written Notice of termination to the other Party one hundred and eighty (180) days prior to the expiration of the Initial Term or any Renewal Term, with such termination to be effective upon the expiration of the then current Initial Term or Renewal Term, as applicable, or;

5.0.0.1 the Agreement is earlier terminated in accordance with this Agreement.

5.0.1 **Termination of Attachments.** An Attachment-specific effective date and term is set forth in certain Attachment(s) to this Agreement. Rather than terminate the entire Agreement, BCBS or Facility, as applicable, may terminate one or more Attachment(s) consistent with the terms set forth in the applicable Attachment(s). If the entire Agreement is not being terminated, Written Notice of termination of one or more Attachment(s) shall indicate the Attachments and, if applicable, Provider Network(s) to which the termination applies in

accordance with the particular Attachment's terms for termination. In the event BCBS or Facility terminates one or more Attachment(s), the Agreement will remain in full force and effect with respect to any Attachment(s) that were not terminated. If all Attachments terminate, the Agreement will also terminate. If the Agreement terminates, all Attachments terminate. An Attachment may only be terminated consistent with the terms set forth in the applicable Attachment. For example, if Attachment C may only be terminated in its entirety, then Attachment C-1 may not be terminated separately from termination of Attachment C or, if an Attachment does not have a termination provision, then such Attachment may not be terminated without termination of the Agreement.

- 5.1 **Termination for Material Breach.** A Party may terminate this Agreement, or any applicable Attachment, for a material breach by the other Party, regardless if the breach was related to all Attachments being terminated, by providing at least sixty (60) calendar days' prior Written Notice of the termination, specifying the nature of the material breach, to the breaching Party. If the material breach remains uncured at the end of such sixty (60) calendar days' notice period, the non-breaching Party may immediately terminate this Agreement, or any applicable Attachment, upon the expiration of such sixty (60) calendar day Written Notice period.
- 5.2 **Immediate Termination by BCBS.** Upon Written Notice to Facility, the following will constitute cause for immediate termination by BCBS of this Agreement or any applicable Attachment, without any opportunity for Facility to cure:
- 5.2.0 **Insolvency.** Facility files a petition for insolvency, bankruptcy or is adjudicated bankrupt, ceases to operate as a going concern, or takes advantage of any insolvency acts or assignment for the benefit of creditors. At no time, nor for any reason, may this Agreement, or any of the compensation contemplated hereunder, be considered an asset of Facility if it becomes insolvent.
- 5.2.1 **Standard of Care.** Facility materially fails to provide or arrange for the provision of Covered Services to Covered Persons in accordance with the standards set forth in this Agreement (including, without limitation, BCBS's quality management program and medical management program) and does not correct such failure as required by and to the satisfaction of BCBS within the time frame required by BCBS's Written Notice to Facility. In addition to the foregoing, BCBS reserves the right to immediately terminate the provision of Covered Services by Facility to any Covered Persons in the event the health or safety of Covered Persons is endangered by the actions of Facility.
- 5.2.2 **Patient Safety.** Facility or a Facility employee or Designee causes, or in BCBS's reasonable determination, is likely to cause: (i) material harm to the safety and well-being of BCBS's Covered Persons, (ii) material harm to the reputation of BCBS, or (iii) material disruption to the provision of services to Covered Persons by Participating Providers. BCBS's termination right under this Section will only be triggered if Facility fails to immediately remove such Facility employee or Designee who is charged or who causes, or is likely to cause, the material harm described herein.
- 5.2.3 **Insurance Requirements.** Facility fails to maintain any of the insurance coverage required under Section 2.11, *Insurance*.
- 5.2.4 **False Data Transmissions.** Facility knowingly submits false or misleading billing information or encounter data to BCBS.
- 5.2.5 **Loss of Status.** Facility loses Medicare certification, is added to the Medicare sanctions list, or is included on the OIG's List of Excluded Individuals/Entities, the General Services Administration Excluded Party List System, a listing of debarred Health Care Providers published by the OPM, or any successor to, or substantial equivalent of, the foregoing sanctions, exclusions, and Debarment sources.

- 5.2.6 **Licensure.** Facility fails to maintain licensure or accreditation status necessary to provide Covered Services under this Agreement or Facility is sanctioned or reprimanded by any licensing authority or review organization, including, but not limited to, any Blue Cross and/or Blue Shield Plan or any state licensing board.
- 5.2.7 **Breach of Warranty.** Facility provides Notice to BCBS regarding any occurrence that contravenes the representations and warranties in Section 2.17, *Representations and Warranties*.
- 5.2.8 **Inducement.** BCBS discovers that any premium or Cost Share payments, or Cost Share waivers, were provided directly by, or at the request of, or instruction from, Facility on behalf of such Covered Persons in violation of Section 2.14, *Third-Party Payment Assistance*.
- 5.2.9 **Failure to File Claims.** Facility has not submitted Claims to BCBS for a network in which it is a Participating Provider, nor otherwise communicated its intent to continue participation in the network, within a twelve-month period, and has failed to respond to Written Notice from BCBS of termination for lack of Claims within thirty (30) days of the date of such Written Notice.
- 5.3 **Severability.** In accordance with Section 7.21, *Partial Invalidity and Severability*, either Party may terminate this Agreement by providing at least sixty (60) calendar days' prior Written Notice to the other Party if the Parties are unable to negotiate an amendment or modification of a provision of this Agreement that an arbitrator has deemed unenforceable.
- 5.4 **Termination Notices Under this Article.** Written Notices concerning termination under this Article shall identify the specific Provider Network(s) or Attachment(s) included in the Written Notice of termination if it does not by its terms apply to the entire Agreement. Written Notices of termination shall be deemed insufficient to terminate any Provider Network(s) or Attachment(s) not included in such Written Notice if it does not by its terms apply to the entire Agreement.
- 5.5 **Rights Upon Termination.**
- 5.5.0 As of the date of termination, this Agreement will be considered of no further force or effect and each of the Parties will be relieved and discharged from this Agreement, except that:
- 5.5.0.0 Termination will not affect any rights or obligations hereunder which have previously accrued or will hereafter arise, with respect to any occurrence prior to termination and such rights and obligations will continue to be governed by the terms of this Agreement, including the dispute resolution provisions described in Article VI.
- 5.5.0.1 In the event of termination of this Agreement, Facility will make available and provide to a Medical Director, to the extent authorized by Covered Persons and directly to Covered Persons, at no cost, copies of such information and records as BCBS and Covered Persons may request concerning such Covered Persons. Upon termination of this Agreement, Facility will provide a Covered Person a copy of his or her Medical Records for a period of up to one (1) year after termination at no cost to the Covered Person.
- 5.5.0.2 Facility's appeal rights, if any, in the event BCBS terminates this Agreement are set forth in more detail in the Policies and Procedures and Attachment B.
- 5.5.1 **Survival.** This Section shall survive termination of this Agreement.
- 5.6 **Transition Period.** If this Agreement is terminated, or any Provider Network is terminated, under Section 5.0, *Term and Termination*, or Section 5.1, *Termination for Material Breach*, or if any

mutually-agreed extensions thereof, expires without the execution of a new provider agreement between the Parties, BCBS may in its sole discretion elect to implement a Transition Period in order to provide for an orderly winding down of the Parties' relationship. This Section, *Transition Period*, shall survive termination or expiration of this Agreement. The intent of the Transition Period is to allow time for both Parties to communicate with their respective stakeholders, to allow time for the transition of care, and to allow for the application of continuity of care benefits, after termination or expiration of this Agreement. If the Parties desire additional time to continue negotiations for a new agreement after the date upon which the contract Term expires, the Parties must mutually agree in writing to extend the contract Term prior to the expiration date.

- 5.6.0 The Transition Period begins at 12:01 a.m. on the day following the termination effective date and shall extend for a period of one hundred twenty (120) days.
- 5.6.1 During the Transition Period, Facility shall provide services to Covered Persons in accordance with the terms of the Agreement, as if the Agreement were still in place, with all provisions surviving termination through 11:59 p.m. of the last day of the Transition Period, with the exception of those provisions which contain a longer survival period
- 5.6.2 Covered Persons who received services from Facility during the Transition Period will have their Claims for benefits processed as if they were in network. BCBS agrees to issue payment directly to Facility for services rendered by Facility during the Transition Period, and payment shall be at the rates negotiated in the Agreement as of the date of termination.
- 5.6.3 Facility agrees to accept payment at the rates negotiated in the Agreement as of the date of termination and to hold the Covered Person harmless from any sums in excess of the Maximum Reimbursement Allowance.
- 5.6.4 During the Transition Period, BCBS shall give notices to Covered Persons and Participating Providers of the termination of the Agreement and the change in Facility's network status. Facility shall cooperate to transition the care of Covered Persons to Participating Providers, if requested to do so by Covered Persons and their treating physicians.

5.7 **Continuity of Care and Transition of Services.**

- 5.7.0 Any Covered Persons for whom Facility is no longer a Participating Provider may seek care from Facility following the effective date of termination of this Agreement or Facility's participation in a Provider Network and the expiration of any applicable Transition Period: (i) at the Covered Person's expense or pursuant to the Covered Person's out of network benefits, or (ii) BCBS may, in its sole discretion, provide in-network benefits for certain Health Care Services provided by Facility after the effective date of termination, and Facility agrees to accept payment for such Health Care Services (which would otherwise constitute Covered Services had Facility remained a Participating Provider) at the same rates and subject to the terms and conditions under this Agreement as of the effective date of termination. Additional information regarding continuity of care and care transitions following termination can be found in the Policies and Procedures.
- 5.7.1 In the event that a Covered Person is enrolled in a Qualified Health Plan, as defined by the Patient Protection and Affordable Care Act and its implementing regulations, BCBS and Facility shall comply with any applicable requirements relating to continuity of care under 45 C.F.R. § 156.230, as it may be amended from time to time, including the requirement to provide continued treatment to the Covered Person in an active course of treatment for ninety (90) days after Facility is terminated without cause or until treatment is complete, whichever is shorter. A "Qualified Health Plan," for purposes of this Section, is a Product that has in effect a certification that it meets the standards to be sold through an American

Health Benefit Exchange established under 42 U.S.C. § 18031, as it may be amended from time to time.

5.7.2 **Survival.** This Section shall survive termination of this Agreement.

ARTICLE VI DISPUTE RESOLUTION

6.0 **Dispute Resolution.** In order to avoid the cost and time consuming nature of litigation, any dispute between BCBS and Facility arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement or any prior Agreement between BCBS and Facility that relates to Facility's role as a Participating Provider for the Provider Networks indicated in this Agreement for Covered Persons, or any Laws relating thereto, shall be resolved using alternative dispute resolution mechanisms instead of litigation. BCBS and Facility agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for mediation and/or, except to the extent prohibited by Laws, arbitration of all disputes arising out of their relationship, including Claims not yet filed that predate this Agreement, as third-party payer and Facility. The Parties further agree that resolution of any dispute pursuant to this Agreement shall be in accordance with the procedures detailed below.

6.0.0 **Initial Resolution by Meeting or Mediation of Dispute.** BCBS or Facility, as the case may be, shall give Written Notice to the other of the existence of a dispute (the "Initial Notice"). BCBS and Facility shall schedule a meeting not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute unless both Parties agree in writing to proceed directly to mediation. If the dispute is not resolved at any meetings held, the Parties shall submit the dispute to a mutually agreed upon mediator. The mediation process shall be subject to the following conditions:

6.0.0.0 The Parties agree to participate in the mediation confidentially and in good faith;

6.0.0.1 The Parties agree to have present at the mediation one or more individuals in the Parties' employ with decision-making authority regarding the matters in dispute. Either Party may, at that Party's option, be represented by counsel;

6.0.0.2 The mediation will be held within sixty (60) days of the mediator's acceptance of the matter unless the Parties agree on a later date. The mediation will be held in Tulsa, OK;

6.0.0.3 The Parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one Party did not participate in the mediation in good faith, in which case that Party shall pay all of the mediator's fees and costs; and

6.0.0.4 The Parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the Effective Date of this Agreement, or that had been submitted to binding arbitration on or before the Effective Date of this Agreement.

6.1 **Binding Arbitration.** In the event mediation is not successful in resolving the dispute, either BCBS or Facility may submit the dispute to confidential, final, and binding arbitration under the commercial rules and regulations of the American Arbitration Association, subject to the following:

6.1.0 The arbitration shall be conducted by a single arbitrator selected by the Parties from a list furnished by the American Arbitration Association. If the Parties are unable to agree on an arbitrator from the list, the arbitrator shall be appointed by the American Arbitration Association;

- 6.1.1 The arbitrator shall be required to render a written decision resolving all disputes, and designating one Party as the “prevailing Party”;
- 6.1.2 Except in the case of fraud, no arbitration decision may require any adjustment in compensation or payments respecting any dispute involving services rendered more than twenty-four (24) months prior to receipt of the Initial Notice;
- 6.1.3 Neither Party shall be entitled to an award of lawyers’, consultants’, or witness fees, it being the intention of the Parties that each side shall bear its own lawyers’, consultants’ and witness fees. The costs of arbitration, including the arbitrator’s fee and any reporting or other costs, but excluding lawyers’, consultants’ and witness fees, shall be borne by the non-prevailing Party unless the arbitrator determines as part of the award that such allocation is inequitable under the totality of the circumstances. In the event that the dispute in arbitration concerns the appropriateness of BCBS’s adjudications of Claims, the Party challenging the adjudications shall have the initial burden of proving that there is a reasonable probability that the disputed Claims adjudications were incorrect adversely to that Party. When the other Party reasonably determines that it is required in its defense, or is required by the discovery process or otherwise by Law, to research the basis for the adjudications of challenged Claims for which such reasonable probability has not been proven, the other Party shall be awarded the administrative cost for such research for each such Claim that is found in the arbitration proceeding, after such research, not to have been adjudicated incorrectly adversely to the challenging Party;
- 6.1.4 The arbitration hearing will be held in Tulsa, OK;
- 6.1.5 The arbitrator may award declaratory or injunctive relief only in favor of the Party seeking relief and only to the extent necessary to provide relief warranted by that Party’s individual claim. Facility and BCBS agree that each may bring claims against the other only in its individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding. Further, unless both Facility and BCBS agree otherwise, the arbitrator may not consolidate Facility’s claims with the claims of any other Health Care Provider or third party, and may not otherwise preside over any form of a representative or class proceeding; and
- 6.1.6 Facility acknowledges that this arbitration provision precludes Facility from filing an action at Law or in equity and from having any dispute covered by this Agreement resolved by a judge or a jury. Facility further acknowledges that this arbitration provision precludes Facility from participating in a class action filed by any other Health Care Provider or any other plaintiff claiming to represent Facility or Facility’s interest. Facility agrees to opt-out of any class action filed against BCBS that raises claims covered by this Agreement to arbitrate, including, but not limited to, class actions that are currently pending.
- 6.2 **Exceptions.** The provisions of this Article shall not be applicable to the following:
- 6.2.0 Any legal proceeding brought by a third-party against BCBS or Facility (a “Defendant”), as well as any cross-claim or third-party claim by such Defendant against BCBS or Facility.
- 6.2.1 Termination of this Agreement pursuant to a termination without cause.
- 6.2.2 Immediate termination of this Agreement if based on external data relating to loss of licensure, status, certification, maintenance of insurance, breach of warranty, inducement, or BCBS’s judgment relating to cases involving standard of care or patient safety. However, a wrongful termination claim may be brought to recover the contractual rates under this Agreement.
- 6.3 **Survival.** This Article VI shall survive termination of this Agreement.

ARTICLE VII GENERAL PROVISIONS

- 7.0 **Recitals.** All recitals contained in the beginning of this Agreement are hereby restated and incorporated into the Agreement as if fully set forth herein.
- 7.1 **Counterparts.** This Agreement may be executed in one or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.
- 7.2 **Electronic Signatures.** Each Party may sign this Agreement electronically. A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder will have the same force and effect for purposes of validity, enforceability, and admissibility as an originally executed signature.
- 7.3 **Headings.** The headings or captions of sections of this Agreement are for reference only and do not affect the meaning or interpretation of this Agreement.
- 7.4 **No Third-Party Beneficiaries.** Except as otherwise specifically set forth herein, BCBS and Facility are the only entities with rights and remedies under this Agreement.
- 7.5 **Relationship.**
- 7.5.0 **Independent Entities.** Neither Party is the agent or representative of the other. Neither Party will have any express or implied right or authority to assume or create any obligation or responsibility on behalf of or in the name of the other Party. Each Party is and will continue to be an independent entity. Neither Party is the agent or representative of the other. BCBS does not practice medicine and does not provide professional and/or medical services, including, but not limited to, Covered Services.
- 7.5.1 **Taxes, Insurance and Other Benefits.** Facility will be solely responsible for paying, , all taxes assessed on Facility, including but not limited to payroll taxes, withholdings, workers' compensation insurance and other insurance or benefits of any kind for itself and Facility's employees providing services under this Agreement and shall have no recourse against BCBS. Facility will indemnify and hold BCBS harmless from all damages, defense costs, or liability incurred by BCBS as a result of claims against BCBS for such tax payments brought by Facility's employees or the government against BCBS.
- 7.6 **Entire Agreement; Amendments.**
- 7.6.0 **Entire Understanding.** This Agreement, together with any Attachments and amendments hereto contains the entire understanding between the Parties pertaining to the subject matter contained herein and supersedes all prior agreements, either oral or in writing, with respect to the subject matter herein.
- 7.6.1 **Amendments Required by Law.** Notwithstanding the foregoing, any amendments or modifications to the Agreement required by Laws may be implemented by BCBS upon at least sixty (60) calendar days' prior Written Notice to Facility, or such shorter time period as may be required by Law. Amendments or modifications required by Laws will be effective retroactively, if applicable, as of the date required by such Law or regulation.
- 7.6.2 **Amendments Not Required by Law.** For amendments to the Agreement that are not required by Law, BCBS may amend this Agreement by providing Facility Written Notice of such amendment at least ninety (90) calendar days in advance of the effective date of such amendment.
- 7.6.3 **Objections to Amendments.** If Facility objects to an amendment or modification to the Agreement within sixty (60) calendar days of receipt of Notice of such amendment or

modification, the Parties will then engage in good faith negotiations to resolve Facility's objection to the proposed amendment. If the Parties are unable to reach agreement on the proposed amendment prior to the effective date of the amendment, then either Party may terminate this Agreement, or any Provider Network Attachment, by providing at least one hundred and eighty (180) calendar days' prior Written Notice to BCBS. If Facility provides such Notice of its intent to terminate this Agreement or any Provider Network(s) Attachment, then the proposed amendment will not go into effect with respect to the Agreement, or as applicable, the applicable Provider Network(s), during the period prior to termination.

- 7.7 **Assignment and Merger.** Neither Party may assign (including, without limitation, by operation of law or, as a result of any Change of Control) this Agreement or any of its rights or obligations hereunder to any other Person, without the prior written consent of the other Party. Any Change of Control shall be deemed an assignment or transfer for purposes of this Agreement that requires BCBS's prior written consent (which BCBS may withhold or delay in its sole discretion). As an exception to the foregoing, any of the rights and obligations of BCBS under this Agreement may be assumed by, or assigned to, an Affiliate of HCSC or BCBS, including, but not limited to, subsidiaries, of HCSC (including any successor corporation, whether by merger, consolidation or reorganization) without the prior written consent by Facility. Any reference in this Agreement to HCSC or BCBS will include its directors, officers and employees, as well as the directors, officers and employees of any of its subsidiaries or Affiliate companies (including any successor corporations, whether by merger, consolidation or reorganization) and HCSC or its successor corporation will be responsible and liable for all rights and obligations in connection with this Agreement. This Agreement will be binding upon and inure to the benefit of the respective Parties hereto and permitted assigns. BCBS's standing or routine contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel from other entities will not constitute an assignment under this Agreement. BCBS does not recognize affiliates of Participating Providers which are not considered Affiliates, as defined in Section 1.0, for purposes of contracting, negotiations and legal relationships.
- 7.8 **Compliance with Laws.** Each Party will comply with all Laws, including the Laws of the State and any other state in which: (a) Health Care Services are provided to Covered Persons or (b) benefits are provided pursuant to a Coverage Agreement. Facility will promptly, upon request by BCBS, provide to BCBS such information and documentation as is reasonably necessary for BCBS's compliance with Laws and accreditation standards. In addition, Facility will cooperate with and provide reasonable assistance to BCBS regarding regulatory compliance efforts as they relate to Facility's and BCBS's activities under this Agreement.
- 7.9 **Cooperation of Parties.** The Parties agree to meet and confer in good faith on common problems or issues including, but not limited to, matters concerning utilization of Covered Services, Claims, Clean Claims, or reporting procedures, and information and forms provided to Facility for use in connection with the provision of Covered Services to Covered Persons.
- 7.10 **Force Majeure.** No Party will be held liable by the other Party for any failure to timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars or restraints of government. Each Party will resume its obligations under this Agreement as soon as practicable after a force majeure event.
- 7.11 **Disaster Recovery/Business Continuity.** During the Term of this Agreement, Facility will maintain and, upon request by BCBS, provide a summary of a comprehensive disaster recovery and/or business continuity plan which is consistent with industry standards and Laws, and at a minimum, allows resumption of performance under this Agreement within a reasonable time following an interruption of operations due to a disaster. If a state or federal agency or regulator requires a copy of Facility's comprehensive disaster recovery and/or business continuity plan, Facility will provide such information in an acceptable format to the state entity or regulator.

- 7.12 **Data Accuracy/Integrity.** During the Term of this Agreement, Facility will use reasonable best efforts to provide accurate data and information, including data and information regarding Claims and/or Clean Claims, as required by this Agreement, in a format requested by BCBS, including, but not limited to, all data received or supplied from any person or entity that is necessary to perform under this Agreement. Facility will comply with all applicable data privacy and security Laws concerning data accuracy, integrity, maintenance, receipt and transmission.
- 7.13 **HCSC Divisions and Affiliates.** The Parties acknowledge that HCSC conducts its insurance business through its respective state operating divisions of Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas. For purposes of this Agreement, the term "HCSC" includes each such operating division, as well as any additional divisions, subsidiaries or affiliates through which it may at any time conduct all or a portion of its group or consumer health insurance business. The term 'affiliate' includes any entity in which HCSC has a material ownership interest or an entity that HCSC controls.
- 7.14 **Use of Name, Trademarks.** Each Party reserves the right to, and control of, its names, symbols, trademarks and service marks presently existing or later established. All names, symbols, trademarks and service marks of, or related to, BCBS and its Products are owned and/or controlled by BCBS, and Facility has no rights in or to such names, symbols, trademarks and service marks. BCBS has the right to use such marks under its licensing agreement with the BCBSA. All names, symbols, trademarks and service marks of Facility are owned and/or controlled by Facility and/or its Affiliates, and BCBS has no rights in or to such names, symbols, trademarks and service marks. Neither Party will use the other Party's name, symbols, trademarks or service marks in advertising, promotional or informational materials, describe the business or services of the Party, or otherwise, without the prior written consent of that Party. This Section will in no way limit the Parties from preparing materials for regulatory filing purposes, or other non-marketing materials that will not be disseminated to the public or externally, as associated with the normal operation of its business. As an exception to the foregoing, Facility agrees that BCBS may list such information as Facility's name, address and telephone number and relevant information, including information relating to Facility's services and performance and any other information required by Law, in BCBS publications provided to Covered Persons, including BCBS's provider directories.
- 7.15 **No Solicitation.** During the Term of this Agreement and for a period of one (1) year thereafter, Facility will not solicit, influence or induce or attempt to solicit, influence, or induce any Covered Person to disenroll from any Product or enroll in any other health care plan that would require such Covered Person to disenroll from a Product, and Facility will not solicit, influence or induce employers, including, but not limited to, ASO Groups, or other entities with which BCBS has entered into agreements to provide health care benefits to cease doing business with BCBS or diminish or otherwise affect their business relationship with BCBS.
- 7.16 **Governing Law.** This Agreement will be interpreted and construed in accordance with the Laws of the State, which Laws will prevail in the event of any conflict of Laws.
- 7.17 **Non-Exclusivity.** This Agreement is non-exclusive and both Parties may enter into similar agreements with other entities.
- 7.18 **Products and Coverage Agreements.** Nothing in this Agreement will be construed to prohibit BCBS from introducing new Products, programs, Plans or networks into the marketplace, nor from revising or amending any Coverage Agreement, or implementing new Product benefit designs or Provider Network strategies.
- 7.19 **No Default.** Each Party warrants that the execution and delivery of this Agreement and compliance with the provisions hereof will not in any material respect conflict with or constitute a default on the part of either Party under any instrument or agreement or under any Laws to which it is subject.

- 7.20 **Partial Invalidity and Severability.** In the event that an arbitrator (in accordance with the provisions of Article VI) determines that a provision, or any portion thereof, contained in this Agreement is unenforceable, then such provision will be deemed stricken and the remaining portions or provisions will continue in full force and effect. In the event that a provision of this Agreement is rendered unenforceable, and its removal has the effect of materially altering the obligations of either Party in such manner as will cause serious financial or administrative hardship to such Party, the Party so affected will have the right, within thirty (30) calendar days of the arbitrator's decision, to request that the Parties enter into good faith negotiations for the purpose of establishing such amendments or modifications to this Agreement as may be appropriate in order to preserve the original intent of the Agreement. If, after thirty (30) calendar days of such negotiations, the Parties are unable to reach an agreement on an appropriate amendment or modification, the affected Party may terminate this Agreement upon sixty (60) calendar days' advance Notice to the other Party. If the affected Party does not request good faith negotiations within thirty (30) calendar day time frame after the arbitrator's decision, the Agreement will continue in force and effect as modified by the arbitrator's decision, and such affected Party thereby waives its right to such good faith negotiations and to termination under this Section.
- 7.21 **Responsibility for Acts.** Each Party will be responsible for its own acts or omissions and any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result in or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that Party, its employees or non-physician agents, in the performance or omission of any act or responsibility of that Party under this Agreement.
- 7.22 **Waiver.** The failure of either Party to exercise any right or strictly enforce any provisions of this Agreement will not be construed as a waiver or relinquishment of such provision or right. No waiver by any Party of any Term of this Agreement will be effective unless it is in writing and signed by the Party waiving its rights.
- 7.23 **BCBSA.** Facility hereby expressly acknowledges that this Agreement constitutes a contract solely between Facility and BCBS, which is an independent corporation operating under a license from the BCBSA, permitting BCBS to use the Blue Cross and Blue Shield Service Marks in the State, and that BCBS is not contracting as the agent of BCBSA. Facility further acknowledges and agrees that Facility has not entered into this Agreement based upon representations by any person other than BCBS and that no person, entity, or organization other than BCBS will be held accountable or liable to Facility for any of BCBS's obligations to Facility created under this Agreement. This paragraph does not create any additional obligations whatsoever on the part of BCBS other than those obligations created under other provisions of this Agreement.
- 7.24 **Attachments.** One or more Attachment(s) may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy requirements under State Law, set forth Claims processing requirements and compensation arrangements, or for other purposes. By executing the cover page to this Agreement, the Parties acknowledge that these Attachments, and any Attachments to them, are expressly incorporated into this Agreement and are binding on the Parties. In the event of any inconsistent or contrary language between an Attachment or any other part of this Agreement, the Attachments will control, to the extent applicable. Each Attachment(s) shall be effective until the effective date of termination of this Agreement unless such Attachment(s) expires by its terms or is separately terminated by either Party pursuant to the terms of this Agreement and/or such Attachment(s).
- 7.25 **Administrative Functions.** BCBS and Facility acknowledge that BCBS may delegate certain responsibilities or activities that are provided for in this Agreement without notice to or approval by Facility.
- 7.26 **Terminology.** Use of the masculine, feminine or neuter gender and the singular or plural numbers will be deemed to include the others whenever the context so indicates or requires.

7.27 **Survival.** In addition to the Sections and Articles already surviving pursuant to the terms of this Agreement, Articles I and VII will also survive termination of this Agreement.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A
PROVIDER NETWORKS**

This Attachment A, including any sub-attachments to this Attachment A listed on the cover page of the Agreement (e.g., Attachment A-1, Attachment A-2, etc.), (collectively, this “Attachment”), is made a part of the Agreement.

By its signature on the cover page of the Agreement, Facility provides its express authority to participate in the Provider Network(s) listed on the cover page of the Agreement and indicated by the sub-attachment(s) to this Attachment pursuant to the terms of the Agreement. Facility acknowledges that each Provider Network may support multiple Products.

**ATTACHMENT A-1
BLUE TRADITIONALSM**

This Blue Traditional Attachment is made a part of the Agreement and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the Blue Traditional Network (“Blue Traditional Covered Persons”). All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

**ARTICLE I
COVERED SERVICES**

- 1.0 **Covered Services.** Facility will furnish Covered Services to Blue Traditional Covered Persons and otherwise perform under the Agreement, including this Blue Traditional Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the Blue Traditional Network (“Blue Traditional Provider”).

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to Blue Traditional Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility’s billed charges for Covered Services or (ii) BCBS’s Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to Blue Traditional Covered Persons. Facility agrees to hold such Blue Traditional Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance.
- 2.1 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Preferred PPO, Blue Advantage PPO and BlueLincs HMO, the terms of this Blue Traditional Attachment, including the Maximum Reimbursement Allowance described in Attachment C, shall be applicable to any Covered Services rendered to a Covered Person enrolled in a Product that utilizes a Provider Network in which Facility does not participate. Facility agrees to hold such Covered Persons harmless from any sums in excess of the Blue Traditional Maximum Reimbursement Allowance.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this Blue Traditional Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement or (ii) termination of only this Blue Traditional Attachment in accordance with the termination provisions in Article V of the Agreement.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A-2
BLUE CHOICE PPOSM**

This Blue Choice PPO Attachment is made a part of the Agreement and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the Blue Choice PPO Network ("Blue Choice PPO Covered Persons"). All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

**ARTICLE I
COVERED SERVICES**

- 1.0 **Covered Services.** Facility will furnish Covered Services to Blue Choice PPO Covered Persons and otherwise perform under the Agreement, including this Blue Choice PPO Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the Blue Choice PPO Network ("Blue Choice PPO Provider").

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to Blue Choice PPO Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility's billed charges for Covered Services or (ii) BCBS's Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to Blue Choice PPO Covered Persons. Facility agrees to hold such Blue Choice PPO Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance.
- 2.1 **Failure to Comply.**
- 2.1.0 **Health Care Services That Are Not Medically Necessary.** If the Health Care Services are determined to be not Medically Necessary or Experimental, Investigational or Unproven, payment will be denied. Except where otherwise provided by applicable Law, the denied amounts may not be collected from the Blue Choice PPO Covered Person unless a waiver has been executed prior to rendering Health Care Services.
- 2.1.1 **Health Care Services That Are Medically Necessary.** If the Health Care Services are determined to be Medically Necessary, but Facility failed to comply with the Prior Authorization requirements set forth in this Agreement and the Policies and Procedures, then the amount due to Facility from BCBS will be reduced by five hundred dollars (\$500.00) per Claim. This five hundred dollar (\$500.00) sanction may not be collected from the Blue Choice PPO Covered Person.
- 2.2 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Preferred PPO, Blue Advantage PPO and BlueLincs HMO, the terms of this Blue Choice PPO Attachment, including the Maximum Reimbursement Allowance described in Attachment C, shall be applicable to any Covered Services rendered to Covered Person enrolled in a Product that utilizes a Provider Network in which Facility does not participate. Facility agrees to hold such Covered Persons harmless from any sums in excess of the Blue Choice PPO Maximum Reimbursement Allowance. This paragraph shall supersede any provision contained in the Blue Traditional Attachment, if applicable, to accept the Blue Traditional Maximum Reimbursement Allowance for any Covered Person whose designated Provider Network is one in which Facility does not participate.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this Blue Choice PPO Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement or (ii) termination of only this Blue Choice PPO Attachment in accordance with the termination provisions in Article V of the Agreement.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A-3
BLUE PREFERRED PPOSM**

This Blue Preferred PPO Attachment is made a part of the Agreement and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the Blue Preferred PPO Network (“Blue Preferred PPO Covered Persons”). All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

**ARTICLE I
COVERED SERVICES**

- 1.0 **Covered Services.** Facility will furnish Covered Services to Blue Preferred PPO Covered Persons and otherwise perform under the Agreement, including this Blue Preferred PPO Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the Blue Preferred PPO Network (“Blue Preferred PPO Provider”).

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to Blue Preferred PPO Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility’s billed charges for Covered Services or (ii) BCBS’s Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to Blue Preferred PPO Covered Persons. Facility agrees to hold such Blue Preferred PPO Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance.
- 2.1 **Failure to Comply.**
- 2.1.0 **Health Care Services That Are Not Medically Necessary.** If the Health Care Services are determined to be not Medically Necessary or Experimental, Investigational or Unproven, payment will be denied. Except where otherwise provided by applicable Law, the denied amounts may not be collected from the Blue Preferred PPO Covered Person unless a waiver has been executed prior to rendering Health Care Services.
- 2.1.1 **Health Care Services That Are Medically Necessary.** If the Health Care Services are determined to be Medically Necessary, but Facility failed to comply with the Prior Authorization requirements set forth in this Agreement and the Policies and Procedures, then the amount due to Facility from BCBS will be reduced by five hundred dollars (\$500.00) per Claim. This five hundred dollar (\$500.00) sanction may not be collected from the Blue Preferred PPO Covered Person.
- 2.2 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Advantage PPO and BlueLincs HMO, the terms of this Blue Preferred PPO Attachment, including the Maximum Reimbursement Allowance described in Attachment C, shall be applicable to any Covered Services rendered to a Covered Person enrolled in a Product that utilizes a Provider Network in which Facility does not participate. Facility agrees to hold such Covered Persons harmless from any sums in excess of the Blue Preferred PPO Maximum Reimbursement Allowance. This paragraph shall supersede any provision contained in the Blue Choice PPO Attachment, if applicable, to accept the Blue Choice PPO Maximum Reimbursement Allowance for any Covered Person whose designated Provider Network is one in which Facility does not participate.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this Blue Preferred PPO Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement or (ii) termination of only this Blue Preferred PPO Attachment in accordance with the termination provisions in Article V of the Agreement.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A-4
BLUE ADVANTAGE PPOSM**

This Blue Advantage PPO Attachment is made a part of the Agreement and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the Blue Advantage PPO Network (“Blue Advantage PPO Covered Persons”). All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

**ARTICLE I
COVERED SERVICES**

- 1.0 **Covered Services.** Facility will furnish Covered Services to Blue Advantage PPO Covered Persons and otherwise perform under this Agreement, including this Blue Advantage PPO Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the Blue Advantage PPO Network (“Blue Advantage PPO Provider”).

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to Blue Advantage PPO Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility’s billed charges for Covered Services or (ii) BCBS’s Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to Blue Advantage PPO Covered Persons. Facility agrees to hold such Blue Advantage PPO Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance.

2.1 **Failure to Comply.**

- 2.1.0 **Health Care Services That Are Not Medically Necessary.** If the Health Care Services are determined to be not Medically Necessary or Experimental, Investigational or Unproven, payment will be denied. Except where otherwise provided by applicable Law, the denied amounts may not be collected from the Blue Advantage PPO Covered Person unless a waiver has been executed prior to rendering Health Care Services.
- 2.1.1 **Health Care Services That Are Medically Necessary.** If the Health Care Services are determined to be Medically Necessary, but Facility failed to comply with the Prior Authorization requirements set forth in this Agreement and the Policies and Procedures, then the amount due to Facility from BCBS will be reduced by five hundred dollars (\$500.00) per Claim. This five hundred dollar (\$500.00) sanction may not be collected from the Blue Advantage PPO Covered Person.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this Blue Advantage PPO Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement or (ii) termination of only this Blue Advantage PPO Attachment in accordance with the termination provisions in Article V of the Agreement.

Refer to cover page for Effective Date, contact information and signatures.

ATTACHMENT A-5 BLUELINCS HMOSM

This BlueLincs HMO Attachment is between GHS Health Maintenance Organization, Inc., d/b/a BlueLincs HMO, a Subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (“BlueLincs HMO”), and Facility and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the BlueLincs HMO Network (“BlueLincs HMO Covered Persons”). This BlueLincs HMO Attachment is made a part of the Agreement. All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

ARTICLE I COVERED SERVICES

- 1.0 **Covered Services.** Facility will furnish Covered Services to BlueLincs HMO Covered Persons and otherwise perform under the Agreement, including this BlueLincs HMO Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the BlueLincs HMO Network (“BlueLincs HMO Provider”).

ARTICLE II PAYMENT

- 2.0 **Claims Payment.** BlueLincs HMO will pay Facility for Covered Services rendered to BlueLincs HMO Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility’s billed charges for Covered Services or (ii) BlueLincs HMO’s Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to BlueLincs HMO Covered Persons. Facility agrees to hold such BlueLincs HMO Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance.
- 2.1 **Failure to Comply.** Failure to comply with the Prior Authorization requirements set forth in the Policies and Procedures will result in nonpayment of Facility’s charges. The denied amounts may not be collected from the BlueLincs HMO Covered Person.
- 2.2 **Hold Harmless.** As required of all Oklahoma Participating Providers by the Oklahoma Insurance Department, Facility agrees that, in no event, including but not limited to nonpayment by BlueLincs HMO, BlueLincs HMO’s insolvency or breach of this BlueLincs HMO Attachment, shall Facility bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against BlueLincs HMO Covered Persons or persons other than BlueLincs HMO for Covered Services provided pursuant to this BlueLincs HMO Attachment. This provision will not prohibit collection of any applicable copayments or deductible billed in accordance with the terms of the BlueLincs HMO Covered Person’s Coverage Agreement.

Facility further agrees that this provision (1) shall survive the termination of this BlueLincs HMO Attachment regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the BlueLincs HMO Covered Persons, and (2) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Facility and the BlueLincs HMO Covered Person or persons acting on the BlueLincs HMO Covered Person’s behalf.

Facility further agrees that any modifications, additions, or deletions to the provisions of this hold-harmless clause shall become effective on a date no earlier than fifteen (15) days after the Oklahoma Insurance Department has received written notice of such proposed changes.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this BlueLincs HMO Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement or (ii) termination of only this BlueLincs HMO Attachment in accordance with the termination provisions in Article V of the Agreement.
- 3.1 **Notification of BlueLincs HMO Covered Persons.** In the event Facility or BlueLincs HMO shall terminate participation under this BlueLincs HMO Attachment in accordance with the termination provisions of the Agreement and this BlueLincs HMO Attachment, BlueLincs HMO shall notify BlueLincs HMO Covered Persons within thirty (30) days of receipt of the termination notice if applicable.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A-7
NATIVEBLUESM**

This NativeBlue Attachment is made a part of the Agreement and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the NativeBlue Network and an employee or eligible member of Tribal Business Entity ("NativeBlue Covered Persons"). For purposes of this NativeBlue Attachment, a Tribal Business Entity is defined as an entity that is wholly owned by one or more Federally recognized tribes, as set forth in the Tribal Leaders Directory maintained by the United States Bureau of Indian Affairs, and may be a wholly owned subsidiary of one or more Tribal Business Entities. All other capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

**ARTICLE I
COVERED SERVICES**

- 1.0 **Covered Services.** Facility will furnish Covered Services to NativeBlue Covered Persons and otherwise perform under the Agreement, including this NativeBlue Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the NativeBlue Network ("NativeBlue Provider").

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to NativeBlue Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility's billed charges for Covered Services or (ii) BCBS's Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to NativeBlue Covered Persons. Facility agrees to hold such NativeBlue Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance.

2.1 **Failure to Comply.**

2.1.0 **Health Care Services That Are Not Medically Necessary.** If the Health Care Services are determined to be not Medically Necessary or Experimental, Investigational or Unproven, payment will be denied. Except where otherwise provided by applicable Law, the denied amounts may not be collected from the NativeBlue Covered Person unless a waiver has been executed prior to rendering Health Care Services.

2.1.1 **Health Care Services That Are Medically Necessary.** If the Health Care Services are determined to be Medically Necessary, but Facility failed to comply with the Prior Authorization requirements set forth in this Agreement and the Policies and Procedures, then the amount due to Facility from BCBS will be reduced by five hundred dollars (\$500.00) per Claim. This five hundred dollar (\$500.00) sanction may not be collected from the NativeBlue Covered Person.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this NativeBlue Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement or (ii) termination of only this NativeBlue Attachment in accordance with the termination provisions in Article V of the Agreement.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A-8
BLUE PLAN65 SELECT**

This Blue Plan65 Select Attachment is made a part of the Agreement and is effective as of the Effective Date set forth on the cover page of the Agreement with respect to Covered Persons enrolled in a Product that utilizes the Blue Plan65 Select Network (“Blue Plan65 Select Covered Persons”). All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The Parties agree as follows:

**ARTICLE I
COVERED SERVICES**

- 1.0 **Covered Services.** Facility will furnish Covered Services to Blue Plan65 Select Covered Persons and otherwise perform under the Agreement, including this Blue Plan65 Select Attachment, in a manner consistent and in compliance with the requirements of all Laws and all applicable Policies and Procedures. Facility shall be a Participating Provider in the Blue Plan65 Select Network (“Blue Plan65 Select Provider”).

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to Blue Plan65 Select Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility’s billed charges for Covered Services or (2) the Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to Blue Plan65 Select Covered Persons. Facility agrees to hold such Blue Plan65 Select Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance. BCBS will reimburse Facility directly for any Cost Share amounts that are applicable to such Medicare Part B Covered Services.
- 2.1 **Failure to Comply.**
- 2.1.0 **Health Care Services That Are Not Medically Necessary.** If the Health Care Services are determined to be not Medically Necessary or Experimental, Investigational or Unproven, payment will be denied. Except where otherwise provided by applicable Law, the denied amounts may not be collected from the Blue Plan65 Select Covered Person unless a waiver has been executed prior to rendering Health Care Services.
- 2.1.1 **Health Care Services That Are Medically Necessary.** If the Health Care Services are determined to be Medically Necessary, but Facility failed to comply with the Prior Authorization requirements set forth in this Agreement and the Policies and Procedures, then the amount due to Facility from BCBS will be reduced by five hundred dollars (\$500.00) per Claim. This five hundred dollar (\$500.00) sanction may not be collected from the Blue Plan65 Select Covered Person.

**ARTICLE III
TERM AND TERMINATION**

- 3.0 **Term and Termination.** The Parties agree that this Blue Plan65 Select Attachment is effective as of the Effective Date and will remain in effect until the earlier of (i) termination of the Agreement, or (ii) termination of only this Blue Plan65 Select Attachment in accordance with the termination provisions in Article V of the Agreement.

Refer to cover page for Effective Date, contact information and signatures.

ATTACHMENT B REQUIREMENTS FOR ACUTE CARE HOSPITALS

This Attachment B is hereby made a part of the Agreement. All capitalized terms not defined in this Attachment will have the meanings ascribed to them in Article I of the Agreement. The definitions in this Attachment apply only to the terms of this Attachment B, Attachment C and where expressly incorporated by reference.

ARTICLE I DEFINITIONS

- 1.0 **3M™ Enhanced Ambulatory Patient Grouping System (“EAPG”)** means the methodology used to categorize Visits into groups that are similar both clinically and in the amount of resources consumed. EAPG types are listed on Attachment C-2.
- 1.1 **Ancillary Entity** means a provider of ambulance, dialysis, home health, hospice, home infusion, durable medical equipment, prosthetics/orthotics, laboratory, ambulatory surgical center (ASC) or skilled nursing facility services, owned and operated in whole or in part by Facility that is identified by its own assigned NPI identifier, regardless of physical location.
- 1.2 **CPT-4 Codes** means the American Medical Association (“AMA”) listing of descriptive terms and identifying Codes for reporting Health Care Services and procedures performed by Health Care Providers. References to CPT-4 Codes include Codes set forth in subsequent revisions of AMA’s listing of descriptive terms and identifying Codes.
- 1.3 **Emergency Care** means Health Care Services provided in a hospital emergency facility to evaluate and stabilize Emergency Medical Conditions.
- 1.4 **HCPCS** means the Centers for Medicare and Medicaid Services (“CMS”) Common Procedure Coding System which consists of Level 1 Current Procedural Terminology (CPT), Level 2 National Codes, and Level 3 Local Codes. References to HCPCS include Codes set forth in subsequent revisions of the coding system.
- 1.5 **Hospital Acquired Conditions** or **HACs** means one of several specific medical conditions identified by CMS and based on ICD-10 Diagnosis Codes.
- 1.6 **Hospital Services** means Inpatient Hospital Services and Outpatient Hospital Services.
- 1.7 **ICD-10-CM Diagnosis Codes and ICD-10-PCS Procedure Codes** means the International Classification of Diseases, Tenth Revision, Clinical Modification, a classification system for diseases, procedures, conditions, causes, etc. References to ICD-10-CM Diagnosis Codes and ICD-10-PCS Procedure Codes include Codes set forth in subsequent revisions of the publication.
- 1.8 **Inpatient Admission** means a person has been admitted to a hospital or skilled nursing facility for bed occupancy to receive Inpatient Hospital Services or skilled nursing services. A person is considered an inpatient if he/she is formally admitted as an inpatient (other than for observation) with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged, or is transferred to another hospital, and does not actually use a hospital bed overnight.
- 1.9 **Inpatient Hospital Services** means Covered Services which involve acute care in an inpatient hospital setting. Acute care is care that is other than observation, convalescent, sanatorium or custodial in nature.

- 1.10 **Locations** means On-Campus Locations and Off-Campus Locations.
- 1.10.0 **On-Campus Location** means any physical location where Hospital Services are provided that is on the Main Campus of Hospital and operates under a separate NPI from Facility. Ancillary Entities as defined in this Agreement are not On-Campus Locations.
- 1.10.1 **Off-Campus Location** means any physical location where Hospital Services are provided that is not on the Main Campus of Hospital and operates under the NPI and license of Facility.
- 1.11 **Main Campus of Hospital** means the acute care facility and all locations within two hundred fifty (250) yards of the main entrance of such facility, or such other locations approved in advance by BCBS.
- 1.12 **Medicare Severity Diagnosis Related Group (“MS-DRG”)** means a method of classifying hospital patients by similar diagnoses, procedures, age, sex, and discharge status.
- 1.13 **Non-Patient** means a Covered Person that is not a patient of Facility, but has a specimen, scan, screening, image, or any other result (collectively and generally, “Test”) that is submitted for analysis or billing by Facility and the Covered Person is not physically present at a location covered under this Agreement at the time of the Test. Non-Patient specifically does not include a Covered Person’s specimens collected or received by Facility that are subsequently transferred to another Health Care Provider for testing and/or analysis, which Facility agrees is also not a billable charge to the Covered Person or BCBS.
- 1.14 **Outpatient** means a patient who receives Covered Services or supplies in the hospital setting, but for whom there is no Inpatient Admission.
- 1.15 **Outpatient Hospital Services** means Covered Services furnished by a hospital for care and treatment rendered to a Covered Person that are Medically Necessary and not considered Inpatient Hospital Services. Outpatient Hospital Services must be performed at the Main Campus of Hospital, or at another Off-Campus Location listed on Attachment D.
- 1.16 **Present on Admission (“POA”)** means conditions present at the time the order for Inpatient Admission occurs, or conditions that develop during a preceding outpatient encounter, including emergency department, observation, or outpatient surgery.
- 1.17 **Principal Diagnosis** means the condition which, after study, is determined to be the primary reason for admission to the hospital.
- 1.18 **Professional Services** means Covered Services provided by a physician or health care professional, rendered within the scope of his/her license.
- 1.19 **Related Service** means all Health Care Services for which the first three (3) digits (rubric) of the Principal ICD-10-CM Diagnosis Codes are the same for all encounters and occur within three (3) days of any Outpatient Hospital Service.
- 1.20 **Secondary Diagnosis** means a condition that is Present on Admission or that develops subsequent to the Inpatient Admission. This condition requires care that is distinct from and independent of the Principal Diagnosis and must include, but is not limited to, therapeutic treatment and either a clinical evaluation or a diagnostic procedure.
- 1.21 **Serious Reportable Event** means, as defined by the National Quality Forum, adverse events that are serious, but largely preventable, and of concern to both the public and Health Care Providers and as may be more fully described in the Policies and Procedures.

- 1.22 **Visit** means the provision of Outpatient Hospital Services to a Covered Person.

ARTICLE II OBLIGATIONS OF FACILITY

- 2.0 **Changes in Services.** Facility shall provide BCBS with at least sixty (60) days' Notice prior to any material change in the services available at any Facility Location listed on Attachment D, including, but not limited to, the cessation or material reduction of any of the following services: emergency room, ambulatory surgery, inpatient services, and neonatal and delivery.
- 2.1 **Credentialing and Recredentialing Notices.** Notwithstanding anything in this Agreement to the contrary, credentialing-related correspondence, including notices of termination for failure to recredential, will be sent to the credentialing address on Facility's most recent credentialing application received by BCBS.
- 2.2 **Locations and Ancillary Entities.** This Agreement and the rights, duties, and obligations of BCBS set forth herein apply to Facility operating on the Main Campus under Facility's NPI, and to the Locations and Ancillary Entities specifically listed on Attachment D to this Agreement as of the effective date of this Agreement. No other Location or Ancillary Entity existing on the effective date is included in this Agreement, and the terms and conditions of this Agreement shall not be deemed to apply to any Location or Ancillary Entity other than those listed on Attachment D.
- 2.2.0 **Notification of Sale, Closure or Address Change.** Facility shall notify BCBS in writing of the sale, closing or change of address of any Location or Ancillary Entity included on Attachment D at least thirty (30) days prior to such change or within five (5) business days of the of the closing date of the transaction if the Location or Ancillary Entity is being sold.
- 2.2.1 **New Locations and Ancillary Entities.** Facility agrees to notify BCBS in writing and provide information requested by BCBS regarding any new Location or Ancillary Entity, acquired or opened after the effective date of this Agreement, which is not listed on Attachment D. Such notice shall occur as soon as possible but at least sixty (60) days prior to rendering Covered Services to any Covered Person, or within five (5) business days of the closing date of the transaction if the Location or Ancillary Entity is being acquired.
- 2.2.1.0 **Denials for New Locations and Ancillary Entities.** BCBS may in its sole discretion deny a proposed addition to Attachment D if (i) Facility fails after request to provide information satisfactory to BCBS regarding the addition; (ii) a proposed Location or Ancillary Entity fails to meet BCBS's credentialing requirements, as applicable; or (iii) Facility is unable to resolve other concerns specified by BCBS to BCBS's satisfaction.
- 2.2.2 **Amendments to Attachment D.** Any changes to the information contained on Attachment D must be made expressly in a written amendment to Attachment D and cannot under any circumstances be deemed to have occurred in the absence of such amendment.
- 2.2.3 **Reimbursement for Locations/Ancillary Entities.** Reimbursement for Covered Services rendered at a Location will be as expressly set forth on Attachment C of this Agreement for each identified Location unless otherwise indicated on Attachment D. Claims for services, items, procedures and/or surgeries rendered at Off-Campus Locations must contain the appropriate modifiers, as required under *Modifiers* in Article III of this Attachment B. Under no circumstances will reimbursement applicable to Facility on the Main Campus under Facility's NPI be deemed to apply to an Off-Campus Location. Reimbursement for Covered Services rendered by an Ancillary Entity will be as set forth in the applicable sub-attachment to Attachment D.

