Agenda
Mangum City Hospital Authority
September 26, 2023 at 5:00 PM
City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on September 26th, 2023, at 5:00 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

SWEARING IN AND SEATING OF NEW TRUSTEE

1. Swearing in of Michelle Ford for Trustee of Mangum City Hospital Authority

2. Welcoming and seating of new Trustee Michelle Ford.

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 August 22, 2023, regular meeting minutes as presented.
2. Approve July 2023 Quality meeting minutes as presented.
3. Approve August 2023 Medical Staff meeting minutes as presented.
4. Approve August 2023 Claims
5. Approve October 2023 Estimated Claims.
6. Approve August 2023 Quality Report.
7. Approve August 2023 Clinic Report.
8. Approve August 2023 CCO Report.
9. Approve August 2023 CEO Report.
10. Approve the following forms, policies, appointments, and procedures previously approved through May 2023 by Corporate Management, on 9/14/2023 Quality Committee and on 9/21/2023 Medical Staff.

- Review & Consideration of Approval of Policy & Procedure: Provision of Healthcare Services for the Care and Treatment of Patients

- Review & Consideration of Approval of Policy & Procedure: Admission Criteria and Process
- Review & Consideration of Approval of Policy & Procedure: Utilization Management
- Review & Consideration of Approval of Policy & Procedure: Hospital Communication Policy
- Review & Consideration of Approval of Policy & Procedure: Hospital Staffing Plan
- Review & Consideration of Approval of Policy & Procedure: Staff Development
- Review & Consideration of Approval of Policy & Procedure: Pet Visitation
- Review & Consideration of Approval of Policy & Procedure: The Use of Service Animals in the Hospital
- Review & Consideration of Approval of Policy & Procedure: Hospital Policy/Protocol and Other Development and Review
- Review & Consideration of Approval of Policy & Procedure: Hospital Education
- Review & Consideration of Approval of Policy & Procedure: Telemedicine Services
- Review & Consideration of Approval of Policy & Procedure: Video Surveillance and Use
- Review & Consideration of Approval of Policy & Procedure: Patient Identification
- Review & Consideration of Approval of Policy & Procedure: Vendor Management Policy
- Review & Consideration of Approval of Policy & Procedure: Prohibiting Firearms and/or Weapons on Hospital Property
- Review & Consideration of Approval of Policy & Procedure: Smoke and Tobacco-Free Policy
- Review & Consideration of Approval of Policy & Procedure: Prevention of Abuse and Neglect in the Hospital
- Review & Consideration of Approval of Policy & Procedure: Patient Visitation
- Review & Consideration of Approval of Policy & Procedure: Patient Rights
- Review & Consideration of Approval of Policy & Procedure: Hospital Services for Very Important Person (VIP)
- Review & Consideration of Approval of Policy & Procedure: Chain of Command
- Review & Consideration of Approval of Policy & Procedure: Patient Rights and Responsibilities Notice
- Review & Consideration of Approval of Policy & Procedure: Interview Evaluation Form

- Review & Consideration of Approval of Policy & Procedure: Education Needs Assessment Form
- Review & Consideration of Approval of Policy & Procedure: Animal Visitation Log
- Review & Consideration of Approval of Policy & Procedure: Pet/Visitation Checklist
- Review & Consideration of Approval of Policy & Procedure: Veterinarian Attestation
- Review & Consideration of Approval of Policy & Procedure: Pet Visitation Log
- Review & Consideration of Approval of Policy & Procedure: Pet & Animal Visitation General Guidelines
- Review & Consideration of Approval of Policy & Procedure: Hospital Policy/Form/Order Set/Protocol Review Process
- Review & Consideration of Approval of Policy & Procedure: Draft Policy/Document Submission & Communication Tracking Form
- Review & Consideration of Approval of Policy & Procedure: Policy, Forms or Other Documents Development, Review & Implementation Process
- Review & Consideration of Approval of Policy & Procedure: Hospital Policy Template
- Review & Consideration of Approval of Policy & Procedure: Hospital Protocol/Standing Order Template
- Review & Consideration of Approval of Policy & Procedure: Hospital Policy/Other Document Feedback Form
- Review & Consideration of Approval of Policy & Procedure: Table of Contents
- Review & Consideration of Approval of Policy & Procedure: Hospital Policy Approval Cover Sheet
- Review & Consideration of Approval of Policy & Procedure: Hospital Policy/Form/Documents/ Appointment & other Reviews Log
- Review & Consideration of Approval of Policy & Procedure: Guideline for Performing a Comprehensive Review of an Existing Policy, Form or Other Document
- Review & Consideration of Approval of Policy & Procedures: Education Training & Attendance Log
- Review & Consideration of Approval of Policy & Procedures: Post Education Evaluation Survey
- Review & Consideration of Approval of Policy & Procedures: Request to Access/View/Copy Video Surveillance Form

- Review & Consideration of Approval of Policy & Procedures: Video Surveillance Viewing Log
- Review & Consideration of Approval of Policy & Procedures: Vender Sign In/Sign Out Log
- Review & Consideration of Approval of Policy & Procedures: MRMC Generic Provider Time Sheet
- Review & Consideration of Approval of Policy & Procedures: Provider Time Sheet Policy
- Review & Consideration of Approval of Policy & Procedures: Immediate use IV Compound Skills Competency
- Review & Consideration of Approval of Policy & Procedures: Intravenous (IV) Compounding for Immediate Use and Preparation Area
- Review & Consideration of Approval of Policy & Procedures: Critical Lab Values

FURTHER DISCUSSION

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

REPORTS

11. August Financial Reports

OTHER ITEMS

12. Discussion and Possible Action to Approve the eClinical Works Addendum for EBO Services
13. Discussion and Possible Action to Approve the Mangum RHC-BCBS-Network Participating Group Agreement
14. Discussion and Possible Action to Approve the Mangum-Sysmex-Service Agreement Quote
15. Discussion and Possible Action to Approve the Mangum-PharmaForce-340B TPA SaaS Agreement and Business Associate Agreement
16. Discussion and Possible Action to Approve the Mangum-Bayer-CT Power Injector Service Contract.
17. Discussion and Possible Action to Approve the Mangum-First Digital-Service Agreement
18. Discussion and Possible Action to Approve the Mangum-Facility Credit Card
19. Discussion: Quality Report Audit

20. Discussion and possible action to appoint a new Compliance Committee member.

21. Discussion and possible action to grant Chrispin Ogama and Todd Williams to view only Mangum's Operating and ARPA accounts with Sovereign Bank due to Andrea Snider no longer being with the organization.

22. Discussion and possible action to approve Resolution No. 2023-0926 to remove Andrea Snider from all accounts.

EXECUTIVE SESSION

23. 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):

- **Re-Credentialing-** Fei-Ling Yeh, DO- Courtesy
- **Amendment Supervisor Agreement-**Dr. Bluth-Sara McDade
- **Amendment Delegation Agreement-** Dr. Bluth-Jeff Brand
- **Amendment to Professional Services Agreement-**Jeff Brand
- **Amendment to Professional Services Agreement-** Kenna Wenthold

OPEN SESSION

24. Discussion and possible action with regard to the executive session.

STAFF AND BOARD REMARKS

Remarks or inquiries by the governing body members, City Manager, City Attorney or City 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 **11:00 a.m. on the 25th day of September 2023**, by the Secretary of the Mangum City Hospital Authority.

_____

Erma Mora Secretary

Minutes
Mangum City Hospital Authority Session
August 22, 2023, at 5:00 PM
City Administration Building at 130 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on August 22, 2023, at 5:00 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 5:00pm.

ROLL CALL AND DECLARATION OF A QUORUM
PRESENT
Chairman Carson Vanzant
Trustee Cheryl Lively
Trustee Heiskell
Trustee Lisa Hopper

ABSENT
Trustee Ronnie Webb

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 items as presented and removing items 2, 4, 5, 6,7.

Motion made by Trustee Vanzant, Seconded by Trustee Lively.
Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

1. Approve July 25, 2023 regular meeting minutes as presented.

2. Approve June 2023 Quality meeting minutes as presented.

   Trustee Lively is asking what the process is for preventing med errors?

   Kelly answers by saying their first step is to find out what caused it. Trustee Lively asks what if it is due to personnel issues? Kelly says they investigate to see how many times they have had that type of error, and they will get re-educated. Trustee Lively wants to know what happens after they get re-educated and if it goes into their personnel file. Kelly explains going forward the disciplinary actions they will be taking if errors keep continuing.

   Motion to approve item #2.

Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

3. Approve July 2023 Medical Staff meeting minutes as presented.

4. Approve July 2023 Claims.

   Motion to approve item #4 on the consent agenda after discussion.

   Motion made by Trustee Heiskell, Seconded by Trustee Lively.
   Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

5. Approve September 2023 Estimated Claims.

   Motion to approve item #5 after discussion.

   Motion made by Trustee Vanzant, Seconded by Trustee Lively.
   Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

6. Approve July 2023 Quality Report.

   Motion to approve item #6 after discussion.

   Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
   Voting yea: Trustee Vanzant, Trustee Heiskell, Trustee Lively, Trustee Hopper

7. Approve July 2023 Clinic Report.

   Motion to approve item #7 after discussion.

   Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
   Voting yea: Trustee Vanzant, Trustee Heiskell, Trustee Lively, Trustee Hopper

8. Approve July 2023 CCO Report.

9. Approve July 2023 CEO Report.

FURTHER DISCUSSION

None.

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

None.

REPORTS

10. July Financial Reports.

    July's reports presented.

OTHER ITEMS

12. Discussion and possible action to approve the DirecTV Proposal/Quote and Hewlett-Packard Business Lease Agreement.

    Motion to approve.

    Motion made by Trustee Vanzant, Seconded by Trustee Lively.
    Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

13. Discussion and possible action to approve the MOU with Safe Haven

    Motion to approve.

    Motion made by Trustee Heiskell, Seconded by Trustee Lively.
    Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

14. Discussion and possible action to approve the Cohesive Fee Sharing Agreement for eClinical Works.

    Motion to table until next month.

    Motion made by Trustee Vanzant, Seconded by Trustee Heiskell
    Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Heiskell, Trustee Hopper

EXECUTIVE SESSION

11. Discussion and possible action with regard to the upcoming settlement conference regarding the SCA v. MCHA et al, CJ-2019-04 lawsuit to set provisional settlement authority limits, discuss strategy, and otherwise prepare for the mediation with possible executive session in accordance with 25 O.S. 307(B)(4).

    Motion to enter into executive session at 6:53pm.

    Motion made by Trustee Vanzant, Seconded by Trustee Heiskell
    Voting Yea: Trustee Vanzant, Trustee Lively, Trustee Hopper

    Chairman Vanzant declared out of executive session at 7:38pm.

OPEN SESSION

15. Discussion and possible action with regard to executive session.

    No action.

STAFF AND BOARD REMARKS
Remarks or inquiries by the governing body members, Hospital CEO, City Attorney or Hospital Employees

None

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)

None.

ADJOURN
Motion to Adjourn

Motion to adjourn at 7:42pm

Carson Vanzant, Chairman

Erma Mora, City Clerk

Mangum Regional Medical Center
Quality Assurance & Performance Improvement Committee Meeting

Meeting Minutes					
CONFIDENTIALITY STATEMENT: These minutes contain privileged and confidential information. Distribution, reproduction, or any other use of this information by any party other than the intended recipient is strictly prohibited.					
Date: 08/10/2023	**T 1314 i m e :**	**Recorder: D. Jackson**	**Reporting Period: July 2023**		
Members Present					
Chairperson: Dr. C		CEO: Kelly Martinez		dical Representative:	
Name	**Title**	**Name**	**Title**	**Name**	**Title**
Nick	CNO	Danielle	Bus Office		Lab
	HR	Kaye via Teams	Credentialing		IT
	HIM		Maintenace/EOC		Dietary
	PT	Pam	Radiology	Claudia Collard	IP
TOPIC	**FINDINGS – CONCLUSIONS**		**ACTIONS – RECOMMENDATIONS**		**FOLLOW-UP**
I. CALL TO ORDER					
Call to Order	The hospital will develop, implement, and maintain a performance improvement program that reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.		This meeting was called to order on 08/10/2023 by Kelly Martinez/ Dr C		
II. REVIEW OF MINUTES					
A. Quality Council Committee	07/13/2023		Committee reviewed listed minutes A-F. Motion to approve minutes as distributed made by Kelly Martinez 2nd by Dr. C Minutes A-F approved. Present a copy of the Meeting Minutes at the next Medical Executive Committee and Governing Board meeting.		
B. EOC/ Patient Safety Committee	06/13/2023				
C. Infection Control Committee	06/07/2023				
D. Pharmacy & Therapeutics Committee	03/30/2023				
E. HIM/Credentialing Committee	06/13/2023				

F. Utilization Review Committee	06/07/2023		
III. REVIEW OF COMMITTEE MEETINGS			
A. EOC/Patient Safety	07/11/2023		
B. Infection Control	07/11/2023		
C. Pharmacy & Therapeutics	Next meeting 09/2023		
D. HIM-Credentials	07/11/2023		
E. Utilization Review	07/11/2023		
F. Compliance	07/12/2023		
IV. OLD BUSINESS			
A. Old Business	340B Drug Policy (updated) First Quarter 2023 Compliance Committee Meeting Minutes	All Approved July 2023 by Quality/Med Staff/Board	
V. NEW BUSINESS			
A. New Business	None		
VI. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT			
A. Volume & Utilization			
1. Hospital Activity	Total ER – 152 Total OBS pt - 2 Total Acute pt - 12 Total SWB - 10 Total Hospital Admits (Acute/SWB) - 22 Total Hospital DC (Acute/SWB) - 22 Total pt days - 295 Average Daily Census - 10		
2. Blood Utilization	10 total units administered, 1 pt c/o itching with transfusion. Medicated/transfusion completed per provider orders. Transfusion completed with no further c/o	Education to staff over consistent use of blood transfusion forms w/i CPSI in 8/2023 and 9/2023	
B. Care Management			
1. CAH Readmissions	1 for the reporting period - 1.) admitted with primary dx, d/c for surgical services and readmitted with both primary dx and different dx		
2. IDT Meeting Documentation	10/10 (100%)	CPSI team aware of on-going issues with notes not saving	

3. Insurance Denials	2 for the reporting period, Insurance denied acute hospital stays		
4. IMM Notice	21/21 (100%)		
C. Risk Management			
1. Incidents	AMA 4 - 1.) er pt in for c/o, pt was agreeable to exam/treatment, once tx was received, pt did not want to stay for treatment follow up. Risks/benefits discussed with pt/AMA signed. 2.) er pt in for c/o, agreeable to exam/treatment but did not want to wait for treatment completion. Risks/benefits discussed with pt/AMA signed. 3.) er pt in for c/o, agreeable to exam/treatment, provider recommended further testing however pt/family declined further testing. Risks/benefits discussed with pt/AMA signed. 4.) In-pt admit for primary dx, pt expressed desire to be d/c home prior to completion of IV therapy, Risks/benefits discussed with pt/AMA signed. CM set pt up with HH for continued services based on pt needs at home.		
2. Reported Complaints	2 for reporting period - 1.) inpt c/o to CEO that staff member addressed pt in an inappropriate manner, CEO voiced that it would be addressed with staff and pt expressed satisfaction with resolution 2.) Pt expressed to CN that staff member was rude during shift, CN assured pt that staff member would no longer be assigned to pt	1.) CEO met with staff member regarding appropriate communication with patient 2.) CNO (DC) and HR met with staff regarding c/o, staff was assigned education and required to complete prior to returning to work	

	per pt request, pt states satisfaction with resolution		
3. Reported Grievances	None for reporting period		
4. Patient Falls without Injury	None for reporting period		
5. Patient Falls with Minor Injury	None for reporting period		
6. Patient Falls with Major Injury	None for reporting period		
7. Fall Risk Assessment	None for reporting period		
8. Mortality Rate	None for reporting period		
9. Deaths Within 24 Hours of Admission	None for the reporting period		
10. Organ Procurement Organization Notification	None for reporting period		
D. Nursing			
1. Critical Tests/Labs	34 for the reporting period		
2. Restraint Use	None for reporting period		
3. Code Blue	1 for reporting period – pt w/respiratory arrest. ACLS protocol/precautions followed. No chest compressions or intubation per pt needs/provider assessment		
4. Acute Transfers	None for reporting period		
5. Inpatient Transfer Forms	None for reporting period		
E. Emergency Department			
1. ED Nursing DC/ Transfer Assessment	20/20 (100%)		
2. ED Readmissions	5 for the reporting period - 1.) pt to the ED for primary c/o, returned for different dx w/i 72 hrs. 2.) pt to the ED for primary c/o, returned for continued symptoms d/t non-compliance and additional tx w/i		

	72 hrs 3.) pt to the ED for primary c/o, returned for continued symptoms and additional tx w/i 72 hrs 4.) pt to the ED for primary c/o, returned for continued symptoms d/t non-compliance and additional tx w/i 72 hrs. 5.) pt to the ED for primary c/o, returned for continued symptoms d/t non-compliance tx w/i 72 hrs		
3. ER Log & Visits	152 (100%)		
4. MSE	Quarterly		
5. EMTALA Transfer Form	7/7 (100%)		
6. Triage	20/20 (100%)		
7. ESI Triage Accuracy	20/20 (100%)		
8. ED Transfers	7 for the reporting period - Patients transferred to Higher Level of Care for: 1.) Atrial Tachy – Cardiology 2.) EOD/SI/SH – InPt Psych 3.) FB – GI/Specialty Unit 4.) AMS – Neurology 5.) SI – ICU 6.) EOD – InPt Psych 7.) DKA - ICU	All ER transfers for the reporting period appropriate for higher level of care	
9. Stroke Management	None for reporting period		
10. Brain CT Scan – Stroke (OP-23)	None for reporting period		
11. Suicide Management	3 for the reporting period		
12. STEMI Care	None for reporting period		

13. Chest Pain	4/5 EKG (80%) 4/5 Xray (80%) - 1 ekg completed in 7 min, per documentation/leads in place for cardiac monitoring as soon as pt transferred to exam bed. 1 chest x-ray not requested by provider due to patient exam findings.	RT reminded of 5 min window. Xray - orders may not be desired based on provider exam/provider orders	
14. ED Departure - (OP-18)	83 min		
F. Pharmacy & Medication Safety			
1. After Hours Access	78 for the reporting period – high volume of refrigerated meds required for the month (fridge in med room)		
2. Adverse Drug Reactions	None for reporting period		
3. Medication Errors	3 for the reporting period: 1) Nurse failed to use correct insulin order which resulted in the patient's FSBS to remain high, and they did not contact provider. 2) Antibiotic was diluted incorrectly, not labeled properly, and also not fully scanned. 3) Pharmacy tech restocked the incorrect Insulin in the medication drawer but was quickly caught and corrected with no harm/administration to any patients.	1) Call and email sent to staffing for follow up with this contract nurse. The contract nurse will no longer be working at this facility. 2) Education in regard to the 6 rights of medication administration by CEO and Pharmacist. 3) Pharmacy ensuring that only 1 vial be restocked at a time to ensure accuracy. Pharmacy tech also acknowledged the 6 rights of medication administration.	
4. Medication Overrides	62 for the reporting period		
5. Controlled Drug Discrepancies	8 for the reporting period	Verified order entry error and no drug diversion with Pharmacist	
G. Respiratory Care Services			
1. Ventilator Days	0 for the reporting period		
2. Ventilator Wean	0 for the reporting period		
3. Unplanned Trach Decannulations	None for the reporting period		

4. Respiratory Care Equipment	6 nebs and mask changes for the reporting period, 0 HME, 0 inner cannula, 0 trach collars/tubing, 0 closed suction kit, 0 suction set ups, 0 vent circuit, 0 trach		
H. Wound Care Services			
1. Development of Pressure Ulcer	None for the reporting period		
2. Wound Healing Improvement	6 for the reporting period		
3. Wound Care Documentation	100%		
I. Radiology			
1. Radiology Films	2 films repeated due to technical error – 133 total for the reporting period		
2. Imaging	27 for the reporting period		
3. Radiation Dosimeter Report	Quarterly		
J. Laboratory			
1. Lab Reports	30 repeated /1987 total for the reporting period – repeated 29 critical labs per protocol, 1 due to hemolyzed specimen	Will redraw labs as needed. Will reposition and stabilize the patient as needed for safe blood draw.	
2. Blood Culture Contaminations	None for the reporting period		
K. Infection Control and Employee Health			
1. Line Events	1 for the reporting period, foley cath incidentally removed secondary to pt level of confusion. No adverse outcome/injury noted.		
2. CAUTI's	0 for the reporting period		
3. CLABSI's	1 for the reporting period - All preventative measures were taken to prevent CLABSI in a high-risk patient with multiple risk factors.		

4. Hospital Acquired MDRO's	0 for the reporting period		
5. Hospital Acquired C-diff	None for the reporting period		
6. HAI by Source	1 for the reporting period - CAUTI (All preventative measures were taken to prevent CLABSI in a high-risk patient with multiple risk factors.)		
7. Hand Hygiene/ PPE & Isolation Surveillance	100%		
8. Patient Vaccinations	0 received influenza vaccine / 1 received pneumococcal vaccine	1 pt with abrupt discharge prior to receiving vaccine, nursing will administer sooner during pt stay	
9. VAE	None for the reporting period		
10. Employee Health Summary	1 employee event/injury, 11 employee health encounters (vaccines/testing) 3 reports of employee illness/injury		
11. Staff COVID19 Vaccine Compliance	No longer a requirement per CMS		
L. Health Information Management (HIM)			
1. History and Physicals Completion	20/20 (100%)		
2. Discharge Summary Completion	20/20 (100%)		
3. Progress Notes (Swing bed & Acute)	SWB – 20/20 (100%) Acute – 20/20 (100%)		
4. Swing Bed Indicators	10/10 (100%)		

5. E-prescribing System	68/85 (80%) pt was given hard scripts at discharge as they do not have established pharmacy at discharge date/time and preferred hard scripts	providers will utilize e-sripts as primary source however in the instance that hard scripts are a better option for the patient, this will be utilized	
6. Legibility of Records	20/20 (100%)		
7. Transition of Care	Obs to acute – none for the reporting period, Acute to SWB – 7/7 (100%)		
8. Discharge Instructions	20/20 (100%)		
9. Transfer Forms	7/7 (100%)		
M. Dietary			
1. Weekly Cleaning Schedules	56/56 (100%)		
2. Daily Cleaning Schedules	403/403 (100%)		
3. Wash Temperature	93/93 (100%)		
4. Rinse Temperature	93/93 (100%)		
N. Therapy			
1. Discharge Documentation	18/18 (100%)		
2. Equipment Needs	10/10 (100%)		
3. Therapy Visits	PT 123– OT 110 - ST 2		
4. Supervisory Log	None for reporting period		

5. Functional Improvement Outcomes	PT 8/8 (100%) – OT 10/10 (100%) – ST 0/0 (100%)		
O. Human Resources			
1. Compliance	100 %		
2. Staffing	Hired – 4, Termed - 1		
P. Registration Services			
1. Compliance	13/13 indicators above benchmark for the reporting period		
Q. Environmental Services			
1. Terminal Room Cleans	8/8 (100%)		
R. Materials Management			
1. Materials Management Indicators	6 – Back orders, 0 – Late orders, 1 – Recalls, 935 items checked out properly		
S. Life Safety			
1. Fire Safety Management	0 fire drills for the reporting period – 24 fire extinguishers checked		
2. Range Hood	(100%)		
3. Biomedical Equipment	(100%)		
T. Emergency Preparedness			
1. Orientation to EP Plan	4/4 (100%)		
U. Information Technology			
A. IT Incidents	62 events for the reporting period		
V. Outpatient			
1. Therapy Visits	87/105 (83%) 7 no show/no call missed visits, 11 visits which patients called and cancelled.		

2. Discharge Documentation	4/4 (100%)		
3. Functional Improvement Outcomes	4/4 (100%)		
4. Outpatient Wound Services	(100%)		
W. Strong Mind Services			
1. Record Compliance	N/A	N/A	N/A
2. Client Satisfaction Survey	N/A	N/A	N/A
3. Master Treatment Plan	N/A	N/A	N/A
4. Suicidal Ideation	N/A	N/A	N/A
5. Scheduled Appointments	N/A	N/A	N/A
VII. POLICY AND PROCEDURE REVIEW			
1. Review and Retire	None for this reporting period		
2. Review and Approve	None for this reporting period		
VIII. CONTRACT EVALUATIONS			
1. Contract Services			
IX. REGULATORY AND COMPLIANCE			
A. OSDH & CMS Updates	None for this reporting period		
B. Surveys	None for this reporting period		

C. Product Recalls	None for this reporting period		
D. Failure Mode Effect Analysis (FMEA)	Water Line Break – Final at Corporate for approval		
E. Root Cause Analysis (RCA)	None for this reporting period		
X. PERFORMANCE IMPROVEMENT PROJECTS			
A. PIP	Proposed – STROKE; The Emergency Department will decrease the door to transfer time to < 60 minutes for all stroke patients who present to the Emergency Department at least 65% of the time or greater by December 2023. Proposed –STEMI/CP; The Emergency Department will decrease the door to transfer time to < 60 minutes for all STEMI patients who present to the Emergency Department at least 80% of the time or greater by December 2023.		
XI. CREDENTIALING/NEW APPOINTMENT UPDATES			
A. Credentialing/New Appointment Updates	None		
XII. EDUCATION/TRAINING			
A. Education/ Training	Q2 competencies and check-offs: 1. Bolus/Gravity tube feeding 2. Continuous/Pump tube feeding 3. TPN/Lipids Administration 4. Transmission-based Precautions (test only) IUC and CVC line necessity charting in CPSI PICC line displacement Lunch and Learn: with Dr Rumsey		
XIII. ADMINISTRATOR REPORT			

A. Administrator Report			
XIV. CCO REPORT			
A. CCO Report			
XV. STANDING AGENDA			
A. Annual Approval of Strategic Quality Plan	Approved 04/2023		
B. Annual Appointment of Infection Preventionist	Approved 02/2023	Approved 02/2023	
C. Annual Appointment of Risk Manager	Approved 02/2023	Approved 02/2023	
D. Annual Appointment of Security Officer	Approved 04/2023	Approved 04/2023	
E. Annual Appointment of Compliance Officer	Approved 02/2023	Approved 02/2023	
F. Annual Review of Infection Control Risk Assessment (ICRA)	Approved 02/2023	Approved 02/2023	
G. Annual Review of Hazard Vulnerability Analysis (HVA)	N/A		
Department Reports			
A. Department reports			
Other			
A. Other	None		
Adjournment			
A. Adjournment	There being no further business, meeting adjourned by Dr C. seconded by Chasity Howell at 13:46.	The next QAPI meeting will be – tentatively scheduled for 9/14/2023	

Mangum Regional Medical Center
Medical Staff Meeting
Thursday
August 17, 2023

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
Greg Morgan, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

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

NON-MEMBERS PRESENT:

Chelsea Church, PhD
Kelley Martinez, RN, CEO
Cindy Tillman, MHA/VP of Operations, Cohesive Management & Consulting
Daniel Coffin, RN, CCO
Chasity Howell, RN, Utilization Review Director
Denise Jackson, RN, Quality
Lynda James, LPN, Pharmacy Tech
Kaye Hamilton, Medical Staff Coordinator
Andrea McBride – Guest Speaker

1. Call to order
    a. The meeting was called to order at 12:30 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the July 20, 2023, 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
    a. There have been some positive COVIDs in the community recently.
    b. The new CCO has started.

- Operations Overview
  - We completed Tourniquet training for Mangum Public Schools.
  - Several Sponsorships have been completed.
  - We are looking at charges to ensure that they are being captured appropriately.
  - We have the quote in for PICC Line placement equipment. We are now completing the Pro forma to ensure that the service line will show benefit.
  - We are hiring some new RN's, LPN's and aides.
  - We are currently looking for a new IT person and a maintenance technician.
  - We continue to see an increase in applicants at the facility.
- Contracts, Agreements and Appointments for Governing Board Approval
  - Mangum – Direct TV – Agreement and Quote
  - Mangum – Safe Haven MOU

5. Committee / Departmental Reports
   a. Medical Records
      i. Written report remains in the minutes.

   b. Nursing

Patient Care

- MRMC Education included:
  1. Q2 competencies and checkoffs:
     a. Bolus/Gravity tube feeding
     b. Continuous/Pump tube feeding
     c. TPN/Lipids Administration
     d. Transmission-based Precautions (test only).
  2. PICC Line displacement – what to do in the event of.
  3. IUC and CVC line necessity charting in CPSI.
- MRMC Emergency Department reports zero patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports Zero contaminated blood cultures.
- MRMC Infection Prevention reports 0 CAUTI's.
- MRMC Infection Prevention report 1 CLABSI.

Client Service

- Patients continue to rely on MRMC as their local hospital. Total Patient Days decreased with 295 patient days in July as compared to 317 patient days in June. This represents an average daily census of 10. In addition, MRMC Emergency Department provided care to 152

patients in July.

- MRMC Case Management reports 22 Total Admissions for the month of July 2023.
- July 2023 COVID-19 Stats at MRMC: Swabs (0 PCR & 20 Antigen) with 0 Positive.

Preserve Rural Jobs

- Recruiting efforts included interviewing regional professionals.