- 2.2.4 **Covered Person Acknowledgement.** In the event that Outpatient Hospital Services are rendered at an Off-Campus Location listed on Attachment D and billed on Facility's UB-04 Claim form under Facility's NPI, Facility shall advise the Covered Person in writing before such services are rendered that the services will be billed as Hospital Services subject to the Covered Person's Cost Share requirements and have the Covered Person sign an acknowledgement prior to receiving such services, which acknowledgement shall be provided to BCBS upon request. In the event that BCBS becomes aware of repeated failure by Facility to obtain signed acknowledgments from Covered Persons prior to rendering such services, BCBS may remove the Off-Campus Location from Attachment D unless Facility cures such failure within sixty (60) days after written notice from BCBS in accordance with *Termination for Material Breach* in Article V of the Agreement.
- 2.3 **Potential Disputes.** Facility represents and warrants that, prior to entering into this Agreement or adding a location, Facility had a full and complete opportunity to investigate whether Facility (a) had any claims or causes of action whatsoever relating to any health benefit Claims for Health Care Services rendered by Facility to Blue Cross and/or Blue Shield members [ninety (90) days] or more prior to the Effective Date of the Agreement ("Potential Actions"), and (b) could assert the Potential Actions against BCBS, HCSC, any other Blue Cross and/or Blue Shield licensees, or any employer sponsors of health benefit plans administered by a Blue Cross or Blue Shield licensee. Facility further represents and warrants that, to the extent it has any Potential Actions, it fully disclosed them to BCBS prior to the Effective Date of this Agreement. In consideration of this Agreement, Facility hereby releases BCBS, HCSC, all other Blue Cross and/or Blue Shield licensees, and all employer sponsors of health benefit plans administered by a Blue Cross or Blue Shield licensee from any and all Potential Actions, whether disclosed to BCBS or not, known or unknown, as of the Effective Date of this Agreement. Notwithstanding the representations and warranties in this paragraph, BCBS retains its right to conduct routine Claim review, audits, adjustments, and recoveries with respect to any health benefit Claims for Health Care Services rendered by Facility to Covered Persons. To the extent such routine Claim activity or recovery occurs after the Effective Date of this Agreement ("Post-Agreement Claim Activity"), Facility retains its right to contest or appeal such Post-Agreement Claim Activity.
- 2.3 **Provider Directories.** Facility agrees to permit BCBS to publish, distribute and disseminate Facility's name and address as a Participating Provider in paper and electronic form. Facility also agrees to cooperate with all applicable laws and regulations regarding the accuracy of provider directory information, including but not limited to, BCBS's process to verify provider directory information.
- 2.4 **Remote Access to Electronic Health Records.** Facility will make best efforts to establish an agreement with BCBS to enable designated staff access to Facility's electronic health record (EHR) system when BCBS is required to conduct regulatory audits such as the Initial Validation Audits (IVA) Department of Health and Human Services' Risk Adjustment Data Validation (HHS-RADV) program, the Healthcare Effectiveness Data and Information Set (HEDIS), and other reviews performed by BCBS. This does not eliminate Facility's responsibility to provide records when requested by BCBS.
- 2.5 **Use of Participating Providers.** Facility acknowledges and agrees that it is in the best interest of Covered Persons to utilize Facilities where all billing Health Care Providers contract with BCBS. With respect to any facility-based Health Care Provider who provides Covered Services to Covered Persons at Facility, Facility shall use best efforts to require that the facility-based Health Care Providers obtain and/or maintain status as a Participating Provider with BCBS. Facility-based Health Care Providers include, but are not limited to, radiologists, pathologists, emergency room physicians, anesthesiologists, and neonatologists. Additionally, Facility will, except in instances of Emergency Care, notify the Covered Person of the possibility that some Covered Services may be provided by out-of-network Health Care Providers, and that the Covered Person may contact BCBS for more information.

ARTICLE III BILLING REQUIREMENTS

- 3.0 **Balance Billing.** Facility agrees to collect amounts from Covered Persons only for Non-Covered Services and for Cost Share amounts required by the applicable Coverage Agreement. Facility may collect from Covered Persons at time of service the applicable Cost Share, including a coinsurance amount calculated by Facility in good faith, unless prohibited by law. However, until BCBS has determined the Maximum Reimbursement Allowance and notified Facility of the amount due from the Covered Person, if any, Facility shall not bill or attempt to collect from the Covered Person for Health Care Services denied under the Utilization Management program, unless Facility has obtained a waiver from the Covered Person prior to rendering Health Care Services. Facility agrees that any amounts which may have been collected from the Covered Person in excess of the Covered Person's responsibility shall be refunded within thirty (30) days of receipt of BCBS's provider Claims summary.
- 3.1 **Billing Requirements.** Facility will submit Clean Claims to BCBS for any and all services rendered to Covered Persons using either the UB-04 paper Claim form and subsequent revisions or BCBS's paperless Claims entry system (electronically). All Claims shall be submitted in accordance with the National Uniform Billing Committee guidelines as published in the UB-04 *Uniform Billing Editor* and subsequent revisions. The following sections, *Billing Requirements for Inpatient Claims* and *Billing Requirements for Outpatient Claims*, shall also apply. For additional information on Claims filing requirements, Facility will refer to the Provider Manual and the provider section of the BCBS website at www.bcbsok.com under Claims and Eligibility.
- 3.2 **Billing Requirements for Inpatient Claims.**
- 3.2.0 **MS-DRG Groupings.** The inpatient reimbursement system described in this Agreement is based upon Medicare Severity Diagnosis Related Groupings (MS-DRG) of Covered Persons according to medically meaningful characteristics. There are six (6) major criteria which are utilized in assigning a particular Inpatient Admission to a specific MS-DRG. These consist of:
- 3.2.0.0 Covered Person's Principal Diagnosis.
 - 3.2.0.1 Procedures performed on the Covered Person.
 - 3.2.0.2 Covered Person's age.
 - 3.2.0.3 Covered Person's sex.
 - 3.2.0.4 Covered Person's discharge status.
 - 3.2.0.5 Multiple diagnoses, complications, or comorbidity.
- 3.2.1 **ICD-10-CM Diagnosis Codes and ICD-10-PCS Procedure Codes.** Facility shall provide all information necessary to adjudicate the Claim, including appropriate ICD-10-CM Diagnosis Codes and ICD-10-PCS Procedure Codes that document the patient's Principal Diagnosis responsible for the Inpatient Admission that affects the treatment received and/or length of stay as documented in the Medical Record.
- 3.2.2 **Other Requirements.** In addition to the above requirements, the following requirements shall apply:
- 3.2.2.0 **Combine Related Outpatient Hospital Services within Three Days of Inpatient Claim.** Facility shall include charges for any Health Care Service related to an Inpatient Admission that are performed within three (3) days of such

admission to Facility. These Health Care Services may not be billed separately from the Inpatient Hospital Services as they are inclusive of the Inpatient Admission.

- 3.2.2.1 **Include All Charges.** A Covered Person cannot be considered an inpatient and an outpatient at the same time. Facility shall include all charges for Health Care Services provided to Covered Person that are obtained from another organization (related or unrelated) while an inpatient at Facility. Facility shall be responsible, and shall not bill BCBS or Covered Person, for reimbursement to other organizations for any fees or charges for oversight or administrative services or any fees or charges not otherwise provided for in this Agreement.
- 3.2.2.2 **Interim Billings.** Facility shall not submit interim billings for Inpatient Hospital Services, unless approved in advance by BCBS on a case-by-case basis. Approvals will be for not less than sixty (60) days of care.
- 3.2.2.3 **Mothers and Newborns.** Facility shall submit separate billings for mothers and newborns.
- 3.2.2.4 **Multiple Claims During an Inpatient Admission.** Facility shall submit all Health Care Services rendered during an inpatient admission on the same Claim, including same day readmissions as described below in Section 3.3.2.1, *Same Day Readmissions*. If a service is not included on the original Claim, Facility shall submit a corrected Claim which includes all Health Care Services rendered. Failure to submit all charges on the same Claim may result in BCBS rejecting the Claim.
- 3.2.2.5 **Number of Inpatient Days.** Facility shall count the date of admission, but not the date of discharge, in computing the number of inpatient hospital days.
- 3.2.2.6 **Physical Location.** Facility shall include the address of the physical location where the Health Care Services are provided on each Claim.
- 3.2.2.7 **Present on Admission.** Facility shall include Present on Admission indicators for every diagnosis submitted for Inpatient Hospital Services. Diagnoses related to any earlier episodes which have no bearing on the current hospital stay are to be excluded from the Claim submitted to BCBS. Failure to populate the Present on Admission indicator may result in Claim adjustments by BCBS to disallow charges for Serious Reportable Events or Hospital Acquired Conditions.
- 3.2.2.8 **Provider-Preventable Errors.** Facility shall report wrong surgeries utilizing the appropriate external causes of morbidity Code and Type of Bill (TOB) Code. BCBS shall not reimburse for wrong surgeries. Amounts for wrong surgeries may not be collected from the Covered Person, and Facility may not obtain a waiver for wrong surgeries. In addition, Facility shall bill for wrong surgeries as set forth below:
- 3.2.2.8.0 One Claim with service(s)/procedure(s) unrelated to the wrong surgery on a TOB 11x (with the exception of 110), and;
- 3.2.2.8.1 The other Claim with the service(s)/procedure(s) for the wrong surgery on a TOB 110 (no-pay Claim);
- 3.2.2.8.2 Both Claims must have a matching date of admission.

- 3.2.2.8.3 If there are not any covered service(s)/procedure(s) provided during the stay other than the wrong surgery, Facility is required to submit a Claim for the wrong surgery with the TOB 110 (no-pay Claim).
- 3.2.2.9 **Same-Day Re-admissions.** If Covered Person is readmitted to Facility on the same day as a prior discharge for the same or a related condition, Facility shall combine the two admissions on one Claim. "Same-Day" is defined as midnight to midnight on a single day.
- 3.2.2.10 **Secondary Diagnosis.** Facility shall include a Secondary Diagnosis/Diagnoses, if applicable, on the Claim and document the care and treatment received in the Medical Record that is distinct and independent of the Principal Diagnosis.
- 3.2.2.11.0 **Violations.** If Facility bills BCBS on a Claim for Health Care Services arising out of, or relating to, Serious Reportable Events or Hospital Acquired Conditions, BCBS reserves the right to adjust the Claims to disallow charges arising from or relating to the Serious Reportable Event or Hospital Acquired Condition. Facility agrees never to bill or balance bill a Covered Person for costs associated with Health Care Services arising out of, or relating to, Serious Reportable Events or Hospital Acquired Conditions. In the event BCBS incurs Claims costs for Covered Services provided by other Health Care Providers that are related to Hospital Acquired Conditions or Serious Reportable Events for which Facility is responsible, then Facility must reimburse BCBS for such costs and BCBS may deduct such Claims costs from amounts otherwise due Facility under this Agreement.
- 3.3 **Billing Requirements for Outpatient Claims.** Facility shall provide all information necessary to adjudicate the outpatient Claim including appropriate Principal and Secondary ICD-10-CM Diagnosis Codes, CPT-4/HCPCS Codes and revenue Codes. Failure to submit any of the aforementioned information will result in return of the Claim to Facility.
- 3.3.0 **Coding.** Facility shall enter the appropriate CPT-4/HCPCS Code on the Claim form for all Outpatient Claims that include the revenue Codes listed on Attachment C-8. Each unique CPT-4/HCPCS Code must appear as a line item with the appropriate Outpatient Units of Service.
- 3.3.1 **Combine Related Outpatient Hospital Services within Three Days of Inpatient Claim.** Facility shall include charges for any Health Care Service related to an Inpatient Admission that are performed within three days of such admission to Facility. These Health Care Services may not be billed separately from the Inpatient Hospital Services as they are inclusive of the Inpatient Admission.
- 3.3.2 **Include All Charges.** A Covered Person cannot be considered an inpatient and an outpatient at the same time. Facility shall include all charges for Health Care Services provided to Covered Person that are obtained from another organization (related or unrelated) while an outpatient at Facility. Facility shall be responsible, and shall not bill BCBS or Covered Person, for reimbursement to other organizations for any fees or charges for oversight or administrative services or any fees or charges not otherwise provided for in this Agreement.
- 3.3.3 **Modifiers.** Facility shall include applicable modifier(s) on the Claim form. Such modifiers include but are not limited to PO, PN and ER modifiers for services, items, procedures, and/or surgeries provided at Off-Campus Locations. Any subsequent additions or changes to modifiers will also be included in this provision.

- 3.3.4 **National Drug Code (“NDC”).** Facility shall follow the facility NDC requirements set forth on BCBS’s website at www.bcbsok.com. BCBS may return the Claim if these NDC requirements are not followed.
- 3.3.5 **Physical Location.** Facility shall include the address of the physical location where the Health Care Services are provided on each Claim.
- 3.3.6 **Provider-Preventable Errors.** Facility shall report wrong surgeries utilizing the appropriate external causes of morbidity Code and TOB Code. Facility shall include the appropriate modifier, i.e. Surgery Wrong Body Part, Surgery Wrong Patient, or Wrong Surgery on Patient. BCBS shall not reimburse for wrong surgeries. Amounts for wrong surgeries may not be collected from the Covered Person, and Facility may not obtain a waiver for such wrong surgeries.
- 3.3.7 **Related Services.** Facility shall include all Outpatient Hospital Services provided to Covered Person for Related Services within a calendar month that occur within three (3) days of any Outpatient Hospital Service, on one Claim form (paper or paperless). Partial or interim billings are subject to rejection.
- 3.3.8 **Returned Claims.** BCBS will return a Claim in the following instances:
- 3.3.8.0 if the revenue Codes, as identified on Attachment C-9, do not have an accompanying CPT-4/HCPCS Code;
 - 3.3.8.1 if the ICD-10-CM Diagnosis Code is inappropriate for the listed CPT-4/HCPCS Code;
 - 3.3.8.2 if the primary diagnosis Code is an external cause Code as defined by ICD-10-CM;
 - 3.3.8.3 if the ICD-10-CM Diagnosis Code indicates a procedure was provided but no corresponding CPT-4/HCPCS Code is present on the Claim;
 - 3.3.8.4 if the CPT-4/HCPCS Codes on the Claim will not group to an EAPG.
- 3.3.9 **Visits.**
- 3.3.9.0 **Single Visit.** Facility shall submit all Health Care Services rendered during a single Visit on the same Claim.
 - 3.3.9.1 **Multiple Visits for a Related Condition(s) on the Same Day.** Facility shall submit all services for multiple Visits for the same or a related condition on the same Claim. If a Health Care Service is not included on the original Claim, Facility shall submit a corrected Claim which includes all services rendered. Failure to submit all charges for the same or a related condition on the same Claim may result in BCBS rejecting the Claim.
 - 3.3.9.2 **Multiple Visits for Unrelated Condition(s) on the Same Day.** Health Care Services rendered during multiple Visits on the same day for different or unrelated conditions are billable as separate Claims.
- 3.4 **Billing Requirements for Ancillary Entities.** Billing requirements for Health Care Services rendered by Ancillary Entities listed on Attachment D are set forth in sub-attachments to Attachment D and the Provider Manual. Claims for Health Care Services performed by a Ancillary Entity not listed on Attachment D may be denied or determined to be provided by a non-Participating Health Care Provider.

3.5 **Changes to Facility's Billing Practices.** Facility shall notify BCBS ninety (90) days in advance of implementing a systematic administrative coding or billing change that increases Facility's revenue for Covered Services without increasing the volume or acuity of Health Care Services. If BCBS becomes aware of such coding or billing change from Facility or other sources, then BCBS shall evaluate the annual financial impact of such administrative coding or billing change. If such administrative coding or billing change results in an increase in expected compensation to Facility more than one hundred thousand dollars (\$100,000) annually for each place of service (i.e., emergency room, outpatient, etc.), then BCBS may amend this Agreement in accordance with *Amendments Not Required by Law* in Article VII of the Agreement to adjust the MS-DRG Rate and/or EAPG rate to neutralize the financial impact of such a change as though the administrative coding or billing change did not occur.

3.6 **Chargemaster Increases.** Facility agrees to notify BCBS of any increase that exceeds an annual aggregate increase of three percent (3%) to its charge description master (CDM) or other similar off-cycle, comprehensive chargemaster changes. Facility also agrees to notify BCBS of a code-specific increase of more than three percent (3%) for either Inpatient Services or Outpatient Services, with primary focus on those services reimbursable based on billed charges applicable to Facility's Blue Cross and Blue Shield population during each twelve (12) month period occurring on or after the effective date of this Agreement or subsequent amendment to this Agreement. Facility will notify BCBS with a thirty (30) day prior written notice of any CDM adjustments expected to be in excess of said three percent (3%) thresholds.

In the event Facility's CDM increase is in excess of three percent (3%), or a code-specific increase is more than three percent (3%) on either Inpatient Services or Outpatient Services reimbursable based on billed charges, both parties will model prior adjudicated Claims data using the most current twelve (12) month period available with an additional ninety (90) day Claims runout. Said data will be modeled with the actual CDM increase to be implemented by Facility.

Within sixty (60) calendar days following the date of receipt of the written notification of Facility's CDM increase, BCBS will propose appropriate adjustments to Facility's base rate to offset the allowed dollar value that is created by the difference in the excess percentage increase above the three percent (3%) as stated above. Both Parties agree to meet in good faith within ten (10) business days to discuss such adjustments. Once agreement is reached by both Parties then the Facility's base rate will be adjusted. If both Parties agree on the required rate adjustments within forty-five (45) calendar days following the meeting, then BCBS will implement the adjusted rates for the adjudication of future Claims (e.g., there will be no retroactive adjustments to processed Claims). If appropriate rate adjustments are not agreed upon within the forty-five (45) calendar day timeframe, BCBS, at its option, may make the rate adjustments retroactive to the forty-sixth (46th) day as described above and adjust any processed Claims as appropriate.

3.7 **Claim Review.** BCBS reserves the right to review Claim payments on an individual or aggregate basis, regardless of whether such payment or payments have already been made, and may make adjustment to such Claim payments, including but not limited to the following:

3.7.0 Medical Necessity or lowest cost setting determinations.

3.7.1 Bill/Claim validation determinations of coding accuracy.

3.7.2 Fragmentation pursuant to Related Services and *Outpatient Reimbursement* in Article II of Attachment C.

3.7.3 Adjustments required for failure to comply with submission of Claim instructions or requirements of BCBS.

3.8 **Claims Subject to MS-DRG Review.** As set forth elsewhere in this Agreement, BCBS may access the Covered Person's hospital patient account records and any related correspondence in order to

audit Claims submitted pursuant to this Agreement and initially subject to audit of Covered Person's records related to the appropriateness of coding and MS-DRG assignment criteria. Where BCBS determines that the coding on the Claim was not supported by the documentation submitted by Facility, BCBS will reimburse Facility the amount consistent with the MS-DRG supported by the documentation submitted, except when administration of the Covered Person's benefits requires otherwise. Facility shall have the right to appeal each such determination, and arbitrate such Claims, pursuant to Article VI of the Agreement and Article V of this Attachment B, unless the Parties agree to collectively arbitrate similar Claims, which agreement shall not be unreasonably withheld by a Party.

- 3.9 **Claims Timely Filing.** Facility will submit Clean Claims to BCBS for any and all services rendered to Covered Persons at Facility's billed charges and in accordance with the billing requirements set forth in this Article.
- 3.9.0 **Original Claims.** Claims will be submitted within one hundred eighty (180) days of the date of discharge or date of service, or within one hundred eighty (180) days of the primary payer's dated provider Claims summary. Claims will be accepted beyond the one hundred eighty (180) day period if the Covered Person's Coverage Agreement allows a longer timely filing period. Claims which are not submitted within the timely filing requirements herein will not be honored and Facility agrees not to bill BCBS or the Covered Person for Health Care Services associated with such Claims.
- 3.9.1 **Corrected Claims.** Corrected Claims will be accepted by BCBS up to twelve (12) months following BCBS's adjudication of the original Claim.
- 3.10 **Impermissible Billing.** Notwithstanding *Include All Charges* in Sections 3.3.2 and 3.3.4 above, BCBS does not permit pass-through billing, billing for Non-Patients, splitting Claims, billing under arrangements with other Health Care Providers ("Under-arrangement" billing), or billing practices where a Health Care Provider or entity submits Claims by or for another Health Care Provider not otherwise provided for in the Health Care Provider's agreement with BCBS or as further described in Policies and Procedures. Only Health Care Services provided to Covered Persons physically present, either in person or appropriately via telemedicine, at locations listed on Attachment D are eligible to be Covered Services. Health Care Services provided not in accordance with this provision shall be the responsibility of Facility.
- 3.11 **Notification of Incorrect Payments.** Notwithstanding *Corrected Claim*, above, Facility agrees to notify BCBS of receipt of any incorrect payment of which it is aware, including underpayments, duplicate payments, or overpayments, within twelve (12) months of the original Claim process date. This obligation survives termination of the Agreement. Overpayments shall not be refunded to the Covered Person until BCBS has determined who is entitled to such funds. Facility agrees BCBS will be permitted to deduct overpayments (whether discovered by Facility or BCBS) from future payments made by BCBS, along with an explanation of the credit action taken.
- 3.12 **Professional Services.** Facility may not bill for Professional Services on a UB-04 Claim form. If charges for Professional Services are included on a UB-04 Claim form, and subsequent revisions, those charges will not be included in the calculation of the Maximum Reimbursement Allowance.
- 3.13 **Reference Lab.** Facility is not permitted to bill or submit lab Claims for reimbursement to BCBS under this Agreement for services provided to a patient who is not physically present at Facility, including billing and/or submitting Claims for laboratory services provided on samples or specimens where the patient was not present at the Facility at the time of collection of the sample/specimen, unless the sample or specimen was collected by a provider located within the county where Facility is located or a contiguous county and delivered or shipped to Facility for processing.
- 3.14 **Report Other Insurance.** Facility will report to BCBS any fact of which it or its agents have knowledge which indicates that the condition requiring services to the Covered Services arises

from any employment related or occupational injury or disease or may be compensated under any State or Federal Worker's Compensation or Employer's Liability law, or that the Covered Services has other insurance in effect which may provide benefits.

3.15 Serious Reportable Events and Hospital Acquired Conditions. Facility agrees that BCBS may apply the CMS standards for Serious Reportable Events and Hospital Acquired Conditions ("HAC") to Facility.

3.15.0 Serious Reportable Events. Facility agrees not to bill BCBS, and BCBS may reduce or eliminate payment for Serious Reportable Events for, or related to, incorrect surgeries as identified below based on a primary or secondary diagnosis code: (i) performance of wrong operation (procedure) on correct patient (Y65.51); (ii) performance of operation (procedure) on patient not scheduled for surgery (Y65.52); or, (iii) performance of correct operation (procedure) on wrong side/body part (Y65.53). The Parties agree that the CMS "Serious Reportable Event" definitions and standards apply to this Agreement, and that the terms of this Section will automatically update in accordance with updates to the CMS Serious Reportable Events definitions and standards.

3.15.1 Hospital Acquired Conditions. Facility agrees not to bill BCBS, and BCBS may reduce or eliminate payment for services rendered as a result of the occurrence of a HAC as defined by CMS. These HACs are identified based on ICD-10 Diagnosis Codes, and consistent with CMS guidelines.

3.15.2 Claims Adjustment for Serious Reportable Events or HACs. In the event that any Facility bills BCBS for Serious Reportable Events or for any costs associated with a HAC, BCBS reserves the right to adjust any such Claims to disallow charges and/or payments related to the Serious Reportable Events or HAC and the Facility agrees not to balance bill the Covered Person for any charges related to such Serious Reportable Events or HAC. No payment reduction for a Serious Reportable Event or HAC shall be permitted that is based on requirements or processes more stringent than the criteria applied by CMS, as specified in the Medicare Claims Processing Manual (or other applicable Medicare policy, guideline or rule) in effect on the date of service. In the event payment to any Facility is reduced as a result of a Serious Reportable Event or HAC, the Facility may request reconsideration and the reduced payment will be reversed if the Facility can demonstrate any of the following: (i) circumstances exist which would be the basis for receiving payment from CMS or pursuing a payment appeal with CMS; or (ii) the Serious Reportable Event or HAC did not occur and was identified as a result of a coding error; or (iii) based on the facts and circumstances as supported by information in the Covered Person's clinical record, the care was Medically Necessary and the HAC or Serious Reportable Event is not attributable to the actions of the Facility. For purposes of this Section, "Medical Necessary" means the same as the definition of "Medically Necessary" or "Medical Necessity" in the applicable Covered Person's Coverage Agreement. In the event BCBS incurs Claims costs for Covered Services provided by other Providers that are related to HACs or Serious Reportable Events for which Facility is responsible, then Facility must reimburse BCBS for such costs and BCBS may deduct such Claims costs from amounts otherwise due Facility under this Agreement.

3.15.3 Termination of the Facility/Patient Relationship. Facility may not terminate the relationship between Facility and a Covered Person because of such Covered Person's medical condition or the amount, types or cost of Covered Services that are required by the Covered Person. Facility acknowledges that a Covered Person may request transfer to another Participating Provider's care in accordance with the Covered Person's Coverage Agreement. Facility will provide patient records, reports and other documentation regarding such Covered Person upon request in order to facilitate such transfer.

Refer to cover page for Effective Date, contact information and signatures.

ATTACHMENT C REIMBURSEMENT FOR ACUTE CARE HOSPITALS

This Attachment C, including all sub-attachments listed on the cover page of the Agreement, e.g., Attachment C-1, Attachment C-2, etc. (collectively, this "Attachment") is hereby made a part of the Agreement. By agreement of the Parties, Attachments C-1 through C-9 are provided to Facility electronically with the Agreement. At BCBS's option, additional sub-attachments or amendments to sub-attachments may be provided either on paper or electronically. All capitalized terms not defined in this Attachment have the meanings ascribed to them in Article I of the Agreement and Article I of Attachment B.

ARTICLE I DEFINITIONS

- 1.0 **Ancillary Packaging** means the inclusion of Ancillary Tests, Ancillary Services or Incidental Procedures into the payment rate for a Significant Procedure or Medical Visit. (See Attachment C-5 for list of Ancillary Packaging).
- 1.1 **Ancillary Service** means a procedure that increases the time and resources expended during a Visit but does not dominate the time or resources expended during a Visit. They are identified on Attachment C-2 as EAPG Category Type Code(s) L, P, R, O, and are subject to discounting (Attachment C-3) and packaging (Attachment C-5).
- 1.2 **Ancillary Test** means a procedure ordered by a physician to assist in patient diagnosis and/or treatment.
- 1.3 **Discount Percentage** means the percentage amount to be applied to Claims containing EAPGs as described on Attachment C-3.
- 1.4 **First Per Diem Period** means the covered inpatient days that are after the First Threshold on Attachment C-1 and before and including the Second Threshold on Attachment C-1.
- 1.5 **Incidental Procedure** means an integral part of a Medical Visit usually associated with Outpatient Hospital Services.
- 1.6 **Inpatient MS-DRG Rate** means the rate used to calculate the inpatient fee in conjunction with Inpatient MS-DRG Weights.
- 1.7 **Inpatient MS-DRG Weight** means the value assigned to each MS-DRG on Attachment C-1.
- 1.8 **Inpatient Outlier** means Inpatient Admissions that have unique characteristics and are considered to be outside established parameters for each MS-DRG. Inpatient Outliers consist of cases with any of the following characteristics:
- 1.8.0 **Deaths** mean Covered Persons who expire in the inpatient setting; Inpatient Outliers are applicable only to specific MS-DRGs listed on Attachment C-1 with a "YES" listed in the Death Limit column.
- 1.8.1 **LAMA** means Covered Persons who leave the hospital or discontinue care against medical advice.
- 1.8.2 **Transfers** mean Covered Persons discharged/transferred to another short-term general hospital for inpatient care, patients discharged/transferred to another type of institution for inpatient care, patients discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital, or patients discharged/transferred to a Medicare certified long-term care hospital.

- 1.8.3 **Rehabilitation** means MS-DRGs 945 and 946.
- 1.9 **Inpatient Unit of Service** means the number of times the service or procedure being reported was performed according to the revenue/HCPSC Code definition.
- 1.10 **Medical Visit** means a grouping that describes medical treatment received by a Covered Person without a Significant Procedure performed during the same Visit. They are identified on Attachment C-2 as EAPG Category Type Code M and are subject to packaging (Attachment C-5).
- 1.11 **Medicare Severity Diagnosis Related Group (“MS-DRG”) Code** means the three (3) digit numeric code for a specific MS-DRG.
- 1.12 **Medicare Severity Diagnosis Related Group (“MS-DRG”) Rate** means the price agreed to by BCBS and Facility for the Hospital Service falling within the definition of a Medicare Severity Diagnosis Related Group for which a Medicare Severity Diagnosis Related Group Code has been assigned.
- 1.13 **Outpatient EAPG Rates** mean the rates used to calculate the Maximum Reimbursement Allowance for Outpatient Hospital Services in conjunction with EAPG weights from Attachment C-2 and all other applicable Attachments. Significant Procedure/Medical Visit EAPG Rate and Ancillary EAPG Rate are collectively referred to as “Outpatient EAPG Rates”.
- 1.13.0 **Significant Procedure/Medical Visit EAPG Rate** means the rate used to calculate the Maximum Reimbursement Allowance for services that are typically only available in an outpatient hospital setting, e.g. outpatient surgical procedures, emergency room procedures, etc.
- 1.13.1 **Ancillary EAPG Rate** means the rate used to calculate the Maximum Reimbursement Allowance for Ancillary Services and significant diagnostic procedures when those services are eligible to receive separate and distinct reimbursement under EAPG methodology.
- 1.14 **Outpatient EAPG Weight** means the value assigned to each EAPG indicated on Attachment C-2.
- 1.15 **Outpatient Unit of Service** means the number of times the service or procedure being reported was performed according to each CPT-4/HCPSC Code definition.
- 1.16 **Per Diem** means a measure of payment for a day of service, including all Covered Services provided to a Covered Person, which is the exclusive payment for Covered Services provided to the Covered Person.
- 1.17 **Principal Procedure** means the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes or the procedure most related to the Principal Diagnosis for an Inpatient Admission.
- 1.18 **Recurring Service** means Health Care Services which are normally and historically batch billed, as listed on Attachment C-9, which will not be subject to consolidation or Discount Percentage.
- 1.19 **Second Per Diem Period** means covered Inpatient days that are after the Second Threshold on Attachment C-1.
- 1.20 **Significant Procedure** means a procedure that is normally scheduled, constitutes the reason for the Visit, and dominates the time and resources expended during the Visit.
- 1.21 **Significant Procedure Consolidation** means the combining of multiple related Significant Procedure EAPGs into a single EAPG for the purpose of the determination of payment. (See Attachment C-4 for a list of Significant Procedure Consolidation Codes).

ARTICLE II REIMBURSEMENT

- 2.0 **Accept Reimbursement.** For Covered Services provided to Covered Persons enrolled in a Product that utilizes a Provider Network in which Facility is a Participating Provider, Facility will accept as payment in full the lesser of (i) Facility's billed charges or (ii) the applicable Maximum Reimbursement Allowance set forth on this Attachment C. Facility agrees to hold such Covered Persons harmless from any sums in excess of the applicable Maximum Reimbursement Allowance.
- 2.1 **Changes in CPT-4/HCPCS Codes/ICD-10-CM Diagnosis Codes/ICD-10-PCS Procedure Codes.** Codes established subsequent to the effective date of this Agreement will be assigned a Maximum Reimbursement Allowance determined by BCBS in a manner consistent with Maximum Reimbursement Allowances of comparable CPT-4/HCPCS Codes/ICD-10-CM Diagnosis Codes or ICD-10-PCS Procedure Codes or a subsequent revision. The assignment of Maximum Reimbursement Allowances for new Codes will be available to Facility upon request.
- 2.2 **Inpatient Reimbursement.** The formula for calculating the Maximum Reimbursement Allowance for Inpatient Hospital Services provided by Facility is as follows:
- 2.2.0 **MS-DRG Payment.** The MS-DRG Payment (except as described in Section 2.2.1, *Inpatient Outlier Payments*, below) is the sum of the three items below:
- 2.2.0.0 The applicable Inpatient MS-DRG Rate multiplied by Inpatient MS-DRG Weight. This amount is the Maximum Reimbursement Allowance for Covered Services rendered on the date of the Inpatient Admission through and including the number of days listed on Attachment C-1 under "First Threshold".
- 2.2.0.1 The number of days in the First Per Diem Period multiplied by the First Per Diem on Attachment C-1.
- 2.2.0.2 The number of days in the Second Per Diem Period multiplied by the Second Per Diem on Attachment C-1.
- 2.2.1 **Inpatient Outlier Payments.** Inpatient Outlier Payments will be reimbursed in the order listed below:
- 2.2.1.0 **Rehabilitation MS-DRGs.**
- 2.2.1.0.0 For MS-DRG 945 (rehabilitation with CC/MCC) the Maximum Reimbursement Allowance shall be \$1,500 Per Diem multiplied by length of stay.
- 2.2.1.0.1 For MS-DRG 946 (rehabilitation without CC/MCC), the Maximum Reimbursement Allowance shall be \$1,200 Per Diem multiplied by length of stay.
- 2.2.1.1 **Deaths, LAMA and Transfers.** (Excludes first per diem period and second per diem period admissions (see Section 2.2.0.1 and Section 2.2.0.2, above)). Claims with discharge status death, LAMA and transfer will be reimbursed using a per diem payment methodology. The Per Diem is calculated using the Inpatient MS-DRG Weight multiplied by the Inpatient MS-DRG Rate divided by the number of days listed on Attachment C-1 under "First Threshold" for each MS-DRG. Facility shall receive the lesser of (i) charges for Covered Services or (ii) the MS-DRG payment as set forth in Section 2.2.0, *MS-DRG Payment*, or (iii) two (2) times the Per Diem for the first day plus the Per Diem for each subsequent day of the Inpatient Admission.

- 2.2.2 **Changes in MS-DRGs.** MS-DRGs established subsequent to the effective date of this Agreement will be assigned weights, thresholds and per diems by BCBS in a manner consistent with weights, thresholds and per diems of comparable MS-DRGs. BCBS will provide Notice to Facility of the weights, thresholds and per diems and the effective date. If a Claim is received containing Codes which have been deleted or which have become invalid for the dates of service on the Claim, the Claim shall be returned for appropriate coding.
- 2.2.3 **POA.** If the diagnosis was not POA, then it will not be considered in the MS-DRG grouping.
- 2.2.4 **Re-Admissions.** If Covered Person is readmitted to Facility within thirty (30) days of the initial discharge for the same, similar, or related diagnosis (i.e. a condition that is clinically related to the prior admission), the subsequent admission(s) may be considered inclusive of the first admission. BCBS may review the appropriateness of the readmission. If BCBS determines that the subsequent admission(s) was inclusive of the first admission, it may make adjustments to such Claim payments in accordance with its right to recover as set forth in the Provider Manual.
- 2.3 **Outpatient Reimbursement.** The formula for calculating the Maximum Reimbursement Allowance for Outpatient Hospital Services is as follows:
- 2.3.0 **EAPG Payment.** Outpatient reimbursement shall be based on Enhanced Ambulatory Patient Groups (EAPGs), which is a methodology used to categorize Visits into groups that are similar both clinically and in the amount of resources consumed. EAPG types are listed on Attachment C-2.
- 2.3.0.0 In certain instances, EAPGs will be consolidated into other EAPGs and/or packaged into other EAPGs, as described on Attachment C-4 and Attachment C-5.
- 2.3.0.1 Recurring Services are not consolidated or discounted for purposes of payment and will be multiplied by Outpatient Units of Service. The Maximum Reimbursement Allowance for an EAPG for Recurring Services shall not be greater than eighty-five percent (85%) of the charges for (Covered) Recurring Services. With regard to the formula for calculating the Maximum Reimbursement Allowance set forth in subparagraphs 3, 4, and 5 below, the calculation shall be adjusted accordingly if the EAPG in question is for Recurring Services.
- 2.3.0.2 The formula for calculating Maximum Reimbursement Allowance for a Claim with only one (1) non-packaged, non-consolidated EAPG is as follows:
- The applicable Outpatient EAPG Rate multiplied by Outpatient EAPG Weight, multiplied by each Outpatient Unit of Service, multiplied by Discount Percentage.
- 2.3.0.3 A multiple EAPG payment is calculated in accordance with the Discount Percentage Matrix on Attachment C-3 when there is more than one (1) non-packaged or non-consolidated EAPG of the same type. An example of multiple EAPG payment calculation is as follows:
- Maximum Reimbursement Allowance equals (EAPG1 Outpatient EAPG Weight multiplied by the applicable Outpatient EAPG Rate multiplied by Discount Percentage multiplied by each Outpatient Unit of Service) plus (EAPG2 Outpatient EAPG Weight multiplied by the applicable Outpatient EAPG Rate multiplied by Discount Percentage multiplied by each Outpatient Unit of Service) plus (EAPGX Outpatient EAPG Weight multiplied by the applicable Outpatient EAPG Rate multiplied by Discount Percentage multiplied by each Outpatient Unit of Service).

Discount Percentage amount will apply to EAPG types. The highest weighted EAPG in a type is reimbursed at one hundred percent (100%), the second non-packaged, non-consolidated EAPG in a type is reimbursed at fifty percent (50%), and subsequent non-packaged, non-consolidated EAPGs in a type are each reimbursed at twenty-five percent (25%).

Non-packaged and non-consolidated EAPGs are ordered based on their EAPG Type (significant, medical, and ancillary, etc.) and descending weight. Utilizing the Discount Percentage Matrix, the appropriate percentage is applied.

2.3.0.4 **Off-Campus Locations.** Claims for Health Care Services rendered at Off-Campus Locations shall be submitted with PN, PO or ER modifiers and will be reimbursed at seventy percent (70%) of the Maximum Reimbursement Allowance for Covered Services.

2.3.0.5 **Terminated Procedures.** When a procedure is terminated after a patient has been prepared for surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but before the induction of anesthesia, payment will be fifty percent (50%) of the Maximum Reimbursement Allowance for Covered Services. When a procedure is terminated after the induction of anesthesia or after the procedure was started (incision made, intubation started, scope inserted), payment will be one hundred percent (100%) of the Maximum Reimbursement Allowance. Facility shall bill the appropriate modifiers for each terminated procedure.

2.4 **Ancillary Entities.** The Maximum Reimbursement Allowances for Health Care Services rendered by Ancillary Entities listed on Attachment D are set forth on sub-attachments to Attachment D. Claims for Health Care Services performed by an Ancillary Entity not listed on Attachment D may be denied or determined to be out of network.

**ARTICLE III
REIMBURSEMENT FOR THE BLUE TRADITIONAL NETWORK**

3.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to Blue Traditional Covered Persons shall be determined as set forth below. Reimbursement shall be in accordance with the billing requirements and payment provisions of the Agreement, including Attachment B and Article II of this Attachment C.

3.1 **Hospital Services.**

3.1.0 **Inpatient.** The Maximum Reimbursement Allowance for Inpatient Hospital Services shall be calculated in the same manner as Section 2.2 of this Attachment C, except the Inpatient MS-DRG Rate shall be as set forth below:

Effective Date	MS-DRG Rate
April 1, 2026 through March 31, 2027	\$12,221
April 1, 2027 through March 31, 2028	\$12,558
April 1, 2028 through March 31, 2029	\$12,966

3.1.1 **Outpatient.** The Maximum Reimbursement Allowance for Outpatient Hospital Services shall be calculated in the same manner as Section 2.3 of this Attachment C, except the Outpatient EAPG Rate shall be as set forth below:

Effective Date	Outpatient EAPG Rate	
	Significant Procedure /Medical Visit	Ancillary
April 1, 2026 through March 31, 2027	\$350.50	\$374.00
April 1, 2027 through March 31, 2028	\$371.50	\$385.25
April 1, 2028 through March 31, 2029	\$393.75	\$396.75

3.2 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Preferred PPOSM, Blue Advantage PPOSM and BlueLincs HMOSM, the Maximum Reimbursement Allowance for the Blue Traditional Network described herein shall be applicable to any Covered Services rendered to a Covered Person who is enrolled in a Product that utilizes a Provider Network in which Facility is not a Participating Provider. Facility agrees to hold such Covered Person harmless from any sums in excess of the Blue Traditional Network Maximum Reimbursement Allowance.

**ARTICLE IV
REIMBURSEMENT FOR THE BLUE CHOICE PPO NETWORK**

4.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to Blue Choice PPO Covered Persons shall be determined as set forth below. Reimbursement shall be in accordance with the billing requirements and payment provisions of the Agreement, including Attachment B and Article II of this Attachment C.

4.1 **Hospital Services.**

4.1.0 **Inpatient.** The Maximum Reimbursement Allowance for Inpatient Hospital Services shall be calculated in the same manner as Section 2.2 of this Attachment C, except the Inpatient MS-DRG Rate shall be as set forth below:

Effective	MS-DRG Rate
April 1, 2026 through March 31, 2027	\$10,627
April 1, 2027 through March 31, 2028	\$10,946
April 1, 2028 through March 31, 2029	\$11,274

4.1.1 **Outpatient.** The Maximum Reimbursement Allowance for Outpatient Hospital Services shall be calculated in the same manner as Section 2.3 of this Attachment C, except the Outpatient EAPG Rate shall be as set forth below:

Effective Date	Outpatient EAPG Rate	
	Significant Procedure /Medical Visit	Ancillary
April 1, 2026 through March 31, 2027	\$304.50	\$374.00
April 1, 2027 through March 31, 2028	\$322.75	\$385.25
April 1, 2028 through March 31, 2029	\$342.00	\$396.75

4.2 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Preferred PPOSM, Blue Advantage PPOSM or BlueLincs HMOSM, the Maximum Reimbursement Allowance for the Blue Choice PPO Network described herein shall be applicable to any Covered Services rendered to a Covered Person who is enrolled in a Product that utilizes a

Provider Network in which Facility is not a Participating Provider. Facility agrees to hold such Covered Person harmless from any sums in excess of the Blue Choice PPO Network Maximum Reimbursement Allowance. This Section shall supersede any provision contained herein, if applicable, requiring Facility to accept the Blue Traditional Network Maximum Reimbursement Allowance for any Covered Person who is enrolled in a Product that utilizes a Provider Network in which Facility is not a Participating Provider.

**ARTICLE V
REIMBURSEMENT FOR THE BLUE PREFERRED PPO NETWORK**

5.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to Blue Preferred PPO Covered Persons shall be determined as set forth below. Reimbursement shall be in accordance with the billing requirements and payment provisions of the Agreement, including Attachment B and Article II of this Attachment C.

5.1 **Hospital Services.**

5.1.0 **Inpatient.** The Maximum Reimbursement Allowance for Inpatient Hospital Services shall be calculated in the same manner as Section 2.2 of this Attachment C, except the Inpatient MS-DRG Rate shall be as set forth below:

Effective Date	MS-DRG Rate
April 1, 2026 through March 31, 2027	\$9,033
April 1, 2027 through March 31, 2028	\$9,304
April 1, 2028 through March 31, 2029	\$9,583

5.1.1 **Outpatient.** The Maximum Reimbursement Allowance for Outpatient Hospital Services shall be calculated in the same manner as Section 2.3 of this Attachment C, except the Outpatient EAPG Rate shall be as set forth below:

Effective Date	Outpatient EAPG Rate	
	Significant Procedure / Medical Visit	Ancillary
April 1, 2026 through March 31, 2027	\$258.75	\$374.00
April 1, 2027 through March 31, 2028	\$274.25	\$385.25
April 1, 2028 through March 31, 2029	\$290.75	\$396.75

5.2 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Advantage PPOSM or BlueLincs HMOSM, the Maximum Reimbursement Allowance for the Blue Preferred PPO Network described herein shall be applicable to any Covered Services rendered to a Covered Person who is enrolled in a Product that utilizes a Provider Network in which Facility is not a Participating Provider. Facility agrees to hold such Covered Person harmless from any sums in excess of the Blue Preferred PPO Network Maximum Reimbursement Allowance. This Section shall supersede any provision contained herein, if applicable, requiring Facility to accept the Blue Choice PPO Network Maximum Reimbursement Allowance for any Covered Person who is enrolled in a Product that utilizes a Provider Network in which Facility is not a Participating Provider.

**ARTICLE VI
REIMBURSEMENT FOR THE BLUE ADVANTAGE PPO NETWORK**

6.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to Blue Advantage PPO Covered Persons shall be determined as set forth below. Reimbursement shall be in accordance with the billing requirements and payment provisions of the Agreement, including Attachment B and Article II of this Attachment C.

6.1 **Hospital Services.**

6.1.0 **Inpatient.** The Maximum Reimbursement Allowance for Inpatient Hospital Services shall be calculated in the same manner as Section 2.2 of this Attachment C, except the Inpatient MS-DRG Rate shall be as set forth below:

Effective Date	MS-DRG Rate
	\$7,440
	\$7,663
	\$7,893

6.1.1 **Outpatient.** The Maximum Reimbursement Allowance for Outpatient Hospital Services shall be calculated in the same manner as Section 2.3 of this Attachment C, except the Outpatient EAPG Rate shall be as set forth below:

Effective Date	Outpatient EAPG Rate	
	Significant Procedure /Medical Visit	Ancillary
April 1, 2026 through March 31, 2027	\$213.00	\$374.00
April 1, 2027 through March 31, 2028	\$225.75	\$385.25
April 1, 2028 through March 31, 2029	\$239.25	\$396.75

**ARTICLE VII
REIMBURSEMENT FOR THE BLUELINCS HMO NETWORK**

7.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to BlueLincs HMO Covered Persons shall be determined as set forth below. Reimbursement shall be in accordance with the billing requirements and payment provisions of the Agreement, including Attachment B and Article II of this Attachment C.

7.1 **Hospital Services.**

7.1.0 **Inpatient.** The Maximum Reimbursement Allowance for Inpatient Hospital Services shall be calculated in the same manner as Section 2.2 of this Attachment C, except the Inpatient MS-DRG Rate shall be as set forth below:

Date Range	MS-DRG Rate
April 1, 2026 through March 31, 2027	\$7,440
April 1, 2027 through March 31, 2028	\$7,663
April 1, 2028 through March 31, 2029	\$7,893

7.1.1 **Outpatient.** The Maximum Reimbursement Allowance for Outpatient Hospital Services shall be calculated in the same manner as Section 2.3 of this Attachment C, except the Outpatient EAPG Rate shall be as set forth below:

Effective Date	Outpatient EAPG Rate	
	Significant Procedure /Medical Visit	Ancillary
April 1, 2026 through March 31, 2027	\$213.00	\$374.00
April 1, 2027 through March 31, 2028	\$225.75	\$385.25
April 1, 2028 through March 31, 2029	\$239.25	\$396.75

**ARTICLE VIII
REIMBURSEMENT FOR THE NATIVEBLUE NETWORK**

8.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to NativeBlue Covered Persons shall be determined as set forth below. Reimbursement shall be in accordance with the billing requirements and payment provisions of the Agreement, including Attachment B and Article II of this Attachment C.

8.1 **Hospital Services.**

8.1.0 **Inpatient.** The Maximum Reimbursement Allowance for Inpatient Hospital Services shall be calculated in the same manner as Section 2.2 of this Attachment C, except the Inpatient MS-DRG Rate shall be as set forth below:

Effective Date	MS-DRG Rate
April 1, 2026 through March 31, 2027	\$7,440
April 1, 2027 through March 31, 2028	\$7,663
April 1, 2028 through March 31, 2029	\$7,893

8.1.1 **Outpatient.** The Maximum Reimbursement Allowance for Outpatient Hospital Services shall be calculated in the same manner as Section 2.3 of this Attachment C, except the Outpatient EAPG Rate shall be as set forth below:

Effective Date	Outpatient EAPG Rate	
	Significant Procedure /Medical Visit	Ancillary
April 1, 2026 through March 31, 2027	\$213.00	\$374.00
April 1, 2027 through March 31, 2028	\$225.75	\$385.25
April 1, 2028 through March 31, 2029	\$239.25	\$396.75

**ARTICLE IX
REIMBURSEMENT FOR THE BLUE PLAN65 SELECT NETWORK**

9.0 **Maximum Reimbursement Allowances.** Maximum Reimbursement Allowances for Covered Services provided to Blue Plan65 Select Covered Persons shall be determined as set forth below.

9.1 **Hospital Services.**

9.1.0 **Inpatient.**

9.1.0.0 **Health Care Services Covered by Medicare.** For Health Care Services provided to the Blue Plan65 Select Covered Person that are covered by Medicare, for which the Blue Plan65 Select Covered Person has Medicare benefits, Facility will accept as total reimbursement the Medicare allowable reimbursement less the Blue Plan65 Select Covered Person's Cost Share amounts, but not less than ninety percent (90%) of the total Medicare allowable reimbursement for each Blue Plan65 Select Covered Person's admission. If Medicare pays an amount that is less than ninety percent (90%) of the Medicare allowable, then BCBS agrees to pay an amount necessary to bring the total reimbursement up to ninety percent (90%) of the Medicare allowable.

9.1.0.1 **After Medicare Benefits Exhausted.** For Health Care Services provided to the Blue Plan65 Select Covered Person that are considered to be covered by Medicare, and for which the Blue Plan65 Select Covered Person has exhausted his/her Medicare benefits, Facility will accept from BCBS the amount that

Medicare would have allowed for such Health Care Services if the Blue Plan65 Select Covered Person had Medicare benefits remaining.

9.1.0.2 **Health Care Services Not Covered by Medicare or BCBS.** For Health Care Services provided to the Blue Plan65 Select Covered Person that are not covered either by Medicare or by the Blue Plan65 Select Covered Person's Blue Plan65 Select Coverage Agreement, and benefits are exhausted, Facility may collect charges for such Health Care Services directly from the Blue Plan65 Select Covered Person.

9.1.1 **Outpatient.**

9.1.1.0 **Health Care Services Covered by Medicare.** For Health Care Services provided to the Blue Plan65 Select Covered Person that are covered by Medicare, for which the Blue Plan65 Select Covered Person has Medicare benefits, Facility will accept Medicare's allowed reimbursement as full reimbursement. Amounts allowed by Medicare for Health Care Services that are ordinarily the responsibility of the Blue Plan65 Select Covered Person will be paid by BCBS, up to the limits of the Covered Person's Blue Plan65 Select Coverage Agreement.

9.1.1.1 **Health Care Services Not Covered by Medicare or BCBS.** For Health Care Services provided to the Blue Plan65 Select Covered Person that are not covered either by Medicare or by the Blue Plan65 Select Covered Person's Coverage Agreement, and benefits are exhausted, Facility may collect charges for such Health Care Services directly from the Blue Plan65 Select Covered Person.

9.1.2 **Terminated Procedures.** When Medicare benefits are exhausted and a Covered Service is terminated after a patient has been prepared for surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but before the induction of anesthesia, BCBS will pay fifty percent (50%) of the charges for Covered Services. When a Covered Service procedure is terminated after the induction of anesthesia or after the procedure was started (incision made, intubation started, scope inserted), BCBS will pay one hundred percent (100%) of the amount that Medicare would have allowed for such Health Care Services if the Blue Plan65 Select Covered Person had Medicare benefits remaining.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT D
LOCATIONS AND ANCILLARY ENTITIES**

This Attachment D and all sub-attachments listed on the cover page of the Agreement (if applicable), which pertain to Ancillary Entities listed below (if applicable), are hereby made a part of the Agreement. In accordance with Locations and Ancillary Entities in Article II of Attachment B, the following Locations and Ancillary Entities are hereby made parties to the Agreement as of the Effective Date:

Mangum City Hospital Authority d/b/a Mangum Regional Medical Center			
<i>Location or Ancillary Entity</i>	<i>Physical Address</i>	<i>NPI</i>	<i>Reimbursement</i>
Mangum Regional Medical Center (main campus)	1 Wickersham Drive Mangum, OK 73554	1033635263	Attachment C

Refer to cover page for Effective Date, contact information and signatures.

Hospital Vendor Contract Summary Sheet

1. Existing Vendor New Vendor
2. **Name of Contract:** Blue Cross Blue Shield Medicare Advantage
3. **Contract Parties:** MRMC/Blue Cross Blue Shield
4. **Contract Type Services:** Insurance
5. **Impacted Hospital Departments:** Hospital Patient Care
6. **Contract Summary:** Provides an agreement with BCBS for the to be able to provide services to Blue Cross Blue Shield Medicare Advantage members.
7. **Cost:** No Cost
8. **Prior Cost:** None
9. **Term:** 3 years- then renews automatically for 1-year intervals
10. **Termination Clause:** Written notice has to be received on or before June 30th of that year and term will be effective at 11:59 PM on December 31st of that year.
11. **Other:**

**BLUE CROSS MEDICARE ADVANTAGESM NETWORK PARTICIPATION AGREEMENT
FOR HOSPITALS**

This Blue Cross Medicare Advantage Network Participation Agreement (“MA Agreement”) constitutes an agreement between the Parties and is made and entered into by and between Blue Cross and Blue Shield of Oklahoma (“BCBS”), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (“HCSC”), and the undersigned hospital (“Facility”). (BCBS and Facility may singularly be referred to as the “Party” or collectively as the “Parties”).

As of the date executed, this MA Agreement includes the following:

- Blue Cross Medicare Advantage Agreement
- Attachment A, Medicare Advantage Compensation Schedule for Hospitals
- Attachment B, Medicare Advantage Downstream Provider Addendum
- Attachment C, Data Certification
- Attachment D, Locations and Ancillary Entities

Facility is participating in the following networks:

- Blue Cross Medicare AdvantageSM (HMO) Blue Cross Medicare AdvantageSM (PPO)

Any notice given pursuant to the terms and provisions of this MA Agreement (except for credentialing-related correspondence) shall be sent as follows:

Notice to BCBS:

Vice President, Provider Network Operations
Blue Cross and Blue Shield of Oklahoma
1400 S. Boston Avenue, Tulsa, OK 74119

Notice to Facility:

Name/Title: Mangum Regional Medical Center, Attn: Administrator
Address: PO Box 280., Mangum, OK 73554
Email: kmartinez@chmcok.com

The undersigned Parties hereby agree to the terms and conditions contained in this MA Agreement. This MA Agreement shall be effective beginning on April 1, 2026.

BLUE CROSS AND BLUE SHIELD OF
OKLAHOMA, A DIVISION OF HEALTH CARE
SERVICE CORPORATION, A MUTUAL LEGAL
RESERVE COMPANY

MANGUM CITY HOSPITAL AUTHORITY D/B/A
MANGUM REGIONAL MEDICAL CENTER

Authorized Signature

Rick Kelly

Name of Signatory

Vice President, Provider Network Operations

Title of Signatory

Date Signed

Authorized Signature

Name of Signatory

Title of Signatory

Date Signed

RECITALS

WHEREAS, BCBS has contracted with the Centers for Medicare and Medicaid Services to offer Medicare Advantage Plans in select counties in the state of Oklahoma;

WHEREAS, Facility is a health care provider licensed by, and in good standing with, the State of Oklahoma, and desires to participate in the Medicare Advantage provider network(s) serving Medicare Advantage Covered Persons;

WHEREAS, BCBS wishes Facility to participate in BCBS's Medicare Advantage provider network(s) and Facility wishes to participate in BCBS's Medicare Advantage provider network(s) serving Medicare Advantage Covered Persons as indicated on the cover page of this MA Agreement;

NOW, THEREFORE, in consideration of the mutual promises and recitals in this MA Agreement, the Parties agree as follows:

ARTICLE I DEFINITIONS

The terms included herein shall have the meaning required by law to be applicable to BCBS and Facility under the terms of BCBS's contract with CMS and/or the regulations promulgated in 42 CFR §422 as well as the following definitions to the extent consistent with the aforementioned contract and regulations:

- 1.0 **BCBS** means Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company. For purposes of this MA Agreement, "BCBS" refers to HCSC as the Medicare Advantage Organization, or any HCSC Affiliate in instances where an HCSC Affiliate holds the CMS Contract.
- 1.1 **Blue Cross Medicare Advantage PPO Network Sharing Program** means a Blue Cross and Blue Shield Association program which gives Blue Cross Medicare Advantage Covered Persons in participating states access to their health care benefits anywhere in the United States. This Program utilizes an electronic data system, which links providers and transmits claims processing information. This Program enables certain Blue Cross Medicare Advantage Covered Persons access to Facility at BCBS's negotiated rates.
- 1.2 **Centers for Medicare and Medicaid Services ("CMS")** means the agency within the Department of Health and Human Services that administers the Medicare program.
- 1.3 **Clean Claim** means a claim for healthcare services rendered by Facility which accurately contains all the data elements required by Federal Medicare provider manuals and/or program transmittals and any other data element(s) required by BCBS as specified in BCBS's MA Provider Manual(s), filed in a timely manner.
- 1.4 **CMS Contract** means the contract(s) between CMS and Health Care Service Corporation (HCSC) or an HCSC Affiliate pursuant to which HCSC or HCSC Affiliate sponsors Medicare Advantage and Part D Plans.
- 1.5 **Cost Share** means that portion of Facility's payment for a Covered Service for which an MA Covered Person is responsible, including, but not limited to, co-payments, co-insurance, deductibles, reduction of benefits, and any other applicable financial responsibility of the MA Covered Person pursuant to the MA Coverage Agreement.
- 1.6 **Covered Services** means Health Care Services that are specified as benefits covered under an MA Coverage Agreement and are provided or arranged for by Facility to MA Covered Persons pursuant to the terms of this MA Agreement.

- 1.7 **Downstream Entity** means the same as defined in 42 C.F.R. §§ 422.2 and 423.4; Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- 1.8 **First Tier Entity** means the same as defined in 42 C.F.R. §§ 422.2 and 423.4; Any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services, including Covered Services, for a Medicare eligible individual under the MA Program.
- 1.9 **HCSC Affiliate** means any current or future wholly-owned subsidiaries or majority-controlled affiliates of HCSC that offer or sponsor Medicare plans in certain service areas, either now or at a future date, including but not limited to: HCSC Insurance Services Company (“HISC”); GHS Health Maintenance Organization, Inc. d/b/a/ BlueLincs HMO (“BlueLincs HMO”); GHS Insurance Company (f/k/a GHS Property and Casualty Insurance Company) (“GHSIC”); Illinois Blue Cross Blue Shield Insurance Company (“ILBCBSIC”); and Texas Blue Cross Blue Shield Insurance Company (f/k/a BCBSTX Government Programs Insurance Company) (“TXBCBSIC”) (by whatever name each may be known in the future if different from the name stated herein), and any successor corporation, whether by merger, consolidation or reorganization. Any reference to BCBS or HCSC herein shall mean the HCSC Affiliate in those instances where an HCSC Affiliate holds the CMS Contract. HCSC has delegated authority from each HCSC Affiliate to be the contracting entity with providers.
- 1.10 **HCSC Medicare Advantage Plan (“HCSC MA Plan”)** means Medicare Advantage and Medicare Advantage Prescription Drug Plan(s) sponsored by HCSC or an HCSC Affiliate pursuant to a CMS Contract.
- 1.11 **Health Care Provider** means any appropriately licensed, or where applicable and appropriate, certified, provider of Health Care Services.
- 1.12 **Health Care Services** means health care related services, items, treatments, testing, drugs, supplies, procedures, investigation or observation for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- 1.13 **HHS** means the U. S. Department of Health and Human Services.
- 1.14 **Laws.** Any and all applicable laws, rules, regulations, statutes, orders, and standards of the United States of America, the states or any department or agency thereof with jurisdiction over any or all of the Parties, as such laws, rules, regulations, statutes, orders and standards are adopted, amended or issued from time to time. Laws include, without limitation, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations, including the HIPAA administrative simplification rules for privacy, security and transaction and code sets at 45 CFR parts 160, 162, and 164; Parts C and D of Title XVIII of the Social Security Act and its implementing regulations, including Parts 422 and 423 of Title 42 of the Code of Federal Regulations; all CMS guidance and instructions relating to the Medicare Advantage and Medicare Prescription Drug Programs; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the requirements applicable to individuals and entities receiving federal funds; the federal False Claims Act (31 U.S.C. §3729, et.seq.); any applicable state false claims statute, the federal anti-kickback statute (42 U.S.C. §1320a-7b of the Social Security Act); and the federal regulations prohibiting the offering of beneficiary inducements.
- 1.15 **Medicare Advantage Coverage Agreement (“MA Coverage Agreement”)** means any policy, contract, document, or certificate entered into or issued by an HCSC MA Plan, which entitles MA Covered Persons to receive benefits for Covered Services, and which identifies the Covered

Services that BCBS has agreed to adjudicate, and, to the extent appropriate, pay for, on behalf of MA Covered Persons, and explains the benefits, limitations, exclusions, terms, and conditions of a MA Covered Person's coverage.

- 1.16 **Medicare Advantage Covered Person ("MA Covered Person")** means a person who is enrolled in an HCSC MA Plan and whose enrollment with BCBS has been confirmed by CMS, and entitled to receive Covered Services pursuant to the terms of an MA Coverage Agreement and the Medicare Advantage provider network(s) covered under the terms of this MA Agreement, at the time Covered Services are furnished.
- 1.17 **Medicare Advantage Organization ("MA Organization")** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the CMS Contract requirements.
- 1.18 **Medicare Advantage Plan** means a Medicare Advantage Plan sponsored by a Medicare Advantage Organization, as the term is defined pursuant to the Medicare Advantage Program.
- 1.19 **Medicare Advantage ("MA") Program** means the Medicare managed care program established and maintained under Laws. The Medicare Advantage Program is an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.
- 1.20 **Medicare Advantage Provider ("MA Provider")** means a Health Care Provider that directly or indirectly contracts with BCBS to deliver Health Care Services, including Covered Services, to MA Covered Persons according to the terms of their MA Coverage Agreements, BCBS direction and this MA Agreement. The term shall be inclusive of any sub-contracted professional and other Health Care Providers to the extent that they have been provided a copy of this MA Agreement and executed a Downstream Addendum (See Attachment B) or other agreement of substantially similar content.
- 1.21 **Medicare Advantage Provider Manual(s) ("MA Provider Manual(s)")** means the documents applicable to the MA Program that are prepared by BCBS and available to Facility via BCBS's website, which may be amended solely at BCBS's option from time to time, setting forth the basic policies and procedures required to be followed by Facility in carrying out this MA Agreement in providing Covered Services to MA Covered Persons. In the event of a conflict between the applicable MA Provider Manual and the terms of this MA Agreement, the terms of this MA Agreement shall apply. Such MA Provider Manual(s), as amended from time to time, is incorporated by reference herein.

ARTICLE II FACILITY OBLIGATIONS

- 2.0 **Provision of Covered Services.** Facility agrees to render Covered Services to BCBS's MA Covered Persons, including MA Covered Persons who may reside in other states, in accordance with the terms and conditions of BCBS's MA Program including the provisions of BCBS's applicable MA Coverage Agreement. BCBS shall afford Facility with access to BCBS's MA Program requirements not set forth in this MA Agreement. Determination of Covered Services shall be governed by coverage guidelines established by BCBS and the MA Program, with BCBS being solely responsible for final coverage determination, subject to the applicable appeal procedures. Facility shall discuss all treatment options with MA Covered Persons, including the option of no treatment, as well as related risks, benefits and consequences of such options. As applicable, Facility shall provide to MA Covered Persons instructions regarding follow-up care and training regarding self-care.

- 2.1 **Direct Access to Certain Benefits.** Facility shall comply with all referral and prior authorization procedures set forth in the applicable MA Provider Manual, provided that no referral or prior authorization obligations shall be required for or imposed upon an MA Covered Person to obtain (1) a screening mammography, (2) an influenza vaccine, or (3) women who receive routine and preventive Covered Services from an in-network women's health care specialist. In addition, no cost sharing obligation shall be required to obtain an influenza vaccine or a pneumococcal vaccine.
- 2.2 **Reports and Administration.** Facility agrees to provide BCBS with encounter data and other informational data sufficient to meet its reporting obligations under its MA Program and Facility's performance under this MA Agreement as required by law. BCBS shall have sole responsibility for filing reports, obtaining approval from, and complying with the applicable laws and regulations of Federal, state and local governmental agencies having jurisdiction over BCBS. BCBS shall perform all the necessary administrative, accounting, enrollment and other functions appropriate for the marketing and administration of its MA Program.
- 2.3 **No Surcharges.** Facility shall not charge the MA Covered Person any fees or surcharges for Covered Services rendered pursuant to this MA Agreement (except for authorized Cost Share). In addition, Facility shall not collect a sales, use, or other applicable tax from an MA Covered Person for the sale or delivery of medical services or collect any other fee or surcharge from the MA Covered Person on behalf of BCBS, the amount of which is solely a legal obligation of BCBS. MA Covered Persons eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when a State or Medicaid managed care organization (MCO) is responsible for paying such amounts. BCBS will inform the provider about Medicare and Medicaid benefits and rules for MA Covered Persons eligible for Medicare and Medicaid. Facility may not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to an individual under Social Security Act Title XIX (Medicaid) if the individual were not enrolled in such a plan. Facility will (a) accept BCBS payment as payment in full, or (b) bill the appropriate State or MCO source. If BCBS receives notice of any additional charge, Facility shall fully cooperate with BCBS to investigate such additional charges and shall promptly refund any payment deemed improper by BCBS, to the party who made the payment.
- 2.4 **Indemnification.** Except as otherwise prohibited or limited by applicable law, Facility will indemnify and hold harmless BCBS and any HCSC affiliate, employee or agent from or against any claims, cause of action, liability, damage, cost or expense, including attorney's fees and court or proceeding costs, arising out of or in connection with any breach of this MA Agreement, negligent or intentional commission or omission of conduct, or violation of any Laws or the CMS Contract by Facility or Facility's affiliate, employee or agent related to services performed under this MA Agreement. Furthermore, Facility will indemnify and hold harmless BCBS and any HCSC affiliate, employee or agent from or against any: (i) damage, cost or expense, including attorney's fees and investigation costs, arising out of or in connection with a finding of non-compliance by CMS or any other governmental agency against BCBS or HCSC Affiliate; and (ii) for the amount of any fine, penalty or liquidated damage assessed by CMS or other governmental agency against and payable by BCBS or an HCSC Affiliate to any agency of government or under law; if the loss described in (i) or (ii) was caused by Facility or Facility's officers, directors, employees, agents, or Downstream Entity(ies) in the performance of or failure to perform any function, duty, responsibility, or performance standard under the MA Agreement or as required to comply with Laws, the CMS Contract, or this MA Agreement. BCBS shall have and retain plenary authority to decide whether, when and how to appeal or contest any fine, penalty or liquidated damage assessed by CMS or other governmental agency. Facility shall not in any situation or circumstance communicate directly with CMS or other governmental agency about any fine, penalty or liquidated damage without prior, express written approval from BCBS in its sole discretion. Notwithstanding the forgoing, if a fine, penalty or liquidated damage is the direct result of acts and omissions of both BCBS and Facility, such shall be apportioned between them based on relative causation as determined by BCBS in its sole discretion. This section shall survive termination of this MA Agreement, regardless of the cause giving rise to termination.

- 2.5 **Downstream Providers.** As applicable for ancillary, facility, or professional provider types, any services performed by Downstream Entities of Facility shall be performed in accordance with the contractual obligations established between CMS and BCBS and all applicable, professionally recognized standards of health care. Accordingly, Facility agrees that it will not contract with any entity (“Downstream Provider”) to administer or deliver Covered Services to MA Covered Persons unless (1) such arrangement is approved by BCBS, at its sole discretion; (2) such Downstream Provider is specifically obligated, through a written agreement between Downstream Provider and BCBS or Downstream Provider and Facility, to comply with all Laws, including all provisions contained in this MA Agreement; (3) Facility agrees to act on BCBS’s behalf and take diligent action to enforce the obligations of all such Downstream Providers, including but not limited to the requirement to comply with Medicare laws, regulations, and CMS instructions; and (4) such written arrangement specifically permits BCBS and CMS to suspend or terminate the subcontractor or take such other remedial action as CMS or BCBS, in its reasonable discretion, deems appropriate, upon determination by CMS in its sole discretion, or BCBS in its reasonable discretion, that such Downstream Provider is not performing the services satisfactorily. For purposes of compliance with *Direct Access to Benefits*, above, the Downstream Provider may, at the election of BCBS or the Facility as applicable, complete either Attachment B, Downstream Provider Addendum, or other agreement of substantially similar content.
- 2.6 **Hospital Privileges.** Certain physicians are required to maintain staff privileges at a hospital designated by BCBS as a “participating” hospital. This requirement is waived if a participating hospital is not available in the physician’s area or the physician’s practice does not require the maintenance of hospital staff privileges.

ARTICLE III BCBS’S OBLIGATIONS

- 3.0 **Marketing and Administrative Responsibilities.** BCBS shall have the sole responsibility for and shall perform all the necessary administrative, accounting, enrollment and other functions appropriate for the marketing and administration of its MA Program.
- 3.1 **MA Covered Person Identification.** Each MA Covered Person will be provided an identification card which includes BCBS’s name or logo, the name of the product, the MA Covered Person’s name, the address for claims submission, telephone number for precertification and verification of eligibility, and the applicable cost-sharing amounts that shall be collected by the Facility.

ARTICLE IV COMPENSATION

- 4.0 **Payment for Covered Services.** BCBS shall pay, and Facility shall accept as payment in full for rendering of Covered Services to MA Covered Persons, the compensation specified in Attachment A to this MA Agreement. Facility shall not request payment for Covered Services under this MA Agreement in any form from CMS, HHS, or any other agency of the United States of America, or their designees, for items and services furnished in accordance with this MA Agreement except as may be approved in advance by BCBS and CMS. Facility may not bill or collect from the MA Covered Person, or anyone responsible for the MA Covered Person, for services, procedures, drugs, supplies or home medical equipment if such care was not medically necessary or not a benefit of the MA Coverage Agreement, as determined by BCBS and explained in BCBS’s MA Provider Manual and/or as set forth in the MA Coverage Agreement.
- 4.1 **Overpayment.** This Section establishes the rights and obligations of each Party with respect to any actual or alleged erroneous payments for claims for health care services under the HCSC MA Plan. This Section shall survive termination of this MA Agreement. Notwithstanding the prescribed timeframes and terms set forth in this Section, both Parties acknowledge and agree that certain Laws governing HCSC MA Plans may require adjustments to claims, or may allow adjustments to

claims, which are different from these prescribed time periods and terms and such Laws shall control in the event of a conflict with this Section.

- 4.1.0 **Notice by HCSC of Overpayment.** HCSC shall provide notice (excluding notice through provider newsletter or HCSC's website) to Facility of any overpayment identified by HCSC within ninety (90) calendar days of HCSC identifying such overpayment.
- 4.1.1 **Written Notice by Facility of Overpayment.** Facility shall provide written notice to HCSC of any overpayment identified by Facility within fifteen (15) calendar days of Facility identifying such overpayment. In order for the written notice to be deemed complete and timely, for each claim, Facility's written notice of an overpayment must include the information required by HCSC and be in the form and format set forth in the MA Provider Manual, as it may be amended from time to time by HCSC, and must contain specific information for each claim that allows HCSC to identify and assess the allegation(s) for each claim.
- 4.1.2 **Maximum Lookback Period.** Unless one of the Parties has provided notice or written notice, as applicable and as required by subsections 4.1.0 or 4.1.1, above, to the other Party of an overpayment within the timeframe allowed by Laws, if any, after HCSC's payment for such Covered Services, any payment made by HCSC and received by Facility will be deemed complete and accurate subject to the exceptions set forth in this Section. Accordingly, HCSC may not assert a claim, repayment request, suit, demand, challenge, or cause of action, whether at law or equity, or commence a proceeding of any kind to recover an overpayment against Facility, whether pursuant to Article VI of the MA Agreement or on any other basis, after such timeframe has expired unless such claim, repayment request, suit, demand, challenge, cause of action, or proceeding is based upon: (i) fraud, (ii) material misrepresentation, (iii) duplicate payment, (iv) coordination of benefits, (v) third-party liability, (vi) MA Covered Person eligibility for a Product, or (vii) other circumstances where adjustments are permitted by Laws.
- 4.1.3 **Facility Overpayment Claim Disputes.** Facility may dispute an HCSC finding of an overpayment by sending written notice to HCSC within fifteen (15) calendar days of receiving notice of such overpayment from HCSC. In order for Facility's written notice to be deemed complete and timely, for each claim, the written notice of an overpayment claim dispute must include the information required by HCSC and be in the form and format set forth in the MA Provider Manual, as it may be amended from time to time by HCSC, and must contain specific information for each claim that allows HCSC to identify and assess the allegation(s) for each claim. Such written notice of dispute will automatically stay the overpayment refund timing requirements under subsection 4.1.4 until such dispute is resolved pursuant to a mutual agreement by the Parties or a final and binding determination. Facility may not assert a claim, repayment request, suit, demand, challenge, or cause of action, whether at law or equity, or commence a proceeding of any kind to dispute an overpayment, whether pursuant to the dispute resolution process set forth in Article VI of this MA Agreement or on any other basis, after the fifteen (15) calendar day period for disputing the overpayment has expired. Unless Facility disputes the finding of an overpayment within fifteen (15) calendar days of receiving notice (excluding notice through provider newsletter or HCSC's website) of such overpayment from HCSC, such overpayment amount as set forth in the HCSC notice shall be deemed correct and final and binding on both Parties and shall be paid to HCSC by Facility within the timeframes set forth in subsection 4.1.4. Both Parties agree to work in good faith to resolve any differences regarding overpayments within sixty (60) calendar days of HCSC receiving timely written notice of Facility's dispute. If the matter cannot be resolved within such time frame, the Parties agree to follow the dispute resolution process set forth in Article VI of this MA Agreement.

- 4.1.4 **Payment by Facility of Overpayment.** Unless the Facility has timely disputed a HCSC finding of an overpayment under subsection 4.1.3 of this section and unless otherwise instructed in writing by HCSC, Facility agrees to pay any overpayment within thirty (30) calendar days of Facility's receipt of HCSC's notice (excluding notice through provider newsletter or website) of overpayment. If the overpayment was identified by Facility, then Facility shall pay such overpayment within thirty (30) calendar days of providing written notice to HCSC. If Facility fails to pay any overpayments due to HCSC within such thirty (30) calendar day timeframe, as applicable, HCSC may recover or offset the amount of the overpayment from future payments due to Facility pursuant to HCSC's standard recovery processes.
- 4.2 **Non-Covered Services.** No benefits are payable pursuant to this MA Agreement if not a covered benefit under the MA Covered Person's MA Coverage Agreement. Subject to Laws, in the event Facility performs noncovered services for which Facility wishes to seek compensation from the MA Covered Person beyond Cost Share, Facility shall inform the MA Covered Person prior to the provision of such services: (1) that the services recommended are not Covered Services, (2) that BCBS shall not pay for or be liable for such services, and (3) that the MA Covered Person shall be financially liable to Facility for such services. Documentation shall include a duly completed and signed Advance Beneficiary Notice.

ARTICLE V TERMINATION

- 5.0 **Term.** The initial term of this MA Agreement shall begin on the Effective Date set forth on the cover page of this MA Agreement and continue in effect for three (3) years (the "Initial Term"). Thereafter, the Agreement will automatically renew for successive one (1) year terms (each, a "Renewal Term," and together with the "Initial Term," the "Term"). This MA Agreement shall remain binding until properly terminated as allowed herein. The Parties agree that this MA Agreement is conditioned upon the CMS Contract and shall terminate automatically upon termination of the CMS Contract. BCBS shall, to the extent practical and feasible, undertake commercially reasonable efforts to advise Facility in advance of the termination of the CMS Contract.
- 5.1 **Voluntary Termination.** After the Initial Term, any Party to this MA Agreement may voluntarily terminate this MA Agreement without cause upon provision of prior written notice to the other Party. If written notice is received on or before June 30th, the termination will be effective at 11:59 PM on December 31st of that year. If written notice is received on or after July 1st, the termination will not be effective until December 31st of the following year.
- 5.2 **Termination as a Result of Exclusion/Adverse Action.** This MA Agreement shall immediately terminate upon notice to Facility of the occurrence of any of the following events:
- 5.2.0 Exclusion from participation in government health care programs as outlined in *Exclusion from Participation in Government Programs* in Article VII of this MA Agreement, or any other action taken against Facility by any governmental agency that may affect Facility's ability to perform the obligations under this MA Agreement, such as, by way of illustration but not limitation, inclusion of Facility in the Office of Inspector General's LEIE database;
 - 5.2.1 Any action against or lapse of Facility's license, controlled substance permit, medical staff membership or clinical privileges, or cancellation of liability insurance that may affect Facility's ability to perform the obligations under this MA Agreement;
 - 5.2.2 Any felony information or indictment naming Facility that may affect the Facility's ability to perform his/her/its obligations under this MA Agreement;
 - 5.2.3 Upon a request by CMS that this MA Agreement terminate; or

- 5.2.4 Determination that Facility's continued provision of Covered Services under this MA Agreement presents an imminent risk of danger to the health of any Covered Person.
- 5.3 **Termination for Cause.** Any Party may terminate this MA Agreement for any material breach of this MA Agreement by the other Party but only if that breach is not cured within thirty (30) days after written notice is provided to the breaching Party.
- 5.4 **Notice of Termination to MA Covered Persons.** Upon termination of this MA Agreement for any reason, BCBS, and not Facility, shall, as required by applicable law, notify MA Covered Persons assigned to, currently receiving care from, or have received care from such provider within the prior three (3) years (for behavioral health and primary care) or the prior three (3) months (for all other provider types) prior to the effective date of the termination of this MA Agreement or of the Facility's participation in the BCBS's provider network(s). [42 C.F.R. § 422.111(e)¹] Facility shall cooperate with and assist BCBS in identifying such MA Covered Persons.
- 5.5 **Transition of MA Covered Persons.** Upon either Party's provision of notice of termination of this MA Agreement to the other Party, Facility shall cooperate fully with the continuation of services requirements of this MA Agreement, including BCBS instructions and protocols, if any, in the transfer of MA Covered Persons to other network providers.
- 5.6 **Provisions Surviving Termination.** The provisions of this MA Agreement related to indemnification, MA Covered Person hold harmless, and any other sections of this MA Agreement which by their nature or express terms extend beyond the duration of this MA Agreement, shall survive termination or expiration of this MA Agreement.

ARTICLE VI GENERAL PROVISIONS

6.0 **Modification and Regulatory Amendment.**

BCBS may modify any provision of this MA Agreement upon ninety (90) day's prior written notice to Facility of such modification. Facility shall have sixty (60) days after receipt of such notice to object in writing to the proposed modification. If Facility objects timely in writing to the modification, the Parties will then engage in good faith negotiations to resolve Facility's objection to the proposed amendment. If the Parties are unable to reach agreement on the proposed amendment prior to the effective date of the amendment, either Party may terminate this MA Agreement upon one hundred eighty (180) days' prior written notice to Facility. If Facility fails to object timely in writing to the modification then Facility will be deemed to have accepted the modification.

Facility agrees that this MA Agreement shall automatically be amended as necessary to conform to Laws and to include any additional terms and conditions as CMS or HCSC may find necessary and appropriate in order to implement and comply with the requirements of Laws. Any such additional or conforming terms and conditions shall be deemed agreed to and incorporated herein by reference upon written notice of such modifications or updates to Facility by HCSC, including the wholesale replacement of this MA Agreement incorporating the same.

- 6.1 **Use of Names.** Facility authorizes BCBS to include Facility's name, gender (if applicable), location, specialty and telephone number and any other information in provider lists such as directory related material. Facility may identify itself as contracted or in-network with BCBS for Medicare Advantage. Except as authorized herein, each Party agrees that it will not use the names, symbols, trademarks or service marks of the other Party in advertising and promotion or otherwise without the prior written consent of the other Party.

¹ Bracketed annotations are subject to change based on future amendments or recompiling.

- 6.2 **Severability.** If any provision of this MA Agreement is held to be illegal, invalid, or unenforceable under present or future laws effective during the term hereof, such provision shall be fully severable. This MA Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provision had never been included, and the remaining provisions shall remain in full force and effect unaffected by such severance, provided that the invalid provision is not material to the overall purpose and operation of this MA Agreement.
- 6.3 **Relationship of the Parties.** The relationship of the Parties is not and shall not be construed or interpreted to be a partnership, joint venture or agency. The relationship between the Parties is an independent contractor relationship, as more fully set forth and described elsewhere in this MA Agreement.
- 6.4 **Relationship of BCBS to Association.** Facility hereby expressly acknowledges the understanding that this MA Agreement constitutes an agreement between Facility and BCBS; that BCBS is an independent non-profit corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBS to use the Blue Cross and Blue Shield Service Marks in certain states, and that BCBS is not contracting as the agent of the Association. Facility further acknowledges and agrees that Facility has not entered into this MA Agreement based upon representations by any person other than BCBS and that no person, entity, or organization other than BCBS shall be held accountable or liable to Facility for any BCBS obligation to Facility created under this MA Agreement. This section shall not create any additional obligations whatsoever on the part of BCBS other than those obligations created under other provisions of this MA Agreement.
- 6.5 **Notice.** All notices and other communications to a Party must be in writing, hand delivered, delivered by prepaid commercial courier service with tracking capabilities, faxed, or delivered by the U.S. Mail, to the address listed on the signature page, or via encrypted email. Notices to terminate this MA Agreement must be sent by Certified U.S. Mail or prepaid commercial courier service with tracking capabilities. The Parties may change the address of record by notifying the other Party of the new address. Notice shall be complete upon the earlier of actual receipt or, if delivered by U.S. Mail, five (5) days after being deposited into the U.S. mail.
- 6.6 **Waiver.** The waiver by any Party of any term, provision or condition or the breach of any term, provision or condition of this MA Agreement will not be construed as a waiver of any subsequent breach of the same or any other term, provision or condition. The failure to exercise any right hereunder will not operate as a waiver of such right. All rights and remedies provided herein are cumulative.
- 6.7 **No Guarantee of Utilization.** Facility understands that BCBS does not warrant or guarantee that Facility will be utilized by any MA Covered Person or any number of MA Covered Persons.
- 6.8 **Blue Cross Medicare Advantage PPO Network Sharing.** Facility agrees to furnish covered benefits, according to the Blue Cross Medicare Advantage PPO Network Sharing Program and procedures and this MA Agreement, to those individuals who at the time of their treatment by Facility are Blue Cross Medicare Advantage Covered Persons in a participating state. Facility will be compensated by BCBS through the Blue Cross Medicare Advantage PPO Network Sharing Program for such covered benefits in accordance with the provisions of this MA Agreement.
- 6.9 **Independent Contractor.** Facility understands that services are provided to MA Covered Persons in the capacity of independent contractor. None of the provisions of this MA Agreement are intended to create, nor shall be deemed or construed to create any relationship between BCBS and Facility other than that of independent parties contracting with each other solely for the purpose of effecting the provisions of this MA Agreement. No Party or any of their respective officers, directors, or employees shall be construed to be the agent, employee or representative of the other. Neither Party is authorized to represent the other for any purpose whatsoever without the prior consent of the other Party.

6.10 **Insurance.** Facility will maintain at his/her/its own expense such policies of malpractice, liability and industry standard insurance coverage sufficient to insure Facility and their employees against claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of services under this MA Agreement. Upon termination of this MA Agreement, Facility agrees to maintain such coverage in effect or to procure and maintain sufficient tail coverage sufficient to ensure continued coverage for any services rendered during the term of this MA Agreement.

6.11 **Dispute Resolution.**

6.11.0 Any dispute between BCBS and Facility arising out of, relating to, involving the interpretation of, or in any other way pertaining to this MA Agreement, that relates to Facility's participation and duties under this MA Agreement, or any Laws relating thereto, shall be resolved using alternative dispute resolution mechanisms instead of litigation. BCBS or Facility, as the case may be, shall give written notice to the other of the existence of a dispute (the "Initial Notice"). BCBS and Facility shall schedule a meeting not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute unless both Parties agree in writing to proceed directly to mediation. If the dispute is not resolved at any meetings held, the Parties shall submit the dispute to a mutually agreed upon mediator. In the event mediation is not successful in resolving the dispute, either BCBS or Facility may submit the dispute to confidential, final, and binding arbitration under the commercial rules and regulations of the American Arbitration Association. If the amount to be arbitrated is less than two hundred fifty thousand dollars (\$250,000.00), the arbitration shall be conducted by a single neutral arbitrator selected by agreement of the Parties. If the Parties are unable to agree on an arbitrator, the arbitrator shall be selected by the ranking process set forth in the applicable section of the rules furnished by the American Arbitration Association. If the amount is \$250,000 or more, the dispute shall be heard by a panel of three arbitrators. Within fifteen (15) days after the commencement of arbitration, each Party shall select one person to act as arbitrator and the two selected shall select a third arbitrator within ten (10) days of their appointment. If the arbitrators selected by the Parties are unable or fail to agree upon the third arbitrator, the third arbitrator shall be selected by the American Arbitration Association. It is the Parties' mutual intention that this provision be construed broadly so as to provide for mediation and/or arbitration of all disputes arising out of the MA Agreement.

6.11.1 Notwithstanding the foregoing, these provisions do not apply to, and the following claims are not arbitrable hereunder: (i) any legal proceeding brought by a third-party against BCBS or Facility (a "Defendant"), as well as any cross-claim or third-party claim by such Defendant against BCBS or Facility; (ii) claims arising from or challenging termination of this MA Agreement pursuant to a termination without cause or immediate termination of this MA Agreement if the termination is based on external data relating to loss of licensure, status, certification, maintenance of insurance, breach of warranty, inducement, or BCBS's judgment relating to cases involving standard of care or patient safety.

6.11.2 Venue for any arbitration hereunder shall be in Tulsa, Oklahoma. The arbitrator shall issue a written, reasoned award. The arbitrator shall have no authority, except in the case of fraud, to enter an award requiring any adjustment in compensation or payments respecting any dispute involving services rendered more than twenty-four (24) months prior to receipt of the Initial Notice. The arbitrator may award declaratory or injunctive relief only in favor of the Party seeking relief and only to the extent necessary to provide relief warranted by that Party's individual claim. Facility and BCBS agree that each may bring claims against the other only in its individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding. Further, unless both Facility and BCBS agree otherwise, the arbitrator may not consolidate Facility's claims with the claims of any other Facility or third-party and may not otherwise preside over any form of a representative or class proceeding.

- 6.12 **Medicare Advantage Network.** By executing this MA Agreement, Facility expressly agrees to participate in BCBS's Medicare Advantage provider network(s) under the terms and conditions of this MA Agreement. For avoidance of doubt, BCBS's Medicare Advantage line of business may contain multiple provider networks and products (e.g., MA HMO, MA PPO, and/or similar plans issued in connection with a contract with the Centers for Medicare and Medicaid Services). Facility is participating in the MA network(s) indicated on the cover page of this MA Agreement.
- 6.13 **Force Majeure.** Neither Party will be liable for any failure to timely perform its obligations under this MA Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, restraints of government, cyber-attacks, or pandemics. Facility agrees to notify BCBS within two (2) business days of the event and cooperate with BCBS in assessing the impact to MA Covered Persons for the duration of the delay.
- 6.14 **Governing Law.** Federal law shall control as to the Medicare Advantage and Part D programs and this MA Agreement shall be governed in all other respects whether relative to validity, construction, capacity and performance, or otherwise by the laws of the State of Oklahoma.
- 6.15 **Attachments.** Attachments to this MA Agreement are incorporated by reference. Attachments that by their nature or terms call for Facility's completion and return to BCBS shall be addressed by Facility accordingly.
- 6.16 **Assignment and Merger.** Neither Party may assign (including, without limitation, by operation of law, as a result of a merger, consolidation, amalgamation, or other transaction or series of transactions or any change of control) this MA Agreement or any of its rights or obligations hereunder to any other person, entity or affiliate, without the prior written consent of the other Party. Facility shall also obtain HCSC's written consent in connection with any transaction, or series of transactions, resulting in a change of control of Facility. As an exception to the foregoing, any of the rights and obligations of HCSC under this MA Agreement may be assumed by, or assigned to, an HCSC Affiliate, including, but not limited to, subsidiaries, of HCSC (including any successor corporation, whether by merger, consolidation or reorganization) without the prior written consent by Facility. Any reference in this MA Agreement to HCSC will include its directors, officers and employees, as well as the directors, officers and employees of any of its subsidiaries or HCSC Affiliate companies (including any successor corporations, whether by merger, consolidation or reorganization) and HCSC or its successor corporation will be responsible and liable for all rights and obligations in connection with this MA Agreement. This MA Agreement will be binding upon and inure to the benefit of the respective Parties hereto and permitted assigns. HCSC's standing or routine contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel from other entities will not constitute an assignment under this MA Agreement. Facility shall also obtain HCSC's written consent prior to consolidating locations, whether covered under this MA Agreement or not. The provider number and physical address listed herein shall be the only permissible billing provider for that location, and for that location alone, unless otherwise agreed to by HCSC.
- 6.17 **Entire Agreement.** This MA Agreement, together with any attachments and amendments hereto contains the entire understanding between the Parties and supersedes all prior agreements, either oral or in writing, with respect to the subject matter hereof. In the event of any conflict between the provisions of the attachments to this MA Agreement and the provisions of this MA Agreement other than the attachments, the provisions of the attachments shall prevail.
- 6.18 **Confidentiality of Agreement.** To the extent permissible by law, this MA Agreement is confidential as between Facility and BCBS (including HCSC) and shall not be disclosed to third parties other than their respective financial, accounting and legal advisors absent prior written consent of the non-disclosing Party or valid, compulsory legal process, of which the recipient shall promptly give notice to the other Party before complying therewith.

- 6.19 **Non-Disparagement.** Facility, on behalf of itself and its Representatives, agrees not to make, or intentionally cause or allow any other person to make, any public statement that is factually false or disparages or casts a negative light on BCBS, HCSC or any of its affiliates, or any of their respective officers, employees or directors. This section shall not be construed to prohibit any person from making truthful public statements in response to incorrect public statements or when required by law, subpoena, court order, or the like.
- 6.20 **No Interference with Business Relationships.** Facility agrees that during the term of this MA Agreement, Facility shall not engage in activities, directly or indirectly, whether written, verbal or electronic, that are designed to or result in any of the following: (a) disturb or attempt to disturb any business relationship or agreement between BCBS and any other person or entity, including but not limited to brokers, agents, MA Providers, group customers, and MA Covered Persons; or (b) solicit or induce, or direct others to solicit or induce, any broker, agent, MA Provider, or group customer with respect to carving out all or some benefits from health plans offered or administered by BCBS. Activities that interfere with business relationships include but are not limited to:
- 6.20.0 soliciting, influencing, encouraging or inducing, or attempting to solicit, influence, encourage or induce any Covered Person or employer group to disenroll from health plans offered by BCBS;
 - 6.20.1 soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any potential MA Covered Person or potential employer group to refrain from enrolling in health plans offered by BCBS;
 - 6.20.2 soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any MA Covered Person, potential MA Covered Person, employer group or potential employer group to enroll for health benefits with any other health benefit plan or insurer
 - 6.20.3 advising or encouraging MA Providers currently under contract with BCBS to cancel, or not renew, said contracts;
 - 6.20.4 directly impeding or interfering with negotiations which BCBS is conducting with any third party relating to BCBS's provision of health benefits or related services;
 - 6.20.5 using or disclosing to any third party BCBS's membership acquired during the term of this MA Agreement unless authorized in advance in writing by BCBS, which authorization shall be within BCBS's sole discretion and following such authorization, use or disclosure is in strict adherence to all privacy and security laws;
 - 6.20.6 mischaracterizing the nature or scope of coverage provided by BCBS.

Nothing in this section is intended or shall be deemed to restrict any communication between Facility and MA Covered Person relating to medical care and/or treatment options. Additionally, nothing in this section shall be deemed as precluding Facility from advising MA Covered Persons and potential MA Covered Persons of all of the insurance plans and network plans which have contracted with Facility, provided such communication shall be done in a manner that is uniform in nature without preference to any insurance or network plans. This section shall survive termination of this MA Agreement.

ARTICLE VII MEDICARE REGULATORY PROVISIONS

- 7.0 **Audit.** HHS, the Comptroller General, and their designees, have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of Facility and any Downstream Entities, related to services provided under the

CMS Contract. HHS's, the Comptroller General's and or their designees' right to inspect, evaluate, collect, and audit any pertinent information for any particular contract period lasts for ten years from the last day the CMS Contract is in effect or from the date of completion of any audit of an MA Organization by the Department of Health and Human Services, the Government Accountability Office, or their designees, whichever is later. Facility shall maintain records a minimum of ten years in accordance with this section. [42 CFR § 422.504(e)(4), (i)(2)(ii)]

- 7.1 **MA Covered Person Hold Harmless.** Facility shall not hold MA Covered Persons liable for payment of any fees that are the obligation of BCBS. [42 CFR § 422.504(g)(1)]
- 7.2 **Dual-Eligible Cost-Sharing.** Facility agrees that, for Covered Persons who are eligible for benefits under both the Medicare and Medicaid Programs ("Dual-Eligible Subscribers"):
- 7.2.0 Facility shall not hold Dual-Eligible Subscribers liable for Medicare Part A and B cost sharing when the state Medicaid program is responsible for payment of such amounts;
- 7.2.1 Facility shall accept payment under the MA Agreement as payment in full for Covered Services provided to a Dual-Eligible Subscriber or submit a claim to the appropriate state Medicaid source for payment; and
- 7.2.2 Facility shall coordinate with BCBS to ensure that Facility is informed of Medicare and Medicaid benefits and cost-sharing rules for Dual-Eligible Subscribers. [42 CFR § 422.504(g)(1)(iii)]
- 7.3 **Compliance with Medicare Law.** Facility and all Downstream Entities must perform all services in compliance with all Medicare laws, regulations and CMS instructions and guidance. [42 CFR § 422.504(i)(4)(v)]
- 7.4 **Services.** Any services or other activity performed by Facility or any Downstream Entities shall be performed in accordance with BCBS's contractual obligations to CMS and applicable professionally recognized standards of health care. [42 CFR § 422.504(i)(3)(iii); 42 CFR § 422.504(a)(3)(iii); MMCM Chapter 11 Section 100.4 Table]
- 7.5 **Compliance with Laws.** Facility shall comply with all Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (Social Security Act § 1128B(b)). and the HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. Facility shall maintain all licenses, permits, and qualifications required under applicable laws and regulations for Facility to perform the services under this MA Agreement. [42 CFR § 422.504(h)(1); MMCM Chapter 11 Section 100.4]
- 7.6 **Compliance Plan.** Facility agrees to implement and maintain a compliance plan that meets the standards for an effective compliance program set forth in applicable Medicare laws, including measures to correct, detect and prevent fraud, waste and abuse, and addresses the scope of services under the MA Agreement. Such compliance program shall require cooperation with BCBS's compliance plan and policies. [42 CFR § 422.503(b)(4)(vi)(A); MMCM Chapter 21/9, sec. 50.1.3]
- 7.7 **Delegated Activities.** Delegated activities and reporting requirements, if any, are contained in this MA Agreement. Facility shall ensure compliance in any delegated activities in accordance with 42 C.F.R. §§ 422.504. BCBS may revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS or BCBS determine that Facility has not performed delegated activities or reporting requirements satisfactorily. [42 C.F.R. § 422.504(i)(4)]

- 7.8 **BCBS Oversight.** BCBS oversees all functions and responsibilities under the MA Agreement described in Laws and maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract. The performance of the parties is monitored by BCBS on an ongoing basis. [42 CFR § 422.504(i); 422.504(i)(4)(iii)]
- 7.9 **Credentialing.** The credentials of medical professionals affiliated with the Facility will be reviewed by BCBS, or to the extent that Facility or any Downstream Entity provides credentialing of Medical Providers, the credentialing process will be reviewed and approved by BCBS and BCBS shall audit the credentialing process on an ongoing basis. [42 CFR § 422.504(i)(4)(iv)]
- 7.10 **Delegation.** BCBS retains the right to approve, suspend, or terminate any arrangement relating to the delegation of selection of providers. [42 C.F.R. § 422.504(i)(5)]
- 7.11 **Claim Payments.** BCBS shall make payment on a clean claim, as defined in Laws, to Facility within thirty (30) days of BCBS's receipt of such claim at such address designated by BCBS. [42 CFR § 422.520]
- 7.12 **Cultural Competency.** Services shall be provided in a culturally competent manner to all MA Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [42 CFR § 422.112(a)(8)]
- 7.13 **Privacy and Confidentiality.** Facility and any Downstream Entities agree to safeguard MA Covered Person privacy and confidentiality of MA Covered Person health records and assure accuracy of MA Covered Person health records. Facility shall abide by all Federal and State laws and regulations regarding confidentiality and timely access to medical records, or other health and enrollment information. [42 CFR § 422.118; MMCM Chapter 11 Section 100.4]
- 7.14 **Data Certification.** Facility agrees that, upon request by BCBS, it will have its CEO or CFO or an individual with authority to sign on behalf of such officers, certify to the accuracy, completeness and truthfulness of all data submitted to BCBS under the MA Agreement in the form and format set out in Attachment C, which is attached and incorporated herein by reference. [42 C.F.R. § 422.504(l)(3)]
- 7.15 **Policies, Procedures, and Provider Manuals.** Facility agrees to comply with BCBS's policies and procedures and BCBS's Medicare Advantage Provider Manuals. Facility shall comply with BCBS's policies and procedures for utilization review, quality management and improvement, credentialing and the delivery of preventive health services. [MMCM Chapter 11 Section 100.4]
- 7.16 **MA Covered Person Appeals and Grievances.** Facility shall cooperate and comply with all BCBS requirements regarding the processing of MA Covered Person grievances, coverage determinations and appeals, including the obligation to provide BCBS any and all information within the time frame reasonably requested by BCBS to ensure compliance with Laws. [42 CFR § 422.504(a)(7), 422.562(a)]
- 7.17 **Physician Incentive Plans.** If the arrangement between the parties involves a physician incentive or risk arrangement, both parties agree to comply with the Physician Incentive Plan (PIP) regulations set forth in 42 CFR § 422.208 and 42 CFR § 422.210.
- 7.18 **Offshore Work.** Facility shall not engage in any activity that allows storage or access to Covered Persons' information outside of the United States of America without the prior written consent of BCBS. [CMS Memoranda to all Part C and D Plan Sponsors, dated 7/23/2007; 9/20/2007; 8/26/2008.]
- 7.19 **Medicare Participation.** Facility must have a signed participation agreement with CMS or suppliers approved by CMS as meeting conditions for coverage, in accordance with 42 CFR § 498.2, 422.204(b)(3), and Medicare Managed Care Manual, Chapter 6 Section 70.