Written report remains in minutes.

c. Infection Control

- Old Business
  a N/A
- New Business:
  N/A
- Data:
  a, N/A
- Policy & Procedures Review:
  a. CMS mandate re: COVID-19 vaccines for HCW is being lifted-policy is in process of being amended.
- Education/In Services
  a. Q2 competencies and check-offs:
    1. Bolus/Gravity tube feeding
    2. Continuous/Pump tube feeding
    3. TPN/Lipids Administration
    4. Transmission-based Precautions (test only).
  b. PICC line displacement – what to do in the event of.
  c. IUC and CVC line necessity charting in CPSI.
- Updates: No updates at this time.
- Annual Items:
  a. N/A

  Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Evaluation and approval of Annual Plans-Plans will be presented in July meeting.
b. Continuing to work on the building. Flooring in Nurses break area and Med Prep room needing replaced – Tile ready for pick up.
c. 15 AMP Receptacles – all 15 AMP Receptacles will be replaced with 20 AMP Receptacles throughout Hospital – replacement has started.

d. Replace all receptacles on generator circuit at Clinic with red receptacles.
e. ER Provider office flooring needing replaced-Tile ready to be picked up.
f. Damaged ceiling tile in patient area due to electrical upgrade-will need more tile to complete.
g. Replace ceiling tile that do not fit properly – will need more tile to complete.
h. North wall in Nurses breakroom in need of repair.
i. Chrome pipe needs cleaned and escutcheons replaced on hopper in ER - - Possibly remove or cover unused hopper.
j. East wall in room 27 needing repair around the A/C unit
k. ISO Caddys installed in patient rooms – ordered pending delivery
l. Sanitizer brackets – additional brackets have arrived pending installation
m. Exposed wire in Room 18 – this is new wire that has been pulled for additional outlet - wire is not connected to power-covered 6-13-2023
n. Phone wire from ceiling in room 19 – needs raceway installed
o. Ceramic tile around toilet paper dispenser missing in rest room in Room 17.
p. IV pumps 72364 – 72345 – 72353 need current inspection stickers – pumps will be removed from service until inspection is completed by vendor. 6-13-2023.

i.i.i. New Business
a. None

Written report remains in minutes.

e. Laboratory
i. Tissue Report – None
i.i. Transfusion Report – Approved – June, 2023
Transfusion Report – Approved – July, 2023

f. Radiology
i. There was a total of – 224 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates:
- No Updates

Written report remains in minutes.

g. Pharmacy
i. Verbal Report by Pharmacist.
i.i. COVID-19 Medications-Have 1 dose of Bebtelovimab, 30 doses of Remdesivir and 18 Paxlovid doses in-house.
i.i.i. P & T Committee Meeting – Next meeting in September 14, 2023
iv. Drug Shortage/Outages are as follows: Clinimix, Optiray (all Contrast), furosemide injection
Children's suspension antibiotics, Tylenol and Ibuprofen

DRS and PIC to monitor on a routine basis.

v. Solu-Medrol has been added to the shortage list. We have plenty in house at this time.

Written report remains in the minutes.

h. Physical Therapy
   i. No report.

i. Emergency Department
   i. No report

j. Quality Assessment Performance Improvement
   Risk
   - Risk Management
     - Grievance – 0
     - 0 - Fall with no injury
     - 1 - Fall with minor injury
     - 0 – Fall with major injury
     - Death – 1
     - AMA/LWBS – 4/0
   - Quality
     - Quality Minutes from previous month included as attachment.

   - HIM – H&P – Completion 20/20 = 100% - Discharge Summary 20/20 = 100%
   - Med event – 1
   - Afterhours access was – 67
   - Compliance

   Written report remains in minutes.

k. Utilization Review
   i. Total Patient days for July: 317
   i.i. Total Medicare days for July: 267
   i.i.i. Total Medicaid days for July: 0
   iv. Total Swing Bed days for July: 279
   v. Total Medicare SB days for July: 240

   Written report remains in the minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports for July, 2023.

6. New Business
   a. Presentation and Discussion presented by Andrea McBride: Update to the Return back to: One-Time Change to Critical Access Hospital (CAH) Annual Average 96-hour Patient Length of Stay Calculations to Account for the COVID-19 Public

Health Emergency.

7. Adjourn
    a. Dr Chiaffitelli made a motion to adjourn the meeting at 01:03 pm.

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center
Claims List
August 2023

Check#	Ck Date	Amount	Paid To	Expense Description
19189	8/22/2023	1,611.87	AETNA	PATIENT REFUND
19101	8/8/2023	19.00	AMBS CALL CENTER	Compliance Hotline
19127	8/15/2023	900.00	APEX MEDICAL GAS SYSTEMS, INC	Maintenance
19066	8/1/2023	2,413.14	ARAMARK	Linens - rental
19102	8/8/2023	2,520.83	ARAMARK	Linens - rental
19128	8/15/2023	2,852.85	ARAMARK	Linens - rental
19161	8/21/2023	2,993.65	ARAMARK	Linens - rental
19192	8/28/2023	3,100.76	ARAMARK	Linens - rental
19103	8/8/2023	715.01	AT&T	Fax Lines
19104	8/8/2023	1,993.44	AT&T	Fax Lines
19129	8/15/2023	1,671.88	AT&T	Fax Lines
19130	8/15/2023	7,486.67	BANKDIRECT CAPITAL FINANCE	OHA Insurance-financed
19067	8/1/2023	4,320.00	BARRY DAVENPORT	1099 Provider
19131	8/15/2023	4,320.00	BARRY DAVENPORT	1099 Provider
19193	8/28/2023	4,320.00	BARRY DAVENPORT	1099 Provider
19132	8/15/2023	1,112.85	BIO-RAD LABORATORIES INC	Lab supplies
19194	8/28/2023	729.37	BIO-RAD LABORATORIES INC	Lab supplies
19105	8/8/2023	2,850.00	BLUTH FAMILY MEDICINE, LLC	1099 Provider
19068	8/1/2023	32.64	BRIGGS HEALTHCARE	Pharmacy Supplies
19069	8/1/2023	5,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
19106	8/8/2023	6,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
19133	8/15/2023	5,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
19162	8/21/2023	5,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
19195	8/28/2023	8,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
19163	8/21/2023	7,150.00	CARNEGIE EMS	Patient Transport
19134	8/15/2023	864.56	CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies
19164	8/21/2023	1,139.06	CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies
19107	8/8/2023	8,940.17	CITY OF MANGUM	Utilities
19165	8/21/2023	180.00	CLIA LABORATORY PROGRAM	lab dues
19073	8/1/2023	3,150.00	CliftonLarsonAllen LLP	Audit fees
19111	8/8/2023	2,100.00	CliftonLarsonAllen LLP	Audit fees
19199	8/28/2023	1,089.38	CliftonLarsonAllen LLP	Audit fees
19166	8/21/2023	55,798.45	COHESIVE HEALTHCARE MGMT	Note Payable
19196	8/28/2023	31,016.76	COHESIVE HEALTHCARE MGMT	Note Payable
19070	8/1/2023	197,053.57	COHESIVE HEALTHCARE RESOURCES	Payment on Old Debt
19167	8/21/2023	154,075.59	COHESIVE HEALTHCARE RESOURCES	Payment on Old Debt
19168	8/21/2023	2,948.75	COHESIVE MEDIRYDE LLC	Patient Transport
19197	8/28/2023	541.00	COHESIVE MEDIRYDE LLC	Patient Transport
19108	8/8/2023	215,662.01	COHESIVE STAFFING SOLUTIONS	Payment on Old Debt
19135	8/15/2023	247,410.38	COHESIVE STAFFING SOLUTIONS	Payment on Old Debt
19109	8/8/2023	2,450.00	COMMERCIAL MEDICAL ELECTRONICS	Maintenance/repairs
19071	8/1/2023	2,000.00	CORRY KENDALL, ATTORNEY AT LAW	Legal fees
19169	8/21/2023	2,000.00	CORRY KENDALL, ATTORNEY AT LAW	Legal fees

Check#	Ck Date	Amount	Paid To	Expense Description
19110	8/8/2023	3,112.00	CPSI	EHR monthly support
19198	8/28/2023	14,258.00	CPSI	EHR monthly support
19170	8/21/2023	57.00	CULLIGAN WATER CONDITIONING	RHC purch svs
19072	8/1/2023	128.66	CURBELL MEDICAL PRODUCTS INC	supplies
19112	8/8/2023	1,314.97	DELL FINANCIAL SERVICES LLC	Server lease
19171	8/21/2023	635.31	DELL FINANCIAL SERVICES LLC	Server lease
19136	8/15/2023	2,150.00	DIAGNOSTIC IMAGING ASSOCIATES	Radiology purch svs
19172	8/21/2023	2,150.00	DIAGNOSTIC IMAGING ASSOCIATES	Radiology purch svs
19173	8/21/2023	1,818.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
19074	8/1/2023	5,000.00	DOERNER SAUNDERS DANIEL ANDERS	Legal fees
19174	8/21/2023	5,000.00	DOERNER SAUNDERS DANIEL ANDERS	Legal fees
19200	8/28/2023	32,030.12	DOERNER SAUNDERS DANIEL ANDERS	Legal fees
19113	8/8/2023	4,766.67	DR W. GREGORY MORGAN III	1099 Provider
19126	8/8/2023	2,875.50	eCLINICAL WORKS, LLC	RHC EHR
19223	8/28/2023	2,875.50	eCLINICAL WORKS, LLC	RHC EHR
19175	8/21/2023	51,887.35	EQUALIZERCM REVOPS	Billing Purch svs
19176	8/21/2023	2,928.00	F1 INFORMATION TECHNOLOGIES IN	IT purch svs
19075	8/1/2023	38.79	FEDEX	Postage
19114	8/8/2023	46.46	FEDEX	Postage
19137	8/15/2023	86.54	FEDEX	Postage
19201	8/28/2023	100.75	FEDEX	Postage
19076	8/1/2023	10,259.90	FIRSTCARE MEDICAL SERVICES, PC	1099 Provider
19138	8/15/2023	10,423.65	FIRSTCARE MEDICAL SERVICES, PC	1099 Provider
19202	8/28/2023	10,423.65	FIRSTCARE MEDICAL SERVICES, PC	1099 Provider
19139	8/15/2023	2,487.13	FORVIS LLP	Finance purch svs
19177	8/21/2023	19.51	FORVIS LLP	Finance purch svs
19077	8/1/2023	160.00	GEORGE BROS TERMITE & PEST CON	Plant Ops purch svs
901519	8/10/2023	1,368.23	GLOBAL PAYMENTS INTEGRATED	CC processing
19140	8/15/2023	870.20	GRAINGER	Supplies
19203	8/28/2023	986.32	GRAINGER	Supplies
19078	8/1/2023	193.39	HAC INC	Dietary Food
19115	8/8/2023	243.98	HAC INC	Dietary Food
19141	8/15/2023	281.18	HAC INC	Dietary Food
19178	8/21/2023	143.56	HAC INC	Dietary Food
19204	8/28/2023	152.42	HAC INC	Dietary Food
19190	8/22/2023	4.00	PATIENT REFUND	PATIENT REFUND
19142	8/15/2023	735.20	HEALTH CARE LOGISTICS	supplies
19079	8/1/2023	1,050.00	HEARTLAND PATHOLOGY CONSULTANT	Lab consultant
19205	8/28/2023	1,050.00	HEARTLAND PATHOLOGY CONSULTANT	Lab consultant
19116	8/8/2023	999.31	HENRY SCHEIN	Lab supplies
19143	8/15/2023	1,825.30	HENRY SCHEIN	Lab supplies
19117	8/8/2023	2,470.95	HILL-ROM COMPANY, INC	Patient Eq rentals
901510	8/2/2023	3,155.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease
19206	8/28/2023	1,000.00	ICU MEDICAL SALES INC.	Drug room library
19080	8/1/2023	102.15	IMPERIAL, LLC.-LAWTON	Dietary food
19179	8/21/2023	204.30	IMPERIAL, LLC.-LAWTON	Dietary food

Check#	Ck Date	Amount	Paid To	Expense Description
19144	8/15/2023	92.23	INSURICA	Passthrough commision
19118	8/8/2023	689.19	JANUS SUPPLY CO	Cleaning Supplies
19145	8/15/2023	934.53	JANUS SUPPLY CO	Cleaning Supplies
19207	8/28/2023	660.23	JANUS SUPPLY CO	Cleaning Supplies
19081	8/1/2023	850.00	JIMALL & KANISHA' LOFTIS	House rent
19208	8/28/2023	850.00	JIMALL & KANISHA' LOFTIS	House rent
19146	8/15/2023	1,240.37	KCI USA	Equipment rental
19209	8/28/2023	881.10	KCI USA	Equipment rental
19147	8/15/2023	4,883.20	LABCORP	Lab purch svs
19119	8/8/2023	1,552.06	LAMPTON WELDING SUPPLY	Patient Supplies
19148	8/15/2023	1,297.69	LAMPTON WELDING SUPPLY	Patient Supplies
19082	8/1/2023	130.00	LANGUAGE LINE SERVICES INC	Admin puch svs
19149	8/15/2023	130.00	LANGUAGE LINE SERVICES INC	Admin puch svs
19120	8/8/2023	100.00	LG PRINT CO	Pharmacy Supplies
19210	8/28/2023	235.21	LOCKE SUPPLY	Supplies
19083	8/1/2023	145.50	MANGUM STAR NEWS	Advertising
19211	8/28/2023	60.00	MANGUM STAR NEWS	Advertising
19121	8/8/2023	531.57	MARK CHAPMAN	Employee Reimbursement
901513	8/3/2023	0.10	MCKESSON - 340 B	Drug Costs
901518	8/8/2023	11.49	MCKESSON - 340 B	Drug Costs
901521	8/11/2023	0.20	MCKESSON - 340 B	Drug Costs
901524	8/14/2023	12.04	MCKESSON - 340 B	Drug Costs
901525	8/15/2023	1,537.62	MCKESSON - 340 B	Drug Costs
901528	8/22/2023	389.91	MCKESSON - 340 B	Drug Costs
901529	8/24/2023	40.50	MCKESSON - 340 B	Drug Costs
901531	8/28/2023	388.95	MCKESSON - 340 B	Drug Costs
901533	8/29/2023	301.29	MCKESSON - 340 B	Drug Costs
901534	8/31/2023	0.10	MCKESSON - 340 B	Drug Costs
901515	8/4/2023	596.84	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901522	8/11/2023	1,407.62	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901526	8/21/2023	1,230.96	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901532	8/28/2023	2,777.31	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
19084	8/1/2023	3,164.10	MEDLINE INDUSTRIES	Patient Care Supplies
19122	8/8/2023	5,155.76	MEDLINE INDUSTRIES	Patient Care Supplies
19150	8/15/2023	2,289.86	MEDLINE INDUSTRIES	Patient Care Supplies
19180	8/21/2023	2,839.37	MEDLINE INDUSTRIES	Patient Care Supplies
19212	8/28/2023	1,193.54	MEDLINE INDUSTRIES	Patient Care Supplies
19085	8/1/2023	758.92	MYHEALTH ACCESS NETWORK, INC	Compliance purch svs
901511	8/2/2023	115.00	NATIONAL DATA BANK	Credentialing
19086	8/1/2023	2,167.62	NEXTIVA, INC.	Phones
19213	8/28/2023	2,167.62	NEXTIVA, INC.	Phones
19087	8/1/2023	123.00	NUANCE COMMUNICATIONS INC	RHC purch svs
19088	8/1/2023	350.00	OFMQ	HIM purch svs
19214	8/28/2023	350.00	OFMQ	HIM purch svs
19089	8/1/2023	325.00	OHERI	Employee ed/training
19151	8/15/2023	10,010.40	OKLAHOMA BLOOD INSTITUTE	Blood Bank

Check#	Ck Date	Amount	Paid To	Expense Description
19152	8/15/2023	60.00	OKLAHOMA MEDICAL LICENSURE	Credentialing
19153	8/15/2023	1,959.00	PARA REV LOCKBOX	CDM purch svs
901512	8/2/2023	608.36	PHARMA FORCE GROUP LLC	340B Purch svs
901535	8/31/2023	1,149.22	PHARMA FORCE GROUP LLC	340B Purch svs
19215	8/28/2023	3,491.43	PHARMACY CONSULTANTS, INC.	340B Purch svs
901520	8/10/2023	2,116.00	PHILADELPHIA INSURANCE COMPANY	Hospital Liability Insurance
19216	8/28/2023	216.00	PIPETTE COM	Lab repair/maint
19090	8/1/2023	710.08	PRESS GANEY ASSOCIATES, INC	Quality purch svs
19091	8/1/2023	62.80	PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies
19154	8/15/2023	12.75	PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies
901517	8/4/2023	132.76	PURCHASE POWER	Postage
19092	8/1/2023	6,800.00	SBM MOBILE PRACTICE, INC	1099 Provider
19155	8/15/2023	6,850.00	SBM MOBILE PRACTICE, INC	1099 Provider
19217	8/28/2023	3,400.00	SBM MOBILE PRACTICE, INC	1099 Provider
19093	8/1/2023	1,750.00	SCHAPEN LLC	RHC rent
19218	8/28/2023	1,750.00	SCHAPEN LLC	RHC rent
19181	8/21/2023	2,480.83	SHRED-IT USA LLC	Secure Doc Disposal
19094	8/1/2023	2,973.50	SIZEWISE	Patient Eq rentals
19156	8/15/2023	300.00	SIZEWISE	Patient Eq rentals
19219	8/28/2023	640.98	SIZEWISE	Patient Eq rentals
19095	8/1/2023	6,400.00	SOMSS LLC	1099 Provider
19157	8/15/2023	6,400.00	SOMSS LLC	1099 Provider
19220	8/28/2023	9,600.00	SOMSS LLC	1099 Provider
19158	8/15/2023	430.12	SPACELABS HEALTHCARE LLC	Supplies
19221	8/28/2023	405.98	SPACELABS HEALTHCARE LLC	Supplies
19123	8/8/2023	445.94	SPARKLIGHT BUSINESS	Cable
19182	8/21/2023	306.68	SPARKLIGHT BUSINESS	Cable
19183	8/21/2023	2,150.57	STANDLEY SYSTEMS LLC	Printer rental
19124	8/8/2023	979.60	STAPLES ADVANTAGE	Office Supplies
19159	8/15/2023	608.87	STAPLES ADVANTAGE	Office Supplies
19096	8/1/2023	233.27	STERICYCLE INC	Waste Disposal
19184	8/21/2023	2,913.17	STERICYCLE INC	Waste Disposal
901514	8/3/2023	834.20	SUMMIT UTILITIES	Gas Utilities
18753	8/22/2023	(4.00)	PATIENT REFUND	PATIENT REFUND
19097	8/1/2023	500.00	TIGER ATHLETIC BOOSTERS	Advertising
19185	8/21/2023	332.00	TOPJET SALES, INC	Pharm purch svs
19186	8/21/2023	563.30	TRIZETTO PROVIDER SOLUTIONS	RHC purch svs
19098	8/1/2023	3,540.00	TRS MANAGED SERVICES	Old agency staffing
19125	8/8/2023	3,042.00	TRS MANAGED SERVICES	Old agency staffing
19160	8/15/2023	2,784.00	TRS MANAGED SERVICES	Old agency staffing
19187	8/21/2023	7,712.50	TRS MANAGED SERVICES	Old agency staffing
19222	8/28/2023	3,950.00	TRS MANAGED SERVICES	Old agency staffing
19188	8/21/2023	1,103.30	ULINE	Supplies
19099	8/1/2023	353.89	ULTRA-CHEM INC	Supplies
901516	8/4/2023	2,299.54	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
901523	8/11/2023	2,202.58	US FOODSERVICE-OKLAHOMA CITY	Dietary Food

Check#	Ck Date	Amount	Paid To	Expense Description
901527	8/21/2023	2,119.83	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
901530	8/25/2023	2,361.21	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
19100	8/1/2023	1,474.79	US MED-EQUIP LLC	Patient Eq rentals
19191	8/22/2023	26.97	WPS/TRICARE	PATIENT REFUND
	TOTAL	**1,352,904.61**		

Mangum Regional Medical Center
October 2023 Estimated Claims

Vendor	Description	Estimated Amount
AMBS CALL CENTER	Hotline	50.00
ANESTHESIA SERVICE INC	Service	3,500.00
APEX MEDICAL GAS SYSTEMS, INC	Supplies	900.00
ARAMARK	Linens purch svs	25,000.00
AT&T	Fax Service	6,500.00
BANKDIRECT CAPITAL FINANCE	Facility insurance	7,486.67
BARRY DAVENPORT	1099 Provider	12,000.00
BAXTER HEALTHCARE	Pharmacy Supplies	3,500.00
BIO-RAD LABORATORIES INC	Supplies	3,500.00
BLUTH FAMILY MEDICINE, LLC	1099 Provider	5,300.00
C & C	Supplies	1,000.00
C&S INSTRUMENTS LLC	Supplies	200.00
CARDINAL 110 LLC	Pharmacy Supplies	50,000.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies	2,500.00
CDW-G LLC	Supplies	3,059.84
CITY OF MANGUM	Utilities & property taxes	10,000.00
COHESIVE HEALTHCARE MGMT	Mgmt and provider Fees	130,000.00
COHESIVE HEALTHCARE RESOURCES	Payroll	550,000.00
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	5,000.00
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	380,000.00
COMMERCIAL MEDICAL ELECTRONICS	Quarterly PM service	2,500.00
COMPLIANCE CONSULTANTS	Lab Consultant	1,000.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	4,000.00
CPSI	EHR software	30,000.00
CRITICAL ALERT	Nurse Call	1,000.00
CULLIGAN WATER CONDITIONING	RHC purch svs	150.00
DELL FINANCIAL SERVICES LLC	Server Lease	636.00
DIAGNOSTIC IMAGING ASSOCIATES	Radiology Purch svs	2,150.00
DOBSON TECHNOLOGIES TRANSPORT	Internet	1,824.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	10,000.00
DR. MORGAN	1099 Provider	4,766.00
eCLINICAL WORKS, LLC	RHC EMR	3,500.00
EMD MILLIPORE CORPORATION	Lab PM service and supply	5,831.05
EQUALIZE RCM REVOPS	Billing purch svs	80,000.00
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	5,856.00
FEDEX	Postage	300.00
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	35,000.00
FOX BUILDING SUPPLY	Plant Ops Supplies	800.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	600.00
GLOBAL EQUIPMENT COMPANY INC.	Supplies	1,500.00
GRAINGER	Maintenance Supplies	3,500.00
GREER COUNTY CHAMBER OF	Advertising	900.00

Vendor	Description	Estimated Amount
HAC INC	Dietary Supplies	1,000.00
HAMILTON MEDICAL INC.	Patient Supplies	500.00
HEALTH CARE LOGISTICS	Patient Supplies	1,500.00
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,100.00
HENGST PRINTING	Pharmacy Supplies	250.00
HENRY SCHEIN	Lab Supplies	12,000.00
HILL-ROM COMPANY, INC	Patient Supplies	3,600.00
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	3,155.00
ICU MEDICAL SALES INC.	Drug Library	1,000.00
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	500.00
INQUISEEK	RHC consulting service	225.00
INSIGHT DIRECT USA INC.	Supplies	1,007.36
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	2,700.00
JIMALL & KANISHA' LOFTIS	Rent house	850.00
KCI USA	Patient Supplies	2,000.00
KING GUIDE PUBLICATIONS INC	Advertising	100.00
LABCORP	Lab purch svs	15,000.00
LAMPTON WELDING SUPPLY	Patient Supplies	6,500.00
LANGUAGE LINE SERVICES INC	Translation service	500.00
LOCKE SUPPLY	Plant Ops Supplies	800.00
MANGUM STAR NEWS	advertising	1,000.00
MCKESSON - 340 B	340B patient supplies	1,500.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	25,000.00
MEASUREMENT SPECIALTIES INC	supplies	175.00
MEDLINE INDUSTRIES	Patient Care Supplies	35,000.00
MISC EMPLOYEE REIMBURSEMENTS	To reimburse employees for travel and sup	3,500.00
MYHEALTH ACCESS NETWORK, INC	Compliance	758.92
NATIONAL RECALL ALERT CENTER	Safety recall alert svs renewal	1,290.00
NEXTIVA, INC.	Phone utility	2,500.00
NP RESOURCES	1099 Provider	9,000.00
NUANCE COMMUNICATIONS INC	RHC purch svs	369.00
OFMQ	Quality purch svs	350.00
OK STATE BOARD	Credentialing	300.00
OKLAHOMA BLOOD INSTITUTE	Blood bank	15,000.00
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	1,203.96
PARA HEALTHCARE ANALYTICS, LLC	CDM Review service	6,827.00
PARTSSOURCE INC,	Misc Supplies	200.00
PATIENT REFUNDS	Credits due to payors	2,500.00
PHARMA FORCE GROUP LLC	340B Purch svs	1,200.00
PHARMACY CONSULTANTS, INC.	340B purch svs	2,530.00
PHILADELPHIA INSURANCE COMPANY	Property ins	2,116.00
PHILIPS HEALTHCARE	Supplies	504.88
PIPETTE COM	Lab maintenance/repair	300.00
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	360.00

Vendor	Description	Estimated Amount
PORT53 TECHNOLOGIES, INC.	Supplies	200.88
PRESS GANEY ASSOCIATES, INC	Purchased Service	1,448.44
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	700.00
PURCHASE POWER	Postage	300.00
RADIATION CONSULTANTS	Radiology Purch svs	3,200.00
RESPIRATORY MAINTENANCE INC	Repairs/maintenance	1,330.00
SBM MOBILE PRACTICE, INC	1099 Provider	8,000.00
SCHAPEN LLC	RHC rent	1,750.00
SHRED-IT	Secure doc disposal	5,000.00
SIEMENS HEALTHCARE DIAGNOSTICS	Lab Eq PM annual renewal	12,600.00
SIZEWISE	equipment rental	4,600.00
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	5,205.00
SOMSS LLC	JEFF BRAND 1099 Provider	25,000.00
SOUTHWEST HOT STEAM CLEANING	Quarterly PM service	350.00
SPACELABS HEALTHCARE LLC	Patient Supplies	1,300.00
SPARKLIGHT BUSINESS	Cable service	1,200.00
STANDLEY SYSTEMS LLC	Printer Lease	5,000.00
STAPLES ADVANTAGE	Office Supplies	3,000.00
STERICYCLE INC	Waste Disposal svs	5,000.00
SUMMIT UTILITIES	Utilities	3,500.00
TECUMSEH OXYGEN & MEDICAL SUPP	Supplies	2,000.00
TELEFLEX	Supplies	500.00
TRENT ELLIOTT	1099 Provider	5,000.00
TRIZETTO PROVIDER SOLUTIONS	RHC purch svs	600.00
TRS MANAGED SERVICES	Agency Staffing(Formerly Conexus)	30,000.00
TSYS	CC processing service	2,000.00
ULINE	Supplies	1,500.00
ULTRA-CHEM INC	housekeeping supplies	800.00
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	12,000.00
US MED-EQUIP LLC	Swing bed eq rental	5,000.00
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	7,500.00
	TOTAL Estimated	**1,719,666.00**

QUALITY MANAGEMENT REPORT

SUMMARY

Current Year 2023
Month : 08

ID	Group	METRICS	Unit	Monthly				Cumulative			
				Previous Year Performance	Benchmark	Current Year Performance	CY/PY % of Change	Previous Year Performance	Benchmark	Current Year Performance	CY/PY % of Change
		VOLUME & UTILIZATION									
00101	Volume & Utilization	Total ER visits	#	169.00		154.00	-15.00	1852.00		1168.00	-684.00
00102	Volume & Utilization	Total # of Observation Patients admitted	#	1.00		6.00	5.00	6.00		14.00	8.00
00103	Volume & Utilization	Total # of Acute Patients admitted	#	14.00		18.00	4.00	169.00		118.00	-51.00
00104	Volume & Utilization	Total # of Swing Bed Patients admitted	#	12.00		15.00	3.00	111.00		92.00	-19.00
00105	Volume & Utilization	Total Hospital Admissions (Acute & Swing bed)	#	26.00		33.00	7.00	280.00		210.00	-70.00
00106	Volume & Utilization	Total Discharges (Acute & Swing bed)	#	26.00		31.00	5.00	263.00		206.00	-57.00
00107	Volume & Utilization	Total Patient Days (Acute & Swing bed)	#	324.00		365.00	41.00	3612.00		3113.00	-499.00
00108	Volume & Utilization	Average Daily Census (Acute & Swing bed)	#	11.00		11.80	0.80	10.00		102.20	92.20
00109	Volume & Utilization	Left Against Medical Advice (AMA)	#	4.00	2.00	4.00		38.00	2.00	35.00	-3.00
		CARE MANAGEMENT									
00201	Care Management	CAH 30 Day Readmission Rate per 100 patient discharges	%	4.00	0.05		100%	0.07	0.05	0.04	48%
		RISK MANAGEMENT									
00301	Risk Management	Total Number of Events	#	169.00		1.00	99%	79.00		2.57	97%
00302	Risk Management	Total number of complaints	#			1.00				0.38	
00304	Risk Management	Total number of complaints from ED	#								
00306	Risk Management	Total number of grievances	#	1.00			100%	1.00		0.13	88%
00308	Risk Management	Total number of grievances from ED	#							0.13	
00310	Risk Management	Inpatient falls without injury	#	22.00			100%	22.00		1.25	94%
00312	Risk Management	ED patient falls without injury	#	3.00			100%	3.00			100%
00314	Risk Management	Patient falls with minor injury	#	5.00		1.00	80%	5.00		0.63	88%
00316	Risk Management	ED patient falls with minor injury	#								
00318	Risk Management	Total number of patient falls with major injury	#	1.00			100%	1.00			100%
00320	Risk Management	Total number of ED patient falls with major injury	#								
00323	Risk Management	Inpatient Mortality Rate	%	15.00	0.10	0.00	100%	15.00	0.10	0.00	100%
00325	Risk Management	ED Mortality Rate	%	9.00	0.10	0.01	100%	9.00	0.10	0.00	100%
00327	Risk Management	OPO Notification Compliance	%	95.00	1.00	1.00	99%	95.00	1.00	1.00	99%
		NURSING									
00408	Nursing	Total Number of Code Blues during reporting period	#	12.00		2.00	83%	12.00		2.00	83%
00409	Nursing	Total number of CAH patients transferred to tertiary facility	#	14.00		2.00	86%	14.00		1.13	92%
		EMERGENCY DEPARTMENT									
00508	Emergency Department	ED Left Without Being Seen Rate	#					95.00		1.00	99%
00509	Emergency Department	Total number of ED patients transferred to a tertiary facility	#	118.00		10.00	92%	118.00		10.00	92%

Clinic Operations Report

Mangum Family Clinic

August 2023

Monthly Stats	August 22	August 23
Total Visits	262	200
Provider Prod	158	124
RHC Visits	262	178
Nurse Visits	4	2
Televisit	0	0
Swingbed	n/a	20

Provider Numbers	
Barnes	4
Chiaffitelli	20
Sims	178

Payor Mix	
Medicare	48
Medicaid	59
Self	26
Private	67

Visits per Geography	
Mangum	152
Granite	20
Altus	6
Duke	5

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Visits	167	123	164	166	164	127	148	200					

Clinic Operations:

- Amy Sims, 16 work days for August, 11 patients per day avg.
- Solid Mangum numbers but appear to have lost visits from the smaller communities.
- 55 revenue generating referrals to hospital.