7.20 Exclusion from Participation in Government Programs.

7.20.0 Facility certifies that neither Facility nor its employees, any Downstream Provider, any affiliated party or any Downstream Entity involved in the provision of services under the MA Agreement has been: (i) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, state or local) contract or subcontract; (ii) listed by a federal governmental agency as debarred; (iii) proposed for debarment or suspension or otherwise excluded from federal program participation or listed on the CMS preclusion list described in 42 C.F.R. § 422.222 (“CMS Preclusion List”); (iv) convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (v) within a three (3) year period preceding the date of this MA Agreement, had one or more public transactions (federal, state or local) terminated for cause or default. [42 CFR § 422.752(a)(8), (a)(12); Social Security Act § 1862(e) [42 U.S.C. 1395y]; §1128 [42 USC 1320a-7f].]

7.20.1 Facility shall check appropriate databases at least monthly to determine whether any of Facility’s employees, subcontractors or affiliated parties or Downstream Entities involved in the provision of services under the MA Agreement have been suspended or excluded from participation in the Medicare Program, any other Federal health care program, state contracts or state medical assistance programs. Databases include, without limitation, the CMS Preclusion List, the HHS Office of Inspector General (“OIG”) List of Excluded Individuals/Entities (“LEIE”), the System for Award Management (“SAM”) exclusion lists, and any other federal or state governmental agency exclusion list of persons who are sanctioned, debarred or voluntarily withdrawn as a result of a settlement agreement. Facility shall provide to BCBS upon request within the timeframe requested, but no later than within 48 hours, documentation showing such databases/exclusion lists were reviewed for all individuals involved in the provision of services under the MA Agreement. [MMCM Chapter 21/9, Section 50.6.8.]

7.20.2 Facility acknowledges and agrees that it has a continuing obligation to notify BCBS in writing within seven (7) business days if any of the above-referenced representations change. Facility further acknowledges and agrees that any misrepresentation of its status or any change in its status at any time during the term of this MA Agreement may be grounds for immediate termination of this MA Agreement, at the sole discretion of BCBS.

7.21 Preclusion List. Facility agrees, for all services on or after January 1, 2020:

7.21.0 MA Covered Persons do not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the MA Covered Person by an MA contracted individual or entity on the Preclusion List, as defined in 42 C.F.R. § 422.2 and as described in 42 C.F.R. § 422.222.

7.21.1 After the expiration of the sixty (60) day period specified in §422.222, Facility will no longer be eligible for payment from BCBS and will be prohibited from pursuing payment from the MA Covered Person as stipulated by the terms of the contract between CMS and BCBS per 42 C.F.R. § 422.504(g)(1)(iv); and

7.21.2 Such provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the MA Covered Person will have already received notification of the preclusion. [42 CFR §422.504(g)(1)(v)]

- 7.22 **Continuation of Services after Termination.** Upon termination of this MA Agreement for any reason, Facility shall continue to provide Covered Services to an MA Covered Person who is under the care of Facility at the time of termination, until the services being rendered to the MA Covered Person by Facility are completed, unless BCBS makes reasonable and medically appropriate provision for the assumption of such services by another provider. Facility shall continue to arrange for Covered Services to those MA Covered Persons who are hospitalized on an inpatient basis at the time this MA Agreement is no longer in effect until the MA Covered Person is discharged from the hospital. [42 CFR § 422.504(g)(2), (3)]

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT A
MEDICARE ADVANTAGE COMPENSATION SCHEDULE FOR HOSPITALS**

- 1.0 **General Compensation, including Professional Services.** Facility will accept as payment in full for the provision of a Covered Service to an MA Covered Person the lesser of (i) one hundred percent (100%) of billed charges or (ii) one hundred percent (100%) of the Medicare allowed amount, or as described in Sections 1.1 and 1.2 below if applicable, taking into account all Medicare claims processing rules, including, but not limited to, claim edits, processes, bundling logic, etc., in effect at the time the Covered Service is provided, less any applicable cost sharing amount that is the responsibility of the MA Covered Person pursuant to the terms of such MA Covered Person's MA Coverage Agreement.
- 1.0.0 **Non-Physician Providers.** Compensation shall be paid to non-physician providers only if such providers are authorized under traditional Medicare to provide services to Medicare beneficiaries. To the extent that the rendering provider is a non-physician provider (e.g. CRNA, NP, PA, Ph.D., MA, etc.) the Medicare Payment Rate shall be adjusted by that percentage published and used by CMS (as of the date of service) to adjust the standard Medicare payment rate.
- 1.1 **Facility Services: Acute Inpatient, Psychiatric and Outpatient Hospital Services.** If Facility is an Acute Inpatient, Psychiatric or Outpatient Hospital, Facility agrees to accept payment for Covered Services provided to an MA Covered Person the lesser of billed charges or as follows:
- 1.1.0 **Inpatient Services.** 100% of the Inpatient Prospective Payment System ("IPPS") as published by CMS for each facility as of the claim processing date for the date(s) of service on the claim. The amount shall include all calculations and components of the IPPS, as updated from time to time by CMS and at least yearly.
- 1.1.1 **Outpatient and Observation Services.** 100% of the Outpatient Prospective Payment System ("OPPS") for applicable services as published and defined by CMS for each facility as of the claim processing date for the date(s) of service of the claim. The amount shall include all calculations and components of the OPPS, as updated from time to time by CMS but at least yearly.
- 1.1.2 If Facility is an Acute Inpatient, Psychiatric or Outpatient Hospital, the following facilities and services are excluded from payment to Facility under the MA Agreement and this Attachment A, and must be billed pursuant to CMS Medicare billing requirements, Medicare Claims processing rules, including, but not limited to, Claim edits, processes, bundling logic, etc., in effect at the time the Covered Service:
- (a) Free-standing Skilled Nursing Facilities
 - (b) Free-standing Urgent Care Centers
 - (c) Outpatient Durable Medical Equipment and Infusion Therapy Services
 - (d) Home Health Services
 - (e) Dialysis Services
 - (f) Ambulance Services (air and ground)
- 1.2 **Facility Services: Critical Access Hospital (CAH), Federally Qualified Health Center (FQHC), and Rural Health Center (RHC) Services.** If Facility is a Critical Access Hospital (CAH), Federally Qualified Health Center (FQHC), or Rural Health Center (RHC), Facility agrees to accept payment for Covered Services provided to an MA Covered Person the lesser of billed charges or as follows:
- 1.2.0 **Inpatient Services.** A per diem equal to Facility's prevailing interim CMS per diem, in accordance with applicable Medicare Advantage laws, rules and regulations, less any Copayments, Coinsurance, Deductible, or other Covered Person cost share due from such Covered Persons. This amount is based on the prevailing interim per diem rate being paid

by CMS to Facility. This amount will be adjusted periodically, based upon CMS fiscal intermediary (FI) review of Facility cost report or financial statements and subsequent interim payment rate changes. Facility shall, within thirty (30) days following receipt of notice from its CMS FI, provide BCBS with a copy of such notice of adjustments of Facility's interim per diem payment rates. BCBS shall begin reimbursing Facility the adjusted interim payment rate on the first day of the month following BCBS's receipt of the notice from Facility.

- 1.2.1 **Outpatient Services.** 100% of the prevailing Original Medicare outpatient percent of charge reimbursement under the CMS Standard Payment Method in effect as of the date such services are rendered and in accordance with applicable Medicare Advantage laws, rules and regulations, less any Copayments, Coinsurance, Deductible, or other Covered Person cost sharing due from such Covered Persons. This amount is based on the prevailing interim percent of charge reimbursement being paid by CMS to Facility. This amount will be adjusted periodically, based upon CMS fiscal intermediary (FI) review of Facility cost report or financial statements and subsequent payment rate changes. Facility shall, within thirty (30) days following receipt of notice from its CMS fiscal intermediary (FI), provide BCBS with a copy of such notice of adjustments of Facility's cost-to-charge ratio. BCBS shall begin reimbursing Facility the adjusted interim payment rate on the first day of the month following BCBS's receipt of the notice from Facility.
- 1.2.2 **Rehabilitation or Psychiatric Distinct Part Units Payment Terms.** If Facility has a Rehabilitation or Psychiatric Distinct Part Unit (DPU), then reimbursement for Inpatient Services will be 100% of the applicable Rehabilitation or Psychiatric Inpatient Prospective Payment System ("IPPS") as published by CMS for each applicable facility DPU as of the date(s) of service on the claim. The amount shall include all calculations and components of the IPPS, as updated from time to time by CMS and at least yearly.
- 1.3 **Readmissions.** If the Covered Person is readmitted to the hospital within thirty (30) days of the initial discharge for the same, similar, or related diagnosis (i.e. a condition that is clinically related) to the prior admission, the subsequent admission(s) may be considered inclusive of the first admission. BCBS may review the appropriateness of the readmission. If BCBS determines that the subsequent admission(s) was inclusive of the first admission, it may make adjustments to such claim payments.
- 1.4 **Sequestration.** Payments shall be made according to standard Medicare payment methodologies. The Parties acknowledge and agree that certain reductions to Medicare provider payments are mandated pursuant to the Budget Control Act of 2011 and its implementing rules, regulations, and guidance as amended from time to time ("Sequestration"). Both parties further acknowledge and agree that additional reductions to Medicare provider payments may be implemented pursuant to similar regulatory authority enacted on or after the effective date of this MA Agreement. Accordingly, both parties agree that the rates payable under this MA Agreement shall be adjusted by the amount proportionally equal to any reductions under Sequestration and such similar legal authority thereafter, if any.
- 1.5 **Disproportionate Share and Indirect Medical Education.** BCBS and Facility agree that the Facility's Medicare Administrative Contractor ("MAC") will make the following payments to the Facility for Covered Persons: (a) bad debt/disproportionate share hospital (DSH) and (b) Plan operating indirect medical education ("IME") payments. BCBS and Facility further agree that BCBS will not make payment under this Agreement for those items or services that are paid by the MAC and/or Medicare directly to Facility.
- 1.6 **Bad Debt.** The Parties further agree that there will be no "bad debt" settlement payments made to Facility by BCBS at any time. "Bad debt" settlement payments are those bad debt reimbursements to providers that meet the minimum Medicare requirements under applicable Laws, rules, regulations and Medicare guidance.

1.7 Claims Submission.

- 1.7.0 Facility shall submit complete and properly executed claims for a Covered Service to BCBS or its designee within one hundred eighty (180) calendar days of the date the Covered Service is rendered. If Facility fails to submit a claim in compliance with this paragraph, Facility forfeits the right to payment from BCBS or the MA Covered Person.
- 1.7.1 If an MA Covered Person has coverage with another plan that is primary to Medicare, Facility will submit a claim for payment to that plan first.
- 1.7.2 Claims may be submitted (i) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format, or (ii) on a completed version of the applicable CMS claim form.

1.8 Claims Payment. BCBS shall make payment on a Clean Claim to Facility within thirty (30) days of BCBS's receipt of such claim at such address designated by BCBS.

Refer to cover page for Effective Date, contact information and signatures.

**ATTACHMENT B
MEDICARE ADVANTAGE DOWNSTREAM PROVIDER ADDENDUM**

This Medicare Advantage Downstream Provider Addendum (“Downstream Addendum”) is a supplement to the MA Agreement between BCBS and Facility.

By execution of this Downstream Addendum, the undersigned health care professional, organization or entity affiliated with Facility by contract (“Downstream Provider”) agrees to provide Covered Services to MA Covered Persons of BCBS pursuant to the Blue Cross Medicare Advantage Network Participation Agreement (“MA Agreement”) between BCBS and Facility (the “Parties”). The MA Agreement sets forth the terms and conditions under which Facility and Downstream Provider shall provide or arrange for the provision of Covered Services to MA Covered Persons under BCBS’s MA Program. The effective date of this Downstream Addendum shall be the later of the effective date of the Parties’ MA Agreement or the effective date specified below.

Downstream Provider hereby understands and agrees to the following:

- 1.0 **The MA Agreement.** Downstream Provider has received and read a copy of the Parties’ MA Agreement, which is incorporated into and made a part of this Downstream Addendum by reference. Downstream Provider agrees to provide Covered Services to MA Covered Persons in accordance with the MA Agreement.
- 1.1 **Conflicting Terms.** Downstream Provider agrees that if any terms in the underlying agreement between Downstream Provider and Facility conflict or appear to conflict with the MA Agreement and/or this Downstream Addendum, the terms in the MA Agreement and/or this Downstream Addendum shall control.
- 1.2 **Downstream Provider Obligations.** Downstream Provider agrees to the obligations set forth in the MA Agreement which are applicable to Facility. Downstream Provider acknowledges and agrees that BCBS may suspend or terminate the Downstream Provider’s delivery of Covered Services to MA Covered Persons or take such other remedial action as BCBS, in its reasonable discretion, deems appropriate, or upon determination by CMS, in its sole discretion, or BCBS, in its reasonable discretion, that the Downstream Provider is not performing the services satisfactorily.
- 1.3 **Compensation.** Downstream Provider shall accept as payment in full from BCBS the amounts set forth in the MA Agreement and any attached payment attachments and shall not bill any of BCBS’s MA Covered Persons for any fees that are the legal obligation of BCBS.

Notwithstanding the effective date of the Parties’ MA Agreement, the effective date of this Downstream Addendum is _____.

Name of Facility

Authorized Signature

Name of Signatory

Title of Signatory

Date of Signatory

**ATTACHMENT C
DATA CERTIFICATION**

(SAMPLE – ONLY TO BE SUBMITTED WITH ANY DATA COLLECTION REQUEST BY BCBS)

Facility acknowledges that the information described below directly affects the calculation of payments to BCBS in connection with its sponsorship of HCSC Medicare Plans pursuant to the CMS Contract and/or additional benefit obligations of BCBS. Facility acknowledges that misrepresentations to BCBS and/or CMS about the accuracy of such information may result in federal civil action and/or criminal prosecution.

Facility has reported to BCBS, for transmission to CMS, and for the period of _____(INDICATE DATES), all _____(INDICATE TYPE OF DATA) data requested by BCBS available to Facility with respect to the HCSC Medicare Plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to BCBS via this report is accurate, complete, and truthful.

Name of Facility

Authorized Signature

Name of Signatory

Title of Signatory

Date Signed

**ATTACHMENT D
LOCATIONS AND ANCILLARY ENTITIES**

The locations listed below are included under this MA Agreement. No other location or ancillary entity existing on the effective date of this MA Agreement is included in this Agreement, and the terms and conditions of this MA Agreement shall not be deemed to apply to any location or ancillary entity other than those listed on this Attachment D. If Facility now has or later opens one or more additional locations or ancillary entities, they shall not be included under this MA Agreement unless and until such locations or ancillary entities are added to this Attachment by amendment. Facility shall provide at least sixty (60) days' advance written notice of any new location or ancillary entity. New locations and ancillary entities may be added to this Attachment D in the sole discretion of BCBS by an amendment and cannot under any circumstances be deemed to have occurred in the absence of such amendment. Facility also agrees to notify BCBS in writing of the sale, closing or change of address of any location or ancillary entity listed on Attachment D.

Mangum City Hospital Authority d/b/a Mangum Regional Medical Center		
<i>Location or Ancillary Entity</i>	<i>Physical Address</i>	<i>NPI</i>
Mangum Regional Medical Center (main campus)	1 Wickersham Drive Mangum, OK 73554	1033635263

Refer to cover page for Effective Date, contact information and signatures.

Hospital Vendor Contract Summary Sheet

1. Existing Vendor New Vendor
2. **Name of Contract:** Stericycle
3. **Contract Parties:** Stericycle/MRMC.
4. **Contract Type Services :** Service Agreement
5. **Impacted Hospital Departments:** Hospital Departments
6. **Contract Summary:** This is for regulated medical waste disposal.
7. **Cost:** \$38.69/container, minimum pick up cost \$193.45 per stop
 \$60.00/ container off-site pick up cost \$193.45 per stop (clinic)
8. **Prior Cost:**
9. **Term:** 36 months
10. **Termination Clause:** None
11. **Other:**

Premier Healthcare Alliance, L.P., (“Premier”) and Stericycle, Inc. (“Stericycle”) have entered into a group purchasing agreement entitled Group Purchasing Agreement-Services (Agreement number PP-FA-985), effective June 1, 2022 (the “GPO Agreement”) for the benefit of certain third-party beneficiaries (the “Participating Members,” as further defined in the GPO Agreement). This is Stericycle’s standard form of agreement for the Services described herein. Stericycle offers the Services described in this Agreement pursuant to the GPO Agreement, and notwithstanding anything to the contrary contained in this Agreement, this Agreement is subject to the terms and conditions of the GPO Agreement. In the event of a conflict between a term or condition in this Agreement and a term or condition in the GPO Agreement, the GPO Agreement controls. The Term of this Agreement will survive the termination or expiration of the GPO Agreement. All capitalized terms not defined in this Agreement have the meanings given to them in the GPO Agreement. For avoidance of doubt, a Participating Member is not subject to this Agreement unless it has been executed by the authorized representatives of both the Participating Member and Stericycle.

TERMS AND CONDITIONS

1. Regulated Medical Waste Services. Stericycle shall collect, transport, treat and dispose of all Regulated Medical Waste (except Non-Conforming Waste) generated by Customer during the term of this Agreement (hereinafter referred to as “Waste”). Stericycle employees may refuse containers that are determined to be or contain Non-Conforming Waste (defined below). Customer shall place only Regulated Medical Waste in the containers provided. “Regulated Medical Waste” shall be as defined by 49 CFR 173.134 or by any other federal, state, and local regulations. Customer warrants that the waste presented for disposal will not contain any “hazardous”, “toxic”, or “radioactive” wastes as defined by all applicable laws or regulations and shall be liable for any injury, loss or damage resulting from violations of such applicable law regarding disposal of “hazardous”, “toxic” or “radioactive waste”. Customer will be responsible for segregating all waste in accordance with federal, state, and local regulations. Customer shall be liable for any injury, loss or damage resulting from Non-Conforming Waste. “Non-Conforming Waste” means (1) fetal remains and human torsos, (2) radioactive, reactive, corrosive, ignitable, volatile or toxic wastes, wastes containing mercury and other heavy metals, batteries of any type, chemicals, solvents, and any and all other hazardous wastes and substances as defined in any applicable federal, state, county municipal, regulations and guidelines, (3) pharmaceutical materials (except to the extent that Stericycle gives prior written approval and the pharmaceuticals are packaged according to instructions provided), (4) bulk chemotherapy and bulk liquids, (5) improperly classified and/or improperly packaged Regulated Medical Waste, (6) any waste which does not fall within the definition of Regulated Medical Waste, and/or is not in accordance with the representations, warranties, descriptions, specifications or limitation set forth in this Agreement, (7) waste that contains infectious substances classified as Division 6.2, Category A infectious substances as described in 49 CFR 173.134, and (8) waste packaged in any container packaged for transport which exceeds the packaging drop-tested weight limit printed on the container. Stericycle’s Waste Acceptance Policy (“WAP”), the current version of which is attached hereto and incorporated herein, contains additional guidelines requirements with respect to the Waste. Stericycle reserves the right to change the WAP at any time to ensure compliance with applicable laws or regulations. A copy of Stericycle’s WAP may also be obtained from your local Stericycle representative. Title to Waste (other than Non-Conforming Waste) shall transfer to and vest in Stericycle at such time as such waste is loaded onto Stericycle vehicles. Customer shall have title to Waste at all prior times. Customer shall hold title to any Non-Conforming Waste at all times, whether refused for collection, returned to the Customer for proper disposal after collection or otherwise disposed of in accordance with Customer’s instructions or arrangements.

2. Recordkeeping and Compliance with Laws Stericycle and Customer shall keep and retain adequate books and records and other documentation including personnel records, correspondence, instructions, plans, receipts, vouchers, permits, required state registrations, copies of manifests and tracking records consistent with and for the periods required by applicable regulations and guidelines pertaining to generation, storage or handling of Waste and the Services to be performed under this Agreement.

3. Term, Pricing and Termination The term (“Term”) of this Agreement is established on Attachment A of this document, 36 months from the date of execution of this Agreement.

- (a) Customer shall pay Stericycle the prices set forth on the Attachment A of this Agreement. Stericycle may increase the contract price annually but no more than four percent (4%). Prices for Services may not be increased for at minimum the first eighteen (18) months of a 60-month term and for the first 12 months for any Term of less than 60 months. Thereafter, price increases may be implemented on each subsequent anniversary date of the Agreement. Additionally, Stericycle may adjust the contract price to account for operational changes it implements to comply with changes in law, regulatory changes, in the waste treatment location changes in customer’s service requirements including changes in waste patterns, and/or to otherwise cover unforeseen, significant cost escalation.
- (b) Stericycle has instituted a per invoice fuel surcharge to manage and isolate the impact of Diesel fuel price fluctuations. The fuel surcharge is based on the U.S. ‘On Highway’ Diesel Price Index. A table outlining the Fuel Surcharge can be found in Attachment C of this Agreement.
- (c) In the event of breach of any provision of this Agreement, the non-breaching party shall notify the breaching party in writing of the specific nature of the breach and shall request that it be cured. If the breaching party does not cure the breach within thirty (30) days of such notice, the non-breaching party may immediately terminate this Agreement on written notice to the breaching party, and such termination shall not preclude the non-breaching party from pursuing any and all remedies available to it at law or in equity.
- (d) If Customer breaches this Agreement by terminating Stericycle’s collections prior to the expiration of its Term or in any other way violates this Agreement in such a way that Stericycle’s continued performance is rendered impossible or commercially impracticable, then Stericycle shall be entitled to collect from Customer an amount in liquidated damages equal to 50% of Customer’s average charge on a monthly basis based on the 12 months’ billings prior to the cessation of collections (or based on any lesser period if the contract began less than twelve months earlier) times the number of months, including prorated partial months, remaining until the expiration date of the Term or Extension Term. Customer hereby acknowledges (i) that Stericycle’s damages resulting from the premature termination of collections include lost profits, inefficiencies resulting from route changes and reduced treatment plant throughput, increased administrative overhead, unrecoverable sunk training/instruction costs, and other elements of injury, (ii) that such damages are extremely difficult to quantify as they relate to any one customer, and (iii) that the foregoing liquidated damages amount is a reasonable estimate of actual expected damages and is not a penalty. Liquidated damages as described herein is Stericycle’s sole remedy for Customer’s improper early termination.
- (e) Stericycle shall have the right to terminate this Agreement at any time by giving Customer at least sixty (60) days’ notice in the event that it is unable to continue performing its obligations under this Agreement due to the suspension, revocation, cancellation or termination of any permit

or required to perform this Agreement or in the event that a change in any law, regulation or ordinance makes it impractical or uneconomical, in Stericycle's sole discretion, to continue performing this Agreement.

- (f) Upon 30 days' notice to Stericycle, Customer shall have the right to add or delete mutually acceptable Customer facilities receiving Services under this Agreement. This addition or exclusion of any facility participating under this Agreement shall have no effect on the Services provided the other participating facilities.
- (g) In addition to Stericycle's charges for Services and products under this Agreement, the Customer shall pay all taxes imposed or levied by any governmental authority with respect to such Services or products. These taxes include all sales, use, excise, occupation, franchise and similar taxes and tax-like fees and charges (but do not include any taxes on Stericycle's net income). Stericycle shall cooperate with the Customer to determine the applicability of any exemption certificates that the Customer provides to Stericycle in a timely manner.
- (h) Any terms or conditions contained in any Purchase Order, Purchase Order Agreement, or other invoice acknowledgment, Order by Customer or proposed at any time by Customer in any manner, which vary from, or conflict with the terms and conditions in this Agreement are deemed to be material alterations and are objected to by Stericycle without need of further notice of objection and shall be of no effect nor in any circumstances binding upon Stericycle unless expressly accepted in writing. If Customer's standard purchase order form is provided to Stericycle in connection with this Agreement, the terms and conditions for that Purchase Order will be superseded by the provisions of this Agreement and the use of the purchase order shall be only to facilitate Customer's payment of fees to Stericycle. Written acceptance or rejection by Stericycle of any such terms or conditions shall not constitute an acceptance of any other additional terms or conditions.

4. Survival The term of this Agreement is established on page one of the documents. If Stericycle is re-awarded a new GPO Agreement for Services, Customers having signed a service agreement under the previous GPO Agreement will continue to have their sales reported and Administrative Fees paid for their Stericycle purchase activity on the new GPO Agreement without any further action being required, through the term of the Stericycle service Agreement.

5. Billing Stericycle shall submit invoices to Customer in accordance with Stericycle's standard billing process. Customer shall pay in full each Stericycle invoice within 30 days of the date of such invoice by ACH or other agreed upon electronic means. Any invoiced amounts not received by Stericycle within that timeframe will be subject to a late fee of 1.5% per month (or the maximum amount allowed by law, if different) on the outstanding balance. Customer shall reimburse Stericycle for all costs that it incurs in collecting overdue amounts from Customer. Stericycle may, with notice, suspend services until any overdue amounts (plus late fees, and enforcement and collection costs, if any) are paid. Customer shall also pay all taxes imposed by any governmental authority with respect to the purchase of any services and products hereunder, including all sales, use, excise, occupation, franchise and similar taxes and tax-like fees and charges (but excluding all taxes on Stericycle's net income). Stericycle will cooperate with Customer to determine the applicability of exemption certificates, if any, that Customer provides in a timely manner to Stericycle. Customer shall not be entitled to withhold payment by way of set-off or counterclaim.

6. Surcharge Stericycle may also impose a 'no waste' surcharge no greater than \$75 in the event that Stericycle attempts to pick up waste at a Customer location (on either a scheduled pick-up or in response to a Customer request) and, through no fault of Stericycle, either (a) there is no Waste for Stericycle to pick up, (b) waste is not ready for pick-up or (c) the Customer location is closed.

7. Liability for Equipment Customer shall have the care, custody and control of containers and other equipment placed at Customer's premises and owned by Stericycle and accepts responsibility and liability for the equipment and its contents except when it is being physically handled by employees of Stericycle. Customer agrees to defend, indemnify and hold harmless Stericycle from and against any and all claims for loss or damage to property, or personal injury or death, resulting from or arising in any manner out of Customer's use, operation or possession of any containers and other equipment furnished under this Agreement, except to the extent any such loss or damage to personal property, or personal injury or death is a result of Stericycle's negligence, intentional misconduct, or breach of this Agreement. Any damage to such property and equipment, other than normal wear and tear, will be charged to the Customer, and payable to Stericycle as additional service cost.

8. Indemnification Stericycle shall indemnify and hold Customer harmless from any liabilities arising from the gross negligence or willful misconduct of Stericycle in the performance of its obligations under this Agreement. Customer shall indemnify and hold harmless Stericycle from any liabilities arising from the gross negligence or willful misconduct of Customer, which shall include, but not be limited to, failure to properly store, package, label, or segregate Waste and any liabilities relating to Non-Conforming Waste, whether or not collected, transported or treated by Stericycle. Customer agrees to pay Stericycle's reasonable attorney's fees incurred for any success defense by Stericycle of a suit for indemnification brought against Stericycle by Customer.

9. Compliance with Laws Stericycle hereby agrees to carry General Liability, Automobile Liability, and Workmen's Compensation Insurance as required by applicable state law, and to otherwise comply with all federal and state laws, rules, and regulations applicable thereto and relating to its performance hereunder. As of the date of this Agreement, Stericycle has obtained, and agrees to maintain during the Term of this Agreement, all necessary permits, licenses, zoning and other federal, state or local authorizations required to perform the Services under this Agreement and will furnish copies of these to Customer upon request. Customer and Stericycle each hereby agrees to comply with all federal and state laws, rules, and regulations applicable to their handling of Waste and their performance under this Agreement, including, without limitation, all applicable record keeping, documentation and manifesting requirements. Stericycle and Customer shall keep and retain adequate books and records and other documentation including personnel records, correspondence, instructions, plans, receipts, vouchers, copies of manifests and tracking records and any other records or reports or memoranda consistent with and for the periods required by applicable regulatory requirements and guidelines pertaining to storage or handling of Waste and the Services to be performed under this Agreement.

10. Exclusivity Customer agrees to use no other Waste disposal service or method during the Term of this Agreement and any Extension Terms.

11. Force Majeure The obligations of either party to perform under this Agreement will be excused during each period of delay caused by acts of God, war or terrorism, or by shortages of power or materials or government orders which are beyond the reasonable control of the party obligated to perform and prevents the party from being able to perform ("Force Majeure Event"). In the event that either party ceases to perform its obligations under this

Agreement due to the occurrence of a Force Majeure Event, such party shall: (1) immediately notify the other party in writing of such Force Majeure Event and its expected duration; (2) take all reasonable steps to recommence performance of its obligations under this Agreement as soon as possible. In the event that any Force Majeure Event delays a party's performance for more than thirty (30) days following notice by such party pursuant to this Agreement, the other party may terminate this Agreement immediately upon written notice to such party.

12. Independent Contractor Stericycle's relationship with Customer pursuant hereto is that of an independent contractor, and nothing in this Agreement shall be construed to designate Stericycle as an employee, agent, or partner of or a joint venture with Customer.

13. Amendment and Waiver Changes in the types, size and amount of equipment and the frequency of service may be mutually agreed to orally or in writing by the parties, without affecting the validity of this Agreement. Consent to oral changes shall be evidenced by the practices and actions of the parties. All other amendments to this Agreement (other than as provided in 3(b)) shall be affected only by a written instrument executed by the parties. Variations from the standard form of agreement, if any, are contained in the Addendum to Customer Service Agreement attached hereto. No waiver shall be effective unless submitted in writing by the party granting such waiver. No waiver of any provision of this Agreement shall be deemed a waiver of any other provision of this Agreement and no waiver of any breach or duty under this Agreement shall be deemed a waiver of any other breach or later instances of the same duty.

14. Savings Clause In case any one or more of the provisions contained in this Agreement shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Agreement; this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein, unless such finding shall impair the rights or increase the obligations of Stericycle hereunder, in which event, at Stericycle's option, this Agreement may be terminated

15. Entire Agreement This Agreement (including any attachments, exhibits and amendments made in accordance with Paragraph 13) constitutes the entire understanding and agreement of the parties and cancels and supersedes all prior negotiations, representations, understandings or agreements, whether written or oral, with respect to the subject matter of this Agreement.

16. Governing Law This Agreement shall be governed by and construed in accordance with the laws in the state of Illinois without regard to the conflicts of laws rules of any jurisdiction.

17. Notices All required notices, or those which the parties may desire to give under this Agreement shall be in writing and sent to the parties' addresses set forth on the first page of this Agreement, and in the case of Stericycle, to the Stericycle LQ Sales Department address as follows: Attn: Stericycle LQ Sales Department, 2355 Waukegan Road, Bannockburn, IL 60015. Notices shall be effective when received.

18. Assignment Neither party will assign any rights or obligations under this Agreement without the express written consent of the other party. Such consent shall not be unreasonably withheld.

19. Counterparts This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which when taken together shall constitute one and the same instrument. A copy or facsimile of this Agreement shall be as effective as an original.

20. Limitation of Liability. Except as explicitly provided in this Agreement, Stericycle shall not be liable for any loss of profits or other consequential damages sustained by Customer in connection with performance or nonperformance under this Agreement.

21. Waste Brokers Stericycle reserves the right to deal solely with the Customer and not with any third-party agents of the customer for all purposes relating to this Agreement (other than as contemplated by the GPO Agreement). Customer represents and warrants to Stericycle that it is the medical waste generator and is acting for its own account and not through a broker or agent. Stericycle shall be entitled to terminate this Agreement and seek all available legal remedies, including but not limited to liquated damages, in the amount set forth herein for Customer's breach of this representation and warranty.

22. LIMITATION OF LIABILITY. NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED IN THIS AGREEMENT OR PROVIDED FOR UNDER ANY APPLICABLE LAW, STERICYCLE WILL NOT BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, OR CONSEQUENTIAL DAMAGES OF ANY KIND (INCLUDING LOST PROFITS, FINES, GOODWILL, DATA, THE COST OF REPLACEMENT GOODS OR SERVICES, OR OTHER INTANGIBLE LOSSES) ARISING FROM OR RELATED TO THIS AGREEMENT, INCLUDING BUT NOT LIMITED TO STERICYCLE'S BREACH OR ALLEGED BREACH OF THIS AGREEMENT OR THE CUSTOMER'S USE OF THE WEB SITE, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHERWISE, EVEN IF STERICYCLE HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

23. DISCLAIMER OF WARRANTIES. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, STERICYCLE MAKES NO REPRESENTATIONS, WARRANTIES OR GUARANTEES OF ANY KIND WHATSOEVER, EXPRESS OR IMPLIED, IN CONNECTION WITH THIS AGREEMENT, THE EQUIPMENT, THE SERVICES, ANY TREATMENT, STORAGE OR DISPOSAL FACILITY, OR ANY INFORMATION, SOFTWARE PROGRAMS OR OTHER DATA OR REPORTS PROVIDED TO CUSTOMER, INCLUDING BUT NOT LIMITED TO WARRANTIES OF MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE, GUARANTEES OF OUTPUTS, OR OTHERWISE. WITHOUT LIMITING THE GENERALITY OF THE FOREGOING, ALL COMPLIANCE INFORMATION AND DATA PROVIDED BY STERICYCLE, INCLUDING INFORMATION AND DATA PROVIDED BY THE FORMULARY REVIEW SYSTEM AND ON STERICYCLE' WEB SITE, IS PROVIDED "AS IS," WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESS OR IMPLIED.

24. Compliance Materials; Confidentiality. To the extent that Stericycle provides Customer with electronic or printed materials ("Compliance Materials"), it provides these subjects to a limited license to Customer to use Compliance Materials for its own, non-commercial use. Stericycle may revoke this license at any time. Customer may not copy or distribute Compliance Materials or use or republish Compliance Materials for or to

any third party or audience. Customer shall use best efforts to return all Compliance Materials to Stericycle at Customer's expense at the expiration or termination of this Agreement. Stericycle may charge Customer a fee for failure to return Compliance Materials. Except as permitted in the GPO Agreement, Customer agrees to not disclose to any third parties Stericycle pricing, policies, and procedures.

Attachment A Pricing

Hospital Price Structure	See Attachments for Applicable Locations	
Service Rate Type	Effective Rate	Unit of Measure
Regulated Medical Waste	\$38.69	Per Container
Path/ Chemo	-	Per Container
Fuel	See Attachment C	% of Invoice
Minimum Pick-up/ No Waste Fee	\$193.45	Per Stop

Offsite Price Structure	See Attachments for Applicable Locations	
Recurring Rate Type	Effective Rate	Unit of Measure
Regulated Medical Waste	\$60.00	Per Container
Path/ Chemo	\$60.00	Per Container
Fuel	See Attachment C	% of Invoice
Minimum Pick-up/ No Waste Fee	\$193.45	Per Stop

Stericycle reserves the right to charge for a minimum container weight for each container collected at a customer's site. The minimum weight is determined to be 65% of a container's gallon capacity. Stericycle will assign a minimum weight per each container type that equates to 1 lb. per each gallon of capacity (e.g., a 30-gallon container has a minimum weight of 19.5lbs). If the weight of each container collected does not meet the assigned minimum weight for that container type, Stericycle will charge the current per lb. rate to the assigned minimum weight to calculate the container price.

Product Place Holder (products and pricing to be added as needed):

Customer approves Stericycle's use of Customer's name and/or logo in Stericycle's marketing and promotional materials, including on Stericycle's website.

Service Locations

Customer locations, serviced by Stericycle under this Agreement

Additional Locations: In the event that Customer acquires, leases, takes control or otherwise adds a location in a Stericycle service area, Customer shall notify Stericycle of the new location, and upon receiving notification, Stericycle shall add those serviced locations under the provisions of this service agreement, via an addendum.

In the event any new Customer Location is party to an existing agreement for Services similar to the Services by a vendor other than Stericycle: (i) Customer will use commercially reasonable efforts to terminate such agreement as soon as possible; and (ii) such locations shall immediately become a Customer Location upon the expiration of such agreement.

Cust #	Price Structure	Location Name	Address	City	ST	Zip	Frequency	GPO ID #
1000780977	Hospital	Mangum Regional Medical	1 Wickersham St	Mangum	OK	73554	E1W – Once a week	
3000886416	Off-Site	Mangum Regional Medical	118 S Louis Tittle Ave	Mangum	OK	73554	E2W – Every 2 Weeks	

Attachment B - Waste Acceptance Policy



Updated February 2024

Waste Acceptance Policy for Non-Incineration Services for Regulated Medical Waste and Sharps Waste Services

This policy defines acceptable and unacceptable waste for Stericycle's regulated medical waste and sharps waste services. The purpose of this policy is to identify the waste that Stericycle will and will not accept for treatment (non-incineration) as part of these services. This policy is not intended to summarize or capture all federal, state or local requirements that may apply to a particular facility's regulated medical waste or sharps waste, and reliance on this policy is not a substitute for seeking legal advice. It is the responsibility of the waste generator to appropriately characterize and manage the waste it generates, and to comply with this policy. It is the responsibility of the waste generator to remove or obscure any protected health information or other personally identifiable information prior to providing waste to Stericycle. If you have questions regarding this policy, please contact your Stericycle representative.

ACCEPTED/CONFORMING WASTE – REGULATED MEDICAL WASTE

- Regulated Medical Waste: biohazardous, biomedical, infectious or regulated medical waste as defined under federal, state or local law; waste known or reasonably expected to contain a pathogen; a waste or reusable material derived from the medical treatment of an animal or human, which includes diagnosis and immunization, or from biomedical research, which includes the production and testing of biological products.
- Containerized Sharps Waste

ACCEPTED/CONFORMING WASTE - SHARPS WASTE

- Sharps Waste: any object contaminated with a pathogen or that may become contaminated with a pathogen through handling or during transportation and also capable of cutting or penetrating skin or a packaging material; needles, syringes, scalpels, broken glass, culture slides, culture dishes, broken capillary tubes, broken rigid plastic, and exposed ends of dental wires

NON-CONFORMING WASTE

- Complete human remains (including heads, full torsos and fetuses)
- Pathological waste (human or animal body parts, organs, tissues and surgical specimens (removed of formaldehyde formalin, or other chemical preservatives) animal carcasses, paraffin wax blocks)*
- Select agents or toxins, and untreated Category A infectious substances
- Prion waste*
- Any waste that is classified as hazardous by the U.S. Environmental Protection Agency or equivalent state agency
- Pharmaceutical waste (hazardous or non-hazardous*)
- Controlled substances which are regulated by the U.S. Drug Enforcement Administration or equivalent state agency (including medical cannabis)
- Chemical wastes (such as solvents or cleaning products)
- Large volumes of liquid and uncontained liquid
- Solidified suction canisters (California only)*
- Universal wastes (such as batteries, fluorescent lamps, or mercury-contaminated equipment)
- Compressed gas cylinders, canisters, aerosol cans or metered dose inhalers
- Electronic or battery powered equipment (such as cauterizers)
- Radioactive waste
- Chemotherapy-related waste*
- Loose Sharps Waste / Sharps Waste that is not in a sharps container
- Any container that is overweight, damaged, leaking or improperly packaged
- Any waste that is not Conforming Waste
- Any waste that is prohibited by law

*Items marked with * may be acceptable if generator has incineration services with Stericycle*

Additional terms and conditions may apply based on treatment/transfer facility and other local restrictions – contact your Stericycle representative for details



Updated January 2024

Waste Acceptance Policy for Incineration Services

This policy defines acceptable and unacceptable waste for Stericycle's incineration services. The purpose of this policy is to identify the waste that Stericycle will and will not accept for treatment as part of these services. This policy is not intended to summarize or capture all federal, state or local requirements that may apply to a particular facility's waste, and reliance on this policy is not a substitute for seeking legal advice. It is the responsibility of the waste generator to appropriately characterize and manage the waste it generates, and to comply with this policy. It is the responsibility of the waste generator to remove or obscure any protected health information or other personally identifiable information prior to providing waste to Stericycle. If you have questions regarding this policy, please contact your Stericycle representative.

ACCEPTED/CONFORMING WASTE ELIGIBLE FOR INCINERATION SERVICES

- Pathological Waste – human or animal tissues, organs, limbs, surgical specimens and other body parts, removed of formaldehyde, formalin, or other chemical preservatives
- Paraffin Wax Blocks – wax blocks with human or animal tissue embedded, packaged according to Stericycle's specific packaging guidelines for this waste stream
- Animal Carcasses – packaged according to Stericycle's specific packaging guidelines for this waste stream
- Prion Waste – packaged according to Stericycle's specific packaging guidelines for this waste stream
- Trace Chemotherapy Waste – any waste contaminated through contact with, or having previously contained, chemotherapeutic agents
- Non-Hazardous Pharmaceutical Waste – pharmaceutical waste not regulated as hazardous by the U.S. Environmental Protection Agency, or equivalent state agency
- Regulated Medical Waste: biohazardous, biomedical, infectious or regulated medical waste as defined under federal, state or local law; waste known or reasonably expected to contain a pathogen; a waste or reusable material derived from the medical treatment of an animal or human, which includes diagnosis and immunization, or from biomedical research, which includes the production and testing of biological products.
- Sharps Waste: any object contaminated with a pathogen or that may become contaminated with a pathogen through handling or during transportation and also capable of cutting or penetrating skin or a packaging material; needles, syringes, scalpels, broken glass, culture slides, culture dishes, broken capillary tubes, broken rigid plastic, and exposed ends of dental wires
- Additional waste streams as approved case-by-case by the Stericycle Materials Management Team

NON-CONFORMING WASTE

- Complete human remains (including heads, full torsos and fetuses)
- Select agents or toxins, and untreated Category A infectious substances
- Any waste that is classified as hazardous by the U.S. Environmental Protection Agency or equivalent state agency
- Controlled substances which are regulated by the U.S. Drug Enforcement Administration or equivalent state agency (including medical cannabis)
- Chemical wastes (such as solvents, chemical preservatives, or cleaning products)
- Large volumes of liquid and uncontained liquid
- Universal wastes (such as batteries, fluorescent lamps, or mercury-contaminated equipment)
- Compressed gas cylinders, canisters, aerosol cans or metered dose inhalers
- Electronic or battery powered equipment (such as cauterizers)
- Radioactive waste
- Loose Sharps Waste / Sharps Waste that is not in a sharps container
- Any container that is overweight, damaged, leaking or improperly packaged
- Any waste that is not Conforming Waste
- Any waste that is prohibited by law

Additional terms and conditions may apply based on treatment/transfer facility and other local restrictions – contact your Stericycle representative for details

Attachment C - Energy Charge

Percent of Invoice Fuel Surcharge

Stericycle uses an index-based surcharge that is adjusted monthly. Changes to the surcharge will be effective the first business day of each month. The surcharge will be based on the National U.S. Average ‘On Highway’ Diesel Fuel Price reported by the U.S. Department of Energy for the prior month to the adjustment.

The prices on these indexes are published by the U.S. Dept. of Energy and Stericycle is not responsible for the information provided.

Stericycle Energy Charge Table		
At Least (price per gallon)	But Less Than (price per gallon)	Surcharge (% of Invoice)
0	\$2.75	5.80%
\$2.76	\$3.00	6.30%
\$3.01	\$3.25	6.90%
\$3.26	\$3.50	7.40%
\$3.51	\$3.75	7.90%
\$3.76	\$4.00	8.50%
\$4.01	\$4.25	9.00%
\$4.26	\$4.50	9.60%
\$4.51	\$4.75	10.10%
\$4.76	\$5.00	10.70%
\$5.01	\$5.25	11.20%
\$5.26	\$5.50	11.70%
\$5.51	\$5.75	12.30%
\$5.76	\$6.00	12.80%

*If the diesel rate rises above \$6.00, the 12.80% surcharge will be increased 0.6% for every \$0.25 increase in the diesel rate.
Stericycle reserves the right to update or modify the fuel table without prior notice.*

Hospital Vendor Contract Summary Sheet

1. Existing Vendor New Vendor
2. **Name of Contract:** Stericycle Rx
3. **Contract Parties:** Stericycle Rx/MRMC.
4. **Contract Type Services :** Service Agreement
5. **Impacted Hospital Departments:** Pharmacy
6. **Contract Summary:** This is for pharmaceutical waste destruction.
7. **Cost:** \$228.80/month
8. **Prior Cost:** \$215/month
9. **Term:** 36 months
10. **Termination Clause:** None
11. **Other:** Each additional container beyond the annual allotment = \$247.25
Each additional stop beyond the annual allotment = \$517.50

Premier Healthcare Alliance, L.P., (“Premier”) and Stericycle, Inc. (“Stericycle”) have entered into a group purchasing agreement entitled Purchasing Agreement-Services (Agreement number PP-FA-985, effective June 1, 2022 (the “GPO Agreement”) for the benefit of certain third-party beneficiaries (the “Participating Members,” as further defined in the GPO Agreement). This is Stericycle’s standard form of agreement for the Services described herein. Stericycle offers the Services described in this Agreement pursuant to the GPO Agreement, and notwithstanding anything to the contrary contained in this Agreement, this Agreement is subject to the terms and conditions of the GPO Agreement. In the event of a conflict between a term or condition in this Agreement and a term or condition in the GPO Agreement, the GPO Agreement controls. The Term of this Agreement will survive the termination or expiration of the GPO Agreement. All capitalized terms not defined in this Agreement have the meanings given to them in the GPO Agreement. For avoidance of doubt, a Participating Member is not subject to this Agreement unless it has been executed by the authorized representatives of both the Participating Member and Stericycle.

TERMS AND CONDITIONS

1. Pharmaceutical Waste Compliance Services Stericycle, Inc. has obtained all necessary licenses, permits, insurance and authorizations required to perform services hereunder and, upon request, shall furnish copies thereof to customer. Stericycle, Inc. shall provide pharmaceutical waste compliance services to Customer as described in detail in Exhibit A hereto. The services shall include, the pick-up, transportation and disposal of Pharmaceutical Waste, which is defined as waste listed under the “Accepted Waste Streams” section of the Waste Acceptance Policy (“WAP”) attached hereto, as the WAP may be amended to ensure compliance with applicable laws or regulations. A copy of Stericycle’s Waste Acceptance Policy may also be obtained from your local Stericycle representative. Customer warrants that the waste presented for disposal will conform to the WAP. Title to Pharmaceutical Waste (other than waste that does not conform to the requirements of the WAP (“Non-Conforming Waste”) shall transfer to and vest in Stericycle at such time as such waste is loaded onto Stericycle vehicles. Customer shall have title to the Pharmaceutical Waste at all prior times. Customer shall hold title to any Non-Conforming Waste at all times, whether refused for collection, returned to the Customer for proper disposal after collection or otherwise disposed of in accordance with Customer’s instructions or arrangements.

2. Recordkeeping and Compliance with Laws Stericycle and Customer shall keep and retain adequate books and records and other documentation including personnel records, correspondence, instructions, plans, receipts, vouchers, permits, required state registrations, copies of manifests and tracking records consistent with and for the periods required by applicable regulations and guidelines pertaining to generation, storage or handling of Waste and the Services to be performed under this Agreement.

3. Term, Pricing and Termination The term (“Term”) of this Agreement is established on Attachment A of this document, 36 month from the date of execution of this Agreement.

- (a) Customer shall pay Stericycle the prices set forth on the Attachment A of this Agreement. Stericycle may increase the contract price annually but no more than four percent (4%). Prices for Services may not be increased for at minimum the first eighteen (18) months of a 60-month term and for the first 12 months for any Term of less than 60 months. Thereafter, price increases may be implemented on each subsequent anniversary date of the Agreement. Additionally, Stericycle may adjust the contract price to account for operational changes it implements to comply with changes in law, regulatory changes, in the waste treatment location changes in customer’s service requirements including changes in waste patterns, and/or to otherwise cover unforeseen, significant cost escalation.
- (b) Stericycle has instituted a per invoice fuel surcharge to manage and isolate the impact of Diesel fuel price fluctuations. The fuel surcharge is based on the U.S. ‘On Highway’ Diesel Price Index. A table outlining the Fuel Surcharge can be found in Attachment D of this Agreement.
- (c) In the event of breach of any provision of this Agreement, the non-breaching party shall notify the breaching party in writing of the specific nature of the breach and shall request that it be cured. If the breaching party does not cure the breach within thirty (30) days of such notice, the non-breaching party may immediately terminate this Agreement on written notice to the breaching party, and such termination shall not preclude the non-breaching party from pursuing any and all remedies available to it at law or in equity.
- (d) If Customer breaches this Agreement by terminating Stericycle’s collections prior to the expiration of its Term or in any other way violates this Agreement in such a way that Stericycle’s continued performance is rendered impossible or commercially impracticable, then Stericycle shall be entitled to collect from Customer an amount in liquidated damages equal to 50% of Customer’s average charge on a monthly basis based on the 12 months’ billings prior to the cessation of collections (or based on any lesser period if the contract began less than twelve months earlier) times the number of months, including prorated partial months, remaining until the expiration date of the Term or Extension Term. Customer hereby acknowledges (i) that Stericycle’s damages resulting from the premature termination of collections include lost profits, inefficiencies resulting from route changes and reduced treatment plant throughput, increased administrative overhead, unrecoverable sunk training/instruction costs, and other elements of injury, (ii) that such damages are extremely difficult to quantify as they relate to any one customer, and (iii) that the foregoing liquidated damages amount is a reasonable estimate of actual expected damages and is not a penalty. Liquidated damages as described herein is Stericycle’s sole remedy for Customer’s improper early termination.
- (e) Stericycle shall have the right to terminate this Agreement at any time by giving Customer at least sixty (60) days’ notice in the event that it is unable to continue performing its obligations under this Agreement due to the suspension, revocation, cancellation or termination of any permit or required to perform this Agreement or in the event that a change in any law, regulation or ordinance makes it impractical or uneconomical, in Stericycle’s sole discretion, to continue performing this Agreement.
- (f) Upon 30 days’ notice to Stericycle, Customer shall have the right to add or delete mutually acceptable Customer facilities receiving Services under this Agreement. This addition or exclusion of any facility participating under this Agreement shall have no effect on the Services provided the other participating facilities.
- (g) In addition to Stericycle’s charges for Services and products under this Agreement, the Customer shall pay all taxes imposed or levied by any governmental authority with respect to such Services or products. These taxes include all sales, use, excise, occupation, franchise and similar taxes and tax-like fees and charges (but do not include any taxes on Stericycle’s net income). Stericycle shall cooperate with the Customer to determine the applicability of any exemption certificates that the Customer provides to Stericycle in a timely manner.
- (h) Any terms or conditions contained in any Purchase Order, Purchase Order Agreement, or other invoice acknowledgment, Order by Customer or proposed at any time by Customer in any manner, which vary from, or conflict with the terms and conditions in this Agreement are deemed to be material alterations and are objected to by Stericycle without need of further notice of objection and shall be of no effect nor in any circumstances binding upon Stericycle unless expressly accepted in writing. If Customer’s standard purchase order form is provided to

Stericycle in connection with this Agreement, the terms and conditions for that Purchase Order will be superseded by the provisions of this Agreement and the use of the purchase order shall be only to facilitate Customer's payment of fees to Stericycle. Written acceptance or rejection by Stericycle of any such terms or conditions shall not constitute an acceptance of any other additional terms or conditions.

4. Survival The term of this Agreement is established on page one of the documents. If Stericycle is re-awarded a new GPO Agreement for Services, Customers having signed a service agreement under the previous GPO Agreement will continue to have their sales reported and Administrative Fees paid for their Stericycle purchase activity on the new GPO Agreement without any further action being required, through the term of the Stericycle service Agreement.

5. Billing Stericycle shall submit invoices to Customer in accordance with Stericycle's standard billing process. Customer shall pay in full each Stericycle invoice within 30 days of the date of such invoice by ACH or other agreed upon electronic means. Any invoiced amounts not received by Stericycle within that timeframe will be subject to a late fee of 1.5% per month (or the maximum amount allowed by law, if different) on the outstanding balance. Customer shall reimburse Stericycle for all costs that it incurs in collecting overdue amounts from Customer. Stericycle may, with notice, suspend services until any overdue amounts (plus late fees, and enforcement and collection costs, if any) are paid. Customer shall also pay all taxes imposed by any governmental authority with respect to the purchase of any services and products hereunder, including all sales, use, excise, occupation, franchise and similar taxes and tax-like fees and charges (but excluding all taxes on Stericycle's net income). Stericycle will cooperate with Customer to determine the applicability of exemption certificates, if any, that Customer provides in a timely manner to Stericycle. Customer shall not be entitled to withhold payment by way of set-off or counterclaim.

6. Surcharge Stericycle may also impose a 'no waste' surcharge no greater than \$75 in the event that Stericycle attempts to pick up waste at a Customer location (on either a scheduled pick-up or in response to a Customer request) and, through no fault of Stericycle, either (a) there is no Waste for Stericycle to pick up, (b) waste is not ready for pick-up or (c) the Customer location is closed.

7. Liability for Equipment Customer shall have the care, custody and control of containers and other equipment placed at Customer's premises and owned by Stericycle and accepts responsibility and liability for the equipment and its contents except when it is being physically handled by employees of Stericycle. Customer agrees to defend, indemnify and hold harmless Stericycle from and against any and all claims for loss or damage to property, or personal injury or death, resulting from or arising in any manner out of Customer's use, operation or possession of any containers and other equipment furnished under this Agreement, except to the extent any such loss or damage to personal property, or personal injury or death is a result of Stericycle's negligence, intentional misconduct, or breach of this Agreement. Any damage to such property and equipment, other than normal wear and tear, will be charged to the Customer, and payable to Stericycle as additional service cost.

8. Indemnification Stericycle shall indemnify and hold Customer harmless from any liabilities arising from the gross negligence or willful misconduct of Stericycle in the performance of its obligations under this Agreement. Customer shall indemnify and hold harmless Stericycle from any liabilities arising from the gross negligence or willful misconduct of Customer, which shall include, but not be limited to, failure to properly store, package, label, or segregate Waste and any liabilities relating to Non-Conforming Waste, whether or not collected, transported or treated by Stericycle. Customer agrees to pay Stericycle's reasonable attorney's fees incurred for any success defense by Stericycle of a suit for indemnification brought against Stericycle by Customer.

9. Compliance with Laws Stericycle hereby agrees to carry General Liability, Automobile Liability, and Workmen's Compensation Insurance as required by applicable state law, and to otherwise comply with all federal and state laws, rules, and regulations applicable thereto and relating to its performance hereunder. As of the date of this Agreement, Stericycle has obtained, and agrees to maintain during the Term of this Agreement, all necessary permits, licenses, zoning and other federal, state or local authorizations required to perform the Services under this Agreement and will furnish copies of these to Customer upon request. Customer and Stericycle each hereby agrees to comply with all federal and state laws, rules, and regulations applicable to their handling of Waste and their performance under this Agreement, including, without limitation, all applicable record keeping, documentation and manifesting requirements. Stericycle and Customer shall keep and retain adequate books and records and other documentation including personnel records, correspondence, instructions, plans, receipts, vouchers, copies of manifests and tracking records and any other records or reports or memoranda consistent with and for the periods required by applicable regulatory requirements and guidelines pertaining to storage or handling of Waste and the Services to be performed under this Agreement.

10. Exclusivity Customer agrees to use no other Waste disposal service or method during the Term of this Agreement and any Extension Terms.

11. Force Majeure The obligations of either party to perform under this Agreement will be excused during each period of delay caused by acts of God, war or terrorism, or by shortages of power or materials or government orders which are beyond the reasonable control of the party obligated to perform and prevents the party from being able to perform ("Force Majeure Event"). In the event that either party ceases to perform its obligations under this Agreement due to the occurrence of a Force Majeure Event, such party shall: (1) immediately notify the other party in writing of such Force Majeure Event and its expected duration; (2) take all reasonable steps to recommence performance of its obligations under this Agreement as soon as possible. In the event that any Force Majeure Event delays a party's performance for more than thirty (30) days following notice by such party pursuant to this Agreement, the other party may terminate this Agreement immediately upon written notice to such party.

12. Independent Contractor Stericycle's relationship with Customer pursuant hereto is that of an independent contractor, and nothing in this Agreement shall be construed to designate Stericycle as an employee, agent, or partner of or a joint venture with Customer.

13. Amendment and Waiver Changes in the types, size and amount of equipment and the frequency of service may be mutually agreed to orally or in writing by the parties, without affecting the validity of this Agreement. Consent to oral changes shall be evidenced by the practices and actions of the parties. All other amendments to this Agreement (other than as provided in 3(b)) shall be affected only by a written instrument executed by the parties. Variations from the standard form of agreement, if any, are contained in the Addendum to Customer Service Agreement attached hereto. No waiver shall be effective unless submitted in writing by the party granting such waiver. No waiver of any provision of this

Agreement shall be deemed a waiver of any other provision of this Agreement and no waiver of any breach or duty under this Agreement shall be deemed a waiver of any other breach or later instances of the same duty.

14. Savings Clause In case any one or more of the provisions contained in this Agreement shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Agreement; this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein, unless such finding shall impair the rights or increase the obligations of Stericycle hereunder, in which event, at Stericycle's option, this Agreement may be terminated

15. Entire Agreement This Agreement (including any attachments, exhibits and amendments made in accordance with Paragraph 13) constitutes the entire understanding and agreement of the parties and cancels and supersedes all prior negotiations, representations, understandings or agreements, whether written or oral, with respect to the subject matter of this Agreement.

16. Governing Law This Agreement shall be governed by and construed in accordance with the laws in the state of Illinois without regard to the conflicts of laws rules of any jurisdiction.

17. Notices All required notices, or those which the parties may desire to give under this Agreement shall be in writing and sent to the parties' addresses set forth on the first page of this Agreement, and in the case of Stericycle, to the Stericycle LQ Sales Department address as follows: Attn: Stericycle LQ Sales Department, 2355 Waukegan Road, Bannockburn, IL 60015. Notices shall be effective when received.

18. Assignment Neither party will assign any rights or obligations under this Agreement without the express written consent of the other party. Such consent shall not be unreasonably withheld.

19. Counterparts This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which when taken together shall constitute one and the same instrument. A copy or facsimile of this Agreement shall be as effective as an original.

20. Limitation of Liability Except as explicitly provided in this Agreement, Stericycle shall not be liable for any loss of profits or other consequential damages sustained by Customer in connection with performance or nonperformance under this Agreement.

21. Waste Brokers Stericycle reserves the right to deal solely with the Customer and not with any third-party agents of the customer for all purposes relating to this Agreement (other than as contemplated by the GPO Agreement). Customer represents and warrants to Stericycle that it is the medical waste generator and is acting for its own account and not through a broker or agent. Stericycle shall be entitled to terminate this Agreement and seek all available legal remedies, including but not limited to liquidated damages, in the amount set forth herein for Customer's breach of this representation and warranty.

22. LIMITATION OF LIABILITY NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED IN THIS AGREEMENT OR PROVIDED FOR UNDER ANY APPLICABLE LAW, STERICYCLE WILL NOT BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, OR CONSEQUENTIAL DAMAGES OF ANY KIND (INCLUDING LOST PROFITS, FINES, GOODWILL, DATA, THE COST OF REPLACEMENT GOODS OR SERVICES, OR OTHER INTANGIBLE LOSSES) ARISING FROM OR RELATED TO THIS AGREEMENT, INCLUDING BUT NOT LIMITED TO STERICYCLE'S BREACH OR ALLEGED BREACH OF THIS AGREEMENT OR THE CUSTOMER'S USE OF THE WEB SITE, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHERWISE, EVEN IF STERICYCLE HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

23. DISCLAIMER OF WARRANTIES EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, STERICYCLE MAKES NO REPRESENTATIONS, WARRANTIES OR GUARANTEES OF ANY KIND WHATSOEVER, EXPRESS OR IMPLIED, IN CONNECTION WITH THIS AGREEMENT, THE EQUIPMENT, THE SERVICES, ANY TREATMENT, STORAGE OR DISPOSAL FACILITY, OR ANY INFORMATION, SOFTWARE PROGRAMS OR OTHER DATA OR REPORTS PROVIDED TO CUSTOMER, INCLUDING BUT NOT LIMITED TO WARRANTIES OF MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE, GUARANTEES OF OUTPUTS, OR OTHERWISE. WITHOUT LIMITING THE GENERALITY OF THE FOREGOING, ALL COMPLIANCE INFORMATION AND DATA PROVIDED BY STERICYCLE, INCLUDING INFORMATION AND DATA PROVIDED BY THE FORMULARY REVIEW SYSTEM AND ON STERICYCLE' WEB SITE, IS PROVIDED "AS IS," WITHOUT WARRANTY OF ANY KIND, EITHER EXPRESS OR IMPLIED.

24. Compliance Materials; Confidentiality To the extent that Stericycle provides Customer with electronic or printed materials ("Compliance Materials"), it provides these subjects to a limited license to Customer to use Compliance Materials for its own, non-commercial use. Stericycle may revoke this license at any time. Customer may not copy or distribute Compliance Materials or use or republish Compliance Materials for or to any third party or audience. Customer shall use best efforts to return all Compliance Materials to Stericycle at Customer's expense at the expiration or termination of this Agreement. Stericycle may charge Customer a fee for failure to return Compliance Materials. Except as permitted in the GPO Agreement, Customer agrees to not disclose to any third parties Stericycle pricing, policies, and procedures.

25. Proprietary Waste Characterization Stericycle's Waste Characterization software, processes, protocols data, reports, and other related intellectual property is proprietary and confidential and shall remain the property of Stericycle. Customer agrees not to disclose Stericycle's proprietary and confidential waste characterization software, processes, protocols, reports, or data except on a need to know basis only for Customer's employees whose job function requires access and use of the data. Customer agrees that any disclosure by Customer or Customer's employees of Stericycle's proprietary and confidential Waste Characterization software, processes, protocols, data, reports and other related intellectual property is a breach of this Agreement and will cause Stericycle irreparable harm, and that in addition to any remedies Stericycle may have at law, Stericycle may seek an injunctive or other equitable relief in the event that Customer breaches the terms of this paragraph.

Exhibit A

Rx Affiliate Self-Service Scope of Work

Program Design & Start-Up:

- Customer will complete a pharmaceutical waste characterization checklist to support the characterization process. If more than 100 NDCs in inventory or a Hospital, Customer will provide Stericycle with a 12-month purchase history of all pharmaceuticals.
- Customer will provide Stericycle how many containers and/or services are needed per calendar year.

Training Resources:

- Stericycle will provide 24-7 access to a hazardous materials training on Stericycle's online training portal at mystericycle.com.
- Stericycle will provide a Welcome Kit and waste segregation poster(s).

Service Process:

- Customer employee will prepare the Rx container for collection per Stericycle training and instructions.
- Customer will contact Stericycle to schedule a Rx waste disposal pick-up and new containers will be shipped to Customer at that time.

On-going Rx Waste Characterization

- Customer sites using a checklist will recomplete as waste characterization changes and will be asked to verify the checklist annually. Customer will be responsible for submitting new NDCs for waste characterization to Stericycle to request annual formulary characterization updates.
- An additional fee will be charged for waste characterization of Clinical Investigational compounds – including multi-component blinded studies.

Attachment A

Pricing

Off-Site Price Structure	See Attachments for Applicable Locations	
Recurring Rate Type	Effective Rate	Unit of Measure
RX Affiliate Program	\$228.80	Per Month
Service Rate Type	Effective Rate	Unit of Measure
Fuel/ Energy Surcharge	See Attachment D	% of Invoice

Note1: Each additional container beyond the annual allotment = \$247.25

Note2: Each additional stop beyond the annual allotment = \$517.50

The Monthly Fee includes the following:

- Waste characterization
- Program design & start-up
- Training
- On-going waste characterization
- Waste Containers
- Pick up of Waste

Ancillary Charges	Item Code	UOM	Price
Profiling Fees			
<24 Hour URGENT Profile Fee	ADMPRORU	Each	\$315
Rejection Fee	ADMREJECT	Each	\$250
Manifest Discrepancy/Paperwork Error	ADMMAN	Each	\$300
Off Spec/Discrepant – Storage Fee	ADMSTOR	Day	\$85
e-Manifest Administration Fee (per manifest)	EMANFSTF	Each	\$30
Minimum Invoice Amount	---	Per Invoice	\$350
Scheduled Pickup Cancellation	ADMCAN	Each	\$315
Repacking/Overpacking Fee	ADMREPK	Each	\$315
Overpack Handling Fee	ADMOVPK	Each	\$110
Technical Lab Pack Review "Flat Rate Fee - The flat fee criteria:	ADTECHRVW	Each	\$350
(1.) Excel submitted inventories;			
(2.) Maximum of 500 inventory items;			
(3.) <5% of items with Trade Names"			

1. The disposal pricing as listed above is based on the information provided and will be confirmed following receipt of a completed waste profile. All pricing is pending profile approval and/or waste sample analysis.
2. For a complete list of process code specifications, visit: <https://www.cleanearthinc.com/sites/default/files/Process-Specifications.pdf>
3. A minimum charge of \$350 applies to the invoice.
4. Transportation, labor and equipment is portal to portal, and requires a four-hour minimum unless otherwise specified.
5. Demurrage rates will be billed in 15-minute increments.
6. All invoices are subject to applicable Federal, State, and local taxes & fees as well as an Energy & Insurance recovery charge tied to the National monthly average price for diesel fuel as published by the Department of Energy. See table titled "Fuel Surcharge – Third-Party Healthcare Waste" at <https://www.stericycle.com/en-us/service-fees>
7. Unless otherwise specified, prices quoted do not include the following:
 - Radioactive Waste
 - Biohazard or Infectious Waste
 - Explosives of any type
 - Liquid or free mercury
 - Isocyanates
 - Reactive materials (metals, solids, liquids)
8. Disposal prices for gas cylinders are for those with original label, operable valve and in acceptable DOT shipping condition.
 - Unknown identification fee of \$350 may be charged for each unknown gas that is sampled and analyzed

- Additional labor fees may apply for inspection and preparation of cylinders for shipment
 - A confirmation fee of \$200 may be charged for each suspected gas that requires confirmation due to lack of original label. If results do not match suspected contents, then unknown ID rate will apply along with additional disposal costs if applicable
 - Inoperable valve fee: No charge for Category A cylinders. For Categories B thru E, a tapping fee of \$350 per cylinder will apply regardless of size of cylinder. For categories F & G, inoperable valve fee will be Case-by-Case
9. Batteries not in original manufacturer's packaging must have both ends taped to avoid arc. Additional fees may apply if Stericycle personnel must tape the battery ends.

Customer approves Stericycle's use of Customer's name and/or logo in Stericycle's marketing and promotional materials, including on Stericycle's website.

Service Locations

Customers Locations, Serviced by Stericycle Under this Agreement

Ship To	Location Name	Address	Service Frequency/Allotment	Pricing Structure	EPA ID Number	Entity #
1000780977	Mangum Regional Medical Center	1 Wickersham St Mangum OK 73554	2 stops a year with 2 containers allotted for the year	Rx Affiliate		

Future Service Locations

Customer Locations to be Serviced by Stericycle

Ship To	Location Name	Address	Service Frequency	Pricing Structure	EPA ID Number	Entity #

Attachment B - WASTE ACCEPTANCE POLICY



Updated February 2024

Waste Acceptance Policy for Non-Hazardous Waste Pharmaceutical Program

This policy defines acceptable and unacceptable waste for Stericycle's non-hazardous waste pharmaceutical services. This policy is not intended to summarize or capture all federal, state or local requirements that may apply to a particular facility's pharmaceutical waste, and reliance on this policy is not a substitute for seeking legal advice. It is the responsibility of the waste generator to appropriately characterize and manage the waste it generates, and to comply with this policy. It is the responsibility of the waste generator to remove or obscure any protected health information or other personally identifiable information prior to providing waste to Stericycle. If you have questions regarding this policy, please contact your Stericycle representative.

ACCEPTED / CONFORMING PHARMACEUTICAL WASTE

Stericycle accepts non-hazardous waste pharmaceuticals generated at healthcare facilities that have been characterized pursuant to the applicable service agreement.

NON-CONFORMING WASTE

Stericycle does not accept the following as part of the non-hazardous waste pharmaceutical services:

- Any waste that is classified as hazardous by the U.S. Environmental Protection Agency or equivalent state agency
- Controlled substances which are regulated by the U.S. Drug Enforcement Administration or equivalent state agency
- Chemical waste (such as lab reagents, solvents, chemical preservatives, cleaning products, amalgam, and/or chemicals used in compounding pharmaceuticals)
- Universal wastes (such as batteries, fluorescent lamps, or mercury-contaminated equipment)
- Regulated medical waste, biohazardous waste other potentially infectious materials
- Radioactive waste
- Any non-hazardous waste pharmaceutical services container that is damaged, breached, leaking or improperly packaged
- Any waste that is not non-hazardous pharmaceutical waste

2655 Waukegan Rd, Barrackburn, IL 60015

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Attachment C – Customer Respiratory Protection Policy



Updated June 2021

Customer Respiratory Protection Policy

This policy applies to U.S.-based Stericycle customers who require Stericycle employees, including in-service technicians, to wear customer-issued respirators when present at the customer's facility.

"Respirator" as used in this policy refers to any device or face covering that is considered a "respirator" by the U.S. Occupational Safety and Health Administration (OSHA) for purposes of its Respiratory Protection standard (29 C.F.R. 1910.134).

When a customer requires Stericycle employees to wear customer-issued respirators, such customer shall, in accordance with 29 C.F.R. 1910.134:

1. Establish and implement a written, work-site specific respiratory protection program that covers contractors and visitors in addition to employees, a copy of which must be made available to Stericycle upon request.
2. Select and provide an appropriate respirator based on the hazards to which the Stericycle employee will be exposed.
3. Conduct a fit test on each Stericycle employee using the same make, model, style and size of respirator that will be provided.
4. Prepare, and retain for at least one (1) year from the date of test, a record of the fit tests administered to Stericycle employees, including: (A) the name of the employee tested; (B) the type of fit test performed; (C) the specific make, model, style and size of respirator tested; (D) the date of the test; and (E) the test results.
5. Provide a copy of the record referenced in item (4), above, to the Stericycle employee immediately following the test.

In accordance with 29 C.F.R. 1910.134, Stericycle trains in-service technicians on respiratory protection and conducts medical evaluations to confirm their ability to use a respirator. Stericycle employees who believe that their safety has been compromised in any way have, and will exercise, stop work authority.

Attachment D - Energy Charge

Percent of Invoice Fuel Surcharge

Stericycle uses an index-based surcharge that is adjusted monthly. Changes to the surcharge will be effective the first business day of each month. The surcharge will be based on the National U.S. Average 'On Highway' Diesel Fuel Price reported by the U.S. Department of Energy for the prior month to the adjustment.

The prices on these indexes are published by the U.S. Dept. of Energy and Stericycle is not responsible for the information provided.

Stericycle Energy Charge Table		
At Least (price per gallon)	But Less Than (price per gallon)	Surcharge (% of Invoice)
0	\$2.75	5.80%
\$2.76	\$3.00	6.30%
\$3.01	\$3.25	6.90%
\$3.26	\$3.50	7.40%
\$3.51	\$3.75	7.90%
\$3.76	\$4.00	8.50%
\$4.01	\$4.25	9.00%
\$4.26	\$4.50	9.60%
\$4.51	\$4.75	10.10%
\$4.76	\$5.00	10.70%
\$5.01	\$5.25	11.20%
\$5.26	\$5.50	11.70%
\$5.51	\$5.75	12.30%
\$5.76	\$6.00	12.80%

If the diesel rate rises above \$6.00, the 12.80% surcharge will be increased 0.6% for every \$0.25 increase in the diesel rate.

Stericycle reserves the right to update or modify the fuel table without prior notice.

Addendum to Customer Service Agreement

Item 12.

Hospital Vendor Contract Summary Sheet

1. Existing Vendor New Vendor
2. **Name of Contract:** MedPro
3. **Contract Parties:** MRMC/MedPro
4. **Contract Type Services:** Professional Liability Insurance
5. **Impacted Hospital Departments:** Hospital
6. **Contract Summary:** This is professional and general liability insurance for clinical providers.
7. **Cost:** \$65,991
8. **Prior Cost:** \$60,488.00
9. **Term:** 12 months
10. **Termination Clause:**
11. **Other:** The increase is due to increased number of providers covered

HEALTHCARE LIABILITY COVERAGE TERMS

ISSUING COMPANY: The Medical Protective Company
Fort Wayne, Indiana

QUOTE NUMBER: H003788

EXPIRING POLICY NUMBER: H003788

FIRST NAMED INSURED:	Mangum City Hospital Authority
ADDRESS:	1 Wickersham St Mangum, OK 73554-9117 <input type="checkbox"/> Administrative First Named Insured
POLICY PERIOD:	From 04/21/2026 to 04/21/2027 both days at 12:01 a.m. at the address of the First Named Insured stated herein.
COVERAGE PARTS SELECTED:	(Please refer to the applicable Schedule of Named Insureds for detailed Retroactive Dates, Limits of Liability, Retentions, etc.)
Professional Liability:	Claims-Made and Reported
General Liability:	Occurrence
Employee Benefits Liability:	Claims-Made and Reported
RETROACTIVE DATE:	
Professional Liability:	10/01/2004
General Liability:	n/a
Employee Benefits Liability:	10/01/2004
All days at 12:01 a.m. at the address of the First Named Insured stated herein.	
LIMITS OF LIABILITY:	
Professional Liability:	
Per Event Limit	\$1,000,000
Aggregate Limit	\$3,000,000
Claims Expenses	Defense Outside Limits
General Liability:	
Per Event Limit	\$1,000,000
General Aggregate Limit	\$3,000,000
Products Completed Operations Hazard Aggregate Limit	\$3,000,000
Personal and Advertising Injury Limit	\$1,000,000 Each Person
Damage to Premises Rented to an Insured	\$ 50,000 Any One Premises
Medical Expense Limit	\$ 5,000 Each Person
Claims Expenses	Defense Outside Limits
Employee Benefits Liability:	
Employee Benefits Liability Per Event Limit	\$1,000,000
Employee Benefits Liability Aggregate Limit	\$3,000,000
Claims Expenses	Defense Outside Limits
RETENTION:	
Professional Liability:	\$5,000 Per Event / \$Nil Aggregate Deductible - Loss and Claims Expense

General Liability:	\$5,000 Per Event / \$Nil Aggregate Deductible - Loss and Claims Expense
Employee Benefits Liability:	\$1,000 Per Event / \$Nil Aggregate Deductible - Loss and Claims Expense

PREMIUM:

Policy Premium	\$65,791
Terrorism Premium (TRIA)	\$ 200
Total Premium	\$65,991

FORMS & ENDORSEMENTS: Refer to attached Schedule of Forms and Endorsements

ADDITIONAL TERMS AND CONDITIONS

<i>Expiration Date of Quotation:</i>	This quote is valid until the requested Policy Effective Date.
<i>Subjectivities:</i>	This quote is provided in reliance upon the representations made prior to the Quotation Date, is contingent upon the underwriting of a completed application and is also subject to the following: <ul style="list-style-type: none"> • N/A
<i>Significant Coverage Provisions:</i>	In addition to the standard policy conditions and terms, the following significant coverage provisions or endorsements will be added to the policy: <ul style="list-style-type: none"> • N/A
<i>Additional Notes:</i>	<ul style="list-style-type: none"> • N/A

THIS NOTICE IS ATTACHED TO AND MADE PART OF YOUR POLICY IN RESPONSE TO THE DISCLOSURE REQUIREMENTS OF THE TERRORISM RISK INSURANCE ACT. THIS NOTICE DOES NOT GRANT ANY COVERAGE OR CHANGE THE POLICY.

Forming Part of Policy No.:	H003788 (Primary Policy)
Issued to:	Mangum City Hospital Authority
Policy Period:	From 04/21/2026 to 04/21/2027 at 12:01 a.m. at the address of the First Named Insured stated herein.

**DISCLOSURE PURSUANT TO TERRORISM RISK INSURANCE ACT
SCHEDULE***

Terrorism Premium Quoted – Primary Policy (for Certified Acts)	\$ 200
Terrorism Premium Quoted – Excess Policy (for Certified Acts)	\$ N/A
<u>The portion of premium that is attributable to coverage for certified acts of terrorism is shown in the Schedule of this endorsement if such coverage is purchased, and does not include any charges for the portion of losses covered by the United States Government under the Act.</u>	
Additional information, if any, concerning the terrorism premium:	
Coverage for acts of terrorism is included in your policy unless you sign and return this document indicating that you are declining coverage for certified acts of terrorism.	
* Information required to complete this Schedule, if not shown on this endorsement, will be shown in the Declarations.	

You are hereby notified that under the Terrorism Risk Insurance Act, as amended and reauthorized, you have a right to purchase insurance coverage for losses resulting from acts of terrorism. *As defined in Section 102(1) of the Act:* The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS SET FORTH ABOVE AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

By receipt of this Disclosure, you have been notified that under the Terrorism Risk Insurance Act, as extended on December 22, 2005, amended on December 31, 2007 and January 12, 2015, and reauthorized on December 20, 2019, any losses resulting from certified acts of terrorism under this policy coverage may be partially reimbursed by the United States Government, and may be subject to a \$100 billion cap that may reduce the coverage provided. By receipt of this Disclosure, you have been notified of the portion of the premium attributable to such coverage.

ELECTION TO PURCHASE TERRORISM COVERAGE:

IF YOU ELECT TO PURCHASE THE TERRORISM COVERAGE DESCRIBED IN THIS DISCLOSURE NOTICE, YOU NEED DO NOTHING FURTHER. COVERAGE FOR ACTS OF TERRORISM WILL BE AUTOMATICALLY ADDED TO YOUR POLICY FOR THE PREMIUM SET FORTH ABOVE.

DECLINATION OF TERRORISM COVERAGE:

IN ORDER TO DECLINE TO PURCHASE COVERAGE, I UNDERSTAND THAT I MUST SIGN BELOW AND RETURN THIS DISCLOSURE FORM TO MY AUTHORIZED REPRESENTATIVE OR INSURANCE COMPANY. I FURTHER UNDERSTAND THAT IF I FAIL TO SIGN THIS DISCLOSURE FORM AND RETURN IT, I HAVE ELECTED TO PURCHASE TERRORISM COVERAGE AND THE PREMIUM AMOUNT(S) SET FORTH ABOVE WILL BE ADDED TO MY POLICY PREMIUM, AND COVERAGE FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WILL BE ADDED TO MY POLICY.

Policyholder/Applicant's Signature – Declination of Terrorism Coverage Only

Print Name

Date

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Policy Period: From 04/21/2026 to 04/21/2027 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
SCHEDULE OF FORMS AND ENDORSEMENTS**

Forms and Endorsements attached to this Policy:

FORM NAME	FORM NUMBER	ENDORSEMENT NUMBER
Healthcare Liability Policy Declarations	0001-PXX-OK-0121	
Schedule of Forms and Endorsements	0002-PXX-00-1215	
Schedule of Named Insureds - Professional Liability	0006-PPX-00-1215	
Schedule of Named Insureds - General Liability	0007-PGX-00-0717	
Schedule of Trade, Fictitious and/or Business Names	0009-PXX-00-1215	
Healthcare Liability Policy Common Policy Provisions and Conditions	0010-PXX-00-0121	
Healthcare Liability Policy - Professional Liability Coverage Part	0011-PPH-00-0121	
Healthcare Liability Policy - General Liability Coverage Part	0012-PGX-00-0121	
Schedule of Additional Insureds - Management Company Endorsement	1124-PXX-00-0121	
Disciplinary, Licensing and Credentialing Actions Endorsement (Professional Liability)	1303-PPX-00-0121	
Blanket Physician Insureds Endorsement (Professional Liability)	1355-PPX-00-0121	
Employee Benefits Liability Endorsement (General Liability) (Claims-Made and Reported Coverage)	1504-PGX-00-0121	
Blanket Waiver of Subrogation Endorsement (General Liability)	1512-PGX-00-1215	
Blanket Additional Insured - Premises and Equipment Lessors Endorsement (General Liability)	1514-PGX-00-0121	
Blanket Hired and Non-Owned Auto Liability Limited Coverage Endorsement (General Liability)	1517-PGX-00-0121	
Cap on Losses from Certified Acts of Terrorism Endorsement (General Liability)	1536-PGX-00-0520	
Evacuation, Disinfection and Public Relations Expenses Endorsement (General Liability)	1563-PGX-00-0121	
Sexual Misconduct with Sublimits for Innocent Insureds Endorsement (General Liability)	1565-PGX-00-0121	
Oklahoma Amendatory Endorsement	1802-PXX-OK-0121	

Forming Part of Policy No.: H003788
Issued to: Mangum City Hospital Authority
Policy Period: From 04/21/2026 to 04/21/2027 at 12:01 a.m. at the address of the First Named Insured stated herein.

HEALTHCARE LIABILITY POLICY
SCHEDULE OF NAMED INSUREDS – PROFESSIONAL LIABILITY

Only with respect to coverage provided under the Professional Liability Coverage Part, and in consideration of the premium due, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree the organizations and persons listed below are designated as **named insureds** and the Retroactive Dates, Limits of Liability and Retentions shown on the Declarations are amended as follows, but only with respect to the designated **named insureds**.

SCHEDULE OF NAMED INSUREDS						
NAMED INSURED	ID NUMBER	RETRO-ACTIVE DATE	TERMINATION DATE	LIMITS OF LIABILITY (PER EVENT LIMIT/ AGGREGATE LIMIT)	RETENTION (PER EVENT/ AGGREGATE)	PREMIUM
Mangum City Hospital Authority	221619	10/01/2004		\$1,000,000 / \$3,000,000	\$5,000 / \$Nil	\$54,291

Physician FTEs :

Physician FTE 1		02/01/2005		\$1,000,000 / \$3,000,000	\$5,000 / \$Nil	\$3,022
All Emergency Medicine and Hospitalist Physicians and Residents Employed and Contracted by Mangum City Hospital Authority	1923944			Physician FTE 1	Physician FTE 1	Included

* Indicates any applicable surcharges, taxes or fees.

As used in this Schedule, "FNI" means the **first named insured**.

All other terms and conditions of the policy remain unchanged.

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Policy Period: From 04/21/2026 to 04/21/2027 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
 SCHEDULE OF NAMED INSUREDS – GENERAL LIABILITY**

Only with respect to coverage provided under the General Liability Coverage Part, and in consideration of the premium due, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree the organizations and persons listed below are designated as **named insureds** and the Retroactive Dates, Limits of Liability and Retentions shown on the Declarations are amended as follows, but only with respect to the designated **named insureds**.

LIMITS OF LIABILITY:

Per Event Limit	\$1,000,000
General Aggregate Limit	\$3,000,000
Products Completed Operations Hazard Aggregate Limit	\$3,000,000
Personal and Advertising Injury Limit	\$1,000,000 Each Person
Damage to Premises Rented to an Insured	\$ 50,000 Any One Premises
Medical Expense Limit	\$ 5,000 Each Person
Claims Expenses	Defense Outside Limits

RETENTION:

\$ 5,000 Per Event / \$ NIL Aggregate Deductible - Loss and Claims Expense

SCHEDULE OF NAMED INSUREDS				
NAMED INSURED	ID NUMBER	RETRO-ACTIVE DATE	TERMIN-ATION DATE	PREMIUM
Mangum City Hospital Authority	221619	n/a		\$8,478

* Indicates any applicable surcharges, taxes or fees.

All other terms and conditions of the policy remain unchanged.

Forming Part of Policy No.: H003788
Issued to: Mangum City Hospital Authority
Policy Period: From 04/21/2026 to 04/21/2027 at 12:01 a.m. at the address of the First Named Insured stated herein.

HEALTHCARE LIABILITY POLICY
SCHEDULE OF TRADE, FICTITIOUS AND/OR BUSINESS NAMES

In consideration of the payment of the premium due, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree that any trade, fictitious, and/or business name listed in the Schedule of Trade, Fictitious and/or Business Names below and any other trade, fictitious and/or business name by which any **named insured** operates or trades as are by reference included in the coverage afforded to the associated **named insured**. Any such trade, fictitious and/or business name shares the Limits of Liability and any other terms and conditions applicable to the associated **named insured**, regardless of the number of **named insured(s)** scheduled below or on the policy.

SCHEDULE OF TRADE, FICTITIOUS AND/OR BUSINESS NAMES		
NAMED INSURED	ID NUMBER	TRADE, FICTITIOUS OR BUSINESS (D/B/A) NAME
Mangum City Hospital Authority	221619	Mangum Family Clinic
Mangum City Hospital Authority	221619	Mangum Regional Medical Center

All other terms and conditions of the policy remain unchanged.



**Issuing Company:
The Medical Protective Company
Fort Wayne, Indiana**

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
SCHEDULE OF ADDITIONAL INSURED – MANAGEMENT COMPANY ENDORSEMENT**

Only with respect to coverage provided under this endorsement and only under the Coverage Part(s) listed in the Schedule of Additional Insureds – Management Company below, and in consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The definition of **additional insured** in the Definitions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

Additional insured means a **management company** named in a **claim** or **potential claim** that arises from a **health care event, event** or offense resulting from the management of a **named insured** or **location** listed in a Schedule of Additional Insureds – Management Company.

The following definition is added to the Definitions section of the Common Policy Provisions and Conditions:

Management company means any person or organization listed in a Schedule of Additional Insureds – Management Company who has a signed management company agreement with a **named insured** that is in effect at the time of the **health care event, event** or offense.

The following subparagraph is added to the Insuring Clause(s) of the Coverage Part(s) listed in the Schedule of Additional Insureds – Management Company below:

The **company's** duty to defend and pay **losses** or **claims expense** on behalf of any **insured** shall extend to any **additional insured** meeting the terms and conditions of this policy, but only with respect to liability arising out of the management of a **named insured** or **location** listed in a Schedule of Additional Insureds – Management Company.

However, the coverage provided to an **additional insured** shall not be broader than that which an **insured** is required by written contract or agreement to provide to that **additional insured** and is subject to all other conditions, definitions, exclusions and terms applicable to the **insured**.

The following provision is added to the Limits of Liability section of the Coverage Part(s) listed in the Schedule of Additional Insureds – Management Company below:

ADDITIONAL INSURED

The **management company** shares the Limits of Liability of the applicable Coverage Part with the corresponding Named Insured/Location listed in a Schedule of Additional Insureds – Management Company, and with any **insured**

who is acting within the scope of their duties for the corresponding Named Insured/Location.

SCHEDULE OF ADDITIONAL INSUREDS – MANAGEMENT COMPANY		
MANAGEMENT COMPANY	NAMED INSURED/LOCATION	COVERAGE PART
Cohesive Healthcare Management & Consulting, LLC	Mangum City Hospital Authority	Professional Liability & General Liability

All other terms and conditions of the policy remain unchanged.

Draft

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
DISCIPLINARY, LICENSING AND CREDENTIALING ACTIONS ENDORSEMENT
(PROFESSIONAL LIABILITY)**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The following provision is added to the Insuring Clause section of the Professional Liability Coverage Part:

DISCIPLINARY, LICENSING, AND CREDENTIALING ACTIONS

The **company's** duty to defend a **claim** includes the defense of any disciplinary, licensing, or credentialing action brought against an **insured** who is a person by (1) a state board of medical examiners or state dental board responsible for investigating and disciplining licensees, (2) a hospital or facility professional review board or committee through formally adopted, written procedures, or (3) the United States Drug Enforcement Administration, subject to the following additional conditions:

- A. If the policy provides coverage to such an **insured** on a Claims-Made and Reported basis:
1. the action must arise from the **insured's** rendering of, or failure to render, **professional services**, after the **retroactive date**, but before the end of the **policy period**, and for which there is no other insurance available; and
 2. the action must be first initiated against the **insured** during the **policy period**.
- B. If the policy provides coverage to such an **insured** on an Occurrence basis, the action must arise from the **insured's** rendering of, or failure to render, **professional services** during the **policy period**, and for which there is no other insurance available.
- C. The payment of **claims expense** for such actions will be in addition to the applicable Limit of Liability. However, the **company** will not pay more than \$25,000 in **claims expense** on behalf of an **insured** for any single action. Furthermore, the **company** will not pay more than \$100,000 for **claims expense** on behalf of all **insureds** for all such actions covered under the policy.
- D. The **company** has no duty to pay any fines, penalties, or other costs assessed against an **insured** as a result of any such action.

However, payments for **claims** under this Insuring Clause shall not be subject to any Deductible or Self-Insured Retention.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
BLANKET PHYSICIAN INSUREDS ENDORSEMENT
(PROFESSIONAL LIABILITY)**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

Only with respect to coverage under the Professional Liability Coverage Part, the definition of **employee** in the Common Policy Provisions and Conditions is deleted and replaced with the following:

Employee means any person who is under the supervision and control of any **named insured** and who was acting within the scope of their duties on behalf of that **named insured** at the time of the **event**, offense, **health care event** or any other act or omission that results in a **claim** or **potential claim**. **Employee** also includes any leased worker, temporary worker or volunteer so long as such person is or was acting within the scope of their duties on behalf of a **named insured** that is an organization.

As used in this definition:

1. "leased worker" means a person leased to, or used by, a **named insured** under an agreement between a **named insured** and organizations providing staffing to a **named insured** to perform duties related to the conduct of that **named insured's** business. Leased worker does not include a temporary worker;
2. "temporary worker" means a person who is furnished to a **named insured** to substitute for a permanent **employee** on leave or to meet seasonal or short-term workload conditions. A temporary worker does not include a leased worker; and
3. "volunteer" means a person who provides their services or labor to a **named insured**, without being paid by that **named insured**, under the supervision or direction of the **named insured**. Volunteer does not include any independent contractor or staff physician.

However, **employee** does not mean any podiatrist, chiropractor, dentist, certified registered nurse anesthetist or midwife.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
EMPLOYEE BENEFITS LIABILITY ENDORSEMENT
(GENERAL LIABILITY)
(CLAIMS-MADE AND REPORTED COVERAGE)**

NOTICE:

This endorsement contains claims-made and reported coverage. Please read this endorsement carefully.

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The following provision is added to the Insuring Clauses section of the General Liability Coverage Part:

EMPLOYEE BENEFITS LIABILITY

1. Claims-Made and Reported

This is Claims-Made and Reported coverage and the following provisions apply:

- a. The **company** will pay on behalf of any **insured** all **loss** and **claims expense**, subject to any applicable Deductible or Self-Insured Retention, and up to the Limits of Liability shown on the Declarations with respect to this Insuring Clause, arising from an **event** related to the **administration** of **employee benefits** that took place on or after the applicable retroactive date shown on the Declarations. Moreover, to be covered under this policy, the **loss** or **claims expense** must arise from:
 - (1) a **claim** that was first made against, and received by, an **insured** during the **policy period**, and reported to the **company**, in writing, during the **policy period** or within any applicable **extended reporting period**; or
 - (2) a **potential claim** that was first known about or discovered by an **insured** during the **policy period**, and reported to the **company**, in writing, during the **policy period** or within the automatic limited **extended reporting period**.
- b. All **claims** and **potential claims** for damages arising out of, or in connection with, the same **event** will be deemed to have been first made on the date that the first of those **claims** is made against any **insured**, or the date the first of such **potential claims** is discovered by an **authorized insured**, whichever date is earlier. Only the policy in effect when the first such **claim** is made and reported to the **company**, or the first such **potential claim** is discovered and reported to the **company**, whichever is earlier, will apply to the **event**, no matter when any subsequent **claims** are made or reported, or **potential claims** are discovered and reported. If, prior to the effective date of this policy, the first such **claim** is made, or the first such **potential claim** is discovered, this policy will not apply to any subsequent **claim** or **potential claim** made during this **policy period** or any **extended reporting period**.

Only with respect to coverage provided under this endorsement, the following definitions are added to the Definitions section of the Common Policy Provisions and Conditions:

Administration means:

1. providing information to **employees**, including their dependents and beneficiaries, with respect to eligibility for or scope of an **employee benefits** program;
2. handling records in connection with an **employee benefits** program; or
3. effecting, continuing, or terminating any **employee's** participation in any **employee benefits** program.

Administration does not mean:

1. the exercise of or failure to exercise any authority or control respecting:
 - a. the management of any **employee benefits** program; or
 - b. the investment or disposition of any **employee benefits** program;
2. the rendering of any advice with respect to the investment of any assets of any **employee benefits** program;
3. handling payroll deductions; or
4. handling overtime requirements or payments, or payroll issues concerning exempt or non-exempt **employees**.

Employee benefits means any group benefits administered on behalf of a **named insured's employees**, including:

1. group insurance plans or programs, such as life, health, accident, dental, or legal advice;
2. individual retirement accounts, salary reduction plans under I.R.S. Code 401(k), or any amendment thereto, savings plans, pension plans, stock ownership plans or employee stock subscription plans;
3. travel or vacation plans; or
4. workers' compensation, occupational disease, unemployment, Social Security, or disability benefits insurance.

Only with respect to coverage provided under this endorsement, the EMPLOYEE BENEFITS LIABILITY exclusion and the ERISA exclusion are deleted from the Exclusions section of the Common Policy Provisions and Conditions.

The following exclusions are added to the Exclusions section of the General Liability Coverage Part:

EXCLUSIONS APPLICABLE TO THE EMPLOYEE BENEFITS LIABILITY INSURING CLAUSE

The coverage provided under the Employee Benefits Liability Insuring Clause does not apply to:

1. Bodily Injury, Property Damage And Personal And Advertising Injury

Any **claim** arising from, or in connection with, **bodily injury, property damage, or personal and advertising injury**.

2. Claim For Benefits Where Funds Available With Reasonable Cooperation

Any **claim** for benefits to the extent that such benefits are available, with reasonable effort and cooperation of the **insured**, from the applicable funds accrued or other collectible insurance.

3. Collective Bargaining

Any **claim** arising from, or in connection with, the breach of any collective bargaining agreement.

4. ERISA

Any **claim** arising from, or in connection with, an **insured's** duty as a sponsor of an employee benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA), or any amendment or regulation that applies thereto. However, this exclusion is limited to:

- a. any breach of any insured's fiduciary duties in violation of any applicable law or regulation;

- b. an **insured's** failure or inability to fund the plan in accordance with the plan document or any applicable law or regulation; and
 - c. liability for the payment of benefits owed to a participant or beneficiary of the plan that have been paid or may lawfully be paid from the plan's funds or those of other employee programs.
5. Failure To Perform Under A Contract
Damages arising out of the failure of an insurer to perform under a contract.
6. Health Care Event
Any **claim** arising from, or in connection with, any **health care event**.
7. Performance Of Investments And Advice Given Regarding Employee Benefits
Any **claim** arising from, or in connection with:
- a. errors in providing information on past performance of investment vehicles; or
 - b. advice given to any person with respect to that person's decision to participate or not to participate in any **employee benefits** plan.
8. Unpaid Obligations Under Employee Benefit Plan
Any **claim** arising from, or in connection with, damages arising out of an insufficiency of funds to meet any obligations under any plan included as an **employee benefit**.

The following provisions are added to the Limits of Liability Section of the General Liability Coverage Part:

EMPLOYEE BENEFITS LIABILITY PER EVENT LIMIT

The Employee Benefits Liability Per Event Limit of Liability shown on the Declarations is the most the **company** will pay under the Employee Benefits Liability Insuring Clause because of **bodily injury** arising out of any one **event**.

EMPLOYEE BENEFITS LIABILITY AGGREGATE LIMIT

The Employee Benefits Liability Aggregate Limit of Liability shown on the Declarations is the most the **company** will pay because of **bodily injury** included in the Employee Benefits Liability Insuring Clause.

Only with respect to the Employee Benefits Liability Insuring Clause, the Settlement condition in the Conditions section of the Common Policy Provisions and Conditions is deleted and replaced by the following:

SETTLEMENT

The **company** may settle any **claim, potential claim,** or other matter brought against an **insured** as the **company** deems expedient. However, the **company** shall first provide written notice to the **first named insured**.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
BLANKET WAIVER OF SUBROGATION ENDORSEMENT
(GENERAL LIABILITY)**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

Only with respect to coverage provided under the General Liability Coverage Part, the following condition is added to the Conditions section of the Common Policy Provisions and Conditions:

WAIVER OF SUBROGATION

The **company** shall waive any right of recovery the **company** may have against a person or organization to the extent that the **insured** has agreed in writing prior to the date of loss to waive the **insured's** rights of recovery against that person or organization.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
BLANKET ADDITIONAL INSURED – PREMISES AND EQUIPMENT LESSORS ENDORSEMENT
(GENERAL LIABILITY)**

Only with respect to coverage provided under this endorsement and under the General Liability Coverage Part, and in consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The definition of **additional insured** in the Definitions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

Additional insured means a **premises lessor or equipment lessor** named in a **claim** or **potential claim** that arises from an **event** or offense resulting from the acts or omissions of an **insured** in the maintenance, operation or use of premises or equipment leased to a **named insured** that took place during the term of the lease for those premises or equipment. However, such **premises lessor or equipment lessor** is not an **additional insured** with respect to **events** or offenses arising from, or in connection with, any acts or omissions alleged to have been committed by that **premises lessor or equipment lessor**.

The following definition is added to the Definitions section of the Common Policy Provisions and Conditions:

Premises lessor or equipment lessor means any person or organization who provides premises and/or equipment to an organization that is a **named insured** pursuant to a written lease agreement during the **policy period**.

The following subparagraph is added to all Insuring Clauses of the General Liability Coverage Part:

The **company's** duty to defend and pay **losses** or **claims expense** on behalf of any **insured** shall extend to any **additional insured** meeting the terms and conditions of this policy, but only with respect to any **loss** or **claims expense** payable as the result of the **additional insured's** vicarious liability for the acts or omissions of an **insured** otherwise covered under this Coverage Part.

However, the coverage provided to an **additional insured** shall not be broader than that which an **insured** is required by written contract or agreement to provide to that **additional insured** and is subject to all other conditions, definitions, exclusions and terms applicable to the **insured**. Additionally, coverage shall not apply to structural alterations, new construction or demolition operations performed by or on behalf of an **additional insured**.

The following provision is added to the Limits of Liability section of the General Liability Coverage Part:

ADDITIONAL INSUREDS

Additional insureds share the Limits of Liability of the **insured** for which the **additional insured** is alleged to be vicariously liable for the acts or omissions of the **insured** otherwise covered under this Coverage Part.

All other terms and conditions of the policy remain unchanged.

Draft

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
BLANKET HIRED AND NON-OWNED AUTO LIABILITY LIMITED COVERAGE ENDORSEMENT
(GENERAL LIABILITY)**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

Only with respect to coverage provided under this endorsement, the following provision is added to the Bodily Injury and Property Damage Liability Insuring Clause of the General Liability Coverage Part:

The **company** will pay on behalf of an **insured** all **loss** and **claims expense**, subject to any applicable Deductible or Self-Insured Retention, and up to the Limits of Liability shown on the Declarations with respect to this Insuring Clause, arising from an **event** resulting in **bodily injury** or **property damage** that, notwithstanding any provision to the contrary in this Insuring Clause, occurred during the **policy period**, and arising from:

1. the maintenance or use by any **insured** of a **hired auto** in the course of the **insured's** business; or
2. the use of a **non-owned auto** by an **insured** in the course of the **insured's** business.

Only with respect to coverage provided under this endorsement, the Aircraft, Auto or Watercraft, Liquor Liability and Mobile Equipment exclusions in the Exclusions section of the General Liability Coverage Part are deleted.