Quality Report:

Improvement Measure	Actual	Goal	Comments
Reg Deficiencies	1	0	10 audited, 1 consent form def.
Patient Satisfaction	9	5	8 Excellent; 1 Good; 1 complaint
New Patients	39	10	Great numbers
No Show	11%	<12%	30
Expired Medications	0	0	New measurement. More to come.

Outreach:

- Minor concern with decrease in numbers from the outlying areas. Attempt to regain.

Summary: Clinic appears to have regained some momentum as August is more representative of the strong numbers of last year. The provider continues to get acquainted with the community and is becoming more comfortable in a Primary Care role. Patient satisfaction scores along with the number of "new patients" noted indicate a significant growth of the clinic.

"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 Regional Medical Center

Chief Clinical Officer Report
August 2023

Patient Care

- MRMC Education included:

  1. Reviewing blood transfusion protocols and documentation

  2. Updated CPSI documentation for ER patients.

  3. Critical lab note created to document more efficiently.

- MRMC Emergency Department reports zero patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports one contaminated blood culture set.
- MRMC Infection Prevention reports 1 CAUTI's.
- MRMC Infection Prevention report 0 CLABSI.

Client Service

- Patients continue to rely on MRMC as their local hospital. Total Patient Days increased with 365 patient days in August as compared to 295 patient days in July. This represents an average daily census of 10. In addition, MRMC Emergency Department provided care to 154 patients in August.
- MRMC Case Management reports 33 Total Admissions for the month of August 2023.
- August 2023 COVID-19 Stats at MRMC: Swabs (17 PCR & 40 Antigen) with 2 Positive.

Preserve Rural Healthcare

Mangum Regional Medical Center												
31 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec 22
Inpatient	13	17	19	11	16	19	22	33				22
Swing Bed	14	14	15	5	12	12	10	15				6
Observation	1	1	1	1	1	1	2	6				0
Emergency Room	159	119	168	138	148	130	152	154				210
Lab Completed	2542	2159	2804	1897	2191	1802	1987	2409				2337
Rad Completed	211	185	244	204	192	196	160	184				214
Ventilator Days	0	0	31	30	7	0	0	0				0

Preserve Rural Jobs

- All allowable/available positions in regard to nursing staff filled at this time!

Mangum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Chief Executive Officer Report
August 2023

Operations Overview

- We are continuing to work with a few physicians for s possible clinic position and midlevel supervision.
- Since the start of our new CCO we have been hiring core staff. We do plan on continuing to hire more core staff later.
- We continue our pursuit of working with the community.
- We continue to work with the nursing home to have a positive working relationship.
- We continue to look at our working relationship with the Oklahoma Department of Mental Health and Substance Abuse for overdose prevention.
- We have now implemented a new part of CPSI called Bamboo Health that allows us to look at narcotic usage of patients across several states.
- We now have access to MyHealth which is an information sharing site that is HIPAA complaint that will improve patient care.
- We continue to work on educating the staff and the Providers on new rules and regulations to ensure compliance.
- We continue to talk with providers and other facilities to let them know the level of care we can provide for their patients.
- Our outpatient physical therapy continues to be steady.

Mangum Board Meeting Financial Reports

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

Mangum Regional Medical Center
August 2023

	Current Month	COVID	Total Less COVID	Year-To-Date	Year-To-Date Less COVID
Cash Receipts	$ 1,600,786	$ -	$ 1,600,786	$ 12,672,911	$ 12,672,911
Cash Disbursements	$ (1,352,905)	$ -	$ (1,352,905)	$ (12,555,072)	$ (12,415,625)
NET	$ 247,881	$ -	$ 247,881	$ 117,839	$ 257,286

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

September 26, 2023

Board of Directors
Mangum Regional Medical Center

August 2023 Financial Statement Overview

- Statistics
  - The average daily census in August was 11.90. This is an increase of 2.39 from the previous month. As a reminder our target remains 11 ADC. YTD 2023 (12.82) continues to reflect a material increase from the 2022 YTD average of 9.85.
  - YTD Inpatient Medicare utilization percentage has dropped slightly to approximately 87%. As a comparison, prior year 2022 was 89%.
  - Cash receipts for the month of July totaled $1.6M (Generally speaking, there is approximately a one-two month lag between the net revenue generated each month & the majority of the cash collected).
  - Cash disbursements totaled $1.35M for the month.

- Balance Sheet Highlights
  - The operating cash balance as of August is $654K, with the cash reserve at $812K, totaling $1.5M. Days cash on hand is equivalent to 12.79.
  - Accounts Payable has increased $216K from the previous month primarily due to decreased cash disbursements relative to operating expenses.
  - The Due to Medicare account reflects a net increase of $160K from the previous month primarily due to a calculated estimate on the 2023 Medicare payable.

COHESIVE HEALTHCARE MANAGEMENT • CONSULTING

- Income Statement Highlights
    - Net patient revenue is $1.43M, of which $13K is related to 340B.
    - Operating expenses for the month of June reflect $1.55M, this is slightly above YTD trends primarily due to a catch up in unaccrued benefits, and increased supply and rental costs associated with higher acuity patients.
    - August resulted in a net loss of $(162)K.

- Clinic (Estimated) Income Statement Highlights
    - YTD visits per day – 6.68
    - Estimated operating revenues - $245K.
    - Estimated operating expenses - $647K.
    - Estimated YTD operating loss – $(401)K.

- Additional Notes

  In response to the potential Medicare liability estimated, a cash reserve has been implemented in the month of March 2023. We will continue to closely monitor the potential payable and adjust the cash reserve correspondingly. The cash reserve referenced is operating cash specifically allocated to repay Medicare monies if overpayment results, and to mitigate the need to request a Medicare ERS loan should a liability be unavoidable.

MANGUM REGIONAL MEDICAL CENTER

Admissions, Discharges & Days of Care
Fiscal Year 2023

	January	February	March	April	May	June	July	August	12/31/2023 YTD	12/31/2022 PY Comparison
Admissions										
Inpatient	13	16	19	11	16	12	13	19	119	114
Swingbed	14	14	15	5	12	7	10	15	92	80
Observation	0	1	1	1	2	1	2	6	14	5
	27	31	35	17	30	20	25	40	225	199
Discharges										
Inpatient	15	16	20	10	16	12	10	18	117	114
Swingbed	10	11	14	11	6	12	12	14	90	81
Observation	0	1	1	1	2	1	2	6	14	5
	25	28	35	22	24	25	24	38	221	200
Days of Care										
Inpatient-Medicare	23	31	43	22	35	27	25	39	245	242
Inpatient-Other	33	29	32	13	19	11	8	21	166	140
Swingbed-Medicare	371	356	386	289	328	240	222	281	2,473	1,991
Swingbed-Other	0	2	42	51	30	39	40	28	232	122
Observation	0	1	1	1	2	1	2	6	14	5
	427	419	504	376	414	318	297	375	3,130	2,500
	371	358	428	340	358	279	262	309		
Calendar days	31	28	31	30	31	30	31	31	243	243
ADC - (incl OBS)	13.77	14.96	16.26	12.53	13.35	10.60	9.58	12.10	12.88	10.29
ADC	13.77	14.93	16.23	12.50	13.29	10.57	9.52	11.90	12.82	10.27
ER	158	119	169	136	148	132	152	154	1,168	1,143
Outpatient	176	132	182	141	177	152	171	190	1,321	2,046
RHC	170	123	167	162	164	125	142	196	1,249	1,329

MANGUM REGIONAL MEDICAL CENTER

Comparative Balance Sheet - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	Prior Month Variance
Cash And Cash Equivalents	980,584	677,752	684,122	724,967	556,140	627,470	566,073	654,397	**88,324**
Reserved Funds	-	-	800,000	1,400,000	768,400	968,400	662,189	812,189	**150,000**
Patient Accounts Receivable, Net	1,696,258	1,823,404	2,265,664	2,231,841	2,003,361	1,480,786	1,551,449	1,553,568	**2,119**
Due From Medicare	74,934	74,956	-	-	-	-	-	-	-
Inventory	243,297	235,738	244,725	260,940	270,700	234,397	228,685	239,652	**10,968**
Prepaids And Other Assets	1,990,291	1,968,284	1,941,610	1,993,890	1,977,854	1,958,215	1,941,193	1,911,984	**(29,209)**
Capital Assets, Net	2,325,712	2,274,924	2,224,332	2,174,390	2,126,662	2,104,656	2,056,492	2,008,327	**(48,164)**
Total Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,118	174,038
Accounts Payable	16,893,910	16,526,357	11,418,965	11,562,124	11,770,040	11,703,708	12,099,854	12,315,821	**215,968**
AHSO Related AP	892,724	892,724	892,724	892,724	892,724	892,724	892,724	892,724	-
Due To Medicare	2,586,010	2,840,280	3,653,730	4,246,353	3,336,103	3,256,838	2,720,743	2,880,235	**159,492**
Covid Grant Funds	-	-	-	-	-	-	-	-	-
Due To Cohesive - PPP Loans	-	-	-	-	-	-	-	-	-
Notes Payable - Cohesive	-	-	5,552,000	5,520,983	5,489,966	5,458,950	5,427,933	5,396,916	**(31,017)**
Notes Payable - Other	23,565	23,565	23,565	95,369	88,382	81,409	74,366	67,281	**(7,084)**
Alliantz Line Of Credit	-	-	-	-	-	-	-	-	-
Leases Payable	273,074	269,075	265,054	261,011	256,946	280,019	276,961	276,057	**(904)**
Total Liabilities	20,669,282	20,552,001	21,806,037	22,578,564	21,834,161	21,673,647	21,492,580	21,829,034	336,454
Net Assets	(13,358,207)	(13,496,944)	(13,645,584)	(13,792,536)	(14,131,044)	(14,299,723)	(14,486,500)	(14,648,915)	**(162,416)**
Total Liablities and Net Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,118	174,038

Mangum Regional Medical Center
Cash Receipts & Disbursements by Month
September 26, 2023 Board Meeting

2021				2022				2023		
Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Disbursements
January-21	830,598		695,473	January-22	2,163,583		1,435,699	January-22	1,290,109	1,664,281
February-21	609,151		1,472,312	February-22	1,344,463	254,626	1,285,377	February-22	1,506,708	1,809,690
March-21	910,623	49,461	866,387	March-22	789,800		1,756,782	March-22	1,915,435	1,109,683
April-21	742,500		999,127	April-22	1,042,122		1,244,741	April-22	2,005,665	1,365,533
May-21	816,551		1,528,534	May-22	898,311		1,448,564	May-22	1,436,542	2,237,818
June-21	936,092		1,455,892	June-22	1,147,564		1,225,070	June-22	1,777,525	1,506,459
July-21	1,009,037		1,774,932	July-22	892,142		979,914	July-22	1,140,141	1,508,702
August-21	1,292,886	100,000	2,156,724	August-22	890,601		1,035,539	August-22	1,600,786	1,352,905
September-21	278,972		753,559	September-22	2,225,347		1,335,451	September-22		
October-21	1,954,204		1,343,425	October-22	1,153,073		1,233,904	October-22		
November-21	1,113,344	316,618	1,800,166	November-22	935,865		1,476,384	November-22		
December-21	1,794,349	305,543	1,325,063	December-22	1,746,862		1,073,632	December-22		
	12,288,308	771,623	16,171,592		15,229,733	254,626	15,531,057		12,672,911	12,555,072
Subtotal FY 2021	13,059,930			Subtotal FY 2022	15,484,359			Subtotal FY 2022	12,672,911	

Mangum Regional Medical Center
Medicare Payables by Year
September 26, 2023 Board Meeting

Year	Original Balance	Balance as of 08/31/2023	Total Interest Paid as of 08/31/2023
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)	581,445.86	251,198.14
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	-	277,488.75
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 MCR pay (rec) estimate	2,515,000.00	2,298,789.00	
Total	**7,511,072.85**	**2,880,234.86**	**1,174,519.75**

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended August 31, 2023
Unaudited

MTD					YTD			
Actual	Budget	Variance	% Change		Actual	Budget	Variance	% Change
346,918	190,415	156,503	82%	Inpatient revenue	2,075,949	1,497,687	578,262	39%
1,406,639	675,775	730,865	108%	Swing Bed revenue	9,950,759	5,293,958	4,656,800	88%
672,465	603,169	69,296	11%	Outpatient revenue	4,633,478	4,716,099	(82,622)	-2%
182,030	162,883	19,147	12%	Professional revenue	1,302,231	1,276,650	25,581	2%
2,608,052	1,632,242	975,810	60%	Total patient revenue	17,962,416	12,784,395	5,178,021	41%
836,330	224,803	611,527	272%	Contractual adjustments	3,863,585	1,680,028	2,183,557	130%
240,000	-	240,000	#DIV/0!	Contractual adjustments: MCR Settlement	2,680,967		2,680,967	#DIV/0!
99,904	110,013	(10,110)	-9%	Bad debts	535,768	861,668	(325,900)	-38%
1,176,234	334,816	841,417	251%	Total deductions from revenue	7,080,320	2,541,696	4,538,624	179%
1,431,818	1,297,425	134,393	10%	Net patient revenue	10,882,096	10,242,699	639,397	6%
1,035	3,618	(2,583)	-71%	Other operating revenue	24,396	28,936	(4,541)	-16%
12,515	59,881	(47,366)	-79%	340B REVENUES	96,733	444,831	(348,098)	-78%
1,445,369	1,360,924	84,444	6%	Total operating revenue	11,003,225	10,716,466	286,758	3%
				Expenses				
441,681	367,109	74,572	20%	Salaries and benefits	3,180,136	2,879,990	300,146	10%
141,126	142,250	(1,124)	-1%	Professional Fees	1,156,531	1,123,657	32,873	3%
396,420	433,230	(36,810)	-9%	Contract labor	3,128,381	3,395,943	(267,562)	-8%
144,927	110,282	34,645	31%	Purchased/Contract services	1,075,307	864,343	210,964	24%
225,000	225,000	-	0%	Management expense	1,800,000	1,800,000	-	0%
109,013	88,610	20,404	23%	Supplies expense	799,028	695,698	103,330	15%
36,558	29,926	6,632	22%	Rental expense	237,718	237,611	107	0%
15,749	16,788	(1,039)	-6%	Utilities	148,039	134,308	13,731	10%
170	1,219	(1,049)	-86%	Travel & Meals	10,265	9,661	603	6%
10,891	12,129	(1,239)	-10%	Repairs and Maintnenance	92,792	96,737	(3,945)	-4%
12,384	12,596	(212)	-2%	Insurance expense	89,381	100,764	(11,383)	-11%
8,940	21,829	(12,889)	-59%	Other Expense	189,728	174,580	15,149	9%
10,877	33,672	(22,795)	-68%	340B EXPENSES	64,259	263,944	(199,685)	-76%
1,553,737	1,494,641	59,096	4%	Total expense	11,971,563	11,777,235.2	194,328	2%
(108,368)	(133,716)	25,348	-19%	EBIDA	(968,339)	(1,060,769)	92,430	-9%
-7.5%	-9.8%	2.33%		EBIDA as percent of net revenue	-8.8%	-9.9%	1.10%	
5,883	5,539	344	6%	Interest	63,000	63,735	(735)	-1%
48,164	48,039	125	0%	Depreciation	400,651	381,671	18,980	5%
(162,416)	(187,295)	24,879	-13%	Operating margin	(1,431,989)	(1,506,175)	74,186	-5%
-	-	-		Other	-	-	-	
-	-	-		Total other nonoperating income	-	-	-	
(162,416)	(187,295)	24,879	-13%	Excess (Deficiency) of Revenue Over Expenses	(1,431,989)	(1,506,175)	74,186	-5%
-11.24%	-13.76%	2.53%		Operating Margin %	-13.01%	-14.05%	1.04%	

MANGUM REGIONAL MEDICAL CENTER
Statement of Revenue and Expense Trend - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	YTD
Inpatient revenue	**248,170**	**273,130**	**272,704**	**168,264**	**292,654**	**256,424**	**217,685**	**346,918**	2,075,949
Swing Bed revenue	**857,835**	**848,580**	**1,159,897**	**1,415,031**	**1,815,525**	**1,219,155**	**1,228,096**	**1,406,639**	9,950,759
Outpatient revenue	**569,774**	**479,203**	**655,242**	**450,232**	**596,547**	**566,829**	**643,187**	**672,465**	4,633,478
Professional revenue	**165,566**	**172,559**	**183,040**	**122,822**	**164,587**	**152,378**	**159,248**	**182,030**	1,302,231
Total patient revenue	1,841,345	1,773,472	2,270,883	2,156,349	2,869,312	2,194,786	2,248,217	2,608,052	17,962,416
Contractual adjustments	**(121,100)**	**19,061**	**(134,294)**	**(23,053)**	**1,539,024**	**831,011**	**916,605**	**836,330**	3,863,585
Contractual adjustments: MCR Settlement	**533,168**	**285,044**	**920,000**	**702,755**	**-**	**-**	**-**	**240,000**	2,680,967
Bad debts	**25,723**	**134,415**	**12,093**	**118,358**	**49,948**	**41,945**	**53,383**	**99,904**	535,768
Total deductions from revenue	437,792	438,520	797,799	798,060	1,588,972	872,957	969,988	1,176,234	7,080,320
Net patient revenue	1,403,553	1,334,952	1,473,084	1,358,289	1,280,341	1,321,829	1,278,229	1,431,818	10,882,096
Other operating revenue	**643**	**481**	**1,746**	**782**	**4,037**	**14,751**	**920**	**1,035**	24,396
340B REVENUES	**17,199**	**11,534**	**9,264**	**6,654**	**7,518**	**25,149**	**6,901**	**12,515**	96,733
Total operating revenue	1,421,395	1,346,967	1,484,094	1,365,725	1,291,895	1,361,730	1,286,050	1,445,369	11,003,225
	89.8%	89.9%	90.2%	89.8%	78.5%	86.4%	86.8%	89.1%	87.5%
Expenses									
Salaries and benefits	**361,005**	**411,948**	**411,789**	**381,508**	**403,854**	**366,863**	**401,488**	**441,681**	3,180,136
Professional Fees	**149,199**	**131,495**	**159,564**	**139,183**	**153,226**	**141,955**	**140,784**	**141,126**	1,156,531
Contract labor	**467,147**	**361,407**	**425,232**	**351,293**	**409,120**	**355,927**	**361,836**	**396,420**	3,128,381
Purchased/Contract services	**107,498**	**115,260**	**160,858**	**144,976**	**166,564**	**132,525**	**102,698**	**144,927**	1,075,307
Management expense	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	1,800,000
Supplies expense	**85,209**	**77,055**	**109,037**	**83,909**	**96,572**	**145,554**	**92,679**	**109,013**	799,028
Rental expense	**25,693**	**25,335**	**22,200**	**40,587**	**37,323**	**28,670**	**21,353**	**36,558**	237,718
Utilities	**19,305**	**20,759**	**20,147**	**17,598**	**17,253**	**19,058**	**18,169**	**15,749**	148,039
Travel & Meals	**721**	**1,537**	**2,377**	**1,470**	**2,279**	**1,610**	**101**	**170**	10,265
Repairs and Maintnenance	**14,713**	**10,390**	**11,618**	**10,943**	**11,837**	**10,109**	**12,289**	**10,891**	92,792
Insurance expense	**13,940**	**13,997**	**5,518**	**6,394**	**12,379**	**12,386**	**12,384**	**12,384**	89,381
Other	**14,963**	**25,844**	**14,797**	**47,046**	**32,512**	**22,132**	**23,495**	**8,940**	189,728
340B EXPENSES	**9,702**	**6,242**	**5,693**	**5,170**	**7,268**	**13,332**	**5,975**	**10,877**	64,259
Total expense	1,494,096	1,426,270	1,573,830	1,455,077	1,575,186	1,475,120	1,418,248	1,553,737	11,971,563
EBIDA	$ (72,701)	$ (79,303)	$ (89,736)	$ (89,352)	$ (283,290)	$ (113,390)	$ (132,198)	$ (108,368)	$ (968,339)
EBIDA as percent of net revenue	-5.1%	-5.9%	-6.0%	-6.5%	-21.9%	-8.3%	-10.3%	-7.5%	-8.8%
Interest	**10,509**	**9,096**	**8,824**	**7,659**	**7,489**	**7,125**	**6,414**	**5,883**	63,000
Depreciation	**58,070**	**50,338**	**50,080**	**49,942**	**47,728**	**48,164**	**48,164**	**48,164**	400,651
Operating margin	$ (141,280)	$ (138,737)	$ (148,640)	$ (146,952)	$ (338,508)	$ (168,680)	$ (186,776)	$ (162,416)	$ (1,431,989)
Other	-	-	-	-	-	-	-	-	-
Total other nonoperating income	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess (Deficiency) of Revenue Over Expenses	(141,280)	(138,737)	(148,640)	(146,952)	(338,508)	(168,680)	(186,776)	(162,416)	(1,431,989)
Operating Margin % (excluding other misc. reve	-9.94%	-10.30%	-10.02%	-10.76%	-26.20%	-12.39%	-14.52%	-11.24%	-13.01%

	8/31/2023
On-Site Visits -->	1,143
On-Site Visit / Bus Day -->	6.68

	"Annualized"		
On-Site Visits -->	1,715	2,006	2,815
On-Site Visit / Bus Day -->	6.62	7.75	11.04

Mangum Family Clinic

Eight Months Ended 08/31/2023

Description	YTD FS Per General Ledger	Eliminate Rev Deduct & Other Inc	Adj Rev Deduct to RHC Calc	Cost Report Allocations	8 RHC Financial Statements	FY 2023 "Annualized" RHC Financial Statements	FY 2022 RHC Financial Statements	FY 2021 RHC Financial Statements
Gross Patient Revenue	138,893	-	-	-	138,893	208,340	275,833	362,255
Less: Revenue deductions	161,469	(161,469)	106,839	-	106,839	160,258	242,729	180,028
Net Patient Revenue	300,362	(161,469)	106,839	-	245,732	368,598	518,562	542,283
Other Income (if any)	1,932	(1,932)	-	-	-	-	-	-
Operating revenue	302,294	(163,401)	106,839	-	245,732	368,598	518,562	542,283
Operating Expenses:								
Salaries	94,478	-	-	-	94,478	141,716	118,718	173,301
Benefits	-	-	-	-	-	-	-	-
Prof Fees	158,906	-	-	27,681	186,587	279,880	280,148	231,819
Contract Labor	40,597	-	-	-	40,597	60,895	10,559	-
Purch Serv	48,066	-	-	-	48,066	72,099	38,489	30,432
Supplies	2,926	-	-	-	2,926	4,390	7,015	8,420
Rent	18,376	-	-	-	18,376	27,565	21,305	21,089
Utilities	6,660	-	-	-	6,660	9,990	10,710	5,517
Repairs	175	-	-	-	175	263	176	426
Other	3,409	-	-	-	3,409	5,113	3,560	1,325
Insurance	1,725	-	-	-	1,725	2,588	2,462	2,359
Travels & Meals	4,188	-	-	-	4,188	6,281	450	-
Management Fee Direct Exp	(0)	-	-	92,322	92,322	138,483	138,484	130,950
Critical Access Hospital Overhead Allocation (a)	-	-	-	147,291	147,291	220,937	202,053	167,258
Total Operating Expenses	379,505	-	-	267,294	646,799	970,200	834,129	772,896
Net Income (loss)	**(77,211)**	**(163,401)**	**106,839**	**(267,294)**	**(401,067)**	**(601,602)**	**(315,567)**	**(230,613)**

MGMT Fee Allocation est. 2023	1 months	11,540
IP Rounding allocation based on 8/31/22 IRR estimate	8 months	27,681
CAH Overhead Allocation - from Chris based on last filed cost report -------->	12 months	220,936
Total allocation ------->		260,157

214.99 <--Rev per vist
565.88 <--Cost per visit

(350.89) <---(loss)profit per visit

MRMC AP AGING SUMMARY
For Month Ending
8/31/2023

VENDOR	Description	0-30	31-60	61-90	Over 90	8/31/2023	7/31/2023	6/30/2023
ANESTHESIA SERVICE INC	Patient Supplies	2,510.17				2,510.17	-	-
APEX MEDICAL GAS SYSTEMS, INC	Supplies		-			-	900.00	900.00
ARAMARK	Linen Services	11,022.47	12,707.27			23,729.74	26,588.50	24,271.94
ASPEN INSPECTION SERVICES	Repairs/maintenance	300.00				300.00	-	-
AT&T	Fax Service	2,413.05				2,413.05	4,380.33	1,999.99
AVANAN, INC.	COVID Capital				16,800.00	16,800.00	16,800.00	16,800.00
BARRY DAVENPORT	1099 Provider	-				-	4,320.00	4,320.00
BIO-RAD LABORATORIES INC	Lab Supplies	1,550.42				1,550.42	1,842.22	1,547.82
BRIGGS HEALTHCARE	Supplies		-			-	32.64	-
CARNEGIE EMS	Patient Transport Svs	8,550.00				8,550.00	7,150.00	7,150.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies				9,869.76	9,869.76	-	-
CDW-G LLC	Supplies				3,059.84	3,059.84	3,059.84	3,059.84
CITY OF MANGUM	Utilities	8,048.85				8,048.85	8,940.17	7,158.78
CliftonLarsonAllen LLP	Audit firm	-	-	-		-	6,300.00	5,250.00
COHESIVE HEALTHCARE MGMT	Mgmt Fees	225,517.50	2,892.21	225,084.93	742,430.96	1,195,925.60	1,026,206.55	866,478.88
COHESIVE HEALTHCARE RESOURCES	Payroll	291,777.71	615,495.83	444,249.84	3,793,678.17	5,145,201.55	5,204,553.00	4,744,235.50
COHESIVE MEDIRYDE LLC	Patient Transportation Service	794.75				794.75	2,948.75	-
COHESIVE STAFFING SOLUTIONS	Agency Staffing Service	359,888.17	331,062.72	446,087.62	3,618,167.16	4,755,205.67	4,858,389.89	4,899,783.16
COMMERCIAL MEDICAL ELECTRONICS	Quarterly Maintenance		2,450.00			2,450.00	4,900.00	2,450.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	2,000.00	1,915.95		20,065.00	23,980.95	25,980.95	24,065.00
CPSI	EHR Software	4,411.00				4,411.00	3,112.00	3,110.00
CULLIGAN WATER CONDITIONING	Clinic Purchased Service	-				-	-	11.00
CURBELL MEDICAL PRODUCTS INC	Supplies		-			-	128.66	128.66
DELL FINANCIAL SERVICES LLC	Server Lease				590.96	590.96	1,314.97	3,184.00
DIAGNOSTIC IMAGING ASSOCIATES	Radiology Purch Svs	4,300.00			6,450.00	10,750.00	4,300.00	-
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees		9,167.70	24,651.40	322,772.45	356,591.55	398,621.67	389,453.97
DR W. GREGORY MORGAN III	1099 Provider	4,766.67				4,766.67	4,766.67	4,766.67
eCLINICAL WORKS, LLC	RHC EHR	-				-	2,875.50	-
EMD MILLIPORE CORPORATION	Lab Supplies		5,831.05			5,831.05	5,831.05	-
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	2,928.00				2,928.00	2,928.00	2,928.00
FEDEX	Postage service	84.71				84.71	171.79	220.97
FEDEX FREIGHT	Reversed in July	-				-	-	1,964.04
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	-				-	10,259.90	10,423.65
FLOWERS UNLIMITED	Patient Other				-	-	-	50.00
FORVIS LLP	Finance Purch Svs(Formerly BKD)		-	-		-	2,487.13	2,341.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	160.00	160.00			320.00	320.00	320.00
GLOBAL PAYMENTS INTEGRATED	CC processing svs	-				-	-	887.32
GRAINGER	Maintenance Supplies	-				-	1,945.24	-
GREER COUNTY CHAMBER OF	Advertising		300.00		600.00	900.00	900.00	1,000.00
HAC INC	Dietary Supplies	591.89				591.89	804.43	526.04
HEALTH CARE LOGISTICS	Pharmacy Supplies		2,473.18			2,473.18	3,208.38	735.20
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	-				-	1,050.00	1,050.00
HENRY SCHEIN	Lab Supplies	-	-	-		-	2,824.61	(491.26)
HILL-ROM COMPANY, INC	Rental Equipment			-		-	2,470.95	2,470.95
ICU MEDICAL SALES INC.	Supplies			-		-	1,000.00	1,000.

VENDOR	Description	0-30	31-60	61-90	Over 90	8/31/2023	7/31/2023	6/30/
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	204.30				204.30	306.45	102.15
INQUISEEK LLC	RHC purch svs				225.00	225.00	225.00	225.00
INSIGHT DIRECT USA INC.	Minor Equipment			1,007.36		1,007.36	1,007.36	1,007.36
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	656.41				656.41	2,283.95	1,266.60
JIMALL & KANISHA' LOFTIS	Rent House	-				-	850.00	-
KCI USA	Rental Equipment		234.96			234.96	2,356.43	2,617.16
KING GUIDE PUBLICATIONS INC	Advertising				100.00	100.00	100.00	100.00
LABCORP	Lab purch svs		2,135.18			2,135.18	4,883.20	5,860.01
LAMPTON WELDING SUPPLY	Patient Supplies	-				-	2,849.75	1,275.29
LANGUAGE LINE SERVICES INC	Translation service		130.00	130.00		260.00	390.00	390.00
LG PRINT CO	Pharmacy Supplies				-	-	-	62.00
LOCKE SUPPLY	Plant Ops supplies	-				-	235.21	-
MANGUM STAR NEWS	Advertising	-	-			-	145.50	499.50
MARK CHAPMAN	Employee Reimbursement	-				-	531.57	640.88
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	20,321.61				20,321.61	5,982.44	20,835.92
MEDLINE INDUSTRIES	Patient Care/Lab Supplies	17,456.39	1,076.89			18,533.28	14,525.73	13,126.06
MYHEALTH ACCESS NETWORK, INC	Compliance purch svs	758.92				758.92	758.92	758.92
NATIONAL RECALL ALERT CENTER	Safety and Compliance				1,290.00	1,290.00	1,290.00	1,290.00
NEXTIVA, INC.	Phone Svs	-				-	2,167.62	-
NUANCE COMMUNICATIONS INC	RHC purch svs		123.00	123.00	123.00	369.00	369.00	246.00
OFMQ	Quality purch svs	350.00				350.00	700.00	350.00
OHERI	Education/Training	-				-	325.00	-
OKLAHOMA BLOOD INSTITUTE	Blood Bank		11,788.30			11,788.30	10,010.40	2,171.00
ORTHO-CLINICAL DIAGNOSTICS INC	Lab purch svs				1,203.96	1,203.96	1,203.96	1,203.96
PARA REV LOCKBOX	CDM purch svs	1,959.00		2,909.00	1,959.00	6,827.00	6,827.00	3,918.00
PHARMA FORCE GROUP LLC	340B purch svs	-				-	608.36	1,210.81
PHARMACY CONSULTANTS, INC.	340B purch svs	-				-	3,491.43	-
PHILADELPHIA INSURANCE COMPANY	OHA Insurance	2,116.00				2,116.00	2,116.00	-
PHILIPS HEALTHCARE	Supplies			504.88		504.88	504.88	504.88
PIPETTE COM	Lab maintenance	-				-	216.00	-
PITNEY BOWES GLOBAL FINANCIAL	Postage rental			359.76		359.76	359.76	-
PORT53 TECHNOLOGIES, INC.	Software license		200.88			200.88	200.88	-
PRESS GANEY ASSOCIATES, INC	Purchased Service		738.48	709.96		1,448.44	2,158.52	1,420.16
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	4.00				4.00	62.80	-
PURCHASE POWER	Postage Fees	-				-	132.76	100.00
RADIATION CONSULTANTS	Radiology maintenance			3,200.00		3,200.00	3,200.00	3,200.00
RESPIRATORY MAINTENANCE INC	Repairs/maintenance			1,330.00		1,330.00	1,330.00	-
REYES ELECTRIC LLC	COVID Capital				20,670.00	20,670.00	20,670.00	20,670.00
SBM MOBILE PRACTICE, INC	1099 Provider	-				-	6,800.00	6,800.00
SCHAPEN LLC	Clinic Rent	-				-	1,750.00	-
SHERWIN-WILLIAMS	Supplies				(11.78)	(11.78)	(11.78)	(11.78)
SHRED-IT USA LLC	Secure Doc disposal service	4,984.78				4,984.78	2,480.83	4,791.78
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract		12,600.00			12,600.00	12,600.00	-
SIZEWISE	Rental Equipment	4,604.00				4,604.00	3,914.48	3,273.50
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider			3,470.00	1,735.00	5,205.00	5,205.00	3,470.00
SOMSS LLC	1099 Provider	-				-	6,400.00	10,600.00
SPACELABS HEALTHCARE LLC	Telemetry Supplies			405.98		405.98	1,242.08	430.12
SPARKLIGHT BUSINESS	Cable service	451.94				451.94	445.94	-

VENDOR	Description	0-30	31-60	61-90	Over 90	8/31/2023	7/31/2023	6/30/
STANDLEY SYSTEMS LLC	Printer lease	2,150.57	2,150.57			4,301.14	2,314.94	2,314.94
STAPLES ADVANTAGE	Office Supplies	-				-	1,588.47	535.82
STERICYCLE INC	Waste Disposal Service	3,255.57				3,255.57	233.27	-
SUMMIT UTILITIES	Utilities	843.30				843.30	834.20	962.97
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	1,755.00		3,195.00		4,950.00	3,195.00	5,690.00
TIGER ATHLETIC BOOSTERS	Advertising	-				-	500.00	-
TOUCHPOINT MEDICAL, INC	Med Dispense Monitor Support				3,285.00	3,285.00	3,285.00	3,285.00
TRS MANAGED SERVICES	Agency Staffing-old				103,999.01	103,999.01	125,027.51	142,169.76
ULINE	Patient Supplies		-			-	1,103.30	1,103.30
ULTRA-CHEM INC	Housekeeping Supplies		-			-	353.89	353.89
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	2,486.53				2,486.53	4,502.12	5,687.66
US MED-EQUIP LLC	Swing bed eq rental		-			-	1,474.79	2,316.28
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service				5,130.00	5,130.00	5,130.00	5,130.00
WELCH ALLYN, INC.	Supplies				(628.66)	(628.66)	(628.66)	(628.66)
WORTH HYDROCHEM	semi-annual water treatment		482.00			482.00	-	-
Grand Total		**995,973.68**	**1,016,116.17**	**1,157,418.73**	**8,673,563.83**	**11,843,072.41**	**11,939,730.05**	**11,318,877.36**
			Reconciling Items:		Conversion Variance	13,340.32	13,340.32	13,340.32
					AP Control	12,722,455.85	12,819,113.49	12,198,260.80
					Accrued AP	486,089.34	173,464.20	398,171.02
					AHSO Related AP	(892,723.76)	(892,723.76)	(892,723.76)
					TOTAL AP	**12,315,821.43**	**12,099,853.93**	**11,703,708.06**

AHSO Related AP	Description	8/31/2023
ADP INC	QMI Payroll Service Provider	4,276.42
ADP SCREENING AND SELECTION	QMI Payroll Service Provider	1,120.00
ALLIANCE HEALTH SOUTHWEST OKLA	Old Mgmt Fees	698,000.00
AMERICAN HEALTH TECH	Rental Equipment-Old	22,025.36
C.R. BARD INC.	Surgery Supplies-Old	3,338.95
COMPLIANCE CONSULTANTS	Lab Consultant-Old	1,000.00
ELISE ALDUINO	1099 AHSO consultant	12,000.00
HEADRICK OUTDOOR MEDIA INC	AHSO Advertising	25,650.00
HERC RENTALS-DO NOT USE	Old Rental Service	7,653.03
IMEDICAL INC	Surgery Supplies-Old	1,008.29
MEDSURG CONSULTING LLC	Equipment Rental Agreement	98,670.36
MICROSURGICAL MST	Surgery Supplies-Old	2,233.80
MID-AMERICA SURGICAL SYSTEMS	Surgery Supplies-Old	3,607.60
NINJA RMM	IT Service-Old	2,625.00
QUARTZ MOUNTAIN RESORT	Alliance Travel	9,514.95
SUBTOTAL-AHSO Related AP		**892,723.76**

Hospital Vendor Contract Summary Sheet

1. ☒ **Existing Vendor** ☐ **New Vendor**

2. Name of Contract:

- Addendum to eClinicalWorks to add Enterprise Business Optimizer (EBO) license agreement.

3. Contract Parties:

- eClinicalWorks
- Mangum Regional Medical Center/Mangum Family Clinic

4. Contract Type Services: Licensing and Services Agreement

a. Impacted Hospital Departments: Information Technology and 340B Program

5. Contract Summary: Allows the hospital to optimize 340B revenues for part-time providers.

6. Cost: $6,000.00 (one-time fee)

7. Prior Cost: $0.00

8. Term: Follow the terms of the original agreement with eClinicalWorks.

a. Termination Clause: Follow the terms of the original agreement with eClinicalWorks.

9. Other: None.

eClinicalWorks

Addendum to eClinicalWorks® ADD Enterprise Business Optimizer (EBO) license AGREEMENT

Customer Name	Mangum Family Clinic	eClinicalWorks
Customer Address	118 S. louis Tittle,	2 Technology Drive
City, State, Zip Code	MANGUM, OK, 73554	Westborough, MA 01581
Customer Phone Number	580-782-2000	Phone : 508-836-2700
Customer Contact Name	Jared Ballard	Fax : 508-475-0842

Effective Date : Sep 13, 2023 APU ID : 320886 Initial Term : 12 Months from Effective Date

This addendum is valid for 30 days from September 15, 2023. If addendum hasn't been signed within 30 days of issuance, please contact Sales at eClinicalWorks for a new addendum.

OPTIONAL ITEM(S) **Case #** **10902494**

Item(s)	Cost	Quantity	Type	Provider Name(s)	Onetime	Monthly	Yearly
Enterprise Business Optimizer (EBO) license	$ 0.00	0.5	FTE	MARY BARNES	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	TRENT ELLIOTT	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	SARA MCDADE	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	Chiaffitelli, John	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	BLUTH, BRIAN	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	JEFFREY BRAND	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.0	FTE	Kenna Wenthold	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	AMY SIMS	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	DAVID ARLES	$ 0.00	$ 0.00	$ 0.00
Maintenance EBO	$ 0.00	0.5	FTE	MARY BARNES	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	TRENT ELLIOTT	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	SARA MCDADE	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	Chiaffitelli, John	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	BLUTH, BRIAN	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	JEFFREY BRAND	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.0	FTE	Kenna Wenthold	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	AMY SIMS	$ 0.00	$ 0.00	$ 0.00
	$ 0.00	0.5	FTE	DAVID ARLES	$ 0.00	$ 0.00	$ 0.00
EBO / HBI Consulting - Remote (per day)	$ 1,500.00	4	Days		$ 6,000.00	$ 0.00	$ 0.00
EBO / HBI Consultating - Onsite (per day)	$ 0.00	0	Days		$ 0.00	$ 0.00	$ 0.00
Total		**12.0**			**$ 6,000.00**	**$ 0.00**	**$ 0.00**

Total Onetime : $ 6,000.00 **Total Yearly : $ 0.00**

Payment Terms	Recurring payments will begin upon installation and will be billed on an annual/quarterly or monthly basis as per original contract. - Training fees will be due upon service being rendered if applicable. - License fee and set up fee is due upon installation

Description	Canned reports and report authoring capabilities. EBO Consultation is an onsite/remote implementation service which will include both training and consultation services. *Airfare is not included and will be billed separately for onsite service Additional Hardware is required (*It is not required for practices with 1-9 providers, who can run their reports after hours or if are a Cloud client.) - 64 bit server required. Quantity Name for Service 8 Hours (1 Day) eBO/HBI consulting Remote Days $1,500.00 8 Hours (1 Day) eBO/HBI consulting Onsite Days $1,800.00 + Airfare

Notes:

- Canned reports and report authoring capabilities.

EBO Consultation is an onsite/remote implementation service which will include both training and consultation services.

***Airfare is not included and will be billed separately for onsite service**

Additional Hardware is required
(*It is not required for practices with 1-9 providers, who can run their reports after hours or if are a Cloud client.) - 64 bit server required.

Quantity	Name for Service		
8 Hours (1 Day)	eBO/HBI consulting	Remote Days	$1,500.00
8 Hours (1 Day)	eBO/HBI consulting	Onsite Days	$1,800.00 + Airfare

- Customer is responsible for returning a signed addendum to eClinicalWorks for any removal of a Service. The Effective Date of removal is the date listed above. If no date is listed above, then the Effective Date of removal will be the date of the last signature below.

CONTRACT EXECUTION

IN WITNESS WHEREOF, the respective authorized representative of each party has executed this Agreement, including any other applicable addenda or exhibits as specified herein, to be effective as of the date set forth above.

Customer	eClinicalWorks
	
(Authorized Signature)	(Authorized Signature)
	Riya Das
(Name - Print or Type)	(Name - Print or Type)
	eClinicalWorks
(Customer Company - Print or Type)	(Company - Print or Type)
	09/15/2023
Date	Date

BlueCross BlueShield of Oklahoma

Blue Traditional[SM] Network Participating Group Agreement
Rural Health Clinics

This Agreement is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), to provide health benefits through administered contracts, and the undersigned medical group, whose members are duly licensed by the State of Oklahoma and authorized to practice as physicians and health care professionals, ("Group").

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

Notice to Group:

Group's payee address on record and/or in electronic format.

Notice to The Plan:

Health Care Delivery/Provider Network Operations
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, OK 74102-3283

The undersigned parties hereby agree to the terms and conditions contained in this Agreement. This Agreement shall be effective beginning on _____

MANGUM FAMILY CLINIC
Name of Group

Authorized Signature

Name of Signatory

Title of Signatory

Date Signed

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

Authorized Signature

RICK KELLY
Name of Signatory

VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS
Title of Signatory

Date Signed

ARTICLE I
DEFINITIONS

1.0 Average Sales Price ("ASP"): A manufacturer's sales of a pharmaceutical or biological to all purchasers in the United States in a calendar quarter divided by the total number of units of the pharmaceutical or biological sold by the manufacturer in that same quarter, as reported to the Centers for Medicare and Medicaid Services ("CMS").

1.1 Average Wholesale Price ("AWP"): A pharmaceutical or biological list price reported by manufacturers. AWP does not account for various rebates, discounts, and purchasing agreements.

1.2 Benefit: The payment, reimbursement, and/or indemnification of any kind received from and through The Plan, as set forth in the Member's Benefit Agreement under a health care plan purchased by the Member or the employer on behalf of the Member.

1.3 Benefit Agreement(s): The written agreement between The Plan or one of HCSC's subsidiaries or affiliates, and an employer group, whether insured or self-funded, or an individual under which The Plan arranges for, indemnifies, or administers health care Benefits for Covered Services, and any written health Benefit plan covering a Member, which includes a detailed explanation of Covered Services.

1.4 BlueCard® Program: A national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan's service area.

1.5 Care Coordinator: A professionally qualified person who is competent to conduct initial review and other functions involving Prior Authorization.

1.6 Cellular Immunotherapy Treatment: The FDA-approved treatment that has been issued an NDC (e.g. Chimeric Antigen Receptor Therapy (CAR-T) such as Kymriah for the treatment of acute lymphoblastic leukemia) that utilizes the body's own immune system cells ("T-Cells") to attack harmful (e.g., cancerous) cells through a process in which T-Cells are harvested from the Member, genetically re-engineered and multiplied in a laboratory, and given to the Member by infusion. For the avoidance of confusion, for purposes of this Agreement, "Cellular Immunotherapy" does not include drugs (outside of the FDA-approved cellular immunotherapy), products or services which are associated with or in addition to the administration of the treatment or other FDA-approved products. Given the rapidly-changing advancements in Cellular Immunotherapy Treatment, as new Cellular Immunotherapy products are FDA-approved, such products will be applied the same methodology.

.

1.7 Claim Form: A CMS 1500 or UB-04 form and subsequent revisions, or electronic versions of those forms, or any other legally recognized form for the submission of claims.

1.8 Concurrent Review: The review by The Plan of the Medical Necessity of the services that are in the process of being utilized. Concurrent Review includes, but is not limited to, continuing review of all inpatient care and outpatient procedures and services.

1.9 Coordination of Benefits: The administrative process of determining coverage between health plans when a Member has eligibility under more than one health plan.

1.10 Covered Services: Health care services or supplies specified in the Member's Benefit Agreement or otherwise eligible for Benefits.

1.11 CPT-4 Codes: The American Medical Association's ("AMA") listing of descriptive terms and identifying codes for reporting services and procedures performed by providers. References to CPT-4 Codes include codes set forth in subsequent revisions of AMA's listing of descriptive terms and identifying codes.

1.12 Experimental/Investigational/Unproven: A drug, device, biological product, or medical treatment or procedure is Experimental, Investigational, or Unproven if The Plan determines that:

1.12.0 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

1.12.1 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

1.12.2 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.

1.13 Gene Therapy Treatment: The FDA-approved treatment that has been issued an NDC consisting of a modification or manipulation of the expression of a gene, or an alteration of the biological properties of living cells for therapeutic use, and which may include a specific technique that replaces a faulty gene, or adds in a new gene, in an attempt to cure a disease or improve the Member's ability to fight disease. For the avoidance of confusion, for purposes of this Agreement, "Gene Therapy Treatment" does not include drugs (outside of the FDA-approved gene therapy treatment), products or services which are associated with or in addition to the administration of the treatment.

1.14 Group Participating Health Care Professional: A health care professional, other than a Medical Doctor, Doctor of Osteopathy, Dentist or Podiatrist, who is licensed by the State of Oklahoma to render Covered Services and perform within the scope of such license and is under contract with or employed by Group. Such individuals include but are not limited to certified registered nurse anesthetists (CRNA), physical/occupational therapists, speech and language therapists, social workers, board certified behavioral analysts, nurse practitioners, and physician assistants.

1.15 Group Participating Physician: A physician who is under contract with or employed by Group, and who is a duly licensed Doctor of Medicine, Osteopathy, or other healing art profession defined and authorized by Oklahoma statutes, licensed to practice medicine, surgery, or other procedures and provide services within the scope of such license (to the extent applicable), and who is in good standing with the Oklahoma State Board of Medical Licensure and Supervision, Oklahoma Board of Osteopathic Examiners, or other Oklahoma Board of Physician Examiners appropriate to the specified healing art profession.

1.16 Group Participating Provider: A Group Participating Physician or Group Participating Health Care Professional.

1.17 HCPCS: 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.

1.18 HCSC: Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

1.19 Health Information Network: A health information network designated by The Plan that provides secure, online access to patients' community-wide medical data.

1.20 Hospital-Based Provider: A physician or health care professional who performs Professional Services within a hospital. Such providers include, but are not limited to, radiologists, anesthesiologists, ER physicians, pathologists, neonatologists and hospitalists.

1.21 ICD-10-CM Diagnosis Codes: International Classification of Diseases, Tenth Revision, Clinical Modification, a classification system for diseases, procedures, conditions, causes, etc. References to ICD-10-CM Diagnosis Codes include codes set forth in subsequent revisions of the publication.

1.22 Maximum Allowable Cost ("MAC"): A Multi-Source Product price utilizing multiple pricing benchmarks. The Plan utilizes a nationally recognized drug information source for MAC pricing.

1.23 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum allowed amount for Covered Services rendered to Members.

1.24 Medical Director: A licensed physician who is selected by The Plan to assist with The Plan's utilization management program.

1.25 Medical Emergency: A medical condition, including injury or illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent lay person could expect the absence of medical attention to result in (1) serious jeopardy to the Member's health; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.26 Medical Injectable: Therapy that involves the delivery of medication through a needle or catheter by a health care professional for the safe administration of the product. This includes but is not limited to chemotherapy, immunosuppressive therapy, inhalation therapy, and other therapies provided through non-oral routes such as intramuscular and epidural routes.

1.27 Medically Necessary or Medical Necessity: Health care services that a physician, hospital or other provider, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1.27.0 in accordance with generally accepted standards of medical practice;

1.27.1 clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease; and

1.27.2 not primarily for the convenience of the Member, 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 Member'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.

1.28 Member:

1.28.0 Any person eligible to receive Professional Services pursuant to the terms of The Plan's underwritten or administered contracts, Medicare supplemental coverage, or any person covered under Benefit Agreements underwritten or administered by other Blue Cross and/or Blue Shield Plans or a participant of a group utilizing The Plan's networks, as described herein, excluding Medicare program beneficiaries.

1.28.1 If Group is a Participating Provider in one or more of The Plan's networks in addition to Blue Traditional, this Agreement applies only to the persons described above who access the Blue Traditional network.

1.29 Multi-Source Product: A pharmaceutical or biological available in multiple brand-name and/or generic versions.

1.30 Noncovered Services: Services not specifically covered by or eligible for Benefits under the Member's Benefit Agreement.

1.31 Participating Provider: A hospital, other health care facility, physician, health care professional, or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to The Plan's Members. For purposes of this Agreement a hospital that is a Participating Provider may be referred to as a Participating Hospital.

1.32 Pass-Through Billing: Pass-through billing occurs when Group bills for a service, but the service was performed by another entity or provider who is not a Group Participating Provider.

1.33 Per Diem: A measure of payment for a day of service, including all Covered Services provided to Member, which is the exclusive payment for services provided to Member.

1.34 Point of Use Convenience Kit: A collection of drugs, injection supplies, and components necessary for various injection procedures.

1.35 Preferred Channel Management: Direct utilization of health care resources to a least costly avenue.

1.36 Prior Authorization: The process required by The Plan to establish in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under the Member's Benefit Agreement as outlined in Article VI of this Agreement.

1.37 Professional Services: Covered Services provided by a physician or health care professional, rendered within the scope of his/her license.

1.38 Properly Filed Claim: A claim with no defects or improprieties, including a lack of any required substantiating documentation or particular circumstances requiring special treatment.

1.39 Recommended Clinical Review: A voluntary request submitted to The Plan prior to rendering services using the applicable form located on The Plan's website at www.bcbsok.com. The purpose of a Recommended Clinical Review request is to determine whether a specific service is Medically Necessary. A Recommended Clinical Review is not a guarantee of Benefits or a substitute for the Prior Authorization process.

1.40 Reference Laboratory: A laboratory that receives a specimen from another entity or provider and performs one or more tests on such specimen.

1.41 Single-Source Product: A brand-name pharmaceutical or biological available from only one (1) manufacturer.

1.42 Specialty Pharmacy Product/Medications: High cost products that includes injectable, infused, and oral medication therapies used to treat complex conditions and/or have special handling or access requirements. Example drug categories include: growth hormone deficiency, hepatitis C, immune deficiency, hemophilia, multiple sclerosis and rheumatoid arthritis.

1.43 Treatment Plan: A plan submitted by Group to The Plan, or its delegated vendor, for certain services provided to Members who have this requirement in their Benefit Agreement.

1.44 Under-Arrangement Billing: Under-Arrangement billing occurs when Group or Group Participating Provider renders services but allows those services to be billed by a hospital, other entity or other provider as if they were provided by that hospital, other entity or other provider.

1.45 Usual Charge: The fee most commonly charged by Group for services provided to most patients.

1.46 Utilization Review Criteria: Written guidelines used by The Plan in completing Prior Authorization.

1.47 Wholesale Acquisition Cost ("WAC"): A price paid by a wholesaler for pharmaceuticals or biologicals purchased from a supplier. WAC does not account for various rebates, discounts, and purchasing agreements.

1.48 Written Waiver: A document signed by the Member or his/her authorized representative, stating that one or both of them shall be responsible for payment denied by The Plan. Such Written Waiver must specifically identify the services not covered, including but not limited to services not Medically Necessary, Experimental/Investigational/Unproven, or not a Benefit, for which the Member or his/her representative agrees to be financially responsible and must be executed before rendering such services.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to Members the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth in Article V and hold Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until The Plan has determined the Maximum Reimbursement Allowance and notified Group as to the amount due from the Member, if any, under the Member's Benefit Agreement, Group shall not bill or attempt to collect from the Member any coinsurance amounts. The total amount collected from The Plan, or administered accounts, and the Member for copayment, deductible, and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Group agrees to promptly refund to the Member any amounts which may have been collected from the Member in excess of the Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Applicability of Reimbursement: The lesser of Group's Usual Charge or the Maximum Reimbursement Allowance herein shall be paid for services provided to Members unless the terms of a separate network participation agreement and/or addendum supersedes. Group agrees to hold such individuals harmless from any sums in excess of the Maximum Reimbursement Allowance.

2.0.1 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the Member for services denied as not Medically Necessary or Experimental/Investigational/Unproven, unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Access Standards: Group agrees to provide Members access to care in compliance with the Access Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

2.2 Audit/Review: Group will allow The Plan or its authorized representatives access to medical records, Member financial and billing records and any other documentation necessary to conduct reviews, desk audits and on-site audits. These audits/reviews may consist of but are not limited to evaluating appropriateness and accuracy of: claims coding and billing; medical record documentation; Member billing statements; utilization; Experimental/Investigational/Unproven; Medical Necessity; physical location where services were rendered; level of care; length of stay; health care setting; quality of care; Coordination of Benefits; worker's compensation; other party liability; billing practices; equipment maintenance; general office and facility environment; compliance assessments; and management of practice areas. At The Plan's option, reviews may be conducted on-site. On-site reviews shall be conducted during Group's regular business hours. The audit rights survive termination of this Agreement, and Group shall provide access to records for a period of two (2) years after the termination of this Agreement.

2.2.0 If Group disagrees with the audit/review findings, Group may request an appeal as set forth in *Post Claim Appeals* and *Contractual Inquiries/Appeals* in Article VII. To the extent the audit/review identifies refunds owed, The Plan shall issue a refund request in accordance with *Right of Recovery* in Article VIII.

2.3 Billing Arrangements: Group shall submit claims for Covered Services rendered by Group Participating Provider. Unless specifically authorized by The Plan in advance and in writing, Group shall:

2.3.0 refrain from submitting claims for services rendered by another entity or provider not affiliated with Group; and

2.3.1 prohibit other entities and/or providers from submitting claims for services performed by Group and/or Group Participating Providers.

This section prohibits Pass-Through Billing and Under-Arrangement Billing.

2.4 Call Coverage: Group agrees to provide coverage for Members twenty-four (24) hours per day, seven (7) days per week by a Blue Traditional Participating Provider.

2.5 Claim Filing: Group shall submit Properly Filed Claims to The Plan for all Covered Services rendered to Member at Group's Usual Charge in The Plan's designated format (refer to *Billing Requirements* in Article IV).

2.5.0 Original Claim: Claims shall be submitted within one hundred eighty (180) days of the date of service or within one hundred eighty (180) days of the primary payer's dated provider claims summary. Claims which are not submitted within the timely filing requirements herein will not be honored and Group agrees not to bill The Plan or Member for services associated with such claims.

2.5.1 Corrected Claim: Corrected claims will be accepted by The Plan up to eighteen (18) months following The Plan's adjudication of the original claim.

2.5.2 Request for Medical Records: When The Plan is unable to adjudicate a claim without first reviewing medical records to verify and substantiate the provision of services and the charges for such services, The Plan will deny the claim, with a request for Group to supply applicable medical records. Notwithstanding *Corrected Claim*, above, Group shall submit requested medical records to The Plan within sixty (60) days of receipt of the request for records by The Plan.

2.6 Discontinuing Care: Group Participating Provider may discontinue providing care for a Member who (1) commits fraud or deception or permits misuse of an identification card; (2) continually fails to keep scheduled appointments; (3) continually fails to pay required deductible, copayment, and coinsurance amounts; (4) continually fails to follow recommended treatment, counsel, or procedure; or (5) is continually disruptive, abusive, or uncooperative. Group Participating Provider will provide the Member and The Plan thirty (30) calendar days advance written notice of Group's discontinuance of care and must continue to provide care for such Member during such thirty (30) calendar day period or until the Member makes a new provider selection, whichever is earlier.

2.7 Eligibility Verification: Group accepts the responsibility of verifying the identity, eligibility, coverage and Prior Authorization requirements of the patient or Member applying for Benefits. If Group does not verify the identity, eligibility, coverage and Prior Authorization requirements of the patient or Member applying for Benefits, Group assumes the risk that the claim may be denied by The Plan, or if The Plan pays Benefits in error, The Plan may recoup payment pursuant to *Right of Recovery* in Article VIII.