Only with respect to coverage provided under this endorsement, the Damage to Property exclusion in the Exclusions section of the General Liability Coverage Part is deleted and replaced with the following:

Damage To Property

Property damage to:

- a. property owned or being transported by, or rented, leased, or loaned to any **insured**.
- b. property in the care, custody, or control of any **insured**.

Only with respect to coverage provided under this endorsement, the following persons and organizations are added to the definition of **insureds** in the Definition section of the Common Policy Provisions and Conditions:

1. any person using a **hired auto** with an **insured's** permission;
2. with respect to a **non-owned auto**, any partner or executive officer of an **insured**, but only while such **non-owned auto** is being used on behalf of the **insured**; and

3. any other person or organization, but only with respect to their liability because of acts or omissions of an **insured** otherwise covered under the Bodily Injury and Property Damage Insuring Clause, or the acts of an **insured** as defined under subparagraphs 1 and 2 above.

Only with respect to coverage provided under this endorsement, the following persons and organizations are not **insureds**, notwithstanding any provision to the contrary in the Definition section of the Common Policy Provisions and Conditions:

1. any person engaged in the business of their employer with respect to **bodily injury** to any co-employee of such person injured in the course of employment, or consequential injury to any relative of such co-employee, or for any obligation to reimburse a third party as the result of the **bodily injury** to the co-employee;
2. any partner, executive officer or manager (if the **insured** is a limited liability company) with respect to any **auto** owned by such partner or officer or a member of their household;
3. any person while employed in or otherwise engaged in performing duties related to the conduct of an **auto business** other than an **auto business** operated by the **insured**;
4. the owner or lessee (of whom the **insured** is a sublessee) of a **hired auto** or the owner of a **non-owned auto** or any agent of **employee** of any such owner or lessee; or
5. any person or organization with respect to the conduct of any current or past partnership, joint venture or limited liability company that is not an **insured**.

Only with respect to coverage provided under this endorsement, the following definitions apply:

Auto business means the business or occupation of selling, repairing, servicing, storing or parking **autos**.

Hired auto means any **auto** an **insured** leases, hires, rents or borrows on a temporary, occasional or infrequent basis. It does not include any **auto** the **insured** leases, hires, rents or borrows from:

1. any of the **insured's employees** or members of their households; or
2. partners, executive officers or managers (if the **insured** is a limited liability company) or members of their households.

Non-owned auto means any **auto** the **insured** does not own, lease, hire or borrow which is used in connection with the **insured's** business. However, if the **insured** is a partnership, a **non-owned auto** does not include any **auto** owned by any partner.

Tort liability means liability that would have been imposed by law in the absence of any contract or agreement.

Only with respect to coverage provided under this endorsement, the Other Insurance in the Conditions section of the Common Policy Provisions and Conditions is deleted and replaced by the following:

If any other valid and collectable insurance is available to any **insured** for a **claim** or **potential claim** under any primary policy covering the "hired auto" or "non-owned auto", then this insurance will be excess over such other insurance even if such other insurance is stated to be primary, excess, contingent or otherwise.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM ENDORSEMENT
(GENERAL LIABILITY)**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The following provision is added to the Limits of Liability section of the General Liability Coverage Part:

CERTIFIED ACTS OF TERRORISM

If losses covered by insurance that are attributable to **certified acts of terrorism** in a calendar year exceed \$100 billion in the aggregate, and the **company** has met its deductible amount under the **TRIA Act** for that calendar year, the **company** shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion. In such case, the losses are subject to pro rata allocation in accordance with the procedures established by the Secretary of the Treasury.

Only with respect to coverage provided under the General Liability Coverage Part, the following definitions are added to the Definitions section of the Common Policy Provisions and Conditions:

Certified act of terrorism means an act that is certified by the Secretary of the Treasury in accordance with the provisions of the **TRIA Act**, to be an act of terrorism pursuant to the **TRIA Act**. The **TRIA Act** sets forth the following criteria for a **certified act of terrorism**:

1. The act resulted in losses covered by insurance in excess of \$5,000,000 in the aggregate, attributable to all types of insurance subject to the **TRIA Act**;
2. The act is a violent act or an act that is dangerous to human life, property or infrastructure and is committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. The act must have resulted in damage within the United States including its territories and possessions and Puerto Rico, or outside the United States in cases of an air carrier or vessel meeting the definitions of such as provided in the **TRIA Act**, or the premises of a United States mission; and
3. No act of terrorism shall be certified if the act is committed as a part of the course of a war declared by Congress.

TRIA Act means the federal Terrorism Risk Insurance Act of 2002, as extended on December 22, 2005, and amended on December 31, 2007 and January 12, 2015, and reauthorized on December 20, 2019.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
EVACUATION, DISINFECTION AND PUBLIC RELATIONS EXPENSES ENDORSEMENT
(GENERAL LIABILITY)**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The following provision is added to the Insuring Clauses section of the General Liability Coverage Part:

EVACUATION, DISINFECTION AND PUBLIC RELATIONS EXPENSES

The **company** will reimburse a **named insured**, upon satisfactory proof of payment, for:

1. **evacuation expenses** paid by the **named insured** resulting from an **evacuation event** that occurred during this **policy period**;
2. **disinfection expenses** paid by the **named insured** resulting from a **disinfection event** that occurred during this **policy period**; or
3. **public relations expenses** paid by the **named insured** resulting from a **public relations event** that occurred during this **policy period**;

provided that no other valid and collectible insurance is available to the **named insured**, whether on a primary, excess, contingent or any other basis, for the **evacuation expense**, **disinfection expense**, or **public relations expense**.

The **company's** duty to reimburse a **named insured** for any **evacuation expenses**, **disinfection expenses**, or **public relations expenses** is strictly conditioned upon an **authorized insured's** forwarding a report of the **evacuation event**, **disinfection event**, or **public relations event**, as applicable, to the **company** during the **policy period**, or within 60 days thereafter. All such reports shall be directed to the **company** in writing and include documented proof, a description, and details regarding the time, date and place of the **evacuation event**, **disinfection event**, or **public relations event**, as applicable.

Only with respect to coverage provided under this endorsement, the following definitions are added to the Definitions section of the Common Policy Provisions and Conditions:

Disinfection event means any case or series of cases of hospital-borne infectious bacteria, virus or disease that requires reporting of such case or series of cases to any local, state or federal governmental or healthcare oversight agency or entity. However, the definition of **disinfection event** does not include a contamination as a result of pollutant, war, or an act of terrorism.

Disinfection expenses means reasonable costs and expenses incurred by a **named insured**:

1. to hire a third party to disinfect an **insured's** premises as a result of a **disinfection event**; or
2. to notify third parties directly affected by such **disinfection event**.

However, **disinfection expenses** do not include any salaries, benefits, remuneration, overhead, fees, or loss of earnings incurred by, or paid to, any **insured**.

Evacuation event means an evacuation of a **named insured's** premises because a determination is made by the **named insured** that imminent danger exists arising from an external event or a condition in the **named insured's** premises which would cause loss of life or harm to **patients** or **residents**. **Evacuation event** does not include an evacuation arising from:

1. a strike, bomb threat or false fire alarm, unless vacating is ordered by a civil authority;
2. a planned vacating drill;
3. the vacating of one or more **patients** or **residents** that is due to, and confined to, an individual's medical condition;
4. a governmental action;
5. a nuclear hazard; or
6. war or military action.

Evacuation expenses means reasonable costs and expenses incurred by a **named insured**:

1. to perform an evacuation; or
2. to notify third parties directly affected by such **evacuation event**.

However, **evacuation expenses** do not include:

1. any other expenses incurred by an **employee**, volunteer, or other person providing assistance with, in any part of, or included in, the evacuation; or
2. any salaries, benefits, remuneration, overhead, fees or loss of earnings incurred by, or paid to, any **insured**.

Public relations event means the publication or broadcast of information which can reasonably be expected to damage a **named insured's** reputation, if such event is caused by:

1. an **evacuation event**;
2. a **disinfection event**;
3. an actual or alleged act, error or omission in the furnishing or failure to furnish **treatment**;
4. an abusive act; or
5. workplace violence or threat of workplace violence.

Public relations expenses means reasonable fees and costs incurred by a **named insured**:

1. to engage attorneys, experts and consultants, including third-party media consultants and security consultants to respond directly to an **evacuation event**, **disinfection event**, or **public relations event**;
2. to notify third parties directly affected by an applicable **evacuation event**, **disinfection event**, or **public relations event**; or
3. incurred in the management of public relations of an applicable **evacuation event**, **disinfection event**, or **public relations event**.

However, **public relations expenses** do not include:

1. any salaries, benefits, remuneration, overhead, fees, or loss of earnings incurred by, or paid to, any **insured**; or
2. expenses for general brand promotion or awareness, business upgrades, redesigns, reconfigurations, improvements, or maintenance expenses, or expenses related to normal or ongoing business operations.

Only with respect to coverage provided under this endorsement, the following provision is added to the Limits of Liability section of the General Liability Coverage Part:

EVACUATION, DISINFECTION AND PUBLIC RELATIONS EXPENSES

Per Event Limit \$100,000

Aggregate Limit \$100,000

The Aggregate Limit shown above is the most the **company** will reimburse for all **evacuation expenses, disinfection expenses, or public relations expenses** in connection with all **evacuation events, disinfection events, or public relations events**.

The Per Event Limit specified above is the most the **company** will reimburse a **named insured** for **evacuation expenses, disinfection expenses, or public relations expenses** in connection with any **evacuation event, disinfection event, or public relations event**.

Only with respect to coverage provided under this endorsement, the following exclusion is added:

Privacy Breach

Any request for reimbursement of **public relations expenses** paid in connection with a criminal or civil investigation, complaint or formal administrative proceeding, if such investigation, complaint, or proceeding arises from or is in connection with an actual or alleged violation or infringement of any right to privacy, or any breach of any of the following regulations, or similar statutes and regulations, associated with the confidentiality, access, control, and use of personally identifiable, non-public information:

1. Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), known as HIPAA, and related state medical privacy laws;
2. Gramm-Leach-Bliley Act of 1999 (G-L-B), also known as the Financial Services Modernization Act of 1999;
3. state and Federal statutes and regulations regarding the security and privacy of consumer information;
4. governmental privacy protection regulations or laws associated with the control and use of personal information;
5. privacy provisions of consumer protection laws, including the Federal Fair Credit Reporting Act (FCRA) and similar state laws;
6. Children's Online Privacy Protection Act or similar laws; and
7. the EU Data Protection Act or other similar privacy laws worldwide.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
SEXUAL MISCONDUCT WITH SUBLIMITS FOR INNOCENT INSUREDS ENDORSEMENT
(GENERAL LIABILITY)
(CLAIMS-MADE AND REPORTED COVERAGE)**

NOTICE:

This endorsement contains claims-made and reported coverage. Please read this endorsement carefully.

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The following provision is added to the Insuring Clauses section of the General Liability Coverage Part:

A. **SEXUAL MISCONDUCT LIABILITY**

1. Claims-Made and Reported

Regardless of whether "Claims-Made and Reported" or "Occurrence" is shown on the Declarations with respect to this Coverage Part, the following provisions apply:

a. The **company** will pay on behalf of any **insured**, not including a **perpetrator**, all **loss**, subject to any applicable Deductible or Self-Insured Retention, and up to the Sexual Misconduct Sublimits of Liability, arising from a **sexual misconduct event** otherwise triggering the General Liability Coverage Part, that took place on or after the Sexual Misconduct Liability retroactive date if the following apply:

- (1) the **insured** did not know at the time of the actual or alleged **sexual misconduct**, that the **perpetrator** had previously engaged in, or was alleged to have previously engaged in, **sexual misconduct**; and
- (2) for a **named insured** organization, that an **authorized insured** did not know at the time of the actual or alleged **sexual misconduct**, that the **perpetrator** had previously engaged in, or was alleged to have previously engaged in, **sexual misconduct**.

Moreover, to be covered under this policy, the **loss** must arise from:

- (1) a **claim** that was first made against, and received by, an **insured** during the **policy period**, and reported to the **company**, in writing, during the **policy period** or within any applicable **extended reporting period**; or
- (2) a **potential claim** that was first known about or discovered by an **insured** during the **policy period**, and reported to the **company**, in writing, during the **policy period** or within the automatic limited **extended reporting period**.

- b. The **company** will pay **claims expense**, subject to any applicable Deductible or Self-Insured Retention, and up to the Sexual Misconduct Sublimits of Liability if shown in this endorsement as "Defense Within Limits," to defend any **insured** against any **claim** or **potential claim** arising from a **sexual misconduct event** otherwise triggering the General Liability Coverage Part, that took place on or after the Sexual Misconduct Liability retroactive date. Moreover, to be covered under this policy, the **claims expense** must arise from:
- (1) a **claim** that was first made against, and received by, an **insured** during the **policy period**, and reported to the **company**, in writing, during the **policy period** or within any applicable **extended reporting period**; or
 - (2) a **potential claim** that was first known about or discovered by an **insured** during the **policy period**, and reported to the **company**, in writing, during the **policy period** or within the automatic limited **extended reporting period**.

However, the **company's** defense of an **insured** will cease when it is established by trial or arbitration verdict, court ruling, regulatory ruling or legal admission, nolo contendere/no contest plea, or Alford plea that the **insured** engaged in **sexual misconduct**. Additionally, the **company's** defense of a **named insured** organization will cease when it is established by trial or arbitration verdict, court ruling, regulatory ruling or legal admission, nolo contendere/no contest plea, or Alford plea that an **authorized insured** knew at the time of the actual or alleged **sexual misconduct** that the person accused of having engaged in the act had previously engaged in, or was alleged to have previously engaged in, **sexual misconduct**.

- c. All **claims** and **potential claims** by all persons or organizations arising out of, or in connection with, a **sexual misconduct event** involving the same **perpetrator**, will be deemed to have been first made on the date that the first of those **claims** is made against any **insured**, or the date the first of such **potential claims** is discovered by an **authorized insured**, whichever date is earlier. Only the policy in effect when the first such **claim** is made and reported to the **company**, or the first such **potential claim** is discovered and reported to the **company**, whichever is earlier, will apply to the **sexual misconduct event** no matter when any subsequent **claims** are made or reported, or **potential claims** are discovered and reported. If, prior to the effective date of this policy, the first such **claim** is made, or the first such **potential claim** is discovered, this policy will not apply to any subsequent **claims** or **potential claims** made during this **policy period** or any **extended reporting period**.

The following provision is added to the Limits of Liability section of the General Liability Coverage Part:

SEXUAL MISCONDUCT LIABILITY

Per Sexual Misconduct Event Sublimit	\$ 1,000,000
Aggregate Sexual Misconduct Event Sublimit:	\$ 3,000,000
Claims Expenses	Defense Outside Limits

Subject to the applicable Aggregate Limit available under this policy for this Coverage Part, the Aggregate Sexual Misconduct Event Sublimit is the most the **company** will pay under this Coverage Part for all **sexual misconduct events** for all **insureds** covered under this policy regardless of the number of **insureds, claims** made or **potential claims** first discovered, person or organizations making **claims** or **potential claims**, or **locations**.

Subject to the applicable Per Event and Aggregate Limits of Liability available under this policy for this Coverage Part, and the Aggregate Sexual Misconduct Event Sublimit shown above, the Per Sexual Misconduct Event Sublimit is the most the **company** will pay under this Coverage Part for any **sexual misconduct event** covered under this policy regardless of the number of **insureds, claims** made or **potential claims** first discovered, persons or organizations making **claims** or **potential claims**, or **locations**.

The Per Sexual Misconduct Event Sublimit and the Aggregate Sexual Misconduct Event Sublimits of Liability specified above are within and shall erode the applicable Per Event and Aggregate Limits of Liability under this Coverage Part.

The following is added to the Retroactive Dates item shown on the Declarations:

Sexual Misconduct Liability: 04/21/2023

The Sexual Misconduct exclusion in the Exclusions section of the General Liability Coverage Part is deleted and replaced with the following:

Sexual Misconduct

Any **claim** or **potential claim** arising from, or in connection with, any actual or threatened **sexual misconduct**. The **company** will, however, provide a defense and indemnity for such allegations subject to the Sexual Misconduct Liability insuring clause.

Only with respect to coverage provided under this endorsement, the following definitions are added to the Definitions section of the Common Policy Provisions and Conditions:

Perpetrator means any individual who allegedly or actually, directly or indirectly participated in, acted in concert with, or aided and abetted, any consensual or non-consensual conduct, physical acts, gestures or communications of a sexual act or nature, including, but not limited to: sexual intimacy, sexual molestation, sexual assault, sexual battery, sexual abuse, sexual harassment, sexual exploitation, or alienation of affection.

Sexual misconduct event means an **event** resulting in **bodily injury** or **property damage**, or an offense resulting in **personal and advertising injury**, arising out of, or in connection with, **sexual misconduct**. All **events** resulting in **bodily injury** or **property damage**, or offenses resulting in **personal and advertising injury**, arising out of, or in connection with, **sexual misconduct** involving the same **perpetrator** shall constitute one **sexual misconduct event** regardless of the number of acts of **sexual misconduct**, persons injured, **insureds**, **locations**, or length of time over which such **sexual misconduct** occurs.

Only with respect to coverage provided under this endorsement, the Settlement condition in the Conditions section of the Common Policy Provisions and Conditions is amended by adding the following:

However, the **company** may settle any **claim** or **potential claim** involving a **sexual misconduct event** as the **company** deems expedient after first providing written notice to the **first named insured**.

All other terms and conditions of the policy remain unchanged.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Endorsement No.:

Forming Part of Policy No.: H003788

Issued to: Mangum City Hospital Authority

Effective Date of Endorsement: 04/21/2026 at 12:01 a.m. at the address of the First Named Insured stated herein.

**HEALTHCARE LIABILITY POLICY
OKLAHOMA AMENDATORY ENDORSEMENT**

In consideration of the payment of the additional premium due, if any, and in reliance upon the representations of all **insureds**, the **company** and the **insureds** agree to amend the policy as follows:

The Economic Sanctions Exclusion in the Exclusions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

ECONOMIC SANCTIONS EXCLUSION

Whenever coverage provided by this policy would be in violation of any U.S. economic trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control, such coverage shall be null and voidable. Similarly, any coverage relating to or referred to in any certificates or other evidences of insurance or any **claim** or **potential claim** that would be in violation of U.S. economic or trade sanctions as described above shall also be null and voidable.

The Fraudulent Claims Exclusion in the Exclusions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

FRAUDULENT CLAIMS

Any **claim** or **potential claim** made by an **insured** who knows that the **claim** or **potential claim** is false or fraudulent, as regards to amount or otherwise; additionally, this policy shall become voidable and all **claims** and **potential claims** hereunder shall be forfeited.

The Cancellation, Nonrenewal and/or Termination of Coverage condition in the Conditions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

CANCELLATION, NONRENEWAL AND/OR TERMINATION OF COVERAGE

1. This policy may be canceled by the **first named insured**. The **first named insured** shall provide written notice to the **company** requesting cancellation. The cancellation shall be effective on the date requested by the **first named insured** or the date the notice is received by the **company**, whichever is later.
2. Any coverage contained within this policy may be terminated by the **first named insured**. The **first named insured** shall provide written notice to the **company** requesting the coverage termination. The termination shall be effective on the date requested by the **first named insured** or the date the notice is received by the **company**, whichever is later.
3. If the **first named insured** cancels this policy, or terminates any coverage contained therein, earned premium shall be computed in accordance with the standard short rate tables and procedure. If the **company** cancels this policy, or terminates any coverage contained therein, earned premium shall be computed pro rata. Premium

adjustments shall be made within a reasonable period of time after cancellation. However, payment or tender of unearned premium shall not be a condition of cancellation.

4. This policy, or any coverage contained therein, may also be canceled or terminated by the **company**. The **company** will provide written notice to the **first named insured** at the last address on record with the **company** not less than 10 days prior to the effective date of such cancellation if the reason for cancellation is nonpayment of premium. If the cancellation is for any reason other than nonpayment of premium, the **company** will provide written notice to the **first named insured** at the last address on record with the **company** not less than 45 days prior to the effective date of such cancellation.
5. If the policy is in place for less than 45 business days and is not a renewal policy, the **company** may cancel the policy for any reason. If the policy is in place for 45 business days or longer, or is a renewal policy, the **company** may only cancel the policy for one or more of the following reasons:
 - a. nonpayment of premium;
 - b. discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any **claims** or **potential claims** submitted thereunder;
 - c. discovery of willful or reckless acts or omissions by an **insured** which increases any hazard insured against;
 - d. the occurrence of a change in the risk which substantially increases any hazard insured against after the coverage has been issued or renewed;
 - e. a violation of any federal, state or local fire, health, safety, building or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;
 - f. a determination by the Oklahoma Commissioner of Insurance that the continuation of the policy would place the **company** in violation of the state's insurance laws;
 - g. an **insured's** conviction of a crime having as one of its necessary elements an act increasing any hazard insured against; or
 - h. **loss** or substantial changes in the **company's** reinsurance.
6. This policy may be nonrenewed by the **company** by providing written notice of the nonrenewal to the **first named insured** at the last known address not less than 45 days prior to the expiration date provided in the policy. If the notice is provided less than 45 days before the end of the **policy period**, the **policy period** shall be extended until 45 days after the notice was provided. Earned premium for such an extension of coverage shall be calculated pro rata based upon the rate applicable at the beginning of the **policy period**. However, no notice is required if:
 - a. the **company** has offered to renew the policy;
 - b. the **insured** obtained replacement coverage;
 - c. the **insured** has agreed in writing to obtain replacement coverage; or
 - d. the **insured** has agreed in writing to obtain replacement coverage.
7. The **company** will provide notice to the **first named insured** at least 45 days prior to the end of the **policy period** if the **company** intends to condition renewal upon:
 - a. an increase in premium;
 - b. a change in the deductible;
 - c. a reduction in the limits of insurance; or
 - d. a reduction in the coverage offered.

If the notice required under this subparagraph is provided less than 45 days prior to the end of the **policy period**, the policy shall remain in effect without change until 45 days after the notice is given, or the effective date of any replacement coverage obtained by the **insured**, whichever occurs first. If the **insured** elects not to renew, earned premium for any extension of the **policy period** shall be calculated pro rata based upon the rate applicable at the beginning of the **policy period**. If the **insured** accepts the change(s), the change(s) shall become effective at the beginning of the new **policy period**. However, no advance notice shall be required for changes:

- a. in a rate or plan filed with or approved by the Insurance Commissioner, or filed pursuant to the Property and Casualty Competitive Loss Cost Rating Act and applicable to an entire class of business;
 - b. based upon the altered nature of the extent of the risk insured; or
 - c. in policy forms filed with or approved by the Oklahoma Insurance Commissioner and applicable to an entire class of business.
8. If the **company** cancels or nonrenews an **insured's** policy, the **insured's** coverage under that policy shall terminate on the earlier of:
- a. the date stated on the cancellation or nonrenewal notice; or
 - b. the date the **insured** procures replacement coverage.

The Fraud Warning condition in the Conditions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

OKLAHOMA FRAUD WARNING

WARNING: Any person who knowingly, and with an intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

The Representations condition in the Conditions section of the Common Policy Provisions and Conditions is deleted and replaced with the following:

REPRESENTATIONS

1. By acceptance of this policy, each **insured** agrees and represents that the statements and particulars made in all **applications** are true and correct. It is further understood and agreed that all **applications** are incorporated into, and shall form a part of, this policy. Therefore, this policy and any endorsements hereto, and all **applications** embody all agreements between the **company** and any of its authorized representatives, and all **insureds** relating to this insurance.
2. In the event any **application** was executed or endorsed by an **insured's** insurance producer, the **insured** acknowledges that the insurance producer has acted under the **insured's** express authority and that the **insured** has thoroughly reviewed the information contained on any **application**.
3. The representations made by an **insured** in the **applications** are the basis for the coverage provided, as well as the **company's** calculation of the applicable premium. Therefore, it is understood and agreed that, to the extent permitted by law, the **company** reserves all rights, including the right to rescind this policy, or deny any coverage provided for a **claim** or **potential claim**, based upon any material misrepresentation made by any **insured**. As used in this condition, "material misrepresentation" means concealment, misrepresentation, omission or fraud which, if known by the **company**, would have led to refusal by the **company** to make this contract or provide coverage, or to make this contract or provide coverage on different terms or conditions.
4. No knowledge or information possessed by any **insured** shall be imputed to any other **insured**, except for material facts or information known to the person or persons who signed or submitted an **application** to the **company**. In the event of any material misrepresentation in connection with any of the particulars or statements in the **application**, this policy shall be voidable with respect to any **insured** who knew of such material misrepresentation or to whom such knowledge is imputed.

The following condition is added to the Conditions section of the Common Policy Provisions and Conditions:

ADDRESS OF COMPANY

The **company** is located at 5814 Reed Road, Fort Wayne, Indiana, 46835.

The following provision is added to the Optional Extended Reporting Period provision of the Extended Reporting Period condition of the Conditions section of the Common Policy Provisions and Conditions:

The **company** has no duty to make an offer for an **extended reporting period** if the policy is cancelled for material misrepresentation, fraud or nonpayment of premium.

All other terms and conditions of the policy remain unchanged.

Draft

DA ENGINEERING, LLC
6701 Broadway Extension, Ste. 301
Oklahoma City, OK 73116
daemep.com

PROJECT PROPOSAL

MEP ENGINEERING DESIGN SERVICES

Regional Medical Center Lab Renovation

March 11, 2026

Prepared For
Mangum Regional Medical Center | Kelley Martinez

We appreciate the opportunity to provide a proposal for the Regional Medical Center Lab Renovation project. This proposal is for MEP design and consulting services as set forth through this agreement. Defined herein is the proposal for scope of work, fees and other terms as it pertains to this project. This project proposal falls under the Terms and Conditions of the DA Engineering Master Client Agreement.

If you have any questions, please contact me at the information below.

Thanks,

DA Engineering, LLC

Dustin Anderson, Principal | Senior Electrical Engineer
479.957.4986 | danderson@daemep.com

SCOPE + DESIGN SERVICES

DA Engineering (DAE) will provide electrical, mechanical drawings and specifications for Mangum Regional Medical Center on the Regional Medical Center Lab Renovation project located in Mangum, OK. The scope of services includes electrical and lighting design for the renovated suite and relocation of existing vent hood.

DESIGN SERVICES

1. Initial site visit for existing conditions and assessment.
2. Mechanical design drawings and necessary specifications for the relocation of the vent hood.
3. Electrical systems and Lighting design drawings and specifications for the new suite

NOTE: Design for conduit and boxes (rough-in) to support telephone, computers, security system and other owner furnished equipment based on complete information provided by the client available by request

4. Energy calculations and submittal forms as required by the authority having jurisdiction for lighting only, building envelope calculations are excluded.
5. Opinions of probable costs will not be provided, but costs developed by others can be reviewed for general conformance with the documented systems relative to this service agreement.

PHASE DESCRIPTION

1. Construction Document (CD)
 - (a) Fully coordinated, permit-and bid ready documents
 - (b) One set of review drawings at **<95%>** completion
 - (c) One set of reproducible construction drawings and specifications
 - (d) A BIM model with Level of Development (LOD) 201: where elements are modeled with approximate quantities, size, shape, location and orientation. Non-geometric information is typically attached to the model elements.
2. Construction Administration (CA) services shall commence upon issuance of the Construction Documents for bidding or permitting and shall continue through Substantial Completion of the Project.
 - (a) CA services are intended to assist the Owner in evaluating the general conformance of the Work with the Contract Documents and shall include the following customary services:
 - i. Review of contractor submittals and shop drawings for general conformance with the design intent
 - ii. Response to Requests for Information (RFIs)
 - iii. Attendance at Owner-Architect-Contractor (OAC) meetings, as reasonably required
 - iv. Periodic site visits (not to exceed two) to observe the progress of the Work
 - v. Review of contractor change order requests for general conformance with the Contract Documents
 - vi. Review of record drawings and closeout documentation

NOTE: Construction Administration services do not include supervision, control, or responsibility for construction means, methods, sequences, procedures, or safety precautions, which remain the sole responsibility of the Contractor.

FEE STRUCTURE FOR SERVICES

DA Engineering will provide **professional design services** for the project as a **fixed lump sum fee** of **\$4,675** in accordance with the Scope of Work and Design Services listed herein. Professional fees for design services shall be billed on a progress basis in accordance with the percentage of completion of each phase. To provide transparency, improve cash flow and align with ongoing design progress, billing shall be issued monthly throughout the duration of the project. **Construction Administration** services shall be provided on an **hourly basis** according to the hourly rate schedule below. Hourly rates are based on personnel classification and reflect salaries, benefits, overhead, and profit. CA billing will commence upon receipt of RFI or Submittals and continue monthly throughout Substantial Completion.

Hourly Rate Fees will be billed on a time and expense basis at the following standard hourly rates:

- **Principal Engineer:** \$250/hour
- **Senior Engineer:** \$225/hour
- **Junior Engineer:** \$200/hour
- **Senior Designer:** \$200/hour
- **Entry Engineer | EIT:** \$175/hour
- **Intermediate Designer:** \$175/hour
- **Junior Designer:** \$150/hour
- **Administrative / Support Staff:** \$100/hour

Reimbursable Expenses: shall be billed above and beyond all fees for professional services at a designated surcharge, reimbursable items shall be as follows:

- 1) Reproductions, plots, postage, handling and delivery of project related documents by request of client.
- 2) Overnight delivery, handling, and postage charges.
- 3) Travel expenses (airfare, lodging, meals, airport parking and car rental).
- 4) Incurred web-based submittal review process fees and charges
- 5) Costs to obtain product samples that are requested by the Client or Owner.
- 6) Expenses related to governing body review(s), including but not limited to State health department plumbing review.

CONDITION OF PROPOSAL

This proposal represents the entire agreement between the Client addressed in this contract and DA Engineering, LLC and supersedes all prior negotiations, representations, or agreements, whether written or oral. This agreement may be amended only by written instrument signed by both the Client and DA Engineering, Inc. If DA Engineering's involvement in the design of the project has not started within 6 months of the date of this agreement, DA Engineering reserves the right to modify the fee. Refer to the DA Engineering Master Client Agreement for clarification on terms and conditions of this proposal.

Please review this proposal, if the terms of this agreement are acceptable to you, please sign and return for record.

We look forward to working with you on this project.



By: DA Engineering, LLC
Dustin Anderson | Principal

For: Mangum Regional Medical Center
Kelley Martinez

GENERAL TERMS AND CONDITIONS

This Agreement for professional services has been entered into by the Client, and DA Engineering. The name DA Engineering shall pertain to all employees, principals, officers, and all divisions of DA Engineering, LLC.

- A. Performance of Services:** DA Engineering shall perform the basic services as outlined above, and any additional services as required or directed by the Client/Owner in consideration of the fee arrangements and payment terms described in "Fee Structure" above. Services performed under this agreement will be performed in a manner consistent with that degree of skill and care ordinarily exercised by members of the same profession currently practicing under similar circumstances. No warranties, express or implied, are made in connection with services performed under this Agreement. Nothing in this Agreement shall be construed to establish a fiduciary relationship between the parties.
- B. Excluded Services:** Where DA Engineering has deemed a service needed or advisable, DA Engineering has made this opinion known to the Client and the Client has confirmed his or her opinion that such services are not requested of DA Engineering and/or the Client has made or shall decide to obtain those services from a source other than DA Engineering. The client agrees to indemnify and hold DA Engineering harmless from any claim, liability for DA Engineering's failure to perform a service listed below which was excluded at the Client's direction. The following design services shall not be provided by DA Engineering under the terms of this Agreement.
- 1) Support for LEED or other similar type Certification.
 - 2) Detailed life-cycle costs and/or energy-use studies for designed systems.
 - 3) Opinions of probable costs; costs developed by others can be reviewed for general conformance with the documented systems relative to this service agreement.
 - 4) Preparation of shop or fabrication drawings
 - 5) Record drawings with contractor changes incorporated.
 - 6) Studies of various schemes to accommodate special energy requirements.
 - 7) Storm drainage system design external to the building(s).
 - 8) Foundation drainage system.
 - 9) Screen wall designs and specifications.
 - 10) Daylighting analysis, modeling, and calculations.
 - 11) Greywater or storm water reuse system design.
 - 12) Design of extension of water, sewer, storm, gas, electric and telephone utilities to the site.
 - 13) Street Lighting.
 - 14) Design of Mechanical Smoke Control systems.
 - 15) Design of any structural Engineering details such as light pole bases, MEP equipment suspension, reinforced concrete pads, seismic bracing and other supports.
 - 16) Filing application for and obtaining a building permit.
 - 17) Full-time, on-site construction observation.
 - 18) Providing financial feasibility or other special studies.
 - 19) Providing extraordinary services to investigate existing conditions or facilities or to make measured drawings thereof.
 - 20) Providing revisions of drawings, specifications or other documents when such revisions are required by changes to previously approved design criteria.
 - 21) Providing consultation concerning the replacement of any work damaged by fire or other causes during construction.
 - 22) Providing professional services made necessary by the default of the contractor or by major defects in the work of the contractor in the performance of the Construction Contract.
 - 23) Providing services or special consultants for other than the normal mechanical, electrical and/or plumbing Engineering services for the Project.
 - 24) Preparing to serve or serving as an expert witness in connection with any public hearing, or legal proceeding where DA Engineering is not a named party to such a hearing or proceeding.
- C. Length of Contract:** This contract shall be in force for a period of 12 months. At the end of the term DA Engineering reserves the right to make modifications to the terms of this agreement and extend the contract an

additional 12 months upon agreement of both parties. If negotiations of modified terms are underway, this contract shall continue under the existing terms until either new terms are agreed upon, or negotiations cease. Either party may stop negotiations at any point.

- D. **Verification of Existing Conditions:** Because evaluation of the existing structure or site requires that certain assumptions be made regarding existing conditions, and because some of these assumptions cannot be verified without expending additional sums of money or destroying otherwise adequate or serviceable portions of the building, the Client agrees to indemnify and hold DA Engineering harmless from and against any and all damage, liability and cost arising or allegedly arising out of the professional services under this Agreement, except for the sole negligence or willful misconduct of DA Engineering. DA Engineering shall not be required to sign any documents, no matter by whom requested, that would result in DA Engineering having to certify, guarantee or warrant the existence of conditions whose existence DA Engineering cannot ascertain.

- E. **Betterment:** If, due to the Engineer's error, any required item or component of the project is omitted from the Construction Documents produced by DA Engineering, DA Engineering's liability shall be limited to the difference between the cost of adding the item at the time of discovery of the omission and the cost had the item or component been included in the construction documents. In no event will DA Engineering be responsible for any cost or expense that provides betterment, upgrade or enhancement of the project.

- F. **Jobsite Safety:** Neither the professional activities of DA Engineering, nor the presence of his or her employees and subconsultants at a construction site, shall relieve the Contractors and any other entity of their obligations, duties and responsibilities including, but not limited to, construction means, methods, sequence, techniques or procedures necessary for performing or coordinating all portions of the Work of construction in accordance with the contract documents and any health/safety precautions required by regulatory agencies. DA Engineering and their personnel have no authority to exercise any control over any contractor or other entity or their employees in connection with their work or any health/safety precautions. The Client agrees that the Contractor is solely responsible for jobsite safety, and warrants that this intent shall be made evident in the Client's agreement with the General Contractor. The Client also agrees that the Client, DA Engineering and DA Engineering's consultants shall be indemnified and shall be made additional insureds under the General Contractor's general liability insurance policy.

- G. **Hazardous Materials:** Both parties acknowledge that DA Engineering's scope of services does not include any services related to asbestos, hazardous or toxic materials. In the event DA Engineering or any other party encounters asbestos or hazardous or toxic materials at the jobsite, or should it become known in any way that such materials may be present at the jobsite or any adjacent areas that may affect the performance of DA Engineering services, DA Engineering may, at their option and without liability for consequential or any other damages, suspend performance of services on the project until the Client retains appropriate specialist consultants or contractors to identify, abate and/or remove the asbestos, hazardous or toxic materials and warrant that the jobsite is in full compliance with applicable laws and regulations. DA Engineering is not responsible for any claims resulting from the existence, discovery, or for the removal of hazardous materials or additional costs the removal will necessitate.

- H. **Information Provided by Others:** DA Engineering shall indicate to the Client the information needed for rendering of services hereunder. The Client shall provide to DA Engineering such information as is available to the Client and the Client's consultants and contractors, and DA Engineering shall be entitled to rely upon the accuracy and completeness thereof. The Client recognizes that it is impossible for DA Engineering to assure the accuracy, completeness, and sufficiency of such information, either because it is impossible to verify, or because of errors or omissions which may have occurred in assembling the information the Client is providing. Accordingly, the Client agrees to indemnify and hold DA Engineering and DA Engineering's subconsultants harmless from any claim, liability or cost for injury or loss arising or allegedly arising from errors, omissions or inaccuracies in documents or other information provided by the Client to DA Engineering.

- I. **Opinions of Probable Costs:** In providing opinions of probable cost, the Client understands that DA Engineering has no control over costs or the price of labor, equipment or materials, or over the Contractor's method of pricing, and that the opinions of probable construction costs provided herein are to be made on the basis of DA Engineering's qualifications and experience. DA Engineering makes no warranty, expressed or implied, as to the

accuracy of such opinions as compared to bid or actual costs. DA Engineering shall be compensated as Additional Service, as provided for herein, for all time spent to review, redesign and to incorporate revisions due to probable costs.

- J. Value Engineering:** If the Client retains the services of a Value Engineer (VE) or allows the General Contractor or any of his or her subcontractors to function as a VE to review the Construction Documents prepared for this project by DA Engineering, it shall be at the Client's sole expense and shall be performed in a timely manner so as not to delay the orderly progress of DA Engineering's services. All recommendations of the VE shall be given to DA Engineering for their review, and adequate time will be provided for DA Engineering to respond to these recommendations. DA Engineering shall be compensated as Additional Service, as provided for herein, for all time spent to review the recommendations of the VE and to incorporate those accepted by both the Client and DA Engineering. If DA Engineering objects to any recommendations made by the VE, DA Engineering shall so state in writing to the Client, along with their reasons for objecting. If the Client insists on incorporating in the Construction Documents any changes to which DA Engineering has objected to in writing, the Client agrees to indemnify and hold DA Engineering harmless from any damage, liability or cost which arise in connection with or as a result of the incorporation of such design changes insisted upon by the Client.
- K. Unauthorized Changes:** In the event the Client consents to, allows, authorizes or approves of changes to the Construction Documents, and these changes are not approved in writing by DA Engineering, the Client recognizes that such changes and the results thereof are not the responsibility of DA Engineering. Therefore, the Client agrees to release DA Engineering from any liability arising from the construction, use or result of such changes. In addition, the Client agrees to indemnify and hold DA Engineering harmless from any damage, liability or cost arising from such changes, except only those damages, liabilities and costs arising from the sole negligence or willful misconduct of DA Engineering.
- L. Changed Conditions:** The Client shall rely on DA Engineering's judgment as to the continued adequacy of this Agreement in light of occurrences or discoveries that were not originally contemplated by or known to DA Engineering. Should DA Engineering call for contract renegotiation, DA Engineering shall identify the changed conditions necessitating renegotiation and DA Engineering and the Client shall promptly and in good faith enter into renegotiation of this Agreement. If terms cannot be agreed to, the parties agree that either party has the absolute right to terminate this Agreement.
- M. Defects in Service:** The Client shall promptly report to DA Engineering any defects or suspected defects in DA Engineering's work or services of which the Client becomes aware, so that DA Engineering may take measures to minimize the consequences of such a defect. The Client warrants that he or she will impose a similar notification requirement on all contractors in his or her Client/Contractor contract and shall require all sub-contracts at any level to contain a requirement like this. Failure by the Client, and the Client's contractors or subcontractors to promptly notify DA Engineering, shall relieve DA Engineering of the costs of remedying the defects above the sum such remedy would have cost had prompt notification been given.
- N. Dispute Resolution:** Any claims or disputes between Mangum Regional Medical Center and DA Engineering arising out of the services to be provided by DA Engineering or out of this Agreement shall, as a condition precedent to litigation, be submitted to non-binding mediation. Mangum Regional Medical Center and DA Engineering agree to include a similar mediation agreement with all contractors, subcontractors, subconsultants, suppliers and fabricators, providing for mediation as the primary method for dispute resolution among all parties.
- O. Fast Track Design and Construction:** In consideration of the benefits to Mangum Regional Medical Center of employing the fast track process (in which some of DA Engineering's design services overlap the construction work and are out of sequence with the traditional project delivery method), and in recognition of the inherent risks of fast tracking to DA Engineering, Mangum Regional Medical Center agrees to waive all claims against DA Engineering for design changes and modifications of portions of the Work already constructed due to Mangum Regional Medical Center decision to employ the fast track process. Mangum Regional Medical Center further agrees to compensate DA Engineering for all Additional Services required to modify, correct or adjust the Construction Documents and coordinate them in order to meet the Client's program requirements because of the Client's decision to construct the project in a fast-track manner.

- P. Ownership of Documents:** All documents, including all documents on electronic media, prepared by DA Engineering under this Agreement are instruments of DA Engineering's professional service and shall remain the property of DA Engineering and may not be used by the Client for any other purpose without the written prior consent of DA Engineering.
- Q. Termination of Services:** This Agreement may be terminated at any time by either party should the other party fail to perform its obligations hereunder. In the event of termination for any reason whatsoever, the Client shall pay DA Engineering for all services rendered to the date of the termination, and all reimbursable expenses incurred prior to termination and reasonable termination expenses incurred because of termination.

Hospital Vendor Contract Summary Sheet

1. Existing Vendor New Vendor
2. **Name of Contract:** Continental Casualty Company
3. **Contract Parties:** MRMC/Continental Casualty Company
4. **Contract Type Services:** Service Agreement
5. **Impacted Hospital Departments:** Hospital
6. **Contract Summary:** Under this agreement Continental Casualty Company provides Mangum Regional Medical Center Directors and Officers and Entity Liability Insurance. This insurance provides coverage of personal assets of those who manage the company.
7. **Cost:** \$11,113.00/year
8. **Prior Cost:** \$11,113.00/year
9. **Term:** 1-year
10. **Termination Clause:** None
11. **Other:**

POLICYHOLDER NOTICE - COUNTRYWIDE

IMPORTANT INFORMATION NOTICE - OFFER OF TERRORISM COVERAGE; DISCLOSURE OF PREMIUM**THIS NOTICE DOES NOT FORM A PART OF THE POLICY, GRANT ANY COVERAGE OR CHANGE THE TERMS AND CONDITIONS OF ANY COVERAGE UNDER THE POLICY.**

As used herein, 1) "we" means the insurer listed on the Declarations or the Certificate of Insurance, as applicable; and 2) "you" means the first person or entity named on the Declarations or the Certificate of Insurance, as applicable.

You are hereby notified that under the Terrorism Risk Insurance Act, as extended and reauthorized ("Act"), you have a right to purchase insurance coverage of losses arising out of acts of terrorism, as defined in Section 102(1) of the Act, subject to all applicable policy provisions. The Terrorism Risk Insurance Act established a federal program within the Department of the Treasury, under which the federal government shares, with the insurance industry, the risk of loss from future terrorist attacks.

This Notice is designed to alert you to coverage restrictions and to certain terrorism provisions in the policy. If there is any conflict between this Notice and the policy (including its endorsements), the provisions of the policy (including its endorsements) apply.

CHANGE IN THE DEFINITION OF A CERTIFIED ACT OF TERRORISM

The Act applies when the Secretary of the Treasury certifies that an event meets the definition of an act of terrorism. Originally, the Act provided that to be certified, an act of terrorism must cause losses of at least five million dollars and must have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest to coerce the government or population of the United States. However, the 2007 reauthorization of the Act removed the requirement that the act of terrorism must be committed by or on behalf of a foreign interest, and now certified acts of terrorism may encompass, for example, a terrorist act committed against the United States government by a United States citizen, when the act is determined by the federal government to be "a certified act of terrorism."

In accordance with the Act, we are required to offer you the ability to purchase coverage for losses resulting from an act of terrorism that is certified under the federal program. The other provisions of this policy, including nuclear, war or military action exclusions, will still apply to such an act.

DISCLOSURE OF FEDERAL PARTICIPATION IN PAYMENT OF TERRORISM LOSSES

The Department of the Treasury will pay a share of terrorism losses insured under the federal program. Beginning in 2020, the federal share equals 80% of that portion of the amount of such insured losses that exceeds the applicable insurer retention.

LIMITATION ON PAYMENT OF TERRORISM LOSSES

If aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed \$100 billion in a calendar year (January 1 through December 31), the Treasury shall not make any payment for any portion of the amount of such losses that exceeds \$100 billion.

Further, this coverage is subject to a limit on our liability pursuant to the federal law where, if aggregate insured losses attributable to terrorist acts certified under the Act exceed \$100 billion in a calendar year (January 1 through December 31) and we have met our insurer deductible under the Act, we shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion. In such case, insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.



CONFIRMATION OF ACCEPTANCE OF COVERAGE

In accordance with the Act, we offered you coverage for losses resulting from an act of terrorism that is certified under the federal program. This notice confirms that you have chosen to accept our offer of coverage for certified acts of terrorism. The policy's other provisions, including nuclear, war or military action exclusions, will still apply to such an act. The premium charge for terrorism coverage, if any, is shown separately on the Declarations or the Certificate of Insurance, as applicable.

Form No: CNA81758XX (01-2021)	Policy No: 6052521241
Policyholder Notice; Page: 2 of 2	Policy Effective Date: 05/01/2026
Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606 Policy Page: 2 of 50	



These Declarations, along with the completed and signed **Application**, the policy, and any written endorsements attached shall constitute the contract between the **Insureds** and the Insurer.

Authorized Representative:

Date: 01/22/2026

SCHEDULE OF FORMS AND ENDORSEMENTS

Form Name	Form Number	Form Edition Date
Amend Exclusion D Endorsement	CNA107359XX	11-2023
Jobs Act Exclusion Endorsement	CNA92966XX	01-2019
Cap On Losses From Certified Acts of Terrorism Endorsement	CNA92970XX	01-2019
Opioid Exclusion Endorsement	CNA93248XX	10-2019
Separate Retention for Claims Brought by Health Care Provider Endorsement	CNA92993XX	10-2021
Opioid Exclusion Endorsement	CNA93248XX	10-2019
Biometrics Privacy Exclusion Endorsement	CNA96392XX	06-2020
Healthcare Endorsement (Sublimited Regulatory Claim Coverage)	CNA92969XX	09-2020
Amendatory Endorsement - Oklahoma	CNA93281OK	03-2019
Conditional Renewal Endorsement - Oklahoma	CNA93315OK	03-2019

Form No: CNA92863XX (04-2019)

Policy Schedule; Page: 1 of 1

Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606 Policy Page: 5 of 50

Policy No: 6052521241

Policy Effective Date: 05/01/2026

GENERAL TERMS AND CONDITIONS

In consideration of the premium, and in reliance upon the **application**, we agree to provide you with the following coverage subject to the terms and conditions of this policy:

I. PREFACE

A Coverage Part is included within this policy and affords coverage only if the Coverage Part is purchased as indicated by a corresponding limit of liability in the respective Coverage Part Declarations.

The terms and conditions in each Coverage Part apply only to such Coverage Part and will not apply to any other Coverage Part.

If any provision in the General Terms and Conditions is inconsistent with the terms and conditions of any applicable Coverage Part, the terms and conditions of such Coverage Part will control.

Bolded terms in the policy will have the special meaning set forth in the definitions. The terms “we”, “us”, and “our” mean the Insurer named on the General Terms and Conditions Declarations; the terms “you”, “your”, and “yours” mean any **insured**.

II. SUPPLEMENTARY BENEFITS

A. Mediation Retention Reduction

If, prior to, or within sixty (60) days of the service of suit or the institution of arbitration proceedings, we and the **named insured** agree to use a non-binding alternative dispute resolution process to resolve any **claim** reported to us, and such **claim** is entirely resolved through such process, then we will reduce the Retention applicable to such **claim** by the lesser amount of fifty percent (50%) of such Retention or ten thousand (\$10,000) dollars.

B. Proceeding Expenses Reimbursement

If we request an **insured person's** presence at a trial, hearing, deposition, mediation, or arbitration, we will pay up to \$250.00 per day, per **insured person** for reimbursement of costs and expenses incurred in connection with such presence, subject to a maximum of \$2,500 per **claim**, per **policy period**. Such payment will be in addition to the applicable limit of liability and no Retention will apply.

C. Pre-Claim Expenses

In the event a **noticed matter** later gives rise to a covered **claim**, then we will credit the **pre-claim expenses** that you have paid up to ten percent (10%) of the applicable Retention for such **claim**.

III. DEFINITIONS

Any defined word not defined in the General Terms and Conditions will have the meaning assigned to it in the applicable Coverage Part.

Application means any signed application, including its warranty and attachments, whether ours or that of another insurance carrier, together with any other materials and representations provided to us in connection with the underwriting and negotiating of the terms and conditions of this policy or any other policy of which this policy is an indirect or direct renewal.

Bodily injury means any actual or alleged bodily injury, sickness, disease, death, emotional distress or mental anguish of any natural person.

Change of control means when: (i) the **named insured** merges into another entity and is no longer the surviving entity; (ii) another person(s) or entity(ies) acquires such an ownership interest in the **named insured** to exercise **management control**; or (iii) the **named insured** emerges from bankruptcy.

Clean-up costs mean any fees, costs, or expenses, including legal and professional fees, incurred in testing for, monitoring, cleaning up, removing, containing, treating, neutralizing, detoxifying, or assessing the effects of **pollutants**.

Extended reporting period means the additional period of reporting time purchased by an **insured** after termination, cancellation, or non-renewal of this policy within which to report a **claim** subject to the provisions of Section V Extended Reporting Period for Liability Coverage Parts Only.