2.8 Equal Treatment of Members: Group agrees to provide services to Members in the same manner, promptness and equal in quality as those services that are provided to all other patients of Group, without regard to age, race, sex, national origin, health status, economic status, veteran status, disability, or

religious conviction. Group will provide Covered Services to Members without regard to Member's designated network as long as Group is contracted for the Member's network.

2.9 Facilities/Offices Maintained to Code: Group will ensure that its facilities and offices in which Members will be received, screened, and treated meet all applicable federal, state and local codes and are in compliance with Physical Setting and Safety Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

2.10 Group Participating Providers: Group affirms that, as of the effective date of this Agreement, all Group Participating Providers who will be rendering services under this Agreement have been submitted to The Plan for inclusion under this Agreement.

2.10.0 Adding and Removing Group Participating Providers: Subsequent to the effective date of this Agreement, Group shall notify The Plan as set forth on The Plan's website at www.bcbsok.com of providers that join or leave Group at least thirty (30) days prior to the start or end date of employment (or within five (5) business days if such change is due to unanticipated circumstances such as death or illness). The Plan shall remove Group Participating Providers from this Agreement as requested by Group. New Group Participating Providers may be added to this Agreement in the sole discretion of The Plan, subject to completion of The Plan's credentialing process (if appropriate). Such additions will be effective on the date designated by The Plan, with notification sent to Group. If The Plan determines that the provider will not be added to this Agreement, all services rendered by that provider shall be determined to be out of network. If the provider is not added to this Agreement, Group must notify the Member in advance of receiving services that the provider is out of network.

2.10.1 Failure to Provide Information: Group's failure to timely provide or disclose information required by this section constitutes material breach of this Agreement.

2.11 Liability Insurance: Group agrees to maintain or ensure that each Group Participating Provider maintains insurance for the professional liability risk at all times while this Agreement is in effect. For the medical group, the minimum requirement is $1,000,000 per occurrence and $3,000,000 aggregate. For physicians, the minimum requirements are the greater of $500,000 per occurrence and $1,000,000 aggregate or the amounts required by the physician's primary admitting hospital. For certified registered nurse anesthetists, nurse practitioners and physician assistants, the minimum requirements are $500,000 per occurrence and $1,000,000 aggregate. For all other health care professionals, the minimum requirements are $500,000 per occurrence and $500,000 aggregate. Group will provide proof of insurance upon request of The Plan. From time to time, The Plan may revise the limits for minimum coverage. The specific amounts of the liability insurance and the carrier must be specified in the Uniform Credentialing Application. Should such arrangements change during the term of this Agreement, Group must notify The Plan in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.11.0 If Group is an agency or political subdivision of the federal or state government (as defined under either the Oklahoma Governmental Tort Claims Act or the Federal Tort Claims Act), and provides evidence of that fact satisfactory to The Plan, Group will not have to provide the required liability insurance coverage for the location(s) covered by law. However, Group must demonstrate that it carries professional liability insurance sufficient to cover any claims for which it can be liable under the applicable Act. Should Group's status as an agency or political subdivision of the federal or state government change during the term of this Agreement, Group must notify The Plan in writing, and provide, within thirty (30) days of such change, evidence that Group has obtained the required liability insurance coverage.

2.12 Licenses and Certifications: Group agrees to ensure that each Group Participating Provider maintains in good standing while this Agreement is in effect a valid and unrestricted license to practice medicine in the State of Oklahoma, a valid Drug Enforcement Administration (DEA) number with unrestricted prescribing privileges, a valid and unrestricted Bureau of Narcotics and Dangerous Drugs (BNDD) certificate, and

certification to participate in the Medicare program under Title XVIII of the Social Security Act, if applicable. Group Participating Providers must be in good standing with Medicare and Medicaid and be free from any state and/or federal sanctions during the past five (5) years for initial credentialing, and free from any state and/or federal sanctions during the past three (3) years for recredentialing.

2.13 Maintain Association/Admitting Privileges: If a Group Participating Health Care Professional is a certified nurse-midwife who provides delivery services, Group will ensure that he/she is associated with and provides delivery services at one of the following:

2.13.0 a Participating Hospital where the certified nurse-midwife or his/her supervising physician has admitting privileges; or

2.13.1 a licensed birthing center located on the campus of a Participating Hospital; or

2.13.2 a licensed birthing center that is a Participating Provider that is located within ten (10) miles of a Participating Hospital where the certified nurse-midwife or his/her supervising physician has admitting privileges.

2.14 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.15 No Incentives: Group agrees to collect all copayment, deductible and coinsurance amounts owed by the Member unless prohibited by law, neither waiving nor rebating any portion thereof, nor providing any other such incentives as a means of advertising or attracting Member to Group.

2.16 Notification of Adverse Action: Group agrees to inform The Plan of any actions, policies, determinations, and internal or external developments which may have a direct impact on the provision of services to the Member. Such notification includes, but is not limited to:

2.16.0 any action against any of Group Participating Providers' licenses or certifications;

2.16.1 any legal or government action initiated against Group or Group Participating Provider which affects this Agreement and/or Group Participating Provider's practice of medicine, including but not limited to, any action for professional negligence, fraud, violation of any law, or against any license.

Failure of Group to provide such notice to The Plan within thirty (30) days may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.17 Notification of Incorrect Payments: Notwithstanding *Corrected Claim,* above, Group agrees to notify The Plan of receipt of any incorrect payment of which it is aware, including underpayments, duplicate payments, or overpayments, within thirty (30) days of discovering the incorrect payment. This obligation survives termination of the Agreement. Overpayments shall not be refunded to the Member until The Plan has determined who is entitled to such funds. Group agrees The Plan will be permitted to deduct overpayments (whether discovered by Group or The Plan) from future payments made by The Plan, along with an explanation of the credit action taken.

2.18 Offices/Locations/Entities: Group affirms that, as of the effective date of this Agreement, all provider offices, locations, and entities owned, operated, or utilized by Group or Group Participating Providers have been submitted to The Plan for inclusion under this Agreement.

2.18.0 Notification of Changes: Group shall notify The Plan as set forth on The Plan's website at www.bcbsok.com of any changes to Group's information, including but not limited to changes in corporate entity name or name under which Group does business, address, phone number, office hours, tax identification number, NPI, and scope of services, at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible, whichever is earliest.

2.18.1 Adding Offices, Locations, or Entities: Subsequent to the effective date of this Agreement, Group shall notify The Plan of any additional offices, locations, or entities owned, operated, or utilized by Group at least thirty (30) days prior to such change, or as soon as legally permissible, whichever is earliest. Group shall notify The Plan as set forth on The Plan's website at www.bcbsok.com for each new office, location, or entity.

2.18.2 Closing or Sale of Office/Location/Entity: Subsequent to the effective date of this Agreement, Group shall notify The Plan of the closing or sale of a provider office, location or entity as set forth on The Plan's website at www.bcbsok.com at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible, whichever is earliest. The Plan, in its sole discretion, reserves the right to review claims history, and if no claims have been billed for a specific location during a twelve (12) month period, to remove that location with ninety (90) days' advance notice to Group.

2.18.3 Failure to Provide Information: Group's failure to timely provide or disclose information required by this section constitutes material breach of this Agreement.

2.19 Policies and Procedures: Group agrees to abide by The Plan's operational policies and procedures and medical policies as set forth in this Agreement, and as described in the Provider section of The Plan's website at www.bcbsok.com, including but not limited to policies related to payment and coding. The Plan shall use its standard communication channels to provide advance notice to Group of substantive changes to information in the Provider section of its website.

2.20 Protection of Members from Out of Network Charges:

2.20.0 Group Participating Providers shall protect Members against out of network penalties/charges and from balance billing to include but not be limited by the following:

(a) All Members receiving services from Group shall be treated by Group Participating Providers. If a Member receives services at any Group participating office or location from a provider that is not a Group Participating Provider, Group agrees to hold the Member harmless from any sums in excess of the Maximum Reimbursement Allowance.

(b) If any Group Participating Providers are Hospital-Based Providers, Group agrees to participate in all of The Plan's networks applicable to each of the hospitals where Group Participating Providers maintain staff privileges.

(c) When a Group Participating Provider refers a Member to another provider or supplier, Group Participating Provider shall explain to the Member the benefit of treating in-network, including lower out of pocket costs for the Member and protections against balance billing. If a Member chooses to be referred to an out of network provider after being informed of the potential financial impact, the Group Participating Provider must obtain an acknowledgement of referral from the Member that shows written consent.

(d) All samples collected by Group or Group Participating Providers shall be sent to laboratories and pathologists that are Participating Providers in the Member's network.

(e) All radiological films or images produced in office shall be reviewed by Group Participating Providers or Participating Providers in the Member's network.

(f) All durable medical equipment, prosthetics, orthotics, and supplies acquired by Group on behalf of the Member or distributed to the Member by the Group Participating Provider shall be obtained from Participating Providers in the Member's network.

(g) If Group is a hospital-based group contracted with a Participating Hospital where Group renders services, Group shall notify The Plan **the earliest of** at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible in the event of a termination, expiration or non-renewal of the contract between Group and the hospital.

(h) If Group contracts with a hospital-based group to provide certain services (e.g. anesthesia, emergency services, etc.) Group shall notify The Plan the earliest of at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible in the event of a termination, expiration or non-renewal of the contract between Group and the hospital-based group.

2.20.1 Failure to comply with this section constitutes material breach of the Agreement.

2.21 Provider Directories: Group agrees to permit The Plan to publish, distribute and disseminate Group's name and address and/or Group Participating Provider's name and address as a Participating Provider in paper and electronic form. Group also agrees to cooperate with all applicable laws and regulations regarding the accuracy of provider directory information, including but not limited to, The Plan's process to verify provider directory information.

2.22 Provision of Records: Group agrees to furnish, within the requested timeframe and without charge, all information reasonably required by The Plan to verify and substantiate the provision of services and the charges for such services. Group also agrees to provide an internal contact person with appropriate authority to work with The Plan to resolve issues related to records requests. Should The Plan not receive the information within sixty (60) days of the original request, The Plan will continue with its review, which may include a request to refund previously paid amounts. Group shall continue to provide such requested information 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). The Plan may be billed by Group for subsequent requests for the same information at a rate not to exceed twenty-five cents (25¢) per page. Ownership and access to records of Member shall be controlled by applicable law, with the understanding that each Member, as a condition of enrollment in The Plan, has authorized such disclosure. Repeated failure of Group to provide such information within the time period designated by The Plan in the request may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.23 Quality Improvement: Group agrees to cooperate with the quality improvement activities of The Plan. All such quality improvement activities of The Plan are considered to be confidential and will not be released to any other party except where required by applicable state or federal laws. This includes but is not limited to the following:

2.23.0 Infection Control Procedures: Group shall, as applicable, maintain and follow infection control procedures. These procedures will address, at a minimum, staff personal hygiene and health status, isolation precautions, aseptic procedures, cleaning and sterilization of equipment, and methods to avoid transmitting infections.

2.23.1 Monitoring and Evaluating Care: Group shall monitor and evaluate the quality and appropriateness of patient care and/or services, including the performance of employees and other personnel who furnish services under arrangements with Group This shall include, but not be limited to:

(a) Scope and objective of the quality improvement activities;

(b) Methods to identify incidents or patterns;

(c) Mechanisms for taking follow-up action; and

(d) Methods for implementing the monitoring and evaluation activities, for reporting the results, and for monitoring corrective action.

2.23.2 Performance Quality Measurement Programs: Group agrees to cooperate with the performance measurement activities and data requirements of The Plan.

2.23.3 Provision of Medical Records: Group agrees to provide, at no charge, medical records of selected Members to The Plan for purposes of quality improvement. Group shall continue to provide such requested information for a period of two (2) years after the termination of this Agreement.

2.24 Recommended Clinical Review: If Group is not required to obtain Prior Authorization for a Member it may elect to submit a Recommended Clinical Review request for such Member's services. Group shall refer to the back of the Member's identification card for more information, or www.bcbsok.com to obtain a form for requesting a Recommended Clinical Review. A Recommended Clinical Review is not a guarantee of Benefits or a substitute for the Prior Authorization process.

2.25 Record Maintenance: Group shall develop and utilize accurate medical, appointment, financial and billing records of all matters relating to obligations under this Agreement. Group shall maintain medical records for Members in accordance with federal, state and local laws and regulations, and comply with the Medical Records Documentation and Confidentiality Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement. Ownership and access to records of Member shall be controlled by applicable law.

2.26 Records Release: Once proper credentials of representatives of The Plan who seek access are presented to Group, access shall be allowed, upon request and at reasonable times, to pertinent medical and financial records relating to Member, with the understanding that each Member, as a condition of enrollment in The Plan, has authorized such disclosure. Group shall continue to allow such access for a period of two (2) years after the termination of this Agreement.

2.27 Reference Laboratories: Group is prohibited from operating as a Reference Laboratory under this Agreement and/or from billing for laboratory services rendered on behalf of other entities or providers, unless Group enters into a separate agreement with The Plan for laboratory services. Failure to comply with this section constitutes material breach of this Agreement.

2.28 Scope of Services: Group Participating Provider agrees to render Covered Services to Members, within the scope of his/her license and consistent with Group Participating Provider's education, training, experience and/or board certification, who are patients identified as requiring, by reason of injury or illness, the intensity of care and level of care which is reasonable, necessary, and appropriate for the Member.

2.29 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified as required by the Member's Benefit Agreement and in accordance with Article VI of this Agreement. Group also agrees to provide a clinical liaison to work with The Plan to resolve issues related to Prior Authorization.

2.30 Verification of Credentials: Group will cooperate with The Plan or other entity to which The Plan has delegated responsibility for credentialing, in the initial and ongoing verification of credentials of individuals employed by and/or contracted by Group who will be providing Covered Services under the terms of this Agreement. 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 the Group Participating Provider's individual credentialing application or the CAQH attestation received by The Plan, whichever is the most recent. Group will report all arrests, criminal actions, disciplinary actions, changes in participation in Medicare or Medicaid programs, changes in admitting privileges and professional licensure of Group Participating Providers, and any changes to the information submitted on Group Participating Provider's initial or recredentialing application to The Plan in writing

within ten (10) days of the action. Group further agrees to ensure that all employees and contracted staff who provide direct patient care maintain current licensure and certification. Group shall allow appropriate representatives of The Plan, or other entity to which The Plan has delegated responsibility for credentialing, access to such documentation upon reasonable request.

ARTICLE III
AGREEMENTS OF THE PLAN

3.0 Direct Payment: The Plan agrees to make payment to Group for Covered Services rendered to Member.

3.1 Licenses: The Plan shall ensure its medical director(s) maintain in good standing a current, valid and unrestricted license to practice medicine.

3.2 Member Identification: The Plan agrees to provide appropriate Member identification with sufficient information to allow Group to verify eligibility and Benefits.

3.3 Network Management Representatives: The Plan agrees to provide a staff of local Network Management Representatives to work with Group and/or Group's office staff to develop and maintain a cooperative working relationship.

3.4 Provide Timely Compensation: Unless otherwise permitted by law, The Plan agrees to adjudicate all Properly Filed Claims for Covered Services provided to Member within thirty (30) days from the date of The Plan's receipt. If upon receipt of a claim, The Plan determines it is not a Properly Filed Claim, written notice shall be given to Group within thirty (30) days of receipt of the claim. Upon receipt of the additional information or corrections to make the claim a Properly Filed Claim, the claim shall be processed by The Plan within thirty (30) days, unless otherwise permitted by law. Payment shall be considered made when it is placed in the United States mail or on the date the electronic payment is sent. If payment is due but not made within the time required by law from receipt of a Properly Filed Claim, it shall bear simple interest at the rate of ten percent (10%) per year. The Plan shall pay interest only on claims for services rendered to Members whose Benefit Agreements are underwritten by Blue Cross and Blue Shield of Oklahoma.

3.5 Provider Claims Summary: The Plan agrees to notify Group and the Member of appropriate copayment, deductible, coinsurance, and noncovered amounts that may, if applicable, be collected directly from the Member.

3.6 Provider Directories: The Plan will include Group's name and address and/or Group Participating Provider's name and address in its' current written and electronic listings of Participating Providers in accordance with its policies and procedures and all applicable laws.

3.7 Quality Improvement: The Plan agrees to coordinate activities related to quality improvement as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

3.8 Reimbursement: The Plan agrees to reimburse Group in accordance with the reimbursement provisions set forth in Article V for Covered Services provided to Members as of the effective date of this Agreement. This reimbursement shall be applicable to all services arranged, provided, and billed by Group. Unless prohibited by law, The Plan shall deduct any copayment, deductible and coinsurance amounts required by the applicable Benefit Agreement from payment due Group.

ARTICLE IV
BILLING REQUIREMENTS

4.0 Billing Requirements: Group is required to submit a Properly Filed Claim for all Covered Services provided to Member. Group shall use either the CMS 1500 paper claim form, and subsequent revisions, or The Plan's paperless claims entry system (electronically).

4.0.0 Group shall submit all Covered Services rendered for a day on the same claim. If a service is not included on the original claim, Group shall submit a corrected claim which includes all Covered Services rendered. Failure to submit all charges on the same claim may result in The Plan rejecting the claim.

4.0.1 Group shall provide all information necessary to adjudicate the claim, including but not limited to:

(a) Primary and, if applicable, secondary ICD-10-CM Diagnosis Codes as appropriate.

(b) Current and appropriate CPT-4 or HCPCS procedure code(s).

(c) Name of the referring physician or other provider.

(d) Any information concerning other insurance or third-party payor coverage.

(e) Group's billing National Provider Identifier (NPI) as well as the rendering NPI.

(f) NDC code for applicable pharmaceutical products and supplies.

(g) The physical address or location where the services were provided.

(h) All other relevant information required by The Plan to adjudicate claims. For additional information on claims filing requirements, please refer to the Provider section of The Plan's website at www.bcbsok.com under Claims and Eligibility.

4.1 Changes in CPT-4/HCPCS Codes/ICD-10-CM Diagnosis Codes: Codes established subsequent to the effective date of this Agreement will be assigned a Maximum Reimbursement Allowance determined in a manner consistent with Maximum Reimbursement Allowances of comparable CPT-4/HCPCS Codes/ICD-10-CM Diagnosis Codes or a subsequent revision. 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 may be returned for appropriate coding.

4.2 Provider-Preventable Errors: The Plan will not reimburse for a procedure/service to treat/diagnose a medical condition when the practitioner erroneously performs: 1) a wrong procedure/service on a patient; 2) the correct procedure/service but on the wrong body part; or 3) the correct procedure/service but on the wrong patient. This encompasses all related services provided when the error occurs, including those separately performed by other physicians, and all other services performed during the same visit or other related services. Group shall bill for the appropriate modifier to indicate type of Provider-Preventable Error. Amounts for Provider-Preventable Errors may not be collected from the Member, and Group may not obtain a Written Waiver for these services.

4.3 Report Other Insurance: Group will report to The Plan any fact of which it or its agents have knowledge which indicates that the condition requiring services to the Member 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 Member has other insurance in effect which may provide Benefits.

ARTICLE V
MAXIMUM REIMBURSEMENT ALLOWANCES

5.0 Maximum Reimbursement Allowances: The basis for reimbursement for Covered Services rendered to Members will be the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Reimbursement shall be made according to The Plan's medical policies and reimbursement guidelines pertaining to subjects such as multiple surgical procedures, surgical assistance, global surgical services, coding and unbundling.

5.1 Conversion Factors: Except as set forth below, the Maximum Reimbursement Allowance is defined as the Centers for Medicare and Medicaid Services Medicare Resource Based Relative Value System (RBRVS) methodology as published in the Federal Register Vol. 85, No. 248 (dated December 28, 2020), multiplied by the Oklahoma Geographic Index Modifier, including CMS site-of service payment differential methodology, hereinafter referred to as 2021 Medicare allowables, less any applicable amounts for which the Member is responsible. The conversion factors are set forth below:

Provider Type	All Codes
Physician & Optometrist	$48.06
Chiropractor	$45.55
Certified Registered Nurse Anesthetist	$39.72
Anesthesiologist Assistant, Nurse Practitioner, Physician Assistant & Psychologist	$36.53
Speech Therapist	$32.96
Dietician	$30.85
Physical/Occupational Therapist	$30.36
Audiologist, LADC, LCSW & LPC	$27.27

5.2 Other Maximum Reimbursement Allowances: Services having no Relative Value Unit established will be reimbursed as set forth below, or in accordance with The Plan's fee schedule in effect as of the date of service.

5.2.0 Anesthesia:

(a) Anesthesia Rates: The reimbursement for anesthesia services shall be the applicable rate set forth below per (base + time) unit, less any applicable amounts for which the Member is responsible, for Covered Services provided to Members. Time units are in 15 minute increments for the first 2 hours, then 10 minute increments thereafter.

Provider Type	Anesthesia Rate
Physician	$55.00
Certified Registered Nurse Anesthetist	$47.00
Anesthesiologist Assistant	$41.80

(b) Labor Epidurals: Labor epidurals will be reimbursed at the flat rate of nine hundred fifty dollars ($950.00).

5.2.1 Durable Medical Equipment: Durable medical equipment and supplies will be reimbursed in accordance with The Plan's fee schedule in effect as of the date of service.

5.2.2 Pathology/Laboratory: Except as provided below, pathology and laboratory codes listed on the Medicare Clinical Laboratory Fee Schedule will be reimbursed at ninety-five percent (95%) of 2020 Medicare allowables, less any applicable amounts for which the Member is responsible.

(a) Reimbursement for the pathology and laboratory codes not listed on the Medicare Clinical Laboratory Fee Schedule that are based on the RBRVS methodology as published by the Centers for Medicare and Medicaid Services will be paid in accordance with Section 5.1, *Conversion Factors*, above.

(b) Reimbursement for the pathology and laboratory codes not listed in the sources described above will be paid in accordance with The Plan's fee schedule in effect as of the date of service.

5.2.3 Pharmaceutical Products: Pharmaceutical products and supplies shall be reimbursed based on National Drug Codes ("NDC codes"), excluding the noted exceptions. The Plan will update The Plan's NDC fee schedule monthly with the price that is in effect at the time of the update. If ASP

is unavailable, pharmaceutical products categorized as Exception will be reimbursed as Single Source or Multi Source. When ASP, WAC, MAC and AWP are unavailable, pharmaceutical products categorized as: Exception, Vaccines and Immunizations, Single Source and/or Multi Source will be reimbursed in accordance with The Plan's NDC fee schedule in effect as of the date of service.

(a) Group A Exception Products: Group A Exception Products include preferred Medical Injectable Products. They will be reimbursed equivalent to the CPT-4/HCPCS Code at ASP+30%. Products in Group A will be identified in The Plan's NDC fee schedule. Information regarding changes to these categories will be published in The Plan's provider newsletter, Blue Review (i.e. Select Medication List) and in the provider section of The Plan's website at www.bcbsok.com.

(b) Group B Exception Products: Group B Exception Products include non-preferred Medical Injectable Products. They will be reimbursed equivalent to the CPT-4/HCPCS Code at ASP+10%. Products in Group B will be identified in The Plan's NDC fee schedule. Information regarding changes to these categories will be published in The Plan's provider newsletter, Blue Review (i.e. Select Medication List) and in the provider section of The Plan's website at www.bcbsok.com.

(c) Group C Exception Products: Group C Exception Products include Specialty Pharmacy Products with Preferred Channel Management, as set forth on The Plan's website at www.bcbsok.com, and new specialty pharmacy drugs to market. Reimbursement will be reflected in The Plan's NDC fee schedule based on The Plan's maximum allowable per package NDC unit (i.e. UN, ML, GR, F2). The Plan shall provide Group with access to Preferred Channel Management resources should Group wish to opt out of purchasing and billing for the Specialty Pharmacy Product. In addition, The Plan shall provide contact information for a vendor through which Group can obtain the Specialty Pharmacy Product. Group C Exception Products without Preferred Channel Management will be reimbursed equivalent to the CPT-4/HCPCS Code at ASP+20%. If ASP is unavailable, then NDC AWP-15% shall apply.

(d) Multi-Source Products: Multi-Source Products, excluding the noted exceptions, will be reimbursed at MAC+25%. If MAC is unavailable, the lower of WAC+9% or AWP-13% shall be reimbursed. If WAC is unavailable, AWP-13% shall apply.

(e) Radiopharmaceuticals: Reimbursement for CPT-4/HCPCS Codes A9500 through A9700 and other radiopharmaceutical CPT-4/HCPCS Codes based on the description as of the date of service of the claim will be reimbursed at the applicable CMS (Medicare) Average Sales Price (ASP) method of pricing drugs and biologicals plus twenty percent (20%). The Plan will update The Plan's NDC fee schedule to reflect changes in the ASP in January and July of each calendar year with the price that is in effect at the time of the update. If ASP is unavailable for any of these codes they will be paid in accordance with The Plan's NDC fee schedule in effect as of the date of service.

(f) Single-Source Products: Single-Source Products, excluding the noted exceptions, will be reimbursed at WAC+9%. If WAC is unavailable, AWP-13% shall apply.

(g) Vaccines and Immunizations: Vaccines and Immunizations, primarily identified as CPT-4/HCPCS Codes 90500 through 90799, will be reimbursed at AWP-5%. Group will bill the applicable CPT-4/HCPCS Code(s) and the appropriate administration code based on the package insert(s) of product tied to the code. If Group obtains the vaccine/immunization from a source that is contracted with The Plan to provide vaccines/immunizations to Participating Providers, Group will be eligible to bill the administration code only.

(h) Cellular Immunotherapy Treatment and Gene Therapy Treatment (C&G) Products: The Plan's standard professional fee schedule rates will default to no coverage, unless an extra-contractual agreement is issued. Given the rapidly-changing advancements in Cellular Immunotherapy Treatment and Gene Therapy Treatment, as new Cellular Immunotherapy Treatment and Gene Therapy Treatment products are FDA-approved, such products will be applied the same methodology.

(i) Point of Use Convenience Kits: Point of Use Convenience Kits are considered equivalent to, but not superior to, the individual drug components. Purchase and use of Point of Use Convenience Kits is subject to Group's preference. Non-drug components include, but are not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages, and gauze. Point of Use Convenience Kits billed with an NOC/NOS code will be reimbursed based on the approximate sum of the individual drug components as identified on The Plan's NDC fee schedule. The Plan will not reimburse separately for the Point of Use Convenience Kits or the items herein.

(j) Administration Fees: If Group obtains the drug product from a source that is contracted with The Plan to provide drug products to Participating Providers, Group will receive the administration fee only. In these situations, Group will bill the applicable administration code.

5.2.4 Services Covered by Per Diem: If Group provides services which are separately reimbursable under a Per Diem, the Per Diem will be the exclusive payment for services provided to the Member. Group is not eligible to bill separately for any services that are also reimbursable under a Per Diem.

5.3 Discontinued or Unrecognized Codes: If Centers for Medicare and Medicaid Services ("CMS") does not recognize or reimburse for a specific code or discontinues use of a specific code, The Plan may not reimburse for the unrecognized or discontinued code or The Plan may reimburse in accordance with The Plan's fee schedule in effect as of the date of service. The Plan may also make a determination to bundle services or pay for services using an alternative or more specific code.

5.4 Rounding: If any calculation set forth in Attachment A results in numbers positioned more than two (2) places to the right of the decimal, The Plan will round to the nearest penny.

5.5 Written Report: The Plan will not reimburse, nor may Group collect from the Member, any amounts for Professional Services unless such services have been rendered to an identifiable individual patient and are supported by a written report.

ARTICLE VI
UTILIZATION MANAGEMENT

6.0 Objective: The overall objective of the Utilization Management Program is to determine Medical Necessity for delivery of Covered Services. Prior Authorization will only determine if a service is Medically Necessary and does not guarantee Benefits. Services that a physician or other provider prescribes or orders may not be determined by The Plan to be Medically Necessary or a Covered Service.

6.1 Process for Obtaining Prior Authorization: The following process shall be followed in order to obtain Prior Authorization.

6.1.0 Submit Request: Group shall contact The Plan as specified in the Provider section of The Plan's website at www.bcbsok.com or call the number on the back of the Member's identification card. Group shall provide the requested information, including but not limited to:

(a) Group's name, telephone number and the pay to National Provider Identifier (NPI) as well as the rendering NPI.

(b) Member's name, address, date of birth, age and sex

(c) Member's identification number including the employer and group number

(d) Admitting or ordering provider's name, address and telephone number (if not a Group Participating Provider)

(e) Primary diagnosis (ICD-10-CM Diagnosis Code, if known), and complicating secondary diagnosis

(f) Principal procedure (CPT-4 codes, if known), and any secondary procedures

(g) Estimated date of admission and discharge or date(s) of service

(h) Patient's history, lab, and test results pertinent to this hospitalization/procedure

(i) Place of service (e.g. hospital, ambulatory surgery center, provider office, etc.)

6.1.1 Weekends/Holidays/After Hours: If The Plan's Prior Authorization Department is not available (i.e. weekend, holiday or after The Plan's business hours), Group must leave message requesting Prior Authorization on the Prior Authorization Department confidential voicemail. Documentation of date and time of call will serve as proof of Group's attempt to obtain Prior Authorization.

6.2 Responsibilities of Group:

6.2.0 Obtain or Verify Prior Authorization: It is the responsibility of Group to ensure The Plan is contacted and Prior Authorization is obtained or verified as set forth above in *Process for Obtaining Prior Authorization*. If Group does not verify the Prior Authorization requirements of the Member, Group assumes the risk that the claim may be denied by The Plan.

(a) BlueCard Program: For Members participating in the BlueCard Program, Group may refer to the back of the Member's identification card for information regarding authorization requirements.

(b) Concurrent Review: Group shall cooperate with The Plan when conducting Concurrent Review on services that are expected to extend beyond The Plan's approved duration of services. Group shall request Prior Authorization for an extension on or before the last day of the duration of services for which Prior Authorization was previously obtained by Group. The Prior Authorization process shall be the same as described above in *Process for Prior Authorization*.

(c) Hospital Admissions (Emergency and Obstetric): Group shall obtain Prior Authorization for all emergency and obstetric admissions within two (2) business days of the admission.

(d) Hospital Admissions (Non-Emergency and Non-Obstetric) and Outpatient Services: Group shall obtain Prior Authorization for all non-emergency and non-obstetric hospital admissions and outpatient services. To the extent practical, Prior Authorization shall be obtained at least five (5) days in advance of, but not less than one (1) business day prior to, the admission or outpatient service.

(e) Medicare Supplements: If a Member exhausts his/her benefits under Medicare or is otherwise eligible for Benefits under his/her Medicare supplement Benefit Agreement, Group shall follow The Plan's Prior Authorization requirements for such Member as set forth in this Agreement.

(f) Other Settings: Services provided by Group Participating Provider in an office or other outpatient setting must be Medically Necessary and appropriate for the diagnosis and treatment of the Member's medical condition. The Plan has designated certain Covered Services which require Prior Authorization in order for the Member to receive the maximum Benefits possible under their Benefit Agreement. Group may request Prior Authorization for services on behalf of the Member. For more information, refer to The Plan's website at www.bcbsok.com.

6.2.1 Treatment Plans: Group shall submit a Treatment Plan to The Plan, or its delegated vendor, for certain services provided to Members who have this requirement in their Benefit Agreement. The Treatment Plan shall include the required information set forth in the provider section of The Plan's website at www.bcbsok.com.

6.3 Responsibilities of The Plan: The Plan will carry out the following responsibilities with respect to Utilization Management.

6.3.0 Assigning a Reference Number: The Plan will assign a reference number to each request for Prior Authorization for purposes of identifying the request and Member case. The reference number shall be given to the admitting/ordering provider or his/her authorized representative and to the provider of services as applicable. This number is for reference purposes only and does not mean that The Plan has granted Prior Authorization for the services.

6.3.1 Care Coordinators: The Plan shall utilize licensed personnel in medical professions to review requests for Prior Authorization and perform the duties of Care Coordinators. Such Care Coordinators shall have authority to perform Utilization Review per established scientific, evidence-based clinical criteria for the purpose of making a determination as to the Medical Necessity for services under the terms and provisions of the Member's Benefit Agreement. Utilization Review Criteria shall be based on currently established and recognized medical and professional expertise, studies, treatises and literature, and current cumulative information, data and studies on health care services available and provided within the local community.

6.3.2 Determining Medical Necessity: In making any Prior Authorization determination regarding whether an admission or services are Medically Necessary, The Plan shall consider all relevant medical and other information furnished pertaining to the Member and the Member's condition for which the admission or services have been requested. In no event is it intended that the Prior Authorization determination by The Plan will interfere with the provider/patient relationship or Group Participating Provider's decision and determination to order admission of the patient to the hospital or provide other services. The Prior Authorization determination by The Plan is only to make a preliminary determination as to whether such admission or provision of other services are Medically Necessary. Prior Authorization does not guarantee that all care and services a Member receives are eligible for payment of Benefits under the Member's Benefit Agreement. Medical Necessity for an inpatient hospital admission or provision of other services may be denied only upon the order of the Medical Director.

6.3.3 Insufficient Information: If submitted clinical information is insufficient for approval of the hospital admission or services requested, the Medical Director shall deny the request due to insufficient information, subject to reconsideration and other appeal as provided.

6.3.4 Notification of Prior Authorization Determination: The Plan shall respond to requests for Prior Authorization by providing a determination within the timeframes provided by law or accreditation requirements if applicable after receipt of all necessary information. The Plan shall provide notification of Prior Authorization determinations to the admitting/ordering provider, provider of services as applicable, and Member.

6.3.5 Reimbursement for Services: Services that are granted Prior Authorization by The Plan, or by the control plan as required by some Benefit Agreements, which are covered Benefits under the terms

of the Member's Benefit Agreement, are determined to be Medically Necessary and will be reimbursed in accordance with the terms of this Agreement. If Prior Authorization is obtained and the information given at that time is accurate, no adjustment to the prior Medical Necessity determination will be made as a result of a subsequent Medical Necessity determination on that specific case, so long as Group adheres to requirements contained in this Article.

6.4 Termination/Denial of Payment: Should Group fail to comply with the above requirements, it may be considered cause for termination of the Agreement and/or payment may be denied for services provided which are not Medically Necessary or found to be Experimental/Investigational/Unproven. Except where otherwise provided by applicable law, such denied charges may not be collected from the Member unless a Written Waiver has been executed prior to rendering services.

ARTICLE VII
APPEALS AND GRIEVANCE PROCEDURES

7.0 Types of Appeals: The Plan has established appeals processes to ensure the timely and organized resolution of provider complaints, grievances and appeals. Complaints and grievances are oral expressions of dissatisfaction with utilization review, network status, and/or quality improvement activities. When permitted by this Agreement, if Group cannot achieve resolution of a complaint or grievance, a written appeal may be filed. The Plan has different appeals processes, depending on the type of appeal and how it is generated.

7.0.0 Utilization Management Appeals are related to clinical services provided to the Member.

7.0.1 Credentialing Committee Appeals are for decisions or actions taken by The Plan's Credentialing Committee ("Credentialing Committee") that result in a change in network status, network cancellation, or the denial of an application for credentials or network participation. These can be for both medical and non-medical reasons.

7.0.2 Contract Termination Requests for Consideration are related to the termination of this Agreement by The Plan, which does not involve a decision or action taken by The Plan's Credentialing Committee.

7.0.3 Contractual Inquiries/Appeals are disagreements relating to this Agreement and all other addendums and amendments, which do not fall into any of the previously stated categories.

7.1 Types of Utilization Management Appeals: Utilization Management (UM) Appeals are related to clinical services provided to the Member and include utilization management decisions. There are two types of UM appeals available to Group: expedited/urgent care or standard. An appeal submitted by Group is a formal process for review or reconsideration of an adverse determination regarding a Recommended Clinical Review or Prior Authorization request. "Adverse determination" means a determination by The Plan that an admission, availability of care, continued stay or other health care service that is a covered Benefit has been reviewed and, based upon the information provided, does not meet The Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied or reduced. If the issue/service has been previously reviewed by an Independent Review Organization, The Plan will rely on that original opinion in processing any additional appeal requests.

7.1.0 Peer to Peer: Prior to an appeal, the attending or ordering provider may request a peer-to-peer conversation with a Medical Director. Group may call the Health Care Management Department as instructed on the back of the Member's identification card. The Medical Director making the adverse determination or another medical director will be available within one business day to discuss the adverse determination. If the adverse determination is upheld after the conversation, Group has the option to proceed with an appeal.

7.1.1 Expedited Appeals: An expedited or urgent care appeal is a request, usually by telephone or fax, for an additional review of an adverse determination. The review is conducted by a clinical peer who was not involved in the original adverse determination and is not the subordinate of the person making the original adverse determination. An expedited appeal applies to urgent care requests. Urgent care requests are defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. This process does not apply to non-urgent, post-service or retrospective requests. Local specialty providers and independent review organizations are external consultants who may be utilized in the appeal process. A final determination following the expedited appeal will be made within seventy-two (72) hours of receipt of the request. To initiate an expedited appeal:

(a) Call the Health Care Management Department at 1-800-672-2378 or as instructed in the original adverse determination letter.

(b) Have all related clinical information available for the denied services including:

- Name of the requestor
- Phone number of the requestor
- Member name
- Member ID number
- Member reference number if known
- Date of service
- Name of facility where services are being rendered, if applicable
- Name of ordering/attending physician
- Any new clinical/medical record information

7.1.2 Standard Appeals: A standard appeal is a verbal or written request to review an adverse determination. The review is conducted by a peer reviewer who was not involved in the original adverse determination nor is the subordinate of the peer making the original adverse determination. A standard appeal applies to non-urgent, pre-service or retrospective pre-claim requests. Local specialty providers and independent review organizations are review consultants who may be utilized in the appeal process. Standard appeals may be requested within one hundred eighty (180) days from the date of notice of the original adverse determination letter. A final determination following the standard appeal will be made within thirty (30) days of receipt of the request. To initiate a standard appeal:

(a) Call the Customer Service number listed on the back of the Member's ID card or submit in writing as instructed on the original adverse determination letter.

(b) Have all related clinical information available for the denied services outlined in a letter/statement indicating the issue and resolution being sought which includes:

- Name of the requestor
- Phone number of the requestor
- Member name
- Member ID number
- Member reference number if known
- Date of service
- Name of facility where services are being rendered, if applicable
- Name of ordering/attending physician
- Any new clinical/medical record information

Group acknowledges that it will have only one (1) standard appeal opportunity and agrees to submit all relevant clinical information with the appeal. Re-review appeal requests will not be accepted.

7.1.3 Post Claim Appeals: An appeal is a written request to review a non-approved service or procedure that The Plan determines does not meet the requirements for Medical Necessity or is Experimental/Investigational/Unproven. The review is conducted by a peer reviewer who was not involved in the original adverse determination nor is the subordinate of the peer making the original adverse determination. A claim appeal applies to a post-service adverse determination. Local specialty providers and independent review organizations are review consultants who may be utilized in the appeal process. Post claim appeals may be requested within one hundred eighty (180) days from the date of notice of the original adverse determination letter. A final determination following the post claim appeal will be made within sixty (60) days of receipt of request. To initiate a post claim appeal:

(a) All post claim appeals must be submitted in writing using the applicable appeals form or electronic process located in the Provider section of The Plan's website at www.bcbsok.com.

(b) Have all related clinical information available for the denied services outlined in a letter/statement indicating the issue and resolution being sought which includes:

- Name of the requestor
- Phone number of the requestor
- Member name
- Member ID number
- Reference number if known
- Date of Service
- Name of facility where services were rendered, if applicable
- Name of ordering/attending physician
- Any new clinical/medical record information

Group acknowledges that it will have only one (1) appeal opportunity and agrees to submit all relevant clinical information with the appeal. Re-review appeal requests will not be accepted.

7.2 Credentialing Committee Appeals: Credentialing Committee Appeals are for decisions or actions taken by The Plan's Credentialing Committee ("Credentialing Committee") that result in a change in network status, network cancellation, or the denial of an application for credentials, denial of an application for network participation, or denial of re-credentialing. These can be for both medical and non-medical reasons. The Plan has developed an appeals process for all Participating Providers whose network contract(s) are cancelled for either a medical or non-medical reason by the Credentialing Committee. Physicians or health care professionals seeking to become Group Participating Providers who are denied acceptance in a network by the Credentialing Committee also have access to this appeals process. All Credentialing appeals are to be sent to the appropriate address provided in the denial letter.

7.2.0 Credentialing Committee Appeals: If the Credentialing Committee initiates the network cancellation, or if Group or Group Participating Provider is denied credentials or network participation by the Credentialing Committee, Group is notified within ten (10) business days and should submit its appeal to the Credentialing Committee Chair. The appeal will be processed as follows:

(a) Level One (1) Written Appeals: All appeals should be made in writing and submitted to the Credentialing Committee Chair within thirty (30) days of receipt of the denial/cancellation notice. The Credentialing Committee Chair will forward the appeal to the Peer Review Committee (East or West) for review. This Committee will review the

written appeal, all additional submitted information and credentialing file documentation pertaining to the deficiencies. At least three qualified individuals of which at least one is a Participating Provider who is not involved with The Plan's management and who is a clinical peer of Group who is filing the appeal (if the appeal is clinical in nature) and not previously involved with the Credentialing Committee decision or action, will participate in the Level One process. Group will be notified by Certified Mail Return Receipt Requested, within ten (10) business days of the Committee's decision.

(b) Level Two (2) Appeals: If the Peer Review Committee upholds the denial/cancellation, Group may request a Level 2 appeal. All appeals should be made in writing and submitted to the Peer Review Committee Chair within thirty (30) days of receipt of the Committee's denial/cancellation notice. It will be heard by the Peer Review Committee (East or West) not involved in the Level 1 appeal or an equivalent Committee. The Committee will review information obtained from the Level 1 Committee and any additional information submitted by Group. At least three qualified individuals of which at least one is a Participating Provider, not involved with The Plan's management, and who is a clinical peer of Group who is filing the appeal (if the appeal is clinical in nature) and who was not involved with the Level 1 Appeal will participate in the Level 2 process. If Group requests a personal appearance before the Committee, the following guidelines will be utilized:

(i) The Chairperson of the committee will select the date for Group representative's appearance before the committee and will notify the provider of the time, date and place for its appearance. Group will be notified of this meeting by Certified Mail Return Receipt Requested.

(ii) At the meeting, the Chairperson will take no more than five (5) minutes to introduce Group representative and give a brief explanation of the appearance.

(iii) Group representative will be given ten (10) minutes to present its appeal.

(iv) The Committee members will be given ten (10) minutes to ask questions.

(v) After the questioning period is completed, the Group representative will be dismissed, the Committee will discuss the issue and a decision/determination will be made.

(vi) Group representative will be notified by Certified Mail Return Receipt Requested within ten (10) business days of the committee's decision. The decision will be final. No other appeal rights are available to Group or Group Participating Provider. The entire appeal process shall be completed within one hundred eighty (180) days of the receipt by The Plan of the appeal, unless extenuating circumstances or request for extension is received.

7.3 Contract Termination Requests for Consideration: Contract termination requests for consideration are related to the termination of this Agreement by The Plan, which does not involve a decision or action taken by The Plan's Credentialing Committee. Termination pursuant to *Immediate Termination by The Plan* or *Termination by Either Party* in Article XI or *Amendments* in Article X of this Agreement shall not entitle Group to the Appeals and Grievance Procedures set forth in this Agreement. If this Agreement is terminated by The Plan other than under *Immediate Termination by The Plan* or *Termination by Either Party* in Article XI or *Amendments* in Article X, Group may submit a written request to The Plan to reconsider its decision to terminate this Agreement. Such written request must be received by The Plan within thirty (30) days of the date of the letter notifying Group of the termination. The request will be considered by an authorized representative or representatives of The Plan not involved in the original termination decision. Group will be provided a written response to the request for reconsideration within sixty (60) days of receipt of the request by The Plan. The effective date of termination will not be extended

by the appeal process, provided, however, that decisions favorable to Group will be applied retroactively to the original effective date of termination. All requests for reconsideration are to be sent to:

Director, Network Management
Blue Cross and Blue Shield of Oklahoma
1400 South Boston
Tulsa, OK 74119-3612

7.4 Contractual Inquiries/Appeals: Contractual Inquiries/Appeals are disagreements relating to this Agreement, other than those arising under *Amendments* in Article X, and which do not fall into any of the previously stated categories. If Group has a contractual inquiry/appeal, an initial attempt should be made to resolve it by communication with The Plan's Network Management Department. If a resolution cannot be reached, a written appeal process is available.

7.4.0 Inquiry: An inquiry is an initial verbal or written communication requesting additional information, confirmation or clarification regarding Benefits, pricing, claim adjudication, and/or claims processing guidelines. Responses range from a quick and informal exchange of information to a written response. An inquiry is not considered an appeal.

7.4.1 Contractual Dispute Appeal: Contractual Dispute appeals can be requested for reconsideration regarding Benefits, pricing, claims adjudication, and/or claims processing guidelines. All contractual appeals must be submitted in writing using the applicable claim review form or electronic process located in the Provider section of The Plan's website at www.bcbsok.com. Contractual appeals must be received by The Plan within one hundred eighty (180) days of the initial claims adjudication date to be considered. The written request should include the following information:

- Name of the Member
- Member ID number
- Nature of the complaint
- Facts upon which the complaint is based
- Resolution Group is seeking
- The Claim Form, copy of the detail of remittance or any documentation (including medical records) that Group wants to include for consideration.

Appeals should be mailed to the applicable address provided on the form. Group will be notified of a decision for contractual appeals in a timely manner. If the appeal results in additional payment, Group will be notified on the detail of remittance. All other appeal responses will be mailed directly to Group.

7.5 Executive Mediation: Executive mediation is for disputes arising out of this Agreement for which the Utilization Management, Credentialing Committee or Contractual Appeals, as applicable, has been exhausted without resolution, and for all other disputes arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement.

The completion of executive mediation is a condition precedent to the invocation of Dispute Resolution. Executive mediation shall consist of good faith negotiations between executives of The Plan and Group who (a) have full authority to settle the controversy; (b) have not been previously involved in appeals of the dispute, if any, or any previous negotiations between the parties regarding the subject matter of the controversy; and (c) are at a higher level of management than the persons with direct responsibility for administration of the subject of the dispute in question.

Either party may invoke Executive Mediation by written notice to the other party. The notice must (a) expressly demand Executive Mediation; (b) provide a statement of the party's position and a summary of supporting arguments; and (c) identify the name and title of the executive(s) who will represent the party.

Within fifteen (15) days after delivery of the notice, the receiving party shall submit to the other a written response containing the same information. Within thirty (30) days after delivery of the receiving party's response, the executives of both parties shall meet at a mutually acceptable time and place, which may be in person or electronically, and thereafter as often as they reasonably deem necessary, to attempt to resolve the dispute.

All negotiations pursuant to this Section shall be confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence. These obligations shall survive termination or expiration of this Agreement.

7.6 Dispute Resolution: In order to avoid the cost and time-consuming nature of litigation, any dispute remaining unresolved after exhaustion of the contractual complaint inquiries and appeals process and executive mediation shall be resolved in accordance with the procedures detailed below.

7.6.0 Binding Arbitration: Within one hundred twenty (120) days of the conclusion of the executive mediation, either party may submit the unresolved dispute to final and binding confidential arbitration under the commercial rules and regulations of the American Arbitration Association, subject to the provisions below.

(a) Any disputes arising out of the terms of this Agreement shall be governed by and subject to the laws of the State of Oklahoma.

(b) All arbitrations will be held in Tulsa, Oklahoma.

(c) Unless otherwise agreed by the parties, each dispute may be arbitrated individually or similar claims may be collectively arbitrated to allow a more efficient process for the resolution of claims, which agreement shall not be unreasonably withheld.

(d) 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.

(e) Unless otherwise determined by the arbitrator, the costs of arbitration, including but not limited to filing fees and arbitrator fees, shall be shared equally by the parties, and each party shall pay its own attorney's fees and other expenses associated with the arbitration.

(f) The Plan and Group 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 The Plan and Group agree otherwise, the arbitrator may not consolidate Group's claims with the claims of any other provider and may not otherwise preside over any form of a representative or class proceeding.

(g) To the extent of the subject matter of the arbitration, the determination of the arbitrator(s) shall be binding not only on the parties to this Agreement, but also on any other entity controlled by or in control of or under common control with the party, to the extent that such affiliate joins in the arbitration.

(h) Group acknowledges that this Binding Arbitration provision precludes Group from filing an action at law or in equity and from having any dispute arising under this Agreement

resolved by a judge or jury. Group further acknowledges that this arbitration provision precludes Group from participating in a class action or class arbitration filed by any other provider or any other plaintiff claiming to represent Group or Group's interest. Group agrees to opt-out of any class action or class arbitration filed against The Plan that raises claims covered by this Agreement to arbitrate.

7.7 Survival: This Article shall survive termination of this Agreement.

ARTICLE VIII
OTHER PROVISIONS

8.0 Acknowledgement: Group hereby expressly acknowledges its understanding that this Agreement constitutes a contract between the Group and The Plan, that The Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting The Plan to use the Blue Cross and/or Blue Shield Service Mark in the State of Oklahoma, and that The Plan is not contracting as the agent of the Association. Group further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than The Plan and that no person, entity, or organization other than The Plan shall be held accountable or liable to Group for any of The Plan's obligations to the Group created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of The Plan other than those obligations created under other provisions of this Agreement.

8.1 Agreement Not Assignable: This Agreement, or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party, which consent shall not be unreasonably withheld or delayed. However, The Plan may transfer, assign, delegate, or extend, all or part of its rights or obligations under this Agreement to any subsidiary or affiliate of HCSC without the prior written consent of Group. The Plan'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. This Agreement will be binding upon and inure to the benefit of the respective Parties hereto and permitted assigns.

8.2 Appeals and Grievance Procedures: Both The Plan and Group agree to abide by and exhaust the Appeals and Grievance Procedures set forth in Article VII.

8.3 Applicability of Agreement:

8.3.0 BlueCard Program: The terms of this Agreement and all Addendums, including but not limited to the Maximum Reimbursement Allowance, shall be applicable to services provided to individuals having their health insurance Benefits underwritten or administered by any Blue Cross and/or Blue Shield company and their affiliated subsidiaries that are licensed by the Blue Cross and Blue Shield Association to use the words "Blue Cross" and or "Blue Shield" and all Blue Cross and Blue Shield symbols, trademarks, and service marks presently existing or hereafter established. Whether or not specific services are Covered Services, and a Member's eligibility, copayment, deductible and coinsurance, will be governed by the Member's Benefit Agreement, and, therefore, will be determined by the Blue Cross and/or Blue Shield Company underwriting or administering the Member's Benefit Agreement. Details concerning the "Blue Card Program" can be found at www.bcbsok.com.

8.3.1 Other Networks: In the event that Group has not contracted with The Plan for its other networks, including but not limited to BlueLincs HMO, Blue Preferred PPO or Blue Advantage PPO, the terms of this Agreement, including the Maximum Reimbursement Allowance described herein, shall be applicable to any Covered Services rendered to a Member whose designated network is one in which Group does not participate. Group agrees to hold such Members harmless from any sums in excess of the Maximum Reimbursement Allowance.

8.3.2 Network Access: The terms of this Agreement and all Addendums shall be in effect for individuals and/or employees of employer groups that are covered by plans not underwritten or fully administered by The Plan, but who have access to the networks in which Group participates, and individuals and/or employees of employer groups that have contracts with The Plan to assist with the administration of their health benefits program. All such individuals and employees shall be included in the term "Member" as used herein. Under such arrangements, it is understood that the health plan or its claims administrator is required to honor the terms of the Agreements in effect between The Plan and Group.

8.3.3 Self-Funded Plans: The Plan has a division that performs services as a Third Party Administrator for employer groups which sponsor self-funded employee benefit programs. The terms of this Agreement and all Addendums shall be applicable to services rendered to participants in such self-funded employee benefit programs. From time to time with self-funded groups, The Plan 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 Addendums shall apply.

8.4 Confidentiality of Member Records and/or Member Information: Both parties will protect the privacy of the Member's medical/clinical records from inappropriate or unauthorized use in accordance with state and federal law. All medical records and Member information shall be treated confidentially and no third party other than Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Oklahoma or another organization affiliated with or contracted with Health Care Service Corporation may obtain such records or Member information except as needed for purposes of quality improvement, utilization management, case management, compliance, and claims processing, or unless otherwise required by law. Member information includes, but is not limited to, any information that identifies an individual and/or relates to the physical or mental health or condition of a Member, or to the provision of health care to the Member (or the payment for such health care).

8.5 Coordination of Benefits: When the Member has another source of healthcare benefits, the following Coordination of Benefits rules shall apply in a manner consistent with *Accept Reimbursement* in Article II and *Applicability of Agreement* in Article VIII of this Agreement:

8.5.0 When The Plan is primary, The Plan shall pay Benefits as if the other payor did not provide benefits.

8.5.1 When The Plan is secondary, unless otherwise provided by the Member's Benefit Agreement or state law, the following provisions shall apply:

(a) The Plan's Benefits will be determined after those of the other payor and may be reduced because of the other payor's benefits, including cost containment reductions;

(b) reimbursement will not be made for any amount for which the Member is contractually held harmless by either payor;

(c) reimbursement will be determined using the lesser of The Plan's Maximum Reimbursement Allowance had The Plan been primary, or the maximum reimbursement allowed by the other payor.

8.5.2 If Medicare is primary and The Plan 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 The Plan's allowable.

8.6 Credentialing: Acceptance of this Agreement by The Plan is conditioned upon approval by The Plan's credentialing committee. After the effective date of this Agreement, Group's or Group Participating Providers' failure to meet credentialing or recredentialing criteria or receive approval from the credentialing committee may result in termination of this Agreement or removal of one or more Group

Participating Providers from this Agreement in accordance with *Immediate Termination by The Plan* in Article XI.

8.7 Data Sharing and Transmittal: The parties acknowledge that health care information pertaining to Members, including "Protected Health Information" as that term is defined in 45 CFR parts 160 and 164 of the federal privacy and security regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 (referred to as the HIPAA "Privacy Rule"), will be disclosed/transmitted to Group in connection with the provision of services to Members pursuant to this Agreement. Accordingly, each party (i) agrees that disclosure transmittals of such information will be made within the requirements of applicable state and federal law, including requirements pertaining to the validation of minimum necessary limitations on such transmittals set forth in the HIPAA and in the American Recovery and Reinvestment Act of 2009 and additional privacy regulations adopted pursuant to ARRA, and (ii) agrees to execute such agreements as are necessary between the parties to enable the disclosure/transmittal of health care information on Members in accordance with state and federal law and regulations.

8.7.0 Group authorizes The Plan to obtain Member PHI and other health care information through a Health Information Network.

8.7.1 Group acknowledges it is a Covered Entity as defined by HIPAA.

8.8 Delegation of Activities: The Plan and Group agree that, to the extent that The Plan delegates to Group the performance of any function, duty, obligation, or responsibility, including reporting responsibilities ("Delegated Activity"):

8.8.0 The Delegated Activity shall be set out in writing, and if such Delegated Activity includes credentialing and/or selection of Participating Providers, such written arrangement shall address The Plan's right to review on an ongoing basis, approve and audit Group's credentialing process and/or right to review on an ongoing basis, approve, suspend and terminate such providers, as applicable;

8.8.1 The Plan shall conduct on-going monitoring and review of Group's performance of the Delegated Activity;

8.8.2 Group's performance of the Delegated Activity shall comply with all applicable laws and this Agreement.

8.8.3 Such delegation shall be subject to the requirements of all applicable laws.

8.8.4 Termination of Delegated Activities: The Plan and Group agree that, with respect to any Delegated Activity delegated to Group, The Plan may revoke the delegation in whole or in part or specify such other remedies as The Plan, in its reasonable discretion, deems appropriate, where The Plan, in its reasonable discretion, determines that Group is not performing such Delegated Activity in a satisfactory manner.

8.9 Enforcement: The provisions of this Agreement may be enforced only by the Group or The Plan. This Agreement is intended for the exclusive benefit of the parties to this Agreement, their respective successors and approved assigns.

8.10 Entire Agreement: This Agreement, together with all attachments, contains the entire Agreement between The Plan and Group relating to the rights granted and the obligations assumed by the parties concerning the provision of services to Member. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

8.11 Good Faith: The Plan and Group agree that their authorized representatives will timely meet and negotiate, in good faith, to resolve any problems or disputes that may arise in the performance of the terms and provisions of this Agreement.

8.12 Governing Laws: This Agreement shall be governed by the laws of the State of Oklahoma.

8.13 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.

8.14 Health Information Network Participation: Group and The Plan agree to appropriately use the Health Information Network related to the services provided to Members under this Agreement.

8.15 Independent Relationship: None of the provisions of this Agreement are intended to create, nor will be deemed or construed to create, any relationship between The Plan and Group other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the parties to this Agreement, nor any of their respective employees, will be construed to be the agent, employer, or representative of the other.

8.16 Legal Compliance: Both parties conduct and cause their employee(s) and contractor(s) to conduct, their operations in compliance with all applicable federal, state and local laws and regulations. Both parties further agree to comply with applicable Executive Orders, state and federal laws, regulations or other guidance regarding debarment or exclusion.

8.17 No Solicitation: To protect the legitimate business interests of the Parties, The Plan and Group agree to the following:

8.17.0 Agreement Not to Interfere with Business Relationships: Group agrees that during the term of this Agreement, Group and Group Participating Provider 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 The Plan and any other person or entity, including but not limited to brokers, agents, Participating Providers, group customers, and Members; or (b) solicit or induce, or direct others to solicit or induce, any broker, agent Participating Provider, or group customer with respect to carving out all or some Benefits from health plans offered or administered by The Plan. Activities that interfere with business relationships include but are not limited to:

(a) soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any Member or employer group to disenroll from health plans offered by The Plan;

(b) soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any potential Member or potential employer group to refrain from enrolling in health plans offered by The Plan;

(c) soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any Member, potential Member, employer group or potential employer group to enroll for health benefits with any other health benefit plan or insurer;

(d) advising or encouraging Participating Providers currently under contract with The Plan to cancel, or not renew, said contracts;

(e) directly impeding or interfering with negotiations which The Plan is conducting with any third party relating to The Plan's provision of health Benefits or related services;

(f) using or disclosing to any third party The Plan's membership acquired during the term of this Agreement unless authorized in advance in writing by The Plan, which authorization shall be within The Plan's sole discretion, and following such authorization, use or disclosure is in strict adherence to all privacy and security laws;

(g) mischaracterizing the nature or scope of coverage provided by The Plan.