Financial insolvency means: (i) the appointment by a federal, state or local agency or court of a receiver, conservator, liquidator, trustee, rehabilitator, or similar official, to take control of, supervise, manage, or liquidate an **insured entity** or **outside entity**; (ii) an **insured entity** becoming a debtor in possession under United States bankruptcy law or any equivalent foreign bankruptcy law; or (iii) when an **insured entity** can establish affirmatively it is unable at the present time, or in the future, to pay its debts in the ordinary course of business.

Independent contractor means any natural person working for an **insured entity** in the ordinary course of such **insured entity's** business, and in the capacity of an independent contractor, pursuant to a written agreement for services between such **insured entity** and either (i) such natural person; or (ii) any other entity acting on behalf of such natural person.

Insured entity means the **named insured** or any **subsidiary**, including any such entity as a debtor in possession under United States bankruptcy law.

Insured person will have the meaning designated in the respective Coverage Part.

With respect to any **liability coverage part**, **insured person** will also include: (i) assigns, estates, heir, legal representatives, or assigns of any **insured person** in their capacity as such, provided such **insured person** is deceased or legally incompetent; or (ii) a spouse or domestic partner of an **insured person** in their capacity as such, or due to legal ownership of property identified as potential recovery relief. There will be no coverage afforded under this policy for any act, error or omission of an estate, heir, legal representative, assign, spouse or domestic partner.

Liability coverage part means those Coverage Parts set forth in Item 5 of the General Terms and Conditions Declarations.

Management control means:

- (i) owning or controlling more than fifty-percent (50%) of the outstanding securities, shares or equity ownership representing the right to control an entity as evidenced by the present power to elect, designate or appoint the majority of the board of directors, management committee members or management board members; or
- (ii) having the present right, pursuant to written contract or an organizational document, to elect, designate or appoint the majority of the board of directors, management committee members or management board members of an entity.

Named insured means the entity set forth in Item 1 of the General Terms and Conditions Declarations.

Non-liability coverage part means those Coverage Parts set forth in Item 5 of the General Terms and Conditions Declarations.

Noticed matter means any written notice of circumstance which we have accepted under a **liability coverage part**.

Policy period means the time period from the inception date to the expiration date of this policy set forth in Item 2 of the General Terms and Conditions Declarations, or any such earlier termination or cancellation date. **Policy period** will also include the **extended reporting period**, if purchased.

Pollutants mean any actual or alleged: (i) solid, liquid, gaseous, thermal or radioactive irritant or contaminant, acids, alkalis, chemicals, fumes, smoke, soot, vapor, waste or waste materials to be recycled, reclaimed or reconditioned, or disposed; or (ii) air emission, odor, waste water, oil or oil products, infectious or medical waste, asbestos or asbestos products, or any noise.

Pollution means any actual, or threat of, discharge, emission, release, dispersal, escape of, or treatment, removal or disposal of any **pollutants**. **Pollution** also includes any regulation, order, direction, or request to test, monitor, clean up, remove contain, treat or detoxify or neutralize any **pollutants**.

Pre-claim expenses mean the reasonable and necessary fees, costs, and expenses incurred by an **insured** in responding to or defending a **noticed matter**, on or after the date we accepted the notice of circumstances and prior to the date the **noticed matter** became a **claim**. **Pre-claim expenses** will not include **overhead expenses, demand response costs** or any fees, costs, or expenses incurred by an **insured** as a result of any **routine examination** or **anti-bribery** investigation, examination, or request. We have the right to determine the reasonableness, necessity, and allocation of the **pre-claim expenses** (including the right to apply any applicable **claim** exclusions to the **pre-claim expenses**).

Property damage means any actual or alleged damage to, or destruction of, any tangible property including loss of use or diminution of value.

Related claims mean all **claims** that are based upon, arising from, or are logically or causally connected by the same, or any related or common, or a series of related or common, facts, circumstances, transactions, or **wrongful acts**.

Responsible person means the Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, the General Counsel, the Risk Manager or such functionally equivalent positions of the **named insured**.

Routine examination means any routine examination, routine inspection, sweep examination, general requests for information, or any other similar reviews, inquiries, or investigations.

Subsidiary means any: (i) entity while under the **management control** of an **insured entity**; or (ii) charitable trust, political action committee or foundation while such entity is controlled by the **named insured**.

IV. LIMIT OF LIABILITY, SUBLIMITS AND RETENTIONS

If Item 6 of the General Terms and Conditions Declarations is elected then the amount indicated in item 6 will be the maximum aggregate amount we will pay for all **loss** regardless of the number of **claims**, parties or requests for coverage under all **liability coverage parts** combined.

If Item 6 of the General Terms and Conditions Declarations is not elected then the amount indicated in Item 2 of the respective **liability coverage part** Declarations will be the maximum aggregate amount we will pay for all **loss** regardless of the number of **claims**, parties or requests for coverage in such Coverage Part.

Defense costs are part of and not in addition to the limit of liability set forth in Item 6 of the General Terms and Conditions Declarations or Item 2 of the respective **liability coverage part** Declarations. Our payment of any **defense costs** will erode and may exhaust the limit of liability.

The respective Declarations for the **non-liability coverage parts** will reflect the maximum amount we will pay for such non-liability coverage.

Coverage Part Declarations will also identify the applicable Retention, if any. Any Retention will be uninsured and your responsibility to pay. If there are two Retentions that apply to the same **claim**, we will only apply the higher Retention.

Any **defense costs** or any sublimited coverage will be part of, and not in addition to, the aggregate limit of liability of that Coverage Part or the combined maximum aggregate limit of the policy.

Form No: CNA92840XX (01-2019) Policy Conditions; Page: 3 of 7 Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606 Policy Page: 8 of 50	Policy No: 6052521241 Policy Effective Date: 05/01/2026
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All premiums, limits, Retentions, **loss** and other amounts under this policy are expressed and payable in United States of America currency unless the parties agree in writing otherwise.

V. EXTENDED REPORTING PERIOD FOR LIABILITY COVERAGE PARTS ONLY

If this policy is terminated, cancelled or non-renewed for any reason other than non-payment of premium or a **change of control**, you have the right to elect an **extended reporting period** for **liability coverage parts** for the additional period(s) and additional premium set forth in Item 4 of the General Terms and Conditions Declarations.

You must notify us in writing of this election within sixty (60) days after the non-renewal, cancellation, or termination. If you do not elect within this time frame, you will have waived your right to purchase the **extended reporting period**.

A purchased **extended reporting period** will extend to selected Coverage Parts coverage for a period of time but only to **claims** that are:

- (i) first made during the **extended reporting period**;
- (ii) reported to us according to this policy's notice and reporting requirements; and
- (iii) for **wrongful acts** that occurred prior to the date of such termination, cancellation or non-renewal.

The purchased **extended reporting period** becomes part of the **policy period**. Any premium for an **extended reporting period** will be deemed fully earned at the beginning of the **extended reporting period**. There will be no additional limit of liability for the **extended reporting period**.

VI. NOTICE AND REPORTING

A. Reporting a Claim in any Liability Coverage Part

As a condition precedent to our policy obligations, you must provide written notice of a **claim** as soon as practicable after a **responsible person** first becomes aware of such **claim**.

- (i) If the policy has been renewed with us, we will not assert that the notice of a **claim** is untimely unless we have been prejudiced by such late notice.
- (ii) If the policy has not been renewed with us, you must at the very latest, submit written notice of a **claim** no later than:
 - (a) ninety (90) days after the **policy period** terminates or expires, if there is no extended reporting period; or
 - (b) the expiration date of the purchased **extended reporting period**.

B. Reporting a Notice of Circumstances in any Liability Coverage Part

- (i) If during the **policy period** you first become aware of circumstances that may give rise to a **claim**, you may elect to submit a written notice of circumstance to us. Such written notice must contain a description of the circumstances, the nature of the **wrongful act**, persons involved and the nature of the relief sought.
- (ii) Any subsequent **claim** that is based upon or arises out of a **noticed matter** will be deemed to have first been made in the **policy period** in which we accepted the notice of circumstances.

C. Non-liability coverage parts will have their own reporting provisions.

D. Except with respect to any applicable **pre-claim expenses** described in Section II Supplementary Benefits paragraph C we will not provide coverage for fees, costs, or expenses incurred prior to the time a **claim** is noticed, even if such fees, costs, or expenses benefit the defense of a covered **claim**.

E. Notice Mailing

Written notices of a **claim** or circumstance should be directed to us at the mailing address or email address indicated in Item 3 of the General Terms and Conditions Declarations. A notice on one Coverage Part will be deemed notice to all Coverage Parts. All other notices should be sent to us at the address or email set forth in Item 3 of the General Terms and Conditions Declarations.

We will send all correspondence to you at the address set forth in Item 1 of the General Terms and Conditions Declarations.

We will consider the effective date of notice to be the date of mailing with sufficient proof of mailing.

VII. RELATED CLAIMS

All **related claims** will be treated as one **claim** first made on the date the first of such **related claims** was first made or deemed made according to the provisions of the applicable Coverage Part of this policy.

VIII. COOPERATION AND CONSENT

You agree:

- (i) to provide us full cooperation, assistance, and any information we may reasonably request when seeking coverage under this policy;
- (ii) to do nothing that may increase our liabilities or prejudice our potential or actual rights of recovery or subrogation;
- (iii) not to incur any **loss**, or any other costs or expenses for which you are seeking coverage under this policy, or admit any liability or assume any contractual obligation, without our prior written consent; and
- (iv) not to accept or consent to any settlement, or make any offer of settlement, or stipulate to any judgment, without our prior written consent; however, our consent will not be required if you can settle the **claim**, including all **related claims** and **loss** (including **defense costs**) for an aggregate amount that does not exceed the Retention.

We will:

- (a) have the right to make any reasonable investigation into any **claim** or **noticed matter** that we deem necessary or appropriate;
- (b) make any settlement of any **claim** that we deem reasonable, provided such settlement is made with your consent;
- (c) not withhold written consent unreasonably; and
- (d) not be liable for any **loss**, or any other costs or expenses for which you are seeking coverage under this policy, or admission of liability, or any contractual obligation unless we have provided prior written consent.

IX. APPLICATION

We have relied upon the truthfulness and accuracy of the statements, representations, and information in the **application**, which is incorporated into this policy.

If the **application's** statements, representations, and information contain any actual or knowing misrepresentations or omissions which materially affect our acceptance of the risk or the hazard assumed by us under this policy, then we will not cover **loss** in connection with any **claim**:

- (i) against an **insured person** based upon or arising out such misrepresentations or omissions if that **insured person** had actual knowledge of such misrepresentations or omissions;

- (ii) against an **insured entity** based upon or arising out such misrepresentations or omissions if the Chief Executive Officer, Chief Financial Officer or such functionally equivalent positions of the **named insured** had actual knowledge of such misrepresentations or omissions.

The **application** will be considered a separate request for coverage by each **insured person**. We will not rescind or void this policy with respect to any **insured**.

X. CHANGE OF CONTROL

With respect to any **liability coverage part**:

In the event of a **change of control**, the premium will become fully earned as of the effective date. We will not be liable for any **wrongful act** committed, attempted, or allegedly committed or attempted by any **insured** after the effective date of a **change of control**. We will however, continue to provide coverage until the policy is otherwise cancelled, terminated, or expires, but only for **wrongful acts** by any **insureds** prior to the date of a **change of control**. The extended reporting provision in Section V will not apply to a **change of control** event.

If you notify us in writing at least sixty (60) days prior to the **change of control**, we will provide you with proposed additional terms and conditions for run-off coverage subject to an additional premium and payment by you.

Non-liability coverage parts will have specific change of control provisions applicable to such Coverage Part.

XI. SUBSIDIARY

With respect to any **liability coverage part**:

A **subsidiary** and its **insureds** acquired or created before or during the **policy period** will be afforded coverage for a **claim** arising from **wrongful acts** which occur while that **subsidiary** is under the **management control** of an **insured entity**. There will be no acquisition threshold with respect to any **subsidiary**.

If an **insured entity** ceases **management control** of a **subsidiary** during the **policy period**, coverage will continue until the policy is otherwise terminated or cancelled, but coverage will apply to such **subsidiary** and its **insureds** only for **claims** for **wrongful acts** which occurred prior to such cessation.

XII. CANCELLATION OR TERMINATION

This policy may only be cancelled or terminated by one of the following events:

- (i) by us, for nonpayment of premium, in which event we will send you a written notice twenty (20) days prior to the effective date of such cancellation;
- (ii) by the **named insured** for any reason if we receive written notice twenty (20) days prior to the date the policy should be cancelled; or
- (iii) the expiration of the **policy period**.

Any returned premium will be computed on a pro rata basis.

XIII. SUBROGATION AND RECOUPMENT

If we pay any **loss** or other similar cost or expense under this policy, we reserve all rights to subrogation. We will not subrogate against you. You agree that we have the right to recoup any amount paid to you, or on your behalf, if such amount was not owed under this policy.

Any amounts recovered by subrogation or recoupment, less costs expended for the recovery, will be applied to the limit of liability of the applicable Coverage Part.

XIV. GENERAL POLICY PROVISIONS

The **named insured** agrees to act on behalf of all **insureds** with respect to:

- (i) providing or receiving any notice;
- (ii) the payment of any premiums;
- (iii) receiving any applicable return premiums; and
- (iv) agreeing to and acceptance of any endorsements.

This policy, including the **application**, constitutes the entire contract existing between you and us or any of our agents relating to this insurance.

The provisions of this policy cannot be waived or changed except by written endorsement issued to form a part of this policy. We will not be bound by any assignment of interest under this policy unless this assignment is specifically endorsed to the policy.

XV. REFERENCE TO LAW

Any reference to United States law will also include United States federal, state and local statutory law, and any rules, regulations and amendments of such law or any such equivalent foreign law.

XVI. FINANCIAL INSOLVENCY

Financial insolvency will not impact our obligations, rights or defenses under this policy. We will not object to your efforts to obtain relief or stay from any injunction issued as a result of **financial insolvency**.

XVII. ACTION AGAINST THE COMPANY

No action may be taken against us unless, as a condition precedent, there has been full compliance with all the terms and conditions of this policy. Further, no person or entity will have any right under this policy to join us as a party to any action against any **insured** to determine such **insured's** liability, nor can we be impleaded by the **insured** or legal representatives of such **insured**.

XVIII. STATE AMENDATORY INCONSISTENCY STATEMENT

In the event that there is an inconsistency between the terms and conditions of this policy and any state amendatory endorsement, where permitted by law, we will apply the terms and conditions that are most favorable for you.

XIX. TERRITORY

Coverage will apply worldwide. This policy does not provide coverage for any **insured**, transaction, that part of **loss**, or other similar cost or expense that is uninsurable under the laws or regulations of the United States concerning trade or economic sanctions.

IN WITNESS WHEREOF, we have caused this policy to be executed by our Chairman and Secretary, but this policy shall not be binding upon us unless completed by the attachment of the Declarations.

Chairman

Secretary

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DIRECTORS AND OFFICERS AND ENTITY LIABILITY COVERAGE PART DECLARATIONS

NOTICE:

THIS COVERAGE PART PROVIDES CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD. THE LIMIT OF LIABILITY TO PAY JUDGMENTS OR SETTLEMENT AMOUNTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY PAYMENT OF DEFENSE COSTS. PLEASE READ THIS POLICY CAREFULLY

- Item 1. **Named Insured:** Mangum City Hospital Authority
- Item 2. **Aggregate Limit of Liability (including defense costs):** \$1,000,000
- Item 3. **Side A Additional Limit of Liability:** \$1,000,000
- Item 4. **Coverage Extensions Sublimits of Liability**
 - A. **demand response costs** \$250,000
 - B. **crisis event expenses** \$25,000
- Item 5. **Retentions:**
 - A. **Insuring Agreement Side B:** \$25,000 per **claim**
 - B. **Insuring Agreement Side C:** \$25,000 per **claim**
- Item 6. **Pending or Prior Litigation Date:** 06/30/2017

These Declarations, along with the completed and signed **application**, and the policy shall constitute the contract between the **insureds** and the Insurer.

Authorized Representative:

Date: 01/22/2026

DIRECTORS AND OFFICERS AND ENTITY LIABILITY COVERAGE PART

In consideration of the premium and subject to the Declarations and the General Terms and Conditions, the parties agree as follows:

I. INSURING AGREEMENTS

A. Side A

We will pay **non-indemnifiable loss** on behalf of an **insured person** arising from a **claim** against such **insured person** first made during the **policy period**.

B. Side B

We will pay **loss** on behalf of an **insured entity** arising from a **claim** against an **insured person** first made during the **policy period** but only to the extent the **insured entity** has indemnified the **insured person** for such **loss**.

C. Side C

We will pay **loss** on behalf of an **insured entity** arising from a **claim** against such **insured entity** first made during the **policy period**.

II. COVERAGE EXTENSIONS

The following coverage extensions, if subject to a sublimit, are part of, and not in addition to, the aggregate limit of liability set forth in Item 2 of this Coverage Part Declarations.

A. Sublimited Demand Response Costs

We will pay **demand response costs** on behalf of an **insured entity** for all **demands** first received by the **insured entity** during the **policy period**. The total amount that we will pay for **demand response costs** will be the sublimit of liability set forth in Item 4A of this Coverage Part Declarations.

B. Sublimited Crisis Event Expenses

We will pay **crisis event expenses** on behalf of an **insured entity** arising from any **crisis event** first occurring during the **policy period**. The total amount that we will pay for **crisis event expenses** will be the sublimit of liability set forth in Item 4B of this Coverage Part Declarations.

C. Side A Additional Limit of Liability

Solely with respect to **non-indemnifiable loss**, we will pay an additional limit of liability for **executives** in the amount set forth in Item 3, Side A Additional Limit of Liability of this Coverage Part Declarations, which will be in addition to and not part of the aggregate limit of liability set forth in Item 2 of this Coverage Part Declarations. The Side A Additional Limit of Liability will be excess of any other insurance specifically written as excess of the aggregate limit of liability in Item 2 of this Coverage Part Declarations.

D. Side A Extended Reporting Period Option

In the event that an **insured entity** does not purchase an **extended reporting period** prior to the expiration of the time frame indicated in Section V Extended Reporting Period for Liability Coverage Parts Only of the General Terms and Conditions, then the **insured person(s)** will have the right to purchase an **extended reporting period**. The **insured person(s)** must notify us of this election in writing within thirty (30) days after such expiration. Any **extended reporting period** purchased by any **insured person(s)** will apply only to **claims** made against such **insured person(s)** under the Side A Insuring

Agreement. All other terms and conditions of Section V Extended Reporting Period for Liability Coverage Parts Only will apply to the **extended reporting period** for such **insured person(s)**. There will not be a separate or additional limit of liability for such **extended reporting period**.

III. DEFINITIONS

Any defined word not defined in this Coverage Part will have the meaning assigned to it in the General Terms and Conditions.

Anti-bribery means any United States law which prohibits direct or indirect bribery or corruption.

Antitrust means any actual or alleged violation of any United States law which prohibits anti-trust, price fixing or price discrimination, restraint of trade or competition, monopolization, or predatory pricing.

Books and records demand means a written request by, or on behalf of, an **insured entity's** securityholder to inspect the **insured entity's** books, records, and stock ledgers pursuant to a statutory right of inspection.

Claim means any:

- (i) written demand (excluding a subpoena) for monetary, non-monetary, injunctive, or declaratory relief including a request for alternative dispute resolution, **extradition**, or request to toll or waive a statute of limitations;
- (ii) civil or criminal proceeding commenced by the earlier of: (a) the return of service of a complaint or indictment upon an **insured**; (b) the filing of an indictment or information with respect to an **insured**; or (c) the arrest or detainment of an **insured**; or
- (iii) a formal administrative or regulatory proceeding evidenced by a formal notice of charges or a formal notice of investigation,

against such **insured** for a **wrongful act**, including any appeal therefrom. **Claim** will also include any **inquiry**. **Claim** will not include a **books and records demand** or any **securityholder derivative demand**.

Unless specifically stated elsewhere in this Coverage Part, a **claim** will be deemed first made on the earliest of the date on which the **claim** is served upon, or first received by, any **insured**, or the applicable notice or order is filed or entered.

Conduct means the: (i) gaining of profit or other advantage to which the **insured** was not legally entitled; or (ii) commission of a deliberate crime, deliberate fraud, or a deliberate dishonest act or omission, or willful violation of any law or regulation, provided such conduct is established by a final non-appealable adjudication (excluding a declaratory action or proceeding by, or against us) in the underlying action.

Contractual liability means your actual or alleged liability voluntarily undertaken by you in any contract or agreement. **Contractual liability** does not include liability that would be imposed upon you in the absence of such contract or agreement.

Crisis event means the:

- (i) death, incapacity, or criminal indictment of the Chief Executive Officer, Chief Financial Officer or such functionally equivalent position of the **named insured**;
- (ii) public announcement that an **insured entity** intends to file for bankruptcy protection; or
- (iii) public announcement of an impending governmental, regulatory, or criminal proceeding against an **insured entity**.

Crisis event does not include any **anti-bribery** investigation, examination, or request, or any **routine examination**.

Crisis event expenses mean the reasonable and necessary fees, costs, and expenses that are incurred by an **insured entity** to minimize potential economic harm in response to a **crisis event**. Such **crisis event expenses** include fees, costs, and expenses to:

- (i) retain an outside law firm, public relations firm, or crisis management firm, to advise the **insured entity**;
- (ii) manage press coverage, publicity and press relationships, advertising and mailing of materials.

Crisis event expenses do not include **overhead expenses**, expenses incurred prior to any notice submitted to us, or expenses incurred after one hundred and eighty (180) days from the date the **crisis event** was noticed to us.

Defense costs mean the reasonable and necessary fees, costs, and expenses, incurred by an **insured** in the investigation, defense, or appeal of any covered **claim**, including the premium for appeal, attachment, or similar bonds arising out of a covered judgment. **Defense costs** do not include **demand response costs** or **overhead expenses**.

Demand means any **books and records demand** or any **securityholder derivative demand**.

Demand response costs mean the reasonable and necessary fees, costs, and expenses incurred by an **insured entity** in responding to: (i) a **books and records demand**; or (ii) in connection with the investigation of a **securityholder derivative demand**. **Demand response costs** do not include **overhead expenses**.

Discrimination/harassment means any actual or alleged discrimination against, or harassment of, a third party by an **insured**.

Employee means any natural person, who is a past, present, or future full-time, part-time, seasonal or temporary worker, or volunteer of an **insured entity**. **Employee** does not include any **executive** or independent contractor.

Employment related means any matter relating to the responsibilities, obligations or duties of an employer to any **employee**, or prospective employee, including **wage and hour**, as imposed by United States law or common law.

ERISA means any actual or alleged violation of the Employee Retirement Income Security Act of 1974, (including the Consolidated Omnibus Budget Reconciliation Act of 1985)(COBRA).

Executive means any:

- (i) past, present, or future duly elected or appointed director (including a shadow or de facto director), trustee (excluding a bankruptcy or litigation trustee), advisory board member, officer, governor, or managing member of a management committee of an **insured entity**;
- (ii) past, present, or future In-House General Counsel or Risk Manager, or such functionally equivalent position, of the **named insured**;
- (iii) holder of such functionally equivalent position to those included in paragraph (i) in an **insured entity** organized and operated outside of the United States of America, its territories or possessions; or
- (iv) holder of such functionally equivalent position to those included in paragraph (i) above in an **outside entity** while serving at an **insured entity's** specific request or direction.

Executive does not include any **employee**.

Extradition means the formal process by which an **executive** outside of the United States is surrendered, or requested to surrender, to another country to respond to a criminal accusation. An **extradition** is commenced by an arrest, detainment, or incarceration of the **executive** by any foreign jurisdiction law enforcement authority.

Inadequate consideration means an allegation that the price or consideration paid or proposed to be paid for the acquisition or completion of the acquisition of all or substantially all the ownership interest in or assets, shares or securities of an entity by an **insured**, or of an **insured entity**, is inadequate.

Inquiry means any:

- (i) investigation against an **insured person** for a **wrongful act**, evidenced by a search warrant, subpoena, or target letter, or similar investigatory document; or
- (ii) written request by an **insured entity** of an **insured person** for an interview, meeting, sworn testimony, or documents in connection with a **securityholder derivative demand**.

Inquiry will not include any **anti-bribery** investigation, examination, or request or any **routine examination**.

Insured means any **insured person** or any **insured entity**.

Insured person means any **employee** or **executive**.

Intellectual property means any actual or alleged misappropriation, violation or infringement of: ideas, confidential information, trade secrets, copyright, trademark, patent, or other intellectual property right.

Loss means the amount you are legally obligated to pay as a result of a **claim** including compensatory damages, settlements, judgments, pre-judgment and post-judgment interest, claimants' attorney fees and costs attributable to the covered portion of a settlement or imposed as a result of a covered judgment, and **defense costs**. **Loss** will include **crisis event expenses**, **pre-claim expenses** and **demand response costs**.

Loss will also include:

- (i) punitive, exemplary, or multiplied damages if such damages are insurable under the law in the jurisdiction which is most favorable to you, provided that such jurisdiction has a substantial relationship to us, you, or to the **claim** giving rise to such **loss**;
- (ii) civil fines or penalties assessed against an **insured person** for an unintentional and non-willful violation of law that are insurable under the law to which this policy is construed, including civil fines or penalties assessed pursuant to 15 U.S.C. §78dd-2(g)(2)(B) (the Foreign Corrupt Practices Act);
- (iii) solely with respect to coverage afforded by the Side A Insuring Agreement, any tax imposed upon an **insured person** in his/her capacity as such in connection with the **financial insolvency** of an **insured entity**.

Loss does not include:

- (a) costs to comply with any order or agreement to provide non-monetary or injunctive relief;
- (b) taxes, fines, or penalties (other than those referenced in (i), (ii) or (iii) above);
- (c) **clean-up costs**;
- (d) amounts not insurable under the law to which this policy is construed; or
- (e) any amount for which an **insured** is absolved from payment by reason of any covenant, agreement, or court order.

Non-indemnifiable loss means any **loss** incurred by an **insured person** that an **insured entity** fails or refuses to pay, advance, or indemnify:

- (i) due to **financial insolvency**; or
- (ii) because such indemnification is not permitted pursuant to law.

Outside entity means any entity exempt from federal income tax pursuant to Sections 501(c)(3),(4),(6),(7), and (10) of the United States Internal Revenue Code, as amended; provided such entity is not an **insured entity**.

Overhead expenses mean the salaries, wages, fees, overhead, or benefit expenses associated with any **insured**.

Pending or prior litigation means any action, proceeding, investigation, inquiry, or written demand commenced against you pending on or prior to the date set forth in Item 6 of this Coverage Part Declarations.

Personal injury means any actual or alleged:

- (i) wrongful entry or eviction, or other invasion of the right of private occupancy;
- (ii) libel, slander, or defamation of any person;
- (iii) violation of any person's right of privacy;
- (iv) false arrest or false imprisonment;
- (v) malicious prosecution, malicious use or abuse of process; or
- (vi) violation of any United States law which regulates or governs commercial solicitation, messaging, automatic contract renewals, or anti-spam (including commercial emails and spam, telemarketing, texts, and electronic commerce).

Prior notice means any matter, fact, circumstance, situation, transaction, event, or **wrongful act** that has been the subject of any notice accepted under any directors and officers liability policy or comparable policy, coverage section or coverage part of which this Coverage Part is a direct or indirect renewal or replacement.

Product defect means, with respect to any goods or products manufactured, produced, processed, packaged, sold, marketed, distributed, or developed by, or on behalf of, any **insured entity**, any actual or alleged:

- (i) failure, malfunction, or performance failure of such goods or products; or
- (ii) false labeling, false advertising, or misrepresentation in advertising of such goods or products.

Professional services mean the performance of, or failure to perform, services for others for a fee or other remuneration.

Publicly traded securities mean any registered debt or equity securities of an **insured entity** or an **outside entity** that are offered for purchase or sale to the public. **Publicly traded securities** will not include any: (i) unregistered securities; (ii) securities related to a failed undertaking of, or failure to complete, an initial public offering; or (iii) preparation for a public offering, including any road show presentation to potential investors.

Securityholder claim means any **claim** by any owner(s) of an **insured entity's** equity or debt securities brought in such capacity. **Securityholder claim** includes a **securityholder derivative suit**.

Securityholder derivative demand means any written demand by one or more securityholders of an **insured entity** upon the board of directors (or such functionally equivalent management body) of such **insured entity** to commence an investigation or to bring a **securityholder derivative suit**.

Securityholder derivative suit means a lawsuit brought derivatively on behalf of an **insured entity** by one or more securityholders of such **insured entity** against: (i) one or more **executives** of such **insured entity**; or (ii) the **insured entity** as a nominal defendant.

Unfair trade practices mean any actual or alleged violation of United States law or common law which prohibits unfair or deceptive trade or business practices.

Wage and hour means any actual or alleged violation of any United States law or common law which regulates or governs employment wage, pay, or labor requirements or standards, including but not limited to:

- (i) the calculation, recordkeeping, timing or manner of payment of minimum wages, prevailing pay rates, overtime pay, or other compensation alleged to be due and owing, including the failure to compensate for any unpaid vacation pay, off the clock or remote work, or for employer sponsored activities;
 - (ii) failure to provide or enforce legally required meal or rest break periods;
 - (iii) the classification of any entity or person for wage and hour purposes;
 - (iv) garnishments, withholdings, or other deductions from wages;
 - (v) use of federal or state tip credits or maintenance and distribution of tip pools; or
 - (vi) reimbursement of work-related expenses or tools to any person providing services or labor to or on behalf of an **insured entity**,
- or any such similar practices, policies, or procedures.

Whistleblower Activity means the lawful activity of an **insured person**, with respect to any alleged wrongdoing by an **insured**, who causes information to be provided to the attention of, or otherwise assists in an investigation by, a governmental or law enforcement agency, provided such activities are protected by statute with rights and remedies for retaliation recognized under United States law.

Wrongful act means any:

- (i) error, misstatement, misleading statement, act, omission, neglect, or breach of duty committed, attempted or allegedly committed, or attempted, by:
 - (a) an **insured person** in his/her capacity as such; or
 - (b) an **insured entity**; or
- (ii) matter claimed against an **insured person** solely by reason of his/her status as such.

IV. COVERAGE PART EXCLUSIONS

We will not cover **loss** in connection with any **claim**:

A. based upon or arising from:

- (i) **conduct**;
- (ii) **prior notice**;
- (iii) **pending or prior litigation**;
- (iv) **discrimination/harassment**;
- (v) **publicly traded securities**;
- (vi) **employment related**; provided this exclusion (vi) will not apply to any **claim** (other than a **wage and hour claim**) against an **insured person**; or
- (vii) **pollution**; provided this exclusion (vii) will not apply to any:
 - (a) **claim for non-indemnifiable loss**; or
 - (b) **securityholder claim**.

B. against an **insured entity** that is based upon or arising from:

- (i) **antitrust**;
- (ii) **contractual liability**;
- (iii) **unfair trade practices**;
- (iv) **intellectual property**;

- (v) **personal injury**;
 - (vi) **product defect**; or
 - (vii) **professional services**,
- provided these exclusions B will not apply to any **securityholder claim**.

C. for:

- (i) **property damage**;
- (ii) **ERISA**;
- (iii) **inadequate consideration**; provided this exclusion (iii) will not apply to **defense costs**; or
- (iv) **bodily injury**; provided this exclusion (iv) will not apply to any:
 - (a) any **claim for non-indemnifiable loss**;
 - (b) any **securityholder claim**;
 - (c) any actual or alleged emotional distress, mental anguish or humiliation made in connection with any **employment related claim** against an **insured person**; or
 - (d) **defense costs** incurred by an **executive** in the defense of a **claim** for any actual or alleged violation of a corporate manslaughter statute by such **executive**.

D. brought by, or on behalf of, any **insured** in any capacity against any **insured**, or an **outside entity** against any **insured**, unless such **claim** is:

- (i) a **securityholder derivative suit** or a derivative action brought on behalf of an **outside entity** against an **insured person** in his/her capacity for such **outside entity**;
- (ii) brought while the **insured entity** or **outside entity** is in **financial insolvency**;
- (iii) brought by an **executive** who has not been in his/her insured capacity for at least one (1) year;
- (iv) for contribution or indemnity arising from a **claim** otherwise covered under this policy;
- (v) brought against an **insured person** by another **insured person** actively engaged in **whistleblower activity**;
- (vi) an **employment related claim** against an **insured person**; or
- (vii) brought in a common law jurisdiction other than the United States or Canada, their territories or possessions.

V. SPECIFIC LIMIT OF LIABILITY, SUBLIMITS AND RETENTIONS

The most we will pay for all **loss** arising from all **claims, demands, and crisis events** is the aggregate limit of liability set forth in Item 2 of this Coverage Part Declarations.

A single Retention will apply to each **claim**. There will be no Retention applicable to **demand response costs, crisis events**, or coverage afforded under the Side A Insuring Agreement.

Item 4 of this Coverage Part Declarations sets forth the maximum amount we will pay for sublimits of liability for **demand response costs and crisis event expenses**.

VI. REQUEST FOR OPTIONAL SPECIFIC COVERAGES

If you choose to request coverage for **demand response costs** or **crisis event expenses** you must submit a written notice to the address located in Item 3 of the General Terms and Conditions Declarations.

With respect to the **demand response costs**, the notice must include the date the **demand** was first received, the parties involved, the nature of the **demand** and the relief sought.

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With respect to **crisis event expenses**, the notice must be sent within sixty (60) days of the **crisis event** and include the date the **crisis event** first occurred, the nature of the **crisis event** and the expenses requested or anticipated.

Should there be a subsequent **claim** that is based upon or arises out of this noticed **demand** or **crisis event** we will consider that **claim** to have first been made during the **policy period** in which we received your first written notice.

VII. INDEMNIFICATION

It is agreed that an **insured entity** will indemnify its **insured person** to the fullest extent permitted by law.

VIII. DEFENSE COSTS AND ADVANCEMENT

We will pay **defense costs** on a current basis, but no later than ninety (90) days after we have received any invoice or bill, as well as any additional supporting documentation that we have reasonably requested.

If an **insured person** makes a written request for indemnification from an **insured entity** and within sixty (60) days of such request the **insured entity** fails to respond, or refuses to indemnify the **insured person**, then we will pay **defense costs** on behalf of the **insured person** after receipt of the **claim** in accordance with the above paragraph. We will continue to pay such **defense costs** until the **insured entity** fulfills its indemnification obligations, or the applicable limit of liability has been exhausted whichever occurs first.

We reserve all rights to recoup or recover from an **insured entity** any amount paid on behalf of an **insured person** in the event we pay **loss** that is an indemnification obligation within the Retention.

IX. DEFENSE OF CLAIMS

Subject to the following paragraph, we will have the right and duty to defend any **claim** even if the allegations in the **claim** are groundless, false, or fraudulent. Our duty to defend any **claim** will end, and we will have no further obligation to defend any **claim**, upon the exhaustion of the applicable limit of liability.

Solely with respect to any **employment related claim** you will have the duty to defend.

X. ALLOCATION

If we have the duty to defend a **claim** that incurs covered **loss** and uncovered loss because such **claim** includes covered and uncovered parties, or covered and uncovered matters, then the following will apply:

- (i) one hundred percent (100%) of **defense costs** incurred by such **insured** will be considered covered **loss**; and
- (ii) with respect to any loss other than **defense costs** you and we will use our best efforts to determine an allocation between covered **loss** and uncovered loss based on the relative legal and financial exposures of the parties to such matters.

Alternatively, if you have the duty to defend a **claim**, you and we will use our best efforts to determine an allocation between covered **loss** and uncovered loss based on the relative legal and financial exposures of the parties to such matters.

XI. OTHER INSURANCE

This Coverage Part will be excess of, and will not contribute with any valid and collectible insurance policy or Coverage Part that provides coverage or indemnifies **loss** for which this Coverage Part also provides coverage, unless such other insurance is written specifically as excess of the limit of liability of this Coverage Part.

This Coverage Part will be specifically excess of any valid and collectible insurance policy: (i) for environmental liability, cyber liability, professional services liability or employment practices liability; or (ii)

written on a duty to defend basis unless such other insurance is written specifically as excess of the limit of liability of this Coverage Part.

With respect to an **executive** serving in his/her capacity as such for an **outside entity**, this Coverage Part will be excess of any insurance or indemnity available to such **insured person** by or on behalf of an **outside entity**.

Notwithstanding the above, this Coverage Part will apply as primary with respect to any personal umbrella or personal directorship liability insurance purchased by an **insured person**.

XII. IMPUTATION

We will only impute the conduct or knowledge of any past, present, or future Chief Executive Officer, Chief Financial Officer, or such functionally equivalent positions of the **named insured** to any **insured entity**.

We will not impute:

- (i) the conduct of any **insured person** with respect to **conduct** exclusion IV A(i) of this Coverage Part;
- (ii) the knowledge possessed by any **executive** with respect to any statements, representations, or information in the **application**; or
- (iii) the failure to provide us with full cooperation, assistance, or information as required,

to any other **insured person**, nor will (i), (ii) or (iii) above impair the rights of any other **insured person** under this Coverage Part.

XIII. PRIORITY OF PAYMENTS

The coverage under this Coverage Part is intended principally to benefit the **insured person**. In the event that **loss** under the Side A Insuring Agreement, and any other insuring agreement or coverage extension are due simultaneously, then we will first pay **non-indemnifiable loss** on behalf of the **insured person**. In all other instances we will pay **loss** as it becomes due.

AMEND EXCLUSION D ENDORSEMENT

In consideration of the premium, Exclusion D set forth in Section IV, Coverage Part Exclusions, of the Directors and Officers and Entity Liability Coverage Part is deleted and replaced with the following:

- D. brought by, or on behalf of, any **insured** in any capacity against any **insured**, or an **outside entity** against any “outside entity executive” in his/her capacity as such for such **outside entity**, unless such **claim** is:
 - (i) a **securityholder derivative suit** or a derivative action brought on behalf of an **outside entity** against an “outside entity executive” in his/her capacity for such **outside entity**;
 - (ii) brought while the **insured entity** or **outside entity** is in **financial insolvency**;
 - (iii) brought by an **executive** who has not been in his/her insured capacity for at least one (1) year;
 - (iv) for contribution or indemnity arising from a **claim** otherwise covered under this policy;
 - (v) brought against an **insured person** by another **insured person** actively engaged in **whistleblower activity**;
 - (vi) an **employment related claim** against an **insured person**; or
 - (vii) brought in a common law jurisdiction other than the United States or Canada, their territories or possessions.

For the purpose of this exclusion “outside entity executive” means an **executive** as defined in subparagraph (iv) of the definition of **executive**.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA107359XX (11-2023)	Endorsement Expiration Date:	Policy No: 6052521241
Endorsement Effective Date:		Policy Effective Date: 05/01/2026
Endorsement No: 1 ; Page: 1 of 1		Policy Page: 23 of 50
Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606		

JOBS ACT EXCLUSION ENDORSEMENT

In consideration of the premium, the Directors and Officers and Entity Liability Coverage Part of the policy is amended as follows:

I. Section III, Definitions is amended to include the following definition:

JOBS Act Offering means any conduct that is governed by the Jumpstart Our Business Startups Act of 2012, including any actual or alleged advertisement, solicitation, crowdfunding, offering, distribution, issuance, sale, purchase, or transaction of securities.

II. Section IV, Coverage Part Exclusions is amended to include the following exclusion:

We will not cover **loss** in connection with any **claim** based upon or arising from any **JOBS Act Offering**; provided this exclusion will not apply to any **claim** involving: (i) securities related to a failed undertaking of, or failure to complete, an initial public offering; or (ii) preparation for a public offering, including any road show presentation to potential investors.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA92966XX (01-2019)

Endorsement Effective Date:

Endorsement No: 2 ; Page: 1 of 1

Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606

Endorsement Expiration Date:

Policy No: 6052521241

Policy Effective Date: 05/01/2026

Policy Page: 24 of 50

**CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM
ENDORSEMENT****SCHEDULE****Directors and Officers and Entity Liability**

Solely with respect to any Coverage Part set forth in the Schedule, it is understood and agreed as follows:

Whenever used in this endorsement, 1) "we" means the insurer listed on the Declarations or the Certificate of Insurance, as applicable; and 2) "you" means the first person or entity named on the Declarations or the Certificate of Insurance, as applicable.

A. Cap on Certified Terrorism Losses

"Certified act of terrorism" means an act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security and the Attorney General of the United States, to be an act of terrorism pursuant to the Terrorism Risk Insurance Act, as extended and reauthorized (the "Act"). The criteria contained in the Act for a "certified act of terrorism" include the following:

1. The act resulted in insured losses in excess of \$5 million in the aggregate, attributable to all types of insurance subject to the Terrorism Risk Insurance Act; and
2. The act is a violent act or an act that is dangerous to human life, property or infrastructure and is committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

If aggregate insured losses attributable to terrorist acts certified under the Act exceed \$100 billion in a calendar year (January 1 through December 31) and we have met our insurer deductible under the Act, we shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion, and in such case insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.

B. Application of Exclusions

The terms and limitations of any terrorism exclusion, or the inapplicability or omission of a terrorism exclusion, do not serve to create coverage for any loss which would otherwise be excluded under this Policy, such as losses excluded by the Nuclear Hazard Exclusion or the War And Military Action Exclusion.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA92970XX (01-2019)

Endorsement Effective Date:

Endorsement Expiration Date:

Policy No: 6052521241

Policy Effective Date: 05/01/2026

Endorsement No: 3 ; Page: 1 of 1

Policy Page: 25 of 50

Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606

OPIOID EXCLUSION ENDORSEMENT

In consideration of the premium, solely with respect to the Directors and Officers and Entity Liability Coverage Part Coverage Part(s), Section IV, Coverage Part Exclusions is amended to add the following exclusion:

We will not cover **loss** in connection with any **claim** based upon or arising out of the sale, distribution, use, misuse, addiction to, prescription for, dependency upon, guidelines for reporting, and/or diversion prevention with respect to any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind including any **claim** based on or arising out of any actual or alleged:

- (i) liability under, non-compliance with, or violation of, any federal, state, local, tribal or foreign act, statute, regulation, ordinance, requirement, law, or common law of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (ii) leasing, licensing, handling, marketing, branding, promoting, diverting, disposing, or labeling of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (iii) improper warning or failure to warn including any warning of the adverse or addictive properties of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (iv) suspicious orders or orders of interest monitoring, rebates, chargebacks, or other similar data sharing concerning any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (v) communications with manufacturers, or distributors of, opioids, opiates or any narcotic drugs, narcotic medications or narcotic substances of any type, nature or kind with respect to guidelines relating to litigation, investigation, enforcement activity, or settlements related to any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (vi) lobbying or advocacy on behalf of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind manufacturers or distributors; or
- (vii) research projects, data metrics, benchmarking data, publications, or dissemination of any such information, relating to any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind,

by any **insured** or by anyone for whose acts the **insured** is liable.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA93248XX (10-2019)	Endorsement Expiration Date:	Policy No: 6052521241
Endorsement Effective Date:		Policy Effective Date: 05/01/2026
Endorsement No: 4 ; Page: 1 of 1		Policy Page: 26 of 50
Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606		

EMPLOYMENT PRACTICES AND THIRD PARTY LIABILITY COVERAGE PART DECLARATIONS

NOTICE:


THIS COVERAGE PART PROVIDES CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD. THE LIMIT OF LIABILITY TO PAY JUDGMENTS OR SETTLEMENT AMOUNTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY PAYMENT OF DEFENSE COSTS. PLEASE READ THIS POLICY CAREFULLY

- Item 1. **Named Insured:** Mangum City Hospital Authority
- Item 2. Aggregate Limit of Liability (including **defense costs**): \$1,000,000
- Item 3. Retention: \$35,000 per **claim**
- Item 4. Pending or Prior Litigation Date: 06/30/2017

Item 5.

Duty to Defend	<input checked="" type="checkbox"/>	Non Duty to Defend	<input type="checkbox"/>
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These Declarations, along with the completed and signed **application**, and the policy shall constitute the contract between the **insureds** and the Insurer.

Authorized Representative: 

Date: 01/22/2026

**EMPLOYMENT PRACTICES AND
THIRD PARTY LIABILITY COVERAGE PART**

In consideration of the premium and subject to the Declarations and the General Terms and Conditions, the parties agree as follows:

I. INSURING AGREEMENT

We will pay **loss** on behalf of the **insureds** arising from a **claim** against such **insureds** first made during the **policy period**.

II. SETTLEMENT RETENTION CREDIT

With respect to the settlement of a **claim**, if you and the claimant consent to the initial settlement offer, as recommended by us, within thirty (30) days of being made aware of such offer by us, we will reduce the applicable Retention for such **claim** by the lesser amount of ten percent (10%) of the Retention or ten thousand dollars (\$10,000) provided the settlement exceeds the Retention and such Retention has been met by the **insured**.

In the event that one **claim** is eligible for both this Settlement Retention Credit and the Mediation Retention Reduction found in Section II A Supplementary Benefits of the General Terms and Conditions, then the **insured entity** will receive only one such benefit.

III. DEFINITIONS

Any defined word not defined in this Coverage Part will have the meaning assigned to it in the General Terms and Conditions.

Antitrust means any actual or alleged violation of any United States law which prohibits antitrust, price fixing or price discrimination, restraint of trade or competition, monopolization, or predatory pricing, including horizontal or other price fixing of wages, hours, salaries, compensation, benefits, or any other terms or conditions of employment.

Applicant means any applicant or prospective applicant for employment with an **insured entity**.

Assumed liability means your voluntary assumption of the liability of others undertaken by you in any oral or written contract or agreement, unless such liability would have attached to you in the absence of such contract or agreement.

Breach means an intentional unauthorized access, intrusion, or control over an **insured's** computer system or network by a third party for some illicit purpose.

Claim means any:

- (i) written demand (excluding a subpoena) for monetary, non-monetary, injunctive, or declaratory relief, including a request to toll or waive a statute of limitations;
- (ii) written request for arbitration, mediation, or other alternative dispute resolution; or
- (iii) civil, administrative, or regulatory proceeding (excluding an audit), including an **EEOC proceeding** or proceeding by the Office of Federal Contract Compliance Programs,

by or on behalf of an **employee, applicant, or third party**, in their capacity as such, against an **insured** for a **wrongful act**.

Claim will not include any criminal proceeding, criminal administrative or regulatory proceeding, criminal investigation, or labor or grievance arbitration or proceeding pursuant to a collective bargaining agreement or similar agreement.

Unless specifically stated elsewhere in this Coverage Part, a **claim** will be deemed first made on the earliest of the date on which the **claim** is served upon, or first received by, any **insured**.

Defense costs mean the reasonable and necessary fees, costs, and expenses, including the cost of expert consultants and witnesses, incurred by an **insured** in the investigation, defense, or appeal of any covered **claim**, including the premium for appeal, attachment, or similar bonds arising out of a covered judgment. **Defense costs** include **diversity sensitivity training costs**. **Defense costs** do not include **overhead expenses**.

Discrimination means any alleged or actual violation of any United States law or common law which prohibits discrimination.

Diversity sensitivity training costs mean the reasonable and necessary costs incurred by an **insured entity** for any training, reeducation, sensitivity, or protected class development programs which the **insured entity** is obligated to establish by reason of a judgment, settlement, or alternative dispute resolution process in a covered **claim**.

EEOC proceeding means any investigative proceeding before the Equal Employment Opportunity Commission, or an adjudicatory or investigative proceeding before any similar federal, state, or local government body whose purpose is to address any **wrongful employment practice**.

Employee means any natural person, who is a past, present, or future full-time, part-time, seasonal or temporary worker, volunteer, intern, or **independent contractor** of an **insured entity**.

Employment related benefits mean perquisites, fringe benefits, deferred compensation, or payments (including insurance premiums and benefit claim payments) in connection with an employee benefit plan, **stock benefits** (or the equivalent value thereof), and any other payment to or for the benefit of an **employee** arising out of the employment relationship. **Employment related benefits** will not include salary, wages, commissions, or non-deferred cash incentive compensation.

ERISA means any actual or alleged violation of the Employee Retirement Income Security Act of 1974, (including the Consolidated Omnibus Budget Reconciliation Act of 1985)(COBRA).

Executive means any:

- (i) past, present, or future duly elected or appointed director, trustee (excluding a bankruptcy or litigation trustee), officer, governor, or managing member of a management committee of an **insured entity**;
- (ii) past, present, or future In-House General Counsel, Risk Manager, or Director of Human Resources, or such functionally equivalent position, of the **named insured**; or
- (iii) holder of such functionally equivalent position to those included in paragraphs (i) and (ii) above in any **insured entity** formed or organized outside of the United States, its territories or possessions.

Executive does not include any **employee**.

Harassment means any actual or alleged sexual harassment or other unlawful harassment, including bullying, quid pro quo sexual harassment, or hostile work environment.

Insured means any **insured person** or any **insured entity**.

Insured person means any **executive** or **employee**.

Invasion of privacy means any actual or alleged failure by an **insured** to secure an **employee's personal information** from unauthorized use or disclosure resulting in injury to such **employee**; provided **invasion of privacy** does not include unauthorized use or disclosure caused by a **breach**.

Loss means the amount that you are legally obligated to pay as a result of a **claim** including awards, settlements, compensatory damages (including back pay and front pay), judgments, pre-judgment and post-judgment interest, and claimants' attorney fees and costs attributable to the covered portion of a settlement or imposed as a result of a covered judgment, and **defense costs**.

Loss will also include:

- (i) punitive, exemplary, or multiplied damages if such damages are insurable under the law in the jurisdiction which is most favorable to you; provided that such jurisdiction has a substantial relationship to us, you, or to the **claim** giving rise to such **loss**;
- (ii) liquidated damages awarded pursuant to the Age Discrimination in Employment Act, the Family Medical Leave Act, or the Equal Pay Act;
- (iii) **pre-claim expenses**.