8.17.1 Nothing in this section is intended or shall be deemed to restrict any communication between Group or a Group Participating Provider and Member relating to medical care and/or treatment options. Additionally, nothing in this section shall be deemed as precluding Group or a Group Participating Provider from advising Members and potential Members of all of the insurance plans and network plans which have contracted with Group, provided such communication shall be done in a manner that is uniform in nature without preference to any insurance or network plans.

8.18 No Third Party Liability: Neither The Plan nor Group nor any agent, employee, or other representative of a party shall be liable to third parties for any act by commission or omission of the other party in performance of this Agreement and the terms and provisions hereunder. Nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party, including, but not limited to, a Member or a provider other than Group.

8.19 Notification of Operational Changes: Each party shall promptly notify the other of changes of its ownership, including but not limited to joint ventures, mergers, acquisitions, bankruptcy, reorganization, change of licensure or any other operational changes which may impact or affect this Agreement. Group shall also notify The Plan of changes to executive management, or operational disruptions that materially affect Group's ability to provide services to Members. In addition, if Group engages the services of a management company in a way that impacts or affects this Agreement, or a consultant who may in the course of providing such services receive or gain access to this Agreement and/or related confidential information, it shall promptly notify The Plan and ensure that each management company representative executes a confidentiality agreement with The Plan before the terms of this Agreement are disclosed.

8.20 Practice of Medicine: The Plan shall neither dictate nor direct Group Participating Provider in the practice of medicine, nor the exercise of medical judgment, nor engage in making health care treatment decisions. Group shall not hinder The Plan in the conduct of its business. The Plan's quality improvement and utilization management activities as permitted in this Agreement shall not be construed as a violation of this provision. Group Participating Provider may communicate freely with Members under his/her care regarding treatment options available to them, including medication treatment options, regardless of Benefit coverage limitations.

8.21 Proprietary Information: The Plan reserves the right to, and controls the use of, the words "Blue Cross" and/or "Blue Shield" and all Blue Cross and Blue Shield symbols, trademarks, and service marks presently existing or hereafter established. Group agrees that it will not use such words, symbols, trademarks, or service marks in any manner without the prior written consent and approval of The Plan and will cease any and all usage upon termination of this Agreement.

8.22 Provider Resources: The Plan utilizes its website at www.bcbsok.com for communicating additional information to providers, including but not limited to billing information, quality improvement standards, and medical policies. The Plan agrees to maintain its website with current information including policies related to payment and coding and reserves the right to make updates to its website without notice. The Plan shall use its standard communication channels to provide advance notice to Group of substantive changes to information in the Provider section of its website. Group agrees to refer to the Provider section of The Plan's website for additional information regarding its relationship with The Plan.

8.23 Right of Recovery:

8.23.0 When a Member's coverage is subject to waiting periods, waivers, exclusion of coverage riders, pre-existing condition limitations, and/or exclusions and other Benefit or membership stipulations

or is subject to cancellation retroactive to the effective date (e.g., in the event of fraud, misrepresentation, or non-payment of dues), The Plan may determine that Benefits were paid for Noncovered Services or when the Member was not eligible for coverage. Group agrees that, if it is determined the patient or Member is not entitled to Benefits on the basis of the facts pertaining to such Benefit exclusion or membership termination, claims may be denied, and any amounts previously reimbursed may be offset against future payments due to Group from The Plan. The Plan will initiate its recovery efforts within six (6) months after the payment to Group by sending written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Group will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset. In such event, Group can, at its option, pursue payment from the Member or other responsible third party.

8.23.1 In accordance with Oklahoma law, when The Plan has granted Prior Authorization for a service and Group has verified the Member's or patient's eligibility within four (4) days of the service, The Plan will not deny Benefits or offset against future payments any amounts previously reimbursed unless:

(a) the claim or payment was made because of fraud or intentional misrepresentation,

(b) the Member or patient is subject to a pre-existing condition limitation and/or exclusion, or

(c) the Member, patient, employer or group failed to pay the applicable premium and membership is retroactively cancelled.

The Plan will initiate its recovery efforts within six (6) months after the payment to Group by sending Group written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Group will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset. In such event, Group can, at its option, pursue payment from the Member or other responsible party. This provision is subject to change or may be rendered null and void if Oklahoma law is otherwise amended or repealed.

8.23.2 When amounts have been reimbursed in error, other than as described in this *Right of Recovery* provision, such amounts may also be offset against future payments due Group from The Plan. The Plan will initiate its recovery efforts within eighteen (18) months after the payment to Group (or such other time period required by law) by sending Group written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Group will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset. When Group believes amounts have been reimbursed in error, other than as described in the first subsection of this Right of Recovery provision, Group may submit an inquiry to review a claim up to eighteen (18) months after the date of payment. If The Plan determines that the claim was paid incorrectly, The Plan will reimburse any applicable amount to Group.

The Plan shall not be prohibited from requesting a refund or retracting a payment outside the time frames set forth in this *Right of Recovery* provision if:

(a) the payment was made because of fraud or intentional misrepresentation, or

(b) Group has otherwise agreed to make a refund.

8.24 Severability: The terms and provisions of this Agreement shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Agreement, or any one of them, in accordance with the intent and purpose of the parties hereto.

8.25 Third Party Premium Assistance: The Plan allows premium payments and cost-sharing assistance for Members from: (i) Members 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) State and Federal Government programs. The Plan may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations make premium or cost-share assistance available to Members (i) regardless of the Member's health status, and (ii) for the entire coverage period of the Member's coverage agreement. The Plan will not accept payments from other third party entities, including, but not limited to, Group, Group Participating Providers, hospitals and other health care providers.

8.25.0 If The Plan discovers that any premium payments were provided directly by, or at the request of, or instruction from, Group or by Group Participating Provider in violation of this section, Group and Group Participating Provider forfeit any and all rights to payment under this Agreement for services rendered to said Member and shall hold the Member harmless for claims for services rendered.

8.25.1 Attempts by the Group or a Group Participating Provider to pay premiums for a patient or Member shall constitute material breach of this Agreement.

8.25.2 This section shall survive termination of this Agreement.

8.26 Unforeseen Circumstances: In the event Group does not have proper facilities to treat a Member due to circumstances beyond Group's reasonable control, such as major disaster, epidemic, war, complete or partial destruction of facilities, disability of a significant number of personnel, or significant labor disputes, civil commotion, government action (whether legal or not), Group shall provide Covered Services to Members to the extent possible according to the best judgment or limitations of such facilities and personnel as are then available, but Group shall have no liability or obligation to The Plan for delay or failure to provide or arrange such services.

8.27 Waiver: The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof or modification of this Agreement. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the parties.

ARTICLE IX
CONFIDENTIALITY AND NON-DISPARAGEMENT

9.0 Confidentiality:

9.0.0 "Confidential Information" means the terms and provisions of this Agreement, any related discussions and negotiations, including contract extension discussions and negotiations, and information of The Plan, in any format, provided or made available by The Plan to Group, including but not limited to the following: information pertaining to business operations, employees, staff, financial information, fee schedules and all Maximum Reimbursement Allowances, technology, suppliers, customers, product administration and management, business practices, trade secrets, policies and procedures, compliance with standards from accreditation and certifying boards or agreements, credentialing applications, project work product, data, any oral discussions or negotiations of the Parties, analyses, compilations, studies or other documents or information prepared by or on behalf of The Plan.

9.0.1 In addition, Confidential Information means correspondence, information, and documents exchanged and statements made by either party or its Representatives during the negotiation of a successor participating provider agreement or any other new agreement, including all exhibits and addendums (a "Proposed Transaction"), including but not limited to proposed rates, charges and fees, reimbursement methodologies, contractual terms and conditions, and discussions and negotiations. Representatives include officers, directors (including trustees and members of other governing boards of any nature, public or private), employees, agents, accountants, auditors and

outside attorneys, and other advisors (collectively, the "Representatives") who the receiving party determines have a need to know such Confidential Information in connection with evaluating the Proposed Transaction and who have been advised of the obligation of confidentiality and are obligated to keep the information confidential, subject to a binding obligation at least as restrictive as this Agreement. Notwithstanding the foregoing, if Group retains a third party specifically to evaluate, and to assist Group in the negotiation of, a Proposed Transaction, who may in the course of providing such services receive or gain access to proprietary information disclosed by The Plan, or a third party under contract to provide management services to Group ("Consultant") after the effective date of this Agreement, Group shall promptly notify The Plan and ensure that each Consultant executes a confidentiality/non-disclosure agreement with The Plan before any Confidential Information or other protected information of The Plan is disclosed to Consultant.

9.0.2 The Plan will remain the sole and exclusive owner of any and all Confidential Information it provides to Group.

9.0.3 Group agrees that the Confidential Information disclosed under this Agreement is confidential. Group may only use Confidential Information for purposes of implementing this Agreement and will restrict disclosure of Confidential Information to those persons who have a "need to know" for purposes of performing under this Agreement. Group agrees to take appropriate and necessary precautions to maintain and hold such Confidential Information confidential and to not use, disclose or release to any person or entity Confidential Information, except as authorized in this Agreement or in writing by the Plan. Should an unauthorized disclosure of Confidential Information occur, Group must notify The Plan within five (5) days of such discovery.

9.0.4 This obligation of confidentiality shall not preclude disclosure of information by Group or The Plan if disclosure is required to fulfill obligations imposed by federal or state law or ethical guidelines; provided, however, that if Group becomes legally compelled by law, process, or order of any court or governmental agency to disclose any Confidential Information, Group will give The Plan maximum practical advance written notice to permit The Plan to seek a protective order or to take any other appropriate action to protect the Confidential Information.

9.1 Non-Disparagement: The Group, on behalf of itself, Group Participating Providers, and its Representatives, agree 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 The Plan, 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.

9.2 Public Disclosures: Notwithstanding anything else in this Article IX to the contrary, during the negotiation of a Proposed Transaction each party's public disclosures regarding the Proposed Transaction shall be limited to statements i) regarding the expiration date of the existing provider agreement between the parties, if any, and extensions of time proposed by either party; ii) generally identifying the nature of the issues being negotiated and the party's position on those issues (including net percentage and/or dollar impact of proposed overall increase/decrease in reimbursement rates); and iii) issues remaining for resolution, so long as the public statements do not disclose specific Confidential Information, make public written documentation or correspondence exchanged between the parties related to the Proposed Transaction, or violate the Non-Disparagement section. Neither party will make, or cause or allow any Consultant, Representative, or other person or entity to make, any public statement regarding the Proposed Transaction, regardless of content, using advertising or paid media, including but not limited to online, digital, outdoor, print, radio, TV, video and social media.

9.3 Remedies of The Plan: Violation of this Article IX may result in immediate termination of this Agreement in accordance with *Immediate Termination by The Plan* in Article XI. Further, Group agrees that any breach (or anticipatory breach) of the obligations set forth in this Article will result in irreparable damage to The Plan for which it will have no adequate remedy at law. Therefore, it is agreed (and as an exception to any dispute resolution provisions in this Agreement) that The Plan may seek equitable relief to prevent

unauthorized use or disclosure by Group, including, but not limited to, an injunction enjoining any such breach or anticipatory breach, and Group will pay all attorneys' fees and court costs incurred by The Plan to secure such equitable relief. Such equitable relief will be without prejudice to any other right or remedy to which The Plan may be entitled.

9.4 Survival: The covenants and obligations set forth in this Article IX shall survive termination of this Agreement.

ARTICLE X
AMENDMENTS

10.0 Amendments: The Plan may amend this Agreement by providing Group written notice via mail or secure electronic format of such amendment at least ninety (90) days in advance of the effective date of the amendment. If Group does not notify The Plan, in writing, of nonacceptance at least forty-five (45) days prior to the effective date of the amendment, the amendment will be deemed to have been accepted by Group. Nonacceptance of proposed amendments will result in representatives of Group and The Plan meeting to resolve problems occurring as a result of the amendment(s). Notwithstanding the above, if an amendment to the Agreement is necessary to comply with requirements of an accreditation body or to comply with state or federal law or regulation, Group agrees to accept such an amendment. If an agreement has not been reached regarding the subject of the amendment prior to its effective date, this Agreement will terminate on the date designated by The Plan, or on the date agreed to by the parties.

ARTICLE XI
TERM AND TERMINATION

11.0 Contract Term: This Agreement shall be effective as stated on the cover page of this Agreement and shall continue for twelve (12) months. This Agreement shall automatically renew for successive twelve (12) month terms and continue in effect unless terminated in accordance with other provisions of this Agreement.

11.1 Immediate Termination by The Plan: The Plan may terminate this Agreement or remove one or more Group Participating Provider(s) from this Agreement, upon any of the occurrences identified in the sub-sections below by providing written notice to Group. A termination made under this section shall be effective upon the later of the date of receipt of written notice, or the date identified by The Plan in the written notice.

11.1.0 Failure to meet or maintain credentialing requirements, or failure to notify The Plan of actions against a Group Participating Provider that would impact credentialing status; or

11.1.1 Engaging in fraud, waste or abuse or filing false claims, or filing inappropriate claims after notification by The Plan, which may include but is not limited to the following:

(a) Billing for costs of Noncovered or non-chargeable services, supplies, or equipment disguised as covered items;

(b) Billing for services, supplies or equipment not furnished, or not furnished at the level claimed;

(c) Billing the claim for an M.D. or D.O. when a P.A., N.P., therapist, surgical assistant or other person delivered the services;

(d) Billing more than once for the same service, billing The Plan and the beneficiary for the same services, submitting claims to both The Plan and other third parties without making full disclosure of relevant facts to, or immediate full refunds in the case of overpayment by, The Plan;

(e) Misrepresentations of location, dates, frequency, duration, description of services rendered, or the identity of the recipient of the service or who provided the service;

(f) Billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed (e.g., under-billing or Pass-Through Billing);

(g) Unbundling, fragmenting or manipulating the CPT® codes as a means of increasing reimbursement and/or misrepresenting the services rendered in a claim and/or medical record submitted to The Plan, or;

(h) Demonstrating a pattern of claims for services not Medically Necessary.

11.1.2 An arrest, plea of guilty or nolo contendere or a conviction for any criminal offense, or placement in a diversion program for any crime related to the payment or provision of health care;

11.1.3 The forfeiture or suspension of a required license, Drug Enforcement Administration (DEA) certificate, or Bureau of Narcotics and Dangerous Drugs (BNDD) certificate;

11.1.4 Censure, reprimand, restriction, suspension, revocation or reduction to probationary status of license to practice or any hospital related privileges;

11.1.5 Suspension or debarment from participation in a government program, including but not limited to Medicare or Medicaid, or censure, restriction, termination of deeming or participation status in Medicare or Medicaid;

11.1.6 Engaging in conduct that threatens the health or well-being of Members;

11.1.7 Disability or infirmity which prevents or reduces Group Participating Provider's ability to meet accepted practice standards at the level of skill and care that any health care practitioner would be expected to observe in caring for patients as set forth in Article II, *Scope of Services*, or the failure to successfully complete a program related to substance abuse.

11.1.8 Intentional or negligent disclosure of Confidential Information.

11.2 Termination by Either Party: Either party may terminate this Agreement by providing the other party with at least ninety (90) days prior written notice. Termination pursuant to this section shall not entitle Group to the Appeals and Grievance Procedures set forth in Article VII of this Agreement.

11.3 Termination for Breach by Group: Upon The Plan's default of any material obligation under this Agreement, including the attachments, Group may provide to The Plan written notice of such breach. The Plan has thirty (30) days to cure the breach. If the default is incapable of cure or which, being capable of cure, has not been cured in the thirty (30) days following receipt of written notice of such default (or such additional cure period as mutually agreed by the parties), Group may terminate this Agreement upon ten (10) business days prior written notice to The Plan.

11.4 Termination for Breach by The Plan: The Plan may terminate this Agreement, or remove one or more Group Participating Providers from this Agreement, upon ten (10) business days' prior written notice to the Group and Group Participating Provider(s), upon any of the following:

11.4.0 Upon the default of any material obligation, under this Agreement, including the attachments, by Group or Group Participating Provider, which default is incapable of cure or which, being capable of cure, has not been cured in the thirty (30) days following receipt of written notice from The Plan of such default (or such additional cure period as The Plan may authorize).

11.4.1 Upon the filing of claims by Group or Group Participating Provider which do not comply with the Agreement or The Plan's policies or guidelines, including but not limited to policies related to payment and coding, following receipt of prior written notice by The Plan of filing requirements and failure to cure within thirty (30) days following receipt of notice of such non-compliance (or such additional cure period as the non-defaulting Party may authorize).

11.4.2 Group or Group Participating Provider's failure to comply with quality improvement, peer review or utilization review procedures, following prior written notice by The Plan and failure to cure within thirty (30) days following receipt of written notice of such non-compliance (or such additional cure period as The Plan may authorize).

11.4.3 Failure to eliminate or remediate conflicts of interests between the Group and The Plan, or Group Participating Provider and The Plan, following prior written notice by The Plan and failure to cure within thirty (30) days following receipt of notice of the conflict of interest (or such additional cure period as The Plan may authorize).

11.4.4 Engaging in unprofessional conduct with a Member or The Plan by Group or Group Participating Provider following prior written notice by The Plan and failure to cure within thirty (30) days following receipt of written notice of such non-compliance.

11.4.5 Engaging in any of the below identified behaviors, following prior written notice by The Plan and failing to cure within thirty (30) days following receipt of written notice (or such additional cure period as The Plan may authorize):

(a) demonstrating a pattern of billing patients for amounts in excess of deductibles and copayments;

(b) demonstrating a pattern of waiving or rebating any portion of deductibles, copayments and coinsurance amounts owed by the Member, without regard for the financial need of the patient;

(c) identified as prescribing/dispensing controlled substances for other than therapeutic reasons;

(d) demonstrating a pattern of billing for services that are not Medically Necessary; or

(e) refusing access to records which are deemed essential by The Plan to determine The Plan's liability.

11.5 Transition Period: If this Agreement terminates under this Article XI, or if the contract period, including any mutually agreed extensions thereof, expires without the execution of a new provider agreement between the parties, The Plan 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 period expires, the Parties must mutually agree in writing to extend the contract period prior to the expiration date.

11.5.0 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.

11.5.1 During the Transition Period, Group and Group Participating Providers shall provide services to Members 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 *Audit/Review* and *Quality Improvement* in Article II, which survive termination for a period of two years commencing on the first day of the Transition Period, and *Notification of Incorrect Payments* (Article II), *Third Party Premium Assistance* (Article VIII), and *Confidentiality and Non-Disparagement* (Article IX) which shall survive such termination indefinitely.

11.5.2 Members who received services from Group and Group Participating Providers during the Transition Period will have their claims for Benefits processed as if they were in network. The Plan agrees to issue payment directly to Group for services rendered by Group and Group Participating Providers during the Transition Period and payment shall be at the rates negotiated in the Agreement as of the date of termination.

11.5.3 Group agrees to accept payment at the rates negotiated in the Agreement as of the date of termination and to hold the Member harmless from any sums in excess of the Maximum Reimbursement Allowance.

11.5.4 During the Transition Period, The Plan shall give notices to Members and Participating Providers of the termination of the Agreement and the change in Group's network status. Group shall cooperate to transition the care of Members to Participating Providers, if requested to do so by Members and their treating physicians.

Refer to cover page for effective date, contact information and signatures.

BlueCross BlueShield of Oklahoma

Blue Cross Medicare Advantage (HMO)SM Addendum to the BlueLincs HMOSM Network Addendum to the Blue Traditional Network Participating Group Agreement Rural Health Clinics

This Blue Cross Medicare Advantage HMO Addendum ("MA HMO Addendum") to the BlueLincs HMO Network Addendum ("BlueLincs HMO Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and among GHS Health Maintenance Organization, Inc., d/b/a BlueLincs HMO ("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 ("HCSC"), and HCSC's subsidiaries and affiliates, and the undersigned rural health clinic, whose providers are duly licensed by the State of Oklahoma and authorized to practice as physicians or health care professionals ("Group"). This MA HMO Addendum supplements and amends the terms of the BlueLincs HMO Addendum and Agreement with respect to the provision of Covered Services to MA HMO Members enrolled in MA HMO Plans as the term is defined below.

As of the date executed, this MA HMO Addendum includes the following:

- ☑ Blue Cross Medicare Advantage (HMO) Addendum for Rural Health Clinics
- ☑ Attachment A, Compensation/Claims Submission for Rural Health Clinics
- ☑ Attachment B, Attestation

The undersigned hereby agree to the terms and conditions contained in this MA HMO Addendum. This MA HMO Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUELINCS HMO, A SUBSIDIARY OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
Name of Signatory	RICK KELLY Name of Signatory
Title of Signatory	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS Title of Signatory
Date Signed	Date Signed

RECITALS

WHEREAS, the Parties entered into the Agreement and BlueLincs HMO Addendum to provide Covered Services to BlueLincs HMO Members;

WHEREAS, the Parties mutually desire to supplement and amend the BlueLincs HMO Addendum to include the provision of Covered Services to BlueLincs HMO Members who are enrolled in MA HMO and Part D Plans (collectively, "MA HMO Members"); and

WHEREAS, CMS requires that specific terms and conditions be incorporated into the agreement between a Medicare Advantage Organization and Provider to comply with the Medicare laws, regulations, and CMS instructions; and

WHEREAS, the Parties agree to supplement and amend the BlueLincs HMO Addendum to include the requirements applicable to BlueLincs HMO Network Providers, as the term is defined below, participating in the MA HMO Network, as the term is defined below.

NOW THEREFORE, in consideration of the terms and conditions set forth in the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum, and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree to the following:

ARTICLE I
DEFINITIONS

All capitalized terms not defined in this MA HMO Addendum shall have the meanings ascribed to them in the Agreement and the BlueLincs HMO Addendum.

1.0 All-Inclusive Rate(s): All-inclusive rate(s) are billed by encounter, which means the calculation of a rate accounts for all of the allowable costs of providing care. This is the opposite of fee-for-service rates, where specific services are billed at specific rates, even if more than one service is provided during an encounter.

1.1 Centers for Medicare and Medicaid Services ("CMS"): means the agency within the Department of Health and Human Services that administers the Medicare program.

1.2 CMS Contract: All contracts between CMS and Health Care Service Corporation ("HCSC") or an HCSC Affiliate pursuant to which HCSC or HCSC Affiliates sponsor MA and Part D Plans

1.3 Covered Services: means those Services which are covered under an MA HMO Plan.

1.4 Downstream Entity: has the same definition that in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this MA HMO Addendum, means 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 BlueLincs HMO and a First-Tier Entity, such as Group. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.5 First Tier Entity: has the same definition as in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this MA HMO Addendum, means any person or entity that enters into a written arrangement with BlueLincs HMO to provide administrative and/or health care services, including Covered Services, to MA HMO Members.

1.6 HCSC Affiliate: An HCSC affiliate may include any current or future subsidiaries or affiliates of Health Care Service Corporation ("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 HCSC herein shall mean the HCSC Affiliate in those instances where an HCSC Affiliate holds the CMS Contract.

1.7 HHS: means the U.S. Department of Health and Human Services.

1.8 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.

1.9 MA HMO Member: A Medicare Advantage or Part D eligible individual who has enrolled in or elected coverage through an MA HMO Plan offered by BlueLincs HMO or HCSC.

1.10 MA HMO Provider: means a person or entity that contracts with BlueLincs HMO to deliver health care services, including Covered Services, to MA HMO Members.

1.11 MA HMO Plan(s): The Blue Cross Medicare Advantage HMO Plan(s) and Part D Plan(s) sponsored by BlueLincs HMO or HCSC pursuant to the CMS Contract.

1.12 MA HMO Network: means the network of Participating Providers maintained by BlueLincs HMO to provide Covered Services to MA HMO Members pursuant to the terms of their MA HMO Plan.

1.13 Medicare Advantage ("MA"): 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.

1.14 Medicare Advantage Organization ("MA Organization"): 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 MA contract requirements.

1.15 Medicare Advantage Plan or MA Plan: means a Medicare Advantage Plan sponsored by a Medicare Advantage Organization, as the term is defined in Laws, pursuant to the Medicare Advantage Program.

1.16 Medicare Advantage Program (MA Program): means the Medicare managed care program established and maintained under Laws.

1.17 Medicare Prescription Drug Plan or Part D Plan: means a Medicare prescription drug benefit plan sponsored by a Part D Plan Sponsor, as the term is defined in Laws, pursuant to the Part D Program.

1.18 Medicare Prescription Drug Program ("Part D Program"): means the Medicare prescription drug benefit program established and maintained under Laws.

1.19 Member or Enrollee: a Medicare Advantage or Part D eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization or Part D Plan Sponsor.

1.20 Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed

or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

1.21 Related Entity: means any entity that is related to the MA organization or Part D Sponsor by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2500 during the contract period.

ARTICLE II
BLUELINCS HMO OVERSIGHT AND ACCOUNTABILITY

2.0 Oversight by BlueLincs HMO: The Parties acknowledge and agree that BlueLincs HMO shall oversee, and ultimately remain responsible and accountable to CMS for, those functions and responsibilities required of BlueLincs HMO pursuant to Laws and its CMS Contract. BlueLincs HMO shall provide ongoing monitoring and oversight of all aspects of Group's performance of its obligations under the Agreement, BlueLincs HMO Addendum and this MA HMO Addendum.

2.1 Cooperation with CMS: The Parties acknowledge and agree that either Party's failure to cooperate with CMS or its designees may result in a referral of BlueLincs HMO and/or Group to law enforcement and/or implementation of other remedial action by CMS, including, without limitation, imposition of intermediate sanctions.

ARTICLE III
COVERED SERVICES

3.0 Provision of Covered Services: Group Participating Provider shall furnish Covered Services to MA HMO Members and otherwise perform other activities under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum in a manner consistent and in compliance with the requirements of all Laws; BlueLincs HMO's contractual obligations under its Medicare Advantage Contract with CMS; all applicable BlueLincs HMO policies, procedures and guidelines, including, but not limited to, BlueLincs HMO's compliance plan and such policies, procedures and initiatives for combating fraud, waste and abuse; and professionally recognized standards of health care. Group Participating Provider shall ensure that Covered Services are provided to MA HMO Members in a culturally competent manner, including for those MA HMO Members with limited English proficiency and/or reading skills, diverse cultural and ethnic backgrounds, physical disabilities, and mental disabilities. Group Participating Provider shall discuss all treatment options with MA HMO Members, including the option of no treatment, as well as related risks, benefits and consequences of such options. As applicable, Group Participating Provider shall provide to MA HMO Members instructions regarding follow-up care and training regarding self-care.

3.1 Direct Access to Certain Benefits: Group Participating Provider shall comply with all referral and Preauthorization procedures set forth in the Provider section of BlueLincs HMO's website at www.bcbsok.com, provided that no referral or prior authorization obligations shall be required for or imposed upon a MA HMO Member 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 for or imposed upon a MA HMO Member to obtain an influenza vaccine or a pneumococcal vaccine.

3.2 Availability: Group Participating Provider shall make necessary and appropriate arrangements with other Participating Providers to ensure that Medically Necessary Covered Services are readily available to MA HMO Members twenty-four (24) hours a day, seven (7) days a week.

3.3 Non-Discrimination: Group Participating Provider shall not deny, limit, or condition coverage or the furnishing of health care services or Benefits, including Covered Services, to MA HMO Members based on any factor related to health status, including, but not limited to, medical condition (including mental and/or

physical illness or disability), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability (including conditions arising out of acts of domestic violence).

3.4 Advance Directives: Group Participating Provider shall comply with advance directive requirements in accordance with Laws and shall document in a prominent part of each MA HMO Member's current medical record whether or not such individual has executed an advance directive as required by Laws. Group Participating Provider shall not condition the provision of health care services or benefits, including Covered Services, or otherwise discriminate against any MA HMO Member based on whether or not the individual has executed an advance directive.

ARTICLE IV
RECORDS AND FACILITIES

4.0 Maintenance of Records: Group shall maintain adequate operational, financial, and administrative records, medical and prescription records, contracts, books, files and other documentation involving transactions related to the CMS Contract and/or the administration or delivery of Covered Services to MA HMO Members under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum ("Records"). At minimum, such Records shall be sufficient to enable BlueLincs HMO to (1) evaluate Group's performance, including accuracy of data submitted to BlueLincs HMO, and (2) enforce BlueLincs HMO's rights under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum and in accordance with Laws.

4.1 Inspection of Records: Group and any Downstream Entities, at Group's sole cost and expense, shall provide BlueLincs HMO, HHS, the Comptroller General, and/or their authorized designees with direct access to audit, evaluate, collect, and inspect all Records, personnel, physical premises, computer and other electronic systems, and facilities and equipment relating to Group's performance under this MA HMO Addendum, including the provision of Covered Services to MA HMO Members. Such direct access will be provided through ten (10) years from the date of the final term of the CMS Contract period or ten (10) years from the date of completion of any audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity, or ten (10) years from the submission of data to CMS to verify for Medical Loss Ratio requirements, whichever is later, or such other time frame as may be required by Laws. Group, at Group's sole cost and expense, will provide all reasonable facilities and assistance for the safety and convenience of the personnel conducting any such auditing, evaluation, collection, and inspection. Group, at Group's sole cost and expense, will provide BlueLincs HMO with copies of any and all Records audited, evaluated, collected or inspected, copied, evaluated and/or audited by HHS, the Comptroller General and/or their authorized designees within the timeframe necessary to allow for BlueLincs HMO's review before production, unless otherwise instructed by the HHS or Comptroller General. Group will notify BlueLincs HMO immediately by telephone, to be followed with written notice within three (3) business days, if it receives any request from HHS, the Comptroller General or their authorized designees for any Records or to inspect Group's premises, physical facilities, or equipment or to confer with Group's personnel, and Group will permit BlueLincs HMO to participate in any such inspection or conference.