Loss does not include:

- (a) costs to comply with any order or agreement to provide non-monetary relief or injunctive relief, or any accommodation under any United States law or common law which prohibits discrimination based on disability;
- (b) taxes, fines or penalties (other than those referenced in (i) above);
- (c) **clean-up costs**;
- (d) compensation earned by the claimant in the course of employment but unpaid by the **insured**, including salary, wages, commissions, severance, bonus, carried interest, or incentive compensation;
- (e) amounts not insurable under the law to which this policy is construed;
- (f) any amount for which an **insured** is absolved from payment by reason of any covenant, agreement, or court order;
- (g) future salary, wages, or commissions of a claimant who is hired, promoted, or reinstated to employment pursuant to a settlement of, order in, or other resolution of any **claim**; or
- (h) **employment related benefits**.

NLRA means any actual or alleged violation of the National Labor Relations Act, or similar law governing employees' rights and employers' duties with respect to unions, bargaining, strikes, boycotts, picketing, lockouts, or collective activities.

OSHA means any actual or alleged violation of the Occupational Safety and Health Act of 1970, or similar law governing workplace safety and health.

Overhead expenses mean the salaries, wages, fees, overhead, or benefit expenses associated with any **insured**.

Pending or prior litigation means any action, proceeding, investigation, inquiry, or written demand commenced against you pending on or prior to the date set forth in Item 4 of this Coverage Part Declarations.

Personal information means any nonpublic personal information relating to an identified or identifiable natural person.

Prior notice means any matter, fact, circumstance, situation, transaction, event, or **wrongful act** that has been the subject of any notice accepted under any employment practices liability policy or comparable policy, coverage section, or coverage part of which this Coverage Part is a direct or indirect renewal or replacement.

Responsible person will also mean the Director of Human Resources or such functionally equivalent position of the **named insured**.

Retaliation means any actual or alleged retaliatory act by an **insured** against an **employee** arising from such **employee's**:

- (i) **whistleblower activity**;

- (ii) participation, assistance, testimony, or cooperation in any internal or external proceeding or investigation regarding violations of law by an **insured**; or
- (iii) exercise of his/her rights, refusal to violate any law, or opposition to any unlawful practice or activity.

Stock benefits mean any:

- (i) offering, plan, or agreement between an **insured entity** and any **employee** which grants stock, stock warrants, or stock options of an **insured entity** to any such **employee**, including grants of stock options, restricted stock, stock warrants, performance stock shares, or any other compensation or incentive granted in the form of securities of the **insured entity**; or
- (ii) payment or instrument in the amount or value of which is derived from the value of securities of the **insured entity**, including stock appreciation rights or phantom stock plans or arrangements.

Stock benefits will not include employee stock ownership plans or employee stock purchase plans.

Third party means any natural person who is not an **employee** or **executive**.

Third party wrongful act means any **discrimination** or **harassment** of a **third party** committed, attempted, or allegedly committed or attempted by an **insured** in such capacity.

Wage and hour means any actual or alleged violation of any United States law which regulates or governs employment wage, pay, or labor requirements or standards (except for the Equal Pay Act) including but not limited to:

- (i) the calculation, recordkeeping, timing or manner of payment of minimum wages, prevailing pay rates, overtime pay or other compensation alleged to be due and owing, including the failure to compensate for any unpaid vacation pay, off the clock or remote work, or for employer sponsored activities;
- (ii) failure to provide or enforce legally required meal or rest break periods;
- (iii) the classification of any entity or person for wage and hour purposes;
- (iv) garnishments, withholdings, or other deductions from wages;
- (v) use of federal or state tip credits or maintenance and distribution of tip pools; or
- (vi) reimbursement of work-related expense or tools to any person providing services or labor to or on behalf of an **insured entity**,

or any such similar practices, policies or procedures.

WARN means any actual or alleged violation of the Workers' Adjustment and Retraining Notification Act, or similar law governing employer notice requirements in advance of lay-offs or facility closings.

Whistleblower activity means the lawful activity by an **employee**, with respect to any alleged wrongdoing by an **insured**, who causes information to be provided to the attention of, or otherwise assists in an investigation by, a governmental or law enforcement agency, provided such activities are protected by statute with rights and remedies for retaliation recognized under United States law.

Worker benefits mean any actual or alleged violation of any United States law governing workers' compensation, unemployment insurance, social security, or disability benefits.

Workplace tort means any:

- (i) negligent hiring, training, supervision, or evaluation of **employees**;
- (ii) failure to adopt or enforce adequate workplace or employment policies and procedures;
- (iii) false imprisonment, false arrest, detention, or malicious prosecution;
- (iv) libel, slander, defamation, or humiliation;

- (v) **invasion of privacy**; or
- (vi) wrongful infliction of emotional distress.

Wrongful act means: (i) any **wrongful employment practice** but only with respect to any **employee** or any **applicant**; or (ii) any **third party wrongful act** but only with respect to any **third party**. A **wrongful act** includes any actual or alleged conduct that takes place via electronic communication, including social media and internet websites.

Wrongful employment decision means any:

- (i) actual or constructive wrongful dismissal, discharge, or termination of employment;
- (ii) wrongful deprivation of career opportunity, demotion, failure to grant tenure, failure to train, failure to employ or promote, or failure to advance to the status of partner or equity partner;
- (iii) employment related misrepresentation, including inducement to become or remain employed based on an erroneous job description; or
- (iv) wrongful discipline of **employees**.

Wrongful employment practice means any employment related:

- (i) breach of any written employment contract or agreement, including any written contract or agreement concerning severance payments or contractual obligation arising out of any employee handbook, personnel manual, policy statement, or other representation;
 - (ii) **discrimination**;
 - (iii) **harassment**;
 - (iv) **retaliation**;
 - (v) **workplace tort**; or
 - (vi) **wrongful employment decision**,
- committed, attempted, or allegedly committed or attempted by an **insured** in such capacity.

IV. COVERAGE PART EXCLUSIONS

We will not cover **loss** in connection with any **claim**:

A. based upon or arising from:

- (i) **assumed liability**;
- (ii) **prior notice**;
- (iii) **pending or prior litigation**;
- (iv) **wage and hour**; provided this exclusion (iv) will not apply to any **claim** on account of **retaliation**;
- (v) **antitrust**; provided this exclusion (v) will not apply to any **claim** on account of **retaliation**; or
- (vi) **pollution**; provided this exclusion (vi) will not apply to any **claim** on account of **retaliation**.

B. for:

- (i) **property damage**;
- (ii) **bodily injury**; provided this exclusion (ii) will not apply to any actual or alleged emotional distress, mental anguish or humiliation when made in connection with any **claim**;
- (iii) **worker benefits, ERISA** (except for Section 510), **OSHA, WARN, or NLRA**; provided these exclusions (iii) will not apply to any **claim** on account of **retaliation**; or

(iv) any breach of any written employment contract or agreement, including any severance agreement or golden parachute agreement, or any compensation agreement payable upon the termination of any **employee**; provided this exclusion (iv) will not apply to:

(a) **defense costs**, or

(b) liability that would be imposed in the absence of such employment contract or agreement.

V. SPECIFIC LIMIT OF LIABILITY, SUBLIMITS AND RETENTIONS

The most we will pay for all **loss** arising from all **claims** is the aggregate limit of liability set forth in Item 2 of this Coverage Part Declarations

A single Retention will apply to each **claim**.

VI. DEFENSE COSTS

We will pay **defense costs** on a current basis, but no later than ninety (90) days after we have received any invoice or bill, as well as any additional supporting documentation that we have reasonably requested.

VII. DEFENSE OF CLAIMS

A. Duty to Defend Coverage

If you have elected duty to defend coverage as indicated in Item 5 of the Declarations for this Coverage Part, then we will have the right and duty to defend any **claim** even if the allegations in the **claim** are groundless, false, or fraudulent. Our duty to defend any **claim** will end, and we will have no further obligation to defend any **claim** upon the exhaustion of the applicable limit of liability.

B. Non-Duty to Defend Coverage

If you have elected non-duty to defend coverage as indicated in Item 5 of the Declarations for this Coverage Part, then you will have the duty to defend any **claim** covered under this Coverage Part.

C. Regardless of your Item 5 election you will have the duty to defend any **claim** alleging a **wage and hour** violation, or any **claim** alleging both a **wage and hour** violation and a **wrongful employment practice**.

VIII. ALLOCATION

If we have the duty to defend a **claim** that incurs covered **loss** and uncovered loss because such **claim** includes covered and uncovered parties, or covered and uncovered matters, then the following will apply:

- (i) one hundred percent (100%) of **defense costs** incurred by such **insured** will be considered covered **loss**; and
- (ii) with respect to any loss other than **defense costs** you and we will use our best efforts to determine an allocation between covered **loss** and uncovered loss based on the relative legal and financial exposures of the parties to such matters.

Alternatively, if you have the duty to defend a **claim**, you and we will use our best efforts to determine an allocation between covered **loss** and uncovered loss based on the relative legal and financial exposures of the parties to such matters.

IX. OTHER INSURANCE

A. This Coverage Part will be excess of, and will not contribute with any valid and collectible insurance policy that provides coverage or indemnifies **loss** for which this Coverage Part also provides coverage, unless such other insurance is written specifically as excess of the limit of liability of this Coverage Part.

B. Coordination of Coverage Provision

Any **loss** otherwise covered by both this policy and any employment practices liability policy or Coverage Part issued by us or any affiliate (“EPL Coverage”) will be covered first under such EPL Coverage subject to such EPL Coverage limit of liability, retention and coinsurance percentage. Any remaining **loss** otherwise covered by this policy that is not paid under such EPL Coverage will then be covered under this policy subject to the applicable Limit of Liability and Retention. Provided, however, that the Retention applicable to such **loss** under this policy will be reduced by the amount of **loss** otherwise covered by this policy that is paid by an **insured** as the retention under such EPL Coverage.

X. **IMPUTATION**

We will only impute the conduct or knowledge of any past, present, or future Chief Executive Officer, Chief Financial Officer, Director of Human Resources, or such functionally equivalent positions of the **named insured** to any **insured entity**.

We will not impute:

- (i) the knowledge possessed by any **executive** with respect to any statements, representations, or information in the **application**; or
- (ii) the failure to provide us with full cooperation, assistance, or information as required,

to any other **insured person**, nor will (i) or (ii) above impair the rights of any other **insured person** under this Coverage Part.

SEPARATE RETENTION FOR CLAIMS BROUGHT BY HEALTH CARE PROVIDER ENDORSEMENT

In consideration of the premium, solely for purposes of coverage provided under this endorsement, the Employment Practices and Third Party Liability Coverage Part is amended as follows:

- I. Section III, Definitions is amended to add the following definition:
 - **Health care provider** means an **insured person** who is licensed to practice medicine in any state and maintains a professional practice, including a doctor of medicine or osteopathy, podiatrist, dentist, veterinarian, chiropractor, clinical psychologist, optometrist, or a clinical social worker.
- II. Section V, Specific Limit of Liability, Sublimits and Retentions is amended to add the following:

Solely with respect to any **claim** brought by a **health care provider**, the Retention for each **claim** will be \$75,000. If there are two Retentions that apply to the same **claim**, we will only apply the higher Retention.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA92993XX (10-2021)	Endorsement Expiration Date:	Policy No: 6052521241
Endorsement Effective Date:		Policy Effective Date: 05/01/2026
Endorsement No: 5 ; Page: 1 of 1		Policy Page: 35 of 50
Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606		

OPIOID EXCLUSION ENDORSEMENT

In consideration of the premium, solely with respect to the Employment Practices and Third Party Liability Coverage Part Coverage Part(s), Section IV, Coverage Part Exclusions is amended to add the following exclusion:

We will not cover **loss** in connection with any **claim** based upon or arising out of the sale, distribution, use, misuse, addiction to, prescription for, dependency upon, guidelines for reporting, and/or diversion prevention with respect to any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind including any **claim** based on or arising out of any actual or alleged:

- (i) liability under, non-compliance with, or violation of, any federal, state, local, tribal or foreign act, statute, regulation, ordinance, requirement, law, or common law of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (ii) leasing, licensing, handling, marketing, branding, promoting, diverting, disposing, or labeling of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (iii) improper warning or failure to warn including any warning of the adverse or addictive properties of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (iv) suspicious orders or orders of interest monitoring, rebates, chargebacks, or other similar data sharing concerning any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (v) communications with manufacturers, or distributors of, opioids, opiates or any narcotic drugs, narcotic medications or narcotic substances of any type, nature or kind with respect to guidelines relating to litigation, investigation, enforcement activity, or settlements related to any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind;
- (vi) lobbying or advocacy on behalf of any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind manufacturers or distributors; or
- (vii) research projects, data metrics, benchmarking data, publications, or dissemination of any such information, relating to any opioid, opiate or any narcotic drug, narcotic medication or narcotic substance of any type, nature or kind,

by any **insured** or by anyone for whose acts the **insured** is liable.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA93248XX (10-2019)	Endorsement Expiration Date:	Policy No: 6052521241
Endorsement Effective Date:		Policy Effective Date: 05/01/2026
Endorsement No: 6 ; Page: 1 of 1		Policy Page: 36 of 50
Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606		

BIOMETRICS PRIVACY EXCLUSION ENDORSEMENT

In consideration of the premium, the Employment Practices and Third Party Liability Coverage Part is amended as follows:

I. Section III, Definitions is amended to add the following definition:

Biometrics privacy means any actual or alleged violation of any United States law or any similar common law pertaining to biometric privacy that governs or relates to the collection, use, safeguarding, handling, storage, retention, or destruction of biometric identifiers, biometric data, or biometric information.

II. Paragraph A of Section IV, Coverage Part Exclusions is amended to add the following exclusion:

We will not cover **loss** in connection with any **claim** based upon or arising from **biometrics privacy**; provided this exclusion will not apply to any **claim** on account of **retaliation**.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

HEALTHCARE ENDORSEMENT
(Sublimated Regulatory Claim Coverage)

In consideration of the premium, the Directors and Officers and Entity Liability and Employment Practices Coverage Parts of the policy are amended as follows:

I. Section III, Definitions of the General Terms and Conditions is amended as follows:

A. The definition **pre-claim expenses** is amended to include the following:

Provided in the event a **noticed matter** gives rise to a **regulatory claim**, **pre-claim expenses** will not include fees, costs, or expenses incurred by an **insured** in defending or responding to such **noticed matter**.

A. The definition of **pollutants** is amended to include **nuclear materials**.

II. The Directors and Officers and Entity Liability Coverage Part of the policy is amended as follows:

A. The following Insuring Agreement is added to Section I, Insuring Agreements:

Regulatory Claim Coverage

We will pay **defense costs** on behalf of an **insured** arising from a **regulatory claim** against such **insured** first made during the **policy period**.

B. Section III, Definitions is amended as follows:

1. Solely with respect to a **regulatory claim**, the definition of **claim** is deleted and replaced with the following:

Claim means any:

- (i) written demand (excluding a subpoena) for monetary, non-monetary, injunctive, or declaratory relief including a request for alternative dispute resolution;
- (ii) civil or criminal proceeding, (including a qui tam or relator proceeding) commenced by the earlier of: (a) the return of service of a complaint or indictment upon an **insured**; (b) the filing of an indictment or information with respect to an **insured**; or (c) the arrest or detainment of an **insured**; or
- (iii) a formal administrative or regulatory proceeding or investigation evidenced by: (a) notice of charges or investigation; (b) service of subpoena, search warrant or similar document requesting witness testimony of an **insured person** who has been identified as a target of such investigation; (c) receipt of a target letter or civil investigative demand by an **insured person** identified as a target of such investigation,

of, or against, an **insured** for a **regulatory wrongful act**, including any appeal therefrom. **Claim** will not include **inquiry, books and record demand** or any **securityholder derivative demand**.

Unless specifically stated elsewhere in this endorsement, a **claim** will be deemed first made on the earliest of the date on which the **claim** is served upon, or first received by, any **insured**, or the applicable notice or order is filed or entered.

2. The definition of **loss** is amended as follows:

Loss will also include **health care fines, penalties and taxes** subject to the applicable sublimit of liability.

The paragraph which begins with **loss** does not include is deleted and replaced with the following:

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Loss does not include:

- (a) costs to comply with any order or agreement to provide non-monetary or injunctive relief;
- (b) taxes, fines or penalties (other than those referenced in (i), (ii) or (iii) above and **health care fines, penalties and taxes**);
- (c) **clean-up costs**;
- (d) amounts not insurable under the law to which this policy is construed;
- (e) any amount for which an **insured** is absolved from payment by reason of any covenant, agreement, or court order; or
- (f) the return of funds which were received directly or indirectly from any federal, state or local governmental agency and any interest, fines or penalties arising out of the return of such funds.

3. The following definitions are added:

Cyber event means any actual or alleged:

- (i) **exploit**;
- (ii) **unauthorized access or use**;
- (iii) **network impairment**, or
- (iv) failure to implement, maintain, or comply with federal, state or local law, statute or regulation, or an **insured entity's** internal written policies and procedures, with respect to **protected information**.

Excess benefit transaction taxes mean those taxes imposed by the Internal Revenue Service, pursuant to Section 4958 (a)(2) of the Internal Revenue Code, upon an **insured person** as a result of such **insured person's** participation in an excess benefit transaction as defined in Section 4958(c) of the Internal Revenue Code ("the Code").

Exploit means the breach of, or unauthorized or unlawful access to, any **network**, resulting in denial of service, delay to a **network**, or infection of a **network** through malware, spyware, virus or any such similar unauthorized code, application or software.

Government entity means any federal, state, or local governmental agency, regulatory or administrative agency or entity, or any such foreign equivalent.

Health care fines, penalties and taxes mean the following civil fines or penalties and taxes:

- (i) taxes or penalties imposed against an **insured entity**, (or its **insured persons**) that is a not-for-profit entity or organization exempt from federal income taxation pursuant to section 501(c)(3) of the Code assessed pursuant to the following provisions of the Code:
 - (a) Section 4911 (tax on excess expenditures to influence legislation);
 - (b) Section 4940 (a) (tax on net investment income of tax-exempt foundations);
 - (c) Section 4941 (taxes on self-dealing);
 - (d) Section 4942 (taxes on failure to distribute income);
 - (e) Section 4943 (taxes on excess business holding);
 - (f) Section 4944 (taxes on investments which jeopardize charitable purpose);
 - (g) Section 4945 (taxes on taxable expenditures);

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- (h) Section 6652 (c) (1) (A) and (B) (penalties for failure to file certain information returns or registration statements);
- (i) Section 6655 (a)(1) (penalties for failure to pay estimated income tax); and
- (j) Section 6656 (a) and (b) (penalties for failure to make deposit of taxes),
 but only if such **insured entity** or its **insured persons** relied upon a written “more likely than not” or “will” opinion of a duly licensed tax attorney, certified public account, or accounting firm or a tax return prepared by a certified public account or accounting firm duly appointed by the Board of Trustees of such **insured entity** in advance of the conduct that gave rise to the fines or penalties (“IRC Fines”);
- (ii) **excess benefit transaction taxes**, provided these do not include the twenty-five (25%) excise tax assessed against any “disqualified person” or the two hundred percent (200%) tax assessed for failure to correct an “excise benefit transaction”, as set forth in Section 4958 of the Code;
- (iii) civil fines or penalties imposed for violations of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1396dd et seq., and any similar state or local statute (“EMTALA Fines”);
- (iv) civil fines or penalties imposed for violations of the privacy provisions of Health Insurance Portability and Accountability Act of 1996 and any similar state or local statute (“HIPAA Fines”).

Network means any computer, program, database, server, mainframe, software, hardware, mobile devices, applications, storage or back-up devices, or such similar components of a digital telecommunication network that is owned or operated by, or on behalf of, or for the benefit of the **insured entity**. **Network** does not include the internet, telephone company networks, electrical grids, or other public infrastructure network.

Network impairment means the disruption, theft, modification, destruction or damage to any **network**, that results in the impairment of the **network** to such an extent that the **insured entity** is substantially unable to conduct normal and customary business operations

Nuclear materials mean any nuclear or radioactive substance or hazardous properties resulting from any nuclear reaction, nuclear radiation or radioactive contamination.

Protected information means nonpublic proprietary and confidential information of a third-party entity, or any nonpublic personal information relating to an identified or identifiable natural person.

Regulatory claim means a **claim** brought by or on behalf of a **government entity** arising out of a **regulatory wrongful act**. **Regulatory claim** does not include **routine examinations**.

Regulatory wrongful act means a **wrongful act** arising out of any **insured’s** alleged or actual violation of: (i) the Federal False Claims Act or any similar common law; (ii) Ethics in Patient Referral Act 1989 (“Stark Law”) or any similar common law; or (iii) any United States law which prohibits kickbacks, self-referrals, or healthcare fraud and abuse.

III. Section III, Definitions of both the Directors and Officers and Entity Liability Coverage Part and the Employment Practices and Third Party Liability Coverage Part are amended as follows:

A. The definition of **insured person** is deleted and replaced with the following:

Insured person means any **employee, executive, independent contractor** any duly constituted committee member, member of the faculty or staff or a medical director.

B. The following definitions are added:

Abuse or molestation means any actual, alleged, attempted, proposed or threatened sexual molestation, abuse, assault, or battery, whether or not intentional, of any natural person.

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Billing and collection services mean billing or collection of fees for any services performed by an insured.

Insurance company operations mean any of the following services or activities:

- (i) the refusal to offer, issue or renew, or any cancellation of, any **insurance contract**;
- (ii) any actual or alleged lack of good faith or unfair dealing in the handling of any claim or obligation under any **insurance contract**;
- (iii) the brokering or underwriting of insurance policies or risks;
- (iv) any actual or alleged conduct of any Insured in the negotiation, placement or maintenance of any **insurance contract**;
- (v) any failure to collect or pay premiums, commissions, brokerage charges, fees or taxes;
- (vi) or any commingling or mishandling of funds with respect to any **insurance contract**;
- (vii) any actuarial determination including without limitation opinions as to reserve adequacy or pricing adequacy;
- (viii) the offering or sale of shares of any unit investment trust or management investment company or of variable annuity plans, including any diminution of assets in connection with said offering or sale of shares.

Insurance contract means any policy or agreement of insurance, reinsurance or indemnity, (including but not limited to any policy or agreement of insurance, reinsurance or indemnity that is administered by a third party administrator) including, but not limited to, bonds, annuities, endowments, health care plans or health care products, dental plans or dental products, life insurance plans or life insurance products, disability plans or disability products, pension contracts and risk management self-insurance programs, pools or similar programs. **Insurance contract** will also include any policy or program of stop loss or provider excess insurance, reinsurance or self-insurance (including any captive insurance arrangement).

Managed care activity means any of the following services or activities performed by, or on behalf of, a **managed care organization**:

- (i) handling, adjustment, payment of claims or determination of coverage benefits;
- (ii) process of evaluating the appropriateness, necessity or cost of **medical services**;
- (iii) providing quality assurance, or reviewing costs, of **medical services**;
- (iv) establishing **medical services** provider networks;
- (v) development of, implementation of, administration of, establishment of, protocols, guidelines and procedures for:
 - (a) managed care network for **medical services** providers;
 - (b) quality assurance reviews;
 - (c) health and wellness education;
 - (d) clinical parameters;
 - (e) financial incentive plans;
 - (f) triage for payment authorization for **medical services**.

Managed care organization means any **insured entity** that is a health maintenance organization, preferred provider organization, or any similar entity which provides, or arranges to provide, **medical services** to members of such entity pursuant to a written contract.

Medical review and provider selection process claim means any **claim** brought by or on behalf of an **independent contractor** of **medical services** for a **wrongful act** occurring as part of the evaluation, credentialing, disciplining, selecting, contracting, privileging or peer review of such **independent contractor** of **medical services** in such capacity, provided such **wrongful act** is not committed by or on behalf of a **managed care organization**.

Medical services mean the furnishing of medicine, pharmaceutical-related, health-related or medical-related services, care or treatment to a natural person.

IV. Section IV, Coverage Part Exclusions of the Directors and Officers and Entity Liability Coverage Part is amended as follows:

A. Exclusion C(iv) is deleted and replaced with the following:

(iv) based upon or arising from **bodily injury**; provided this exclusion (iv) will not apply to any:

- (a) **claim** for **non-indemnifiable** loss;
- (b) **securityholder claim**;
- (c) actual or alleged emotional distress, mental anguish or humiliation made in connection with any **employment related claim** (other than an **abuse or molestation claim**) against an **insured person**;
- (d) **defense costs** incurred by an **executive** in the defense of a **claim** for any actual or alleged violation of a corporate manslaughter statute by such **executive**

B. Exclusion D is amended by adding the following:

brought by, or on behalf of, any **insured** in any capacity against any **insured**, or an **outside entity** against any **insured**.

C. The following exclusions are added:

- We will not cover **loss** in connection with any **medical review and provider selection process claim**.
- We will not cover **loss** in connection with any **claim** based upon or arising from any:
 - (a) **managed care activity**;
 - (b) **insurance company operations**;
 - (c) **billing and collection services**, provided this exclusion (c) will not apply to any **regulatory claim**;
 - (d) **cyber event**, provided this exclusion (d) will not apply to any **claim** for **non-indemnifiable loss**; or
 - (e) **abuse or molestation** (this exclusion (e) will apply regardless of the legal theory or basis upon which an insured is alleged to be liable, including but not limited to assertions of improper or negligent employment, continued employment, investigation, failure to investigate, supervision, or failure to supervise).

V. Section V, Specific Limit of Liability, Sublimits and Retentions of the Directors and Officers and Entity Liability Coverage Part is amended by adding the following:

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- The most we will pay for all **health care fines, penalties and taxes**, including **defense costs**, in connection with all **claims** for IRC Fines is \$100,000, such sublimited coverage will be part of, and not in addition to, the Aggregate Limit of Liability set forth in Item 2 of this Coverage Part.
- The most we will pay for all **health care fines, penalties and taxes**, including **defense costs**, in connection with all **claims** for **excess benefit transaction taxes** is \$100,000, such sublimited coverage will be part of, and not in addition to, the Aggregate Limit of Liability set forth in Item 2 of this Coverage Part.
- The most we will pay for all **health care fines, penalties and taxes**, including **defense costs**, in connection with all **claims** for EMTALA Fines is \$100,000, such sublimited coverage will be part of, and not in addition to, the Aggregate Limit of Liability set forth in Item 2 of this Coverage Part.
- The most we will pay for all **health care fines, penalties and taxes**, including **defense costs**, in connection with all **claims** for HIPAA Fines is 25,000, such sublimited coverage will be part of, and not in addition to, the Aggregate Limit of Liability set forth in Item 2 of this Coverage Part.
- The most we will pay for all **defense costs** arising from all **regulatory claims** is \$100,000, such sublimited coverage will be part of, and not in addition to, the Aggregate Limit of Liability set forth in Item 2 of this Coverage Part.
- A separate Retention of \$25,000 will apply to each **regulatory claim**.
- A separate coinsurance percentage of 20 percent will apply to all **defense costs** for each **regulatory claim**. The coinsurance percentage will apply in excess of any Retention and will be uninsured and your responsibility to pay. Our liability will apply only to the remaining percent of all such **defense costs**.

VI. Section IX, Defense of Claims of the Directors and Officers and Entity Liability Coverage Part is amended to include the following:

With respect to any **regulatory claim** you will have the duty to defend.

VII. Section IV, Coverage Part Exclusions of the Employment Practices and Third Party Liability Coverage Part is amended as follows:

A. Exclusion B(ii) **bodily injury** is deleted.

B. The following exclusions are added:

- We will not cover **loss** in connection with any **claim** based upon or arising from **bodily injury**, provided this exclusion will not apply to any actual or alleged emotional distress, mental anguish or humiliation when made in connection with any **claim** brought by an **employee**.
- We will not cover **loss** in connection with any **medical review and provider selection process claim**.
- We will not cover **loss** in connection with any **claim** based upon or arising from any:
 - (a) **managed care activity**;
 - (b) **insurance company operations**;
 - (c) **billing and collection services**; or
 - (d) **abuse or molestation** (this exclusion (d) will apply regardless of the legal theory or basis upon which an **insured** is alleged to be liable, including but not limited to assertions of improper or negligent employment, continued employment, investigation, failure to investigate, supervision, or failure to supervise).

VIII. The Other Insurance Sections of both the Directors and Officers and Entity Liability Coverage Part and the Employment Practices and Third Party Liability Coverage Part are amended to include the following:

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In addition to the above, this Coverage Part will be excess of and will not contribute with any valid and collectible managed care errors and omissions insurance policy, medical professional liability or professional liability insurance policy.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

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AMENDATORY ENDORSEMENT - OKLAHOMA

In consideration of the premium, Section III, Definitions of the undefined is amended as follows:

I. The following new paragraph is added to the definition of **defense costs**:

Defense costs also do not include salaries of our officers or employees and adjusting expenses, or other expenses incurred by us in the ordinary course of our business.

II. With respect to punitive damages the following new paragraph is added:

Notwithstanding anything to the contrary, any coverage of punitive damages will be provided to the extent allowed by Oklahoma law.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA93281OK (03-2019)

Endorsement Effective Date:

Endorsement No: 9 ; Page: 1 of 1

Underwriting Company: Continental Casualty Company, 151 N Franklin St, Chicago, IL 60606

Endorsement Expiration Date:

Policy No: 6052521241

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CONDITIONAL RENEWAL ENDORSEMENT - OKLAHOMA

Wherever used in this endorsement: 1) Insurer means "we", "us", "our" or the "Company" as those terms are defined in the policy; and 2) Named Insured means the first person or entity named on the declarations page; and 3) "Insured(s)" means all persons or entities afforded coverage under the policy.

Any cancellation, non-renewal or termination provision(s) in the Epac 3 policy are amended to add the following:

CONDITIONAL RENEWAL

- I. The Insurer shall give to the Named Insured at the last address known to the Insurer, written notice of premium increase, change in deductible, reduction in limits or coverage at least forty-five (45) days prior to the expiration date of the policy. If the Insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the Named Insured prior to the change shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the Named Insured, whichever first occurs. If notice is given by mail, said notice shall be deemed to have been given on the day said notice is mailed. If the Named Insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the Named Insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.
- II. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the Named Insured at the address shown in the policy, shall be sufficient proof of notice.
- III. This subsection shall not apply to:
 - A. changes in a rate or plan filed with or approved by the Insurance Commissioner or filed pursuant to the Property and Casualty Competitive Loss Rating Act and applicable to an entire class of business; or
 - B. changes based upon the altered nature of extent of the risk insured; or
 - C. changes in policy forms with or approved by the Insurance Commissioner and applicable to an entire class of business.

All other terms and conditions of the policy remain unchanged.

This endorsement, which forms a part of and is for attachment to the policy issued by the designated Insurers, takes effect on the Policy Effective Date of said policy at the hour stated in said policy, unless another effective date (the Endorsement Effective Date) is shown below, and expires concurrently with said policy unless another expiration date is shown below.

Form No: CNA93315OK (03-2019)

Endorsement Effective Date:

Endorsement No: 10 ; Page: 1 of 1

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Endorsement Expiration Date:

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PREMIUM NOTICE

Insured: Mangum City Hospital Authority
Date: 01/22/2026
Producer: INSURICA INSURANCE SERVICES LLC
Company: Continental Casualty Company

THIS NOTICE IS TO BE ATTACHED TO AND FORM A PART OF THE EPACK 3 POLICY REFERENCED BELOW.

Policy Number: 6052521241
Policy Period: From 05/01/2026 to 05/01/2027

PRODUCT	EFFECTIVE DATE	PREMIUM
Epac 3	05/01/2026	\$11,113.00

*The amount displayed includes taxes and fees, and surcharges (if applicable).

TOTAL POLICY PREMIUM	\$11,113.00
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Thank you for purchasing EPL coverage from CNA. As a CNA Epack 3 policyholder, you are entitled to a package of services, offered **at no additional charge**, to help you manage your business risks.

Beyond HRsm

Beyond HRsm is an interactive, web-based platform that helps CNA policyholders train their employees on a variety of employment topics and develop employment policies, practices and procedures.

The Equal Employment Opportunity Commission, courts, and certain state laws have made it clear that employers must take all necessary steps, including periodic training, to prevent certain wrongful employment practices. To assist you in diminishing this risk to your company, CNA's Beyond HRsm provides complimentary training in areas such as preventing harassment, wrongful termination and retaliation. For companies with employees in states where the law requires employers to provide sexual harassment prevention training, Beyond HRsm can assist your company in meeting these requirements by providing training in an interactive web-based format, with the capability to track employee participation through an easy to use, online mechanism. Comparable training and materials may cost hundreds or thousands of dollars if purchased separately.

Beyond HRsm also offers a variety of other features to assist your company in mitigating employment practices risks, such as:

- A searchable database of articles and checklists on important workplace topics.
- Refresher bulletins to support the online training modules.
- A model employment handbook and model policies and forms.
- Webinars and Best practices minutes podcasts on various workplace topics such as disability accommodation, bullying, social media and cyber crime.

Registration is quick and easy. From your web browser, navigate to www.cnabeyondhr.com, click on the "How to Register" link, and follow the instructions. Your CNA policy number will be required to register for the first time.

H.R. HELP LINE

Eligible CNA policyholders can receive human resources consulting advice through the H.R. Help Line, provided by Jackson Lewis, LLP, a national law firm that specializes in employment law. Simply have your human resources representative call the toll-free H. R. Help Line at 1-888-CNA-EPL1 (1-888-262-3751), identify your company as a CNA employment practices policyholder and provide your company's policy number. The H.R. Help Line is serviced by attorneys who do not act as legal counsel to callers, but rather as human resources consultants, providing information regarding risk control strategies. You can begin using the Help Line today by following the enclosed instructions.

We think you will find these services to be valuable to your business. For more details, please go to our website at <http://www.cna.com/html/riskmanagement.html> or contact your insurance representative.....and **Thank You for insuring with CNA.**

These services are available at no additional charge to most CNA employment practices liability policyholders.

The McCalmon Group, Inc. and Jackson Lewis, LLP are neither affiliates of CNA, nor an agent or broker. As such, information reported to them is not notice to CNA of any claim or potential claim. Please contact CNA or your insurance agent or broker to report claims or potential claims. Risk Management is your responsibility. H.R. Web Training is not intended to substitute for your own risk management and compliance programs.

CNA Employment Practices Liability policies are underwritten by one of the CNA member property and casualty companies. One or more of the CNA companies provide the products and/or services described. CNA accepts no responsibility for the accuracy or completeness of this material and recommends the consultation with competent legal counsel and/or other professional advisors before applying this material in any particular factual situations. This material is for illustrative purposes and is not intended to substitute for the guidance of retained legal or other professional advisors, or to constitute a contract. Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and



exclusions for an insured. All products and services may not be available in all states and may be subject to change without notice. Any references to non-CNA Web sites are provided solely for convenience and CNA disclaims any responsibility with respect thereto. CNA is a registered trademark of CNA Financial Corporation. Copyright © 2013 CNA. All rights reserved.

HOW TO ACCESS THE H.R. HELP LINE

CNA Epack 3 policyholders that purchase EPL receive the benefit of professional risk management consultation provided by Jackson Lewis, a national law firm that specializes in employment practices law.

CNA Epack 3 policyholders are entitled to human resources consulting advice for their Human Resources representative or senior managers, at no additional charge, through a toll-free number at **1-888-CNAEPL1 (1-888-262-3751)**. They can receive proactive, effective information and strategies to help manage employment practices risks.

Policyholders who have accessed the H. R. Help Line find it to be a useful resource to properly understand and manage sensitive Human Resources issues. The service is of particular value to small businesses that may not have a dedicated Human Resources department. The following five areas appear to generate the most questions and discussions:

- Medical leave issues especially in regard to an employee who is currently on leave and may have a
- change in job status;
- Proper handling of a reduction in force – a common situation in today’s economy;
- Allegations of unfair treatment or harassment;
- Handling employee disciplinary situations; and
- Unique circumstances that “textbooks” do not address.

The Jackson Lewis attorneys are first and foremost active listeners. They can offer valuable guidance on proper procedures (file documentation, best practices, etc), consideration of potential options, and development of a game plan.

For more information on CNA’s Risk Control products and services, please visit <http://www.cna.com/html/riskmanagement.html>. The H.R. Help Line is not for advice concerning specific legal matters. For these types of issues, we encourage you to speak to your own employment attorney.

Jackson Lewis is neither an affiliate of CNA, nor an agent or broker. As such, information reported to Jackson Lewis is not notice to CNA of any claim or potential claim. Please contact your insurance agent or broker to report claims or potential claims.

These services are available only to CNA policyholders that have employment practices liability coverage with CNA.

CNA accepts no responsibility for the accuracy or completeness of the services described herein or the information supplied by the HR Help Line or Jackson Lewis and recommends the consultation with competent legal counsel and/or other professional advisors before applying the information obtained in any particular factual situations. This material is for illustrative purposes and is not intended to substitute for the guidance of retained legal or other professional advisors, or to constitute a contract. Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and exclusions for an insured. All products and services may not be available in all states and may be subject to change without notice. CNA does not endorse, recommend, or make any representations or warranties as to the accuracy, completeness, effectiveness, suitability, or performance of any of the products, applications, software, or programs identified herein.

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BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“**Agreement**”), entered into by _____ with offices located at _____ and its subsidiaries (“**Covered Entity**”) and CommuniCare Technology, Inc. d/b/a Pulsara (“**Business Associate**”), a Delaware corporation, with an address of 1627 West Main Street, Suite #229, Bozeman, MT 59715, is effective as of _____.

RECITALS

- A. Covered Entity possesses Protected Health Information (“PHI”) that is protected under HIPAA Rules (as defined below), and wishes to ensure that Business Associate will appropriately safeguard such information; and
- B. Business Associate is licensing certain software and related technology to Covered Entity.

Based upon the above recitals and the mutual covenants in this Agreement, Covered Entity and Business Associate agree as follows:

1. Definitions

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Disclosure, Health Care Operations, Individual, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured and Use.

- a. “*Business Associate*” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Pulsara.
- b. “*Covered Entity*” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Covered Entity first written above.
- c. “*HIPAA Rules*” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
- d. “*Part 2*” shall mean the Confidentiality of Alcohol and Drug Abuse Patient Records under 42 CFR Part 2.

2. Permitted Uses and Disclosures

- a. *Performance of Services.* Business Associate may use and disclose PHI in connection with the performance of the services as described in the Terms of Use (“Services”) if such use or disclosure of PHI would not violate HIPAA Rules, or such use or disclosure is expressly permitted hereunder.
- b. *Proper Management and Administration.* Business Associate may use PHI for the proper management and administration of Business Associate in connection with the performance of Services described in the Terms of Use. Business Associate may disclose PHI for such proper management and administration of Business Associate. Any such disclosure of PHI shall only be made if the disclosure is required by law or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that: (1) the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and (2) Business Associate will be notified by

such person of any instances of which it becomes aware in which the confidentiality of the PHI has been breached.

c. *Other Permitted Uses.* Unless otherwise limited herein, the Business Associate may also: (1) perform Data Aggregation for the health care operations of Covered Entity; (2) may use, analyze, and disclose the PHI in its possession for the public health activities and purposes set forth at C.F.R. § 164.512(b); (3) de-identify any and all PHI provided that Business Associate implements de-identification criteria in accord with 45 C.F.R. §164.514(b); and (4) may otherwise use and disclose the PHI as authorized by Covered Entity pursuant to the Terms of Use.

d. *Minimum Necessary.* Covered Entity shall provide, and Business Associate shall request, Use and Disclose, only the minimum amount of PHI necessary to accomplish the purpose of the request, Use or Disclosure. The Parties acknowledge that the Secretary may issue guidance with respect to the definition of “minimum necessary” from time to time, and agree to stay informed of any relevant changes to the definition.

3. Nondisclosure

As Provided In Agreement. Business Associate shall not use or further disclose PHI except as permitted or required by this Agreement or as required by law.

4. Responsibilities of Business Associate

a. *Safeguards.* Business Associate shall use appropriate safeguards to protect PHI, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of PHI not provided for by this Agreement.

b. *Business Associate’s Agents.* Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI agree in writing to be bound by the same restrictions and conditions that apply to Business Associate with respect to such PHI.

c. *Reporting.* Business Associate shall promptly report to Covered Entity any use or disclosure of PHI in violation of this Agreement or applicable law of which it becomes actually aware. Business Associate further agrees to promptly report to Covered Entity any Security Incident of which it becomes actually aware. In addition, Business Associate shall promptly report to Covered Entity any Breach of Unsecured PHI.

d. *Mitigation.* Business Associate shall have procedures in place to mitigate any deleterious effect from any use or disclosure of PHI in violation of this Agreement or applicable law.

e. *Cost Reimbursement.* In the event of a Breach involving PHI maintained, used, or disclosed by Business Associate that is the fault of Business Associate, Business Associate shall reimburse Covered Entity for the reasonable cost of providing any legally required notice to affected individuals and the cost of credit monitoring for such individuals to the extent deemed necessary by Covered Entity in its reasonable discretion.

f. *Sanctions.* Business Associate shall have and apply appropriate sanctions against any employee, subcontractor or agent who uses or discloses PHI in violation of this Agreement or applicable law.

g. *United States Department of Health and Human Services.* Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary for purposes of determining Covered Entity’s compliance with the HIPAA Rules; provided, however, that Business Associate shall promptly notify Covered Entity upon receipt by Business Associate of any such request for access by the Secretary, and shall provide Covered Entity with a copy thereof as well as a copy

of all materials disclosed pursuant thereto. The parties' respective rights and obligations under this Section shall survive termination of this Agreement.

5. Obligation to Provide Access, Amendment and Accounting of PHI

- a. *Access to PHI.* Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill Covered Entity's obligations to provide access to, and copies of, PHI in accordance with HIPAA Rules.
- b. *Amendment of PHI.* Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill Covered Entity's obligations to amend PHI in accordance with HIPAA Rules.
- c. *Accounting of Disclosures of PHI.* Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill Covered Entity's obligations to provide an accounting of disclosures with respect to PHI in accordance with HIPAA Rules. Business Associate shall make this information available to Covered Entity upon Covered Entity's request.
- d. *Forwarding Requests From Individual.* In the event that any individual requests access to, amendment of, or accounting of PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or Business Associate to violate HIPAA Rules, Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

6. Responsibilities of Covered Entity

Covered Entity will:

- a. provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520 as well as any changes to such notice;
- b. provide Business Associate with any changes in, or revocation of, permission by Individual to the use and/or disclosure of PHI, if such changes affect Business Associate's permitted or required uses and/or disclosures;
- c. notify Business Associate of any restriction to the use and/or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522.

7. Indemnification

Business Associate agrees to indemnify, defend, and hold harmless Covered Entity, its directors, officers, employees, contractors and agents, against, and in respect of, any and all claims, losses, expenses, costs, damages, obligations, penalties, and liabilities which Covered Entity may incur by reason of Business Associate's breach of or failure to perform any of its obligations pursuant to this Agreement.

8. Term and Termination

- a. *Term.* This Agreement shall be effective as of the Effective Date, and shall continue until the earlier of when this Agreement is terminated in accordance with the provisions of this Section or the underlying agreement terminates.
- b. *Termination.*
 - 1) If Covered Entity determines that Business Associate has breached or violated a material term of this Agreement, Covered Entity may, at its option, pursue any and all of the following

remedies:

- a) Take any reasonable steps that Covered Entity, in its sole discretion, shall deem necessary to cure such breach or end such violation; and/or
 - b) Covered Entity may terminate this Agreement in the event of Business Associate's uncured material breach of this Agreement following 30 days' notice and opportunity to cure, if curable.
- 2) If Business Associate determines that Covered Entity has breached or violated a material term of this Agreement, Business Associate may, at its option, pursue any and all of the following remedies:
- a) take any reasonable steps that Business Associate, in its sole discretion, shall deem necessary to cure such breach or end such violation; and/or
 - b) terminate this Agreement in the event of Covered Entity's uncured material breach of this Agreement following 30 days' notice and opportunity to cure, if curable.
- c. *Return or Destruction of Records.* Upon termination of this Agreement for any reason, Business Associate shall return or destroy, as specified by Covered Entity, all PHI that Business Associate still maintains in any media, and shall retain no copies of such PHI. If Covered Entity, in its sole discretion, requires that Business Associate destroy any or all PHI in its possession, Business Associate shall certify to Covered Entity that the PHI has been destroyed. If return or destruction is not feasible, Business Associate shall inform Covered Entity of the reason it is not feasible and shall continue to extend the protections of this Agreement to such information and limit further use and disclosure of such PHI to those purposes that make the return or destruction of such PHI infeasible. The foregoing will not apply, however, to any PHI for which Business Associate has received from the applicable individual (with respect to whom the PHI pertains) authorization in accordance with HIPAA that Business Associate may retain such PHI for the purposes authorized by the individual. Business Associate's obligations with respect to such PHI will become outside the scope of this Agreement and will be governed by HIPAA and the agreement between Business Associate and the individual.

9. Part 2 Responsibilities

- a. To the extent that in performing its services for Covered Entity, Business Associate uses, discloses, maintains, or transmits protected health information that is protected by Part 2, Business Associate: (1) will rely on Covered Entity to obtain necessary patient consent before Covered Entity transmits patient information subject to Part 2 through Business Associate's Services; (2) acknowledges and agrees that in receiving, storing, processing or otherwise dealing with any such patient records, it must comply with the Part 2 regulations in connection with any requests for access by parties other than those with which Covered Entity communicates through Business Associate's Service; and (3) if necessary, will resist in judicial proceedings any efforts to obtain access to patient information except as permitted by the Part 2 regulations.
- b. Notwithstanding any other language in this Agreement, Business Associate acknowledges and agrees that any patient information it receives from Covered Entity that is protected by Part 2 is subject to protections that prohibit Business Associate from disclosing such information to agents or subcontractors without the specific written consent of the subject individual.
- c. Business Associate acknowledges that any unauthorized disclosure of information under this section is a federal criminal offense.

10. General Provisions.

- a. State Law. Nothing in this Agreement shall be construed to require Business Associate to use or disclose PHI without a written authorization from an individual who is a subject of the PHI, or written authorization from any other person, where such authorization would be required under state law for such use or disclosure.
- b. Amendment. Covered Entity and Business Associate agree that amendment of this Agreement may be required to ensure that Covered Entity and Business Associate comply with changes in state and federal laws and regulations relating to the privacy, security, and confidentiality of PHI, including, but not limited to, changes under the HIPAA Rules. This Agreement may not otherwise be amended except by written agreement between both parties.
- c. Governing Law and Venue. This Agreement will be construed in accordance with and governed by the internal law of Covered Entity's state, without regard to the choice or conflicts of law provisions of any jurisdiction. In the event that either party institutes any action or proceeding arising out of or relating to this Agreement, exclusive jurisdiction will be in the state or federal court in the county where Covered Entity is located.
- d. Attorney's Fees. The prevailing party in any action or proceeding to enforce any of the provisions of this Agreement shall be entitled to recover reasonable attorneys' fees, costs and expenses incurred in connection with actions or proceedings.
- e. Waiver. The failure of either party to enforce any right or provision in this Agreement shall not constitute a waiver of such right or provision unless acknowledged and agreed to by that party in writing.
- f. Severability. If any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then such provision(s) shall be construed, as nearly as possible, to reflect the intentions of the invalid or unenforceable provision(s), with all other provisions remaining in full force and effect.
- g. Assignment. The rights and/or obligations contained in this Agreement may not be assigned, delegated or otherwise transferred by either party (except to a direct or indirect parent or subsidiary) without the prior written approval of the other party, not to be unreasonably withheld, provided, however that either party may assign this agreement in connection with a merger, consolidation or acquisition of a party resulting in a change of control or a transfer or sale of all or substantially all of the assets of either party. No assignment or delegation shall relieve either party of liability for its obligations hereunder.
- h. Counterparts. This Agreement may be executed in one or more counterparts, each of which may be deemed an original, but all of which constitute one and the same instrument. Delivery of an executed counterpart of a signature page of this Agreement by facsimile or other electronic transmission shall be effective as delivery of a manually executed counterpart of this Agreement.
- i. Notices. All notices, requests, or consents required or permitted under this Agreement will be in writing (including electronic form) to each party or to such other party and/or address as any of such parties may designate in a written notice served upon the other party in the manner provided for below. Each notice, request, consent, or other communication will be given and will be effective: (1) if delivered by hand, when so delivered; (2) if delivered by nationally recognized overnight courier service or sent by United States Express Mail, upon confirmation of delivery; (3) if delivered by certified or registered mail, on the third following day after deposit with the United States Postal Service.

The parties have executed this Agreement duly authorized to be effective as of the Effective Date.

COVERED ENTITY

BUSINESS ASSOCIATE

CommuniCare Technology, Inc. dba Pulsara

By: _____

By:  _____

Anna Larson, Director of Commercial Operations

(Printed Name, Title)

(Printed Name, Title)



March 25, 2026

Via Email & Via Certified Mail, Return Receipt Requested

Tyto Care Inc.
215 West 40th St.
9th Floor
New York, NY 10018

**Re: Mangum Regional Medical Center
Notice of Non-Renewal**

Dear Tyto Care:

Please accept this letter as formal written notice of Mangum Regional Medical Centers' (the "Hospital") intent not to renew the Master Services Agreement dated June 10, 2021 (the "MSA") and any other ancillary agreements currently in effect (collectively, the "Agreements") with Tyto Care, Inc. ("Tyto").

According to Section 10.1 of the MSA, "This Agreement shall continue in full force and effect from the Effective Date for a period of 60 months unless earlier terminated by either Party in accordance herewith (the "Initial Term"). Thereafter, this Agreement shall be renewed automatically, for consecutive periods of one year each (the "Renewal Term(s)) unless either Party notifies the other Party in writing of non-renewal not less than 60 days prior to the beginning of the then next renewal term.

Therefore, this letter serves as the Hospital's notice of non-renewal of the Agreements which will terminate on June 10, 2026.

We appreciate the services Tyto Care has provided for Mangum Regional Medical Center. If you have any questions or would like to discuss, please contact me at 580-782-3353 ext. 249 or email kmartinez@chmcok.com

Kind Regards,

Kelley Martinez
Administrator
Mangum Regional Medical Center
kmartinez@chmcok.com