ARTICLE V
PRIVACY, SECURITY AND CONFIDENTIALITY

5.0 Protected Health Information: Group shall obtain, analyze, store, transmit and report Protected Health Information, as defined under Laws, in accordance with all Laws. As applicable, Group and any Downstream Entities shall abide by all Laws and BlueLincs HMO procedures regarding privacy, confidentiality, and accuracy of MA HMO Members' medical and prescription records and other health and enrollment information, including (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

ARTICLE VI
PAYMENT

6.0 Claims Payment: BlueLincs HMO shall pay Group for Covered Services rendered to MA HMO Members pursuant to this MA HMO Addendum in accordance with Attachment A to this MA HMO Addendum.

6.1 Claims to Federal Government Prohibited: Group shall not request payment for Covered Services provided under the Agreement, the BlueLincs HMO Addendum or this MA HMO Addendum 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 HMO Addendum, except as may be approved in advance by BlueLincs HMO and CMS.

6.2 Overpayment: Group shall provide notice to BlueLincs HMO of any overpayment(s) identified by Group, including duplicate payments, within ten (10) calendar days of identifying such overpayment, and, unless otherwise instructed by BlueLincs HMO in writing, Group shall refund any amounts due to BlueLincs HMO within thirty (30) calendar days of identifying such overpayment.

6.3 Notwithstanding the provisions above, in the event of any overpayment, duplicate payment, or other payment in excess of that to which Group is entitled for Covered Services furnished to a MA HMO Member under the Agreement, the BlueLincs HMO Addendum and/or this MA HMO Addendum, BlueLincs HMO may recover the amounts owed by way of offset or recoupment from current or future amounts due from BlueLincs HMO to Group.

ARTICLE VII
HOLD HARMLESS

7.0 MA HMO Member Hold Harmless: Group hereby agrees that in no event, including, but not limited to, non-payment by BlueLincs HMO, insolvency of BlueLincs HMO, or breach of the Agreement, the BlueLincs HMO Addendum or this MA HMO Addendum by BlueLincs HMO, shall Group bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against MA HMO Members or persons other than BlueLincs HMO acting on such MA HMO Member's behalf for fees that are the legal obligation of BlueLincs HMO. This provision shall not prohibit Group from collecting charges for non-Covered Services or cost-sharing obligations for Covered Services imposed on MA HMO Member pursuant to the terms of such MA HMO Member's MA HMO Plan.

Group further agrees that: (1) this provision shall survive the termination of this MA HMO Addendum regardless of the cause giving rise to termination and shall be construed to be for the benefit of the MA HMO Member; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Group and the MA HMO Member or persons other than BlueLincs HMO acting on such MA HMO Member's behalf.

7.1 Dual-Eligible Cost-Sharing: Group agrees that, to the extent Group Participating Provider provides Covered Services to MA HMO Members who are eligible for benefits under both the Medicare and Medicaid Programs ("Dual-Eligible Member"), and unless otherwise instructed by BlueLincs HMO in writing:

7.1.0 Group shall not bill, charge, collect a deposit from or seek compensation, remuneration or reimbursement from or have any recourse against any Dual-Eligible Member for payment of Medicare Part A and/or Part B cost-sharing when the state Medicaid program is responsible for payment of such amounts; furthermore, Group shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan.

7.1.1 Group shall accept payment under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum as payment in full for the Covered Service provided to a Dual-Eligible Member or submit a claim to the state Medicaid source for payment of any cost-sharing amount that is the obligation of the state Medicaid program.

7.2 Dual-Eligible Benefits: Group shall coordinate with BlueLincs HMO to ensure that Group is informed of Medicare and Medicaid benefits available to Dual-Eligible Members, including cost-sharing obligations of such Dual Eligible Members as well as any applicable eligibility requirements or other rules.

ARTICLE VIII
COMPLIANCE WITH QUALITY IMPROVEMENT AND GRIEVANCE AND APPEAL REQUIREMENTS

8.0 Quality Improvement: Group shall cooperate and comply with BlueLincs HMO medical policies as well as MA HMO Plan policies, procedures and programs for quality improvement, performance improvement and medical management, including, as applicable, drug utilization management, medication therapy management, and e-prescribing programs. Such cooperation and compliance shall include, but not be limited to, making all information regarding medical policy, medical management and quality improvement available to BlueLincs HMO and CMS upon request, and providing to BlueLincs HMO such data as may be necessary for BlueLincs HMO to implement and operate any and all quality improvement and medical management programs and credentialing and recredentialing requirements.

8.1 Grievances, Coverage Determinations and Appeals: Group shall cooperate and comply with all requirements of BlueLincs HMO regarding the processing of MA HMO Member grievances, coverage determinations and appeals relating to such MA HMO Members' MA HMO Plans, including the obligation to provide to BlueLincs HMO any and all information within the time frame reasonably requested by BlueLincs HMO to ensure BlueLincs HMO's compliance with Laws.

ARTICLE IX
DATA COLLECTION

9.0 Data Reporting: Group acknowledges that BlueLincs HMO collects, analyzes and integrates data relating to the provision of Covered Services to MA HMO Members in order for BlueLincs HMO to meet its obligations under Laws, including, without limitation, 42 C.F.R. §§ 422.310, 422.516, 423,329, and 423.514, the CMS Contract and BlueLincs HMO policies, procedures and programs. Group agrees to provide to BlueLincs HMO any and all data, without limitation, including encounter data, diagnosis codes, and medical and prescription records, relating to the provision of health care services and benefits, including Covered Services, by Group to MA HMO Members pursuant to the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum as BlueLincs HMO so requests, and to submit such data to BlueLincs HMO, or such other party designated by BlueLincs HMO, in the format and within such time frames as may be prescribed by BlueLincs HMO. Group agrees that all data Group submits to BlueLincs HMO under this MA HMO Addendum shall conform to all relevant national standards and to the requirements for equivalent data for Medicare fee-for-service, as applicable.

9.1 Acknowledgement of Data Used to Obtain Payment Under Federal Program: Group acknowledges and agrees that data furnished by Group to BlueLincs HMO in connection with the provision of Covered Services under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum will be used by BlueLincs HMO to obtain payment from CMS under the CMS Contract and to support BlueLincs HMO's participation in the MA and Part D Programs, including submission of bids for renewal of the CMS Contract in future years and for risk-adjusting MA HMO Plan payments from CMS. Furthermore, Group acknowledges and agrees that BlueLincs HMO and CMS will rely on the accuracy, completeness and truthfulness of any data Group submits to BlueLincs HMO under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum.

9.2 Certification of Data Accuracy: Group shall, upon request by BlueLincs HMO, have its CEO or CFO or an individual delegated the authority to sign on behalf of one of these officers and who reports directly to such officer, certify to the accuracy, completeness and truthfulness of all data submitted under the Agreement, the BlueLincs HMO Addendum or this MA HMO Addendum in the form and format set out in Attachment B to this MA HMO Addendum.

9.3 Potential Financial Penalties: BlueLincs HMO reserves the right to adopt, upon notice to Group, a schedule of financial penalties to be imposed on Group, in BlueLincs HMO's sole discretion, for Group's failure to comply with the terms and conditions of this section.

ARTICLE X
DELEGATION AND SUBCONTRACTING

10.0 Delegation of Activities: The Parties agree that to the extent that BlueLincs HMO delegates to Group performance of any function, duty, obligation, or responsibility, including reporting responsibilities, imposed on BlueLincs HMO under the CMS Contract ("Delegated Activity"):

10.0.0 The Delegated Activity shall be set out in writing, and if such Delegated Activity includes credentialing of MA HMO Network Providers and/or selection of MA HMO Network Providers, such written arrangement shall address BlueLincs HMO's right to review on an ongoing basis, approve and audit Group's credentialing process and/or right to review on an ongoing basis, approve, suspend and terminate such providers, as applicable;

10.0.1 BlueLincs HMO shall conduct on-going monitoring and review of Group's performance of the Delegated Activity;

10.0.2 Group's performance of the Delegated Activity shall comply with Laws, the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum; and

10.0.3 Such delegation shall be subject to the requirements of Laws.

10.1 Termination of Delegated Activities: The Parties agree that, with respect to any Delegated Activity delegated to Group, CMS and BlueLincs HMO may revoke the delegation in whole or in part or specify such other remedies as CMS or BlueLincs HMO, in its reasonable discretion, deems appropriate, where CMS, in its sole discretion, or BlueLincs HMO, in its reasonable discretion, determine that Group is not performing such Delegated Activity in a satisfactory manner.

10.2 Subcontracting: Group agrees that BlueLincs HMO may, at its option and in its sole discretion, outsource various functions of its CMS Contract, including but not limited to marketing, claims processing and membership. The Parties acknowledge that all vendors involved in the provision of a Delegated Activity and MA HMO Providers are considered First Tier or Downstream Entities and that all First Tier and Downstream Entities must comply with all Laws, including all provisions contained in this MA HMO Addendum. Any services performed by Group, or any Downstream Entities, shall be performed in accordance with the contractual obligations established between CMS and BlueLincs HMO and all applicable, professionally recognized standards of health care. Accordingly, Group, as a First-Tier Entity, agrees that it will not contract with any entity ("Subcontractor") to administer or deliver Covered Services to MA HMO Members unless (1) such arrangement is approved by BlueLincs HMO in writing in advance; (2) such Subcontractor is specifically obligated, through a written agreement between Subcontractor and BlueLincs HMO or Subcontractor and Group, to comply with all Laws, including all provisions contained in this MA HMO Addendum; and (3) such written arrangement specifically permits BlueLincs HMO and CMS to suspend or terminate the subcontractor or take such other remedial action as CMS or BlueLincs HMO, in its reasonable discretion, deems appropriate, upon determination by CMS, in its sole discretion, or BlueLincs HMO, in its reasonable discretion, that such Subcontractor is not performing the services satisfactorily.

ARTICLE XI
COMPLIANCE, FRAUD, WASTE, AND ABUSE PROGRAM AND REPORTING

11.0 Compliance Program: Group shall implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that addresses the scope of services under the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum. Such compliance program shall require cooperation with BlueLincs HMO's compliance plan and policies and shall include, without limitation, the following:

11.0.0 A code of conduct particular to Group that reflects a commitment to preventing, detecting and correcting fraud, waste, and abuse in the administration or delivery of Covered Services to MA HMO Members. BlueLincs HMO's code of conduct is available upon request.

11.0.1 Compliance training for all employees, Subcontractors, any affiliated party or any Downstream Entity involved in the administration or delivery of Covered Services to MA HMO Members or involved in the provision of Delegated Activities.

11.0.2 Group shall provide general compliance training to employees, Subcontractors, any affiliated party or any Downstream Entity involved in the administration or delivery of Covered Services to MA HMO Members or involved in the provision of Delegated Activities at the time of initial hiring (or contracting) and annually thereafter. Such general compliance training shall address matters related to Group's compliance responsibilities, including, without limitation, (1) Group's code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues; (2) Group's obligations to comply with Laws; (3) common issues of non-compliance in connection with the provision of health care services to Medicare beneficiaries; and (4) common fraud, waste and abuse schemes and techniques in connection with the provision of health care services to Medicare beneficiaries.

11.0.3 Group also shall provide specialized compliance training to personnel whose job function directly relates to the administration or delivery of Covered Services to MA HMO Members on issues particular to such personnel's job function. Such specialized training shall be provided (1) upon each individual's initial hire (or contracting); (2) annually; (3) upon any change in the individual's job function or job requirements; and (4) upon Group's determination that additional training is required because of issues of non-compliance.

11.0.4 Group shall maintain records of the date, time, attendance, topics, training materials, and results of all training and related testing. Group shall, upon request, provide to BlueLincs HMO annually and upon request a written attestation certifying that Group has provided compliance training in accordance with this section. Such training shall be subject to BlueLincs HMO review/prior approval and shall incorporate those provisions that BlueLincs HMO determines to be important.

11.0.5 Policies and procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and Group's compliance and anti-fraud, anti-waste, and anti-abuse initiatives. Such program shall include implementation and publication to Group's directors, officers, employees, agents and contractors of a compliance hotline, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and Group's anti-fraud, anti-waste, and anti-abuse initiatives;

11.0.6 Annual compliance risk assessments, performed at Group's sole expense. Group shall, upon request, share the results of such assessments with BlueLincs HMO to the extent any part of the assessment directly or indirectly relates to the Agreement, the BlueLincs HMO Addendum and/or this MA HMO Addendum.

11.0.7 Routine monitoring and auditing of Group's responsibilities and activities with respect to the administration or delivery of Covered Services to MA HMO Members and the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum. Group hereby represents and warrants to BlueLincs HMO that Group has an adequate work plan in place to perform such monitoring and audit activities. Group shall take corrective action to remedy any deficiencies found as appropriate.

11.0.8 Upon request, provision of a report to BlueLincs HMO of the activities of Group's compliance program required by this MA HMO Addendum, including, without limitation, reports and investigations, if any, of alleged failures to comply with laws, regulations, the terms and conditions of the CMS Contract, or the Agreement, the BlueLincs HMO Addendum, or this MA HMO Addendum so that BlueLincs HMO can fulfill its reporting obligations under Laws. Upon request,

Group shall provide to BlueLincs HMO the results of any audits related to the administration or delivery of Covered services to MA HMO Members. Group shall make appropriate personnel available for interviews related to any audit or monitoring activity.

11.1 Incidents of Suspected Non-Compliance, Fraud, Waste or Abuse: Group shall promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the Agreement, the BlueLincs HMO Addendum, this MA HMO Addendum, and/or the administration or delivery of Covered Services to MA HMO Members ("Incident") and report any such Incident to BlueLincs HMO as soon as reasonably possible, but in no instance later than thirty (30) calendar days after Group becomes aware of such Incident. Such notice to BlueLincs HMO shall include a statement regarding Group's efforts to conduct a timely, reasonable inquiry into the Incident, proposed or implemented corrective actions in response to the Incident, and any other information that may be relevant to BlueLincs HMO in making its decision regarding self-reporting of such Incident.

Group shall cooperate with any investigation by BlueLincs HMO, HHS or its authorized designees relating to such Incident, and Group acknowledges that its failure to cooperate with any such investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

Group shall cause its Downstream Entities to promptly report to Group, who shall report to BlueLincs HMO, any Incidents in accordance with this section.

11.2 Compliance Reviews: In addition to any other audits or reviews agreed to pursuant to the Agreement, the BlueLincs HMO Addendum or this MA HMO Addendum, Group shall provide BlueLincs HMO with access to Group's records, physical premises and facilities, equipment and personnel in order for BlueLincs HMO, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum.

11.3 Conflicts of Interest: Group shall require any manager, officer, director or employee associated with the administration or delivery of Covered Services to MA HMO Members to sign a conflict of interest statement, attestation or certification at the time of hire and annually thereafter certifying that such individual is free from any conflict of interest in administering or delivering Covered Services to MA HMO Members. Group shall supply the form of such statement, attestation or certification to BlueLincs HMO upon request.

11.4 Exclusion of Certain Individuals: Group certifies that neither Group nor its employees, any Subcontractor, any affiliated party or any Downstream Entity involved in the provision of a Delegated Activity under this MA HMO Addendum has been: (1) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, state or local) contract or subcontract, (2) listed by a federal governmental agency as debarred, (3) proposed for debarment or suspension or otherwise excluded from federal program participation, (4) been 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; or (5) within a three (3) year period preceding the date of this MA HMO Addendum, had one or more public transactions (federal, state or local) terminated for cause or default.

Group shall check appropriate databases at least annually to determine whether any of Group's employees, Subcontractors or affiliated parties or Downstream Entities involved in the provision of a Delegated Activity under this MA HMO Addendum 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 HHS Office of Inspector General List of Excluded Individuals-Entities (http://exclusions.oig.hhs.gov/), the Healthcare Integrity and Protection Data Bank (http://www.npdb-hipdb.hrsa.gov/), and the General Service Administration List of Parties Excluded from Federal Procurement and Non-procurement Programs (https://www.epls.gov/).

Group acknowledges and agrees that it has a continuing obligation to notify BlueLincs HMO in writing within seven (7) business days if any of the above-referenced representations change. Group 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 HMO Addendum may be grounds for immediate termination of this MA HMO Addendum, at the sole discretion of BlueLincs HMO.

11.5 Preclusion List: Group agrees, for all services performed on or after January 1, 2020:

11.5.0 MA HMO Members do not have any financial liability for services, items, or drugs furnished. ordered, or prescribed to the MA HMO Member 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;

11.5.1 After the expiration of the sixty (60) day period specified in §422.222, Group will no longer be eligible for payment from BlueLincs HMO and will be prohibited from pursuing payment from the MA HMO Member as stipulated by the terms of the CMS Contract per 42 C.F.R. § 422.504(g)(1)(iv); and,

11.5.2 Group will hold financial liability for services, items and drugs that are furnished, ordered, or prescribed after this sixty (60) day period, at which point, Group and the MA HMO Member will have already received notification of the preclusion.

ARTICLE XII
OFF-SHORE OPERATIONS

12.0 Group shall not itself nor directly or indirectly through another person or entity, undertake any functions, activities, or services in connection with the Agreement, the BlueLincs HMO Addendum or this MA HMO Addendum, including without limitation, storage of Medicare Member information, outside of the United States of America without the prior written consent of BlueLincs HMO.

ARTICLE XIII
TERM AND TERMINATION

In addition to the termination provisions in Article VII of the Agreement, the following provisions shall apply to this MA HMO Addendum:

13.0 Term: The Parties agree that this MA HMO Addendum is effective as stated on the cover page of this MA HMO Addendum and shall remain in effect for the duration of the term of the Agreement and the BlueLincs HMO Addendum unless otherwise terminated according to the terms specified herein.

13.1 Termination Upon Termination of CMS Contract: The Parties agree that this MA HMO Addendum is conditioned upon the CMS Contract and shall terminate automatically upon termination of the CMS Contract. BlueLincs HMO shall, to the extent practical and feasible, undertake commercially reasonable efforts to advise Group in advance of the termination of the CMS Contract.

13.2 Termination Upon CMS Request: The Parties agree that this MA HMO Addendum shall terminate immediately upon the request of CMS.

13.3 Termination Without Cause: Either Party may terminate this MA HMO Addendum without cause by providing the other Party with advance written notice of termination at least ninety (90) days prior to the effective date of such termination.

13.4 Notice of Termination to MA HMO Members: Upon termination of this MA HMO Addendum for any reason, BlueLincs HMO, and not Group, shall, as required by Laws, notify MA HMO Members treated by Group in the six (6) months prior to the effective date of the termination of this MA HMO Addendum and Group's participation in the MA HMO Network. Group shall cooperate with and assist BlueLincs HMO in identifying such MA HMO Members.

13.5 Continuation of Benefits: Upon termination of this MA HMO Addendum for any reason, Group shall continue to provide Covered Services to MA HMO Members through the date of such MA HMO Member's discharge or when medically appropriate alternative care is arranged for the MA HMO Member ("Continuation Services"). Such Continuation Services shall be provided in accordance with the terms and conditions of the Agreement, the BlueLincs HMO Addendum and this MA HMO Addendum, including, but not limited to, the compensation rates and terms set forth herein, unless the Parties otherwise agree in writing.

13.6 Transition of MA HMO Members: Upon either Party's provision of notice of termination of this MA HMO Addendum to the other Party, Group shall cooperate fully with BlueLincs HMO and BlueLincs HMO protocols, if any, in the transfer of MA HMO Members to other MA HMO Providers.

The terms of this section shall survive the termination of this MA HMO Addendum.

ARTICLE XIV
CONFLICT AND PREEMPTION

14.0 Conflict: To the extent any provision of this MA HMO Addendum conflicts with any provision in the Agreement or the BlueLincs HMO Addendum, this MA HMO Addendum shall control with respect to the provision of Covered Services or Group's obligation or duty under the Agreement, the BlueLincs HMO Addendum or this MA HMO Addendum as the same relates to MA HMO Members, MA HMO Plans, or the CMS Contract.

14.1 Preemption: The Parties acknowledge and agree that the standards established by the Medicare Advantage Program and Part D Program supersede any state law or regulation, other than state licensing laws or state laws relating to the solvency of sponsors of MA Plans or Part D Plans, with respect to MA HMO Plans.

ARTICLE XV
AMENDMENT DUE TO LEGAL OR REGULATORY CHANGES

15.0 Amendments: The Parties acknowledge and agree that this MA HMO Addendum shall supersede any previous amendment or addendum to the Agreement or the BlueLincs HMO Addendum regarding the subject matter herein. Further, the Parties agree that this MA HMO Addendum shall automatically be amended as necessary to conform to Laws and to include any additional terms and conditions as CMS and/or BlueLincs HMO may find necessary and appropriate in order to implement and comply with the requirements of Laws, and any such additional or conforming terms and conditions will be considered incorporated herein, as if fully stated, pending formal amendment.

ARTICLE XVI
COUNTERPARTS

16.0 This MA HMO Addendum may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

ATTACHMENT A
COMPENSATION/CLAIMS SUBMISSION

COMPENSATION

Group agrees to accept Group's CMS Interim Rate as payment in full for the provision of a Covered Service to an MA HMO Member. Any applicable cost-sharing amount that is the responsibility of the MA HMO Member pursuant to the terms of such MA HMO Member's MA HMO Plan shall be deducted from this Maximum Reimbursement Allowance.

Group must provide official written notice to BlueLincs HMO of any modification to Group's CMS Interim Rate upon receipt of the notification letter. Changes to Group's CMS Interim Rate will be applied prospectively beginning no later than thirty (30) days after receipt of the notification from Group and will not be applied retroactively. If notification is not received for a twelve-month period, Group's CMS Interim Rate will revert to the CMS All-Inclusive Rate.

If applicable, services that do not have an All-Inclusive Rate posted on the CMS web site will be reimbursed based upon the applicable MA HMO Plan fee schedule in effect at the time the Covered Service is provided, less any applicable Copayments, Coinsurance or Deductible amounts. Payment of compensation shall be in accordance with MA HMO applicable policies and procedures. Such fees shall be payment in full for services rendered except for applicable Copayments, Coinsurance or Deductible amounts. It is acknowledged by the parties that the fee schedule is not updated at the same time as the CMS reimbursement rate update. Changes to the fee schedule shall be applied prospectively beginning on the effective date of the update and will not be applied retroactively.

Both parties acknowledge and agree that certain reductions to Medicare provider payments are mandated pursuant to the Budget Control Act of 2011 and it's 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 HMO Addendum. Accordingly, both parties agree that the rates payable under this MA HMO Addendum shall be adjusted by the amount proportionally equal to any reductions under Sequestration and such other regulatory authority.

CLAIMS SUBMISSION

Group shall submit complete and properly executed claims for a Covered Service to BlueLincs HMO or its designee within one hundred eighty (180) calendar days of the date the Covered Service is rendered. If Group fails to submit a claim within one hundred eighty (180) calendar days of the date the Covered Service is rendered, Group forfeits the right to payment from BlueLincs HMO or MA HMO Member.

Claims may be submitted (1) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format, or (2) on a completed version of the applicable CMS claim form.

CLAIMS PAYMENT

BlueLincs HMO shall make payment on a clean claim, as defined in Laws and/or the Provider section of BlueLincs HMO's website at www.bcbsok.com, to Group within thirty (30) days of BlueLincs HMO's receipt of such claim.

ATTACHMENT B
ATTESTATION

THIS ATTESTATION SHALL BE COMPLETED ONLY UPON REQUEST BY BLUELINCS HMO

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

_____ has reported to BlueLincs HMO, for transmission to CMS, and for the period of _____ to _____, all _____ data requested by BlueLincs HMO available to _____ with respect to the MA HMO Plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to BlueLincs HMO and/or CMS via this report is accurate, complete, and truthful.

_____
Authorized Signature

_____
Indicate title (CEO, CFO, or delegate)

_____
on behalf of

_____
Name of Group

_____
Date

BlueCross BlueShield of Oklahoma

Blue Cross Medicare Advantage (PPO)[SM] Addendum to the Blue Traditional Network Participating Group Agreement including the Blue Choice PPO Network Addendum Rural Health Clinics

This Blue Cross Medicare Advantage PPO Addendum ("MA PPO Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, 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 rural health clinic, whose providers are duly licensed by the State of Oklahoma and are authorized to practice as physicians and health care professionals ("Group"). This MA PPO Addendum includes and incorporates all applicable terms and conditions of the Agreement and the Blue Choice PPO Network Addendum ("Blue Choice PPO Addendum") with respect to the provision of Covered Services to MA PPO Members enrolled in MA PPO Plans offered by HCSC or its subsidiaries or affiliates ("The Plan").

As of the date executed, this MA PPO Addendum includes the following:

- ☑ Blue Cross Medicare Advantage (PPO) Addendum for Rural Health Clinics
- ☑ Attachment A, Compensation/Claims Submission for Rural Health Clinics
- ☑ Attachment B, Attestation

The undersigned hereby agree to the terms and conditions contained in this MA PPO Addendum. This MA PPO Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
	RICK KELLY
Name of Signatory	Name of Signatory
	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS
Title of Signatory	Title of Signatory
Date Signed	Date Signed

RECITALS

WHEREAS, the Parties entered into the Agreement and Blue Choice PPO Addendum to provide Covered Services to The Plan's Members;

WHEREAS, the Parties mutually desire to supplement the Agreement and the Blue Choice PPO Addendum to include the provision of Covered Services to The Plan's PPO Members who are enrolled in MA PPO and Part D Plans (collectively, "MA PPO Members"); and

WHEREAS, CMS requires that specific terms and conditions be incorporated into the agreement between a Medicare Advantage Organization and Provider to comply with the Medicare laws, regulations, and CMS instructions; and

WHEREAS, the Parties agree to supplement the Agreement and the Blue Choice PPO Addendum to include the requirements applicable to MA PPO Providers, as the term is defined below, participating in the MA PPO Provider Network, as the term is defined below.

NOW THEREFORE, in consideration of the terms and conditions set forth in the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum, and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree to the following:

ARTICLE I
DEFINITIONS

All capitalized terms not defined in this MA PPO Addendum shall have the meanings ascribed to them in the Agreement and the Blue Choice PPO Addendum.

1.0 All-Inclusive Rate(s): All-inclusive rate(s) are billed by encounter, which means the calculation of a rate accounts for all of the allowable costs of providing care. This is the opposite of fee-for-service rates, where specific services are billed at specific rates, even if more than one service is provided during an encounter

1.1 Centers for Medicare and Medicaid Services ("CMS"): means the agency within the Department of Health and Human Services that administers the Medicare program.

1.2 CMS Contract: All contracts between CMS and Health Care Service Corporation ("HCSC") or an HCSC Affiliate pursuant to which HCSC or HCSC Affiliates sponsor MA and Part D Plans

1.3 Covered Services: means those Services which are covered under an MA PPO Plan.

1.4 Downstream Entity: has the same definition that in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this MA PPO Addendum, means 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 The Plan and a First-Tier Entity, such as Group. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.5 First Tier Entity: has the same definition as in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this MA PPO Addendum, means any person or entity that enters into a written arrangement with The Plan to provide administrative and/or health care services, including Covered Services, to MA PPO Members.

1.6 HCSC Affiliate: An HCSC affiliate may include any current or future subsidiaries or affiliates of Health Care Service Corporation ("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 HCSC herein shall mean the HCSC Affiliate in those instances where an HCSC Affiliate holds the CMS Contract.

1.7 HHS: means the U.S. Department of Health and Human Services.

1.8 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.

1.9 MA PPO Member: A Medicare Advantage or Part D eligible individual who has enrolled in or elected coverage through an MA PPO Plan offered by The Plan or HCSC.

1.10 MA PPO Provider: means a person or entity that contracts with The Plan to deliver health care services, including Covered Services, to MA PPO Members.

1.11 MA PPO Plan(s): The Blue Cross Medicare Advantage PPO Plan(s) and Part D Plan(s) sponsored by The Plan or HCSC pursuant to the CMS Contract.

1.12 MA PPO Provider Network: means the network of Participating Providers maintained by The Plan to provide Covered Services to MA PPO Members pursuant to the terms of their MA PPO Plan.

1.13 Medicare Advantage ("MA"): 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.

1.14 Medicare Advantage Organization ("MA Organization"): 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 MA contract requirements.

1.15 Medicare Advantage Plan or MA Plan: means a Medicare Advantage Plan sponsored by a Medicare Advantage Organization, as the term is defined in Laws, pursuant to the Medicare Advantage Program.

1.16 Medicare Advantage Program (MA Program): means the Medicare managed care program established and maintained under Laws.

1.17 Medicare Prescription Drug Plan or Part D Plan: means a Medicare prescription drug benefit plan sponsored by a Part D Plan Sponsor, as the term is defined in Laws, pursuant to the Part D Program.

1.18 Medicare Prescription Drug Program ("Part D Program"): means the Medicare prescription drug benefit program established and maintained under Laws.

1.19 Member or Enrollee: a Medicare Advantage or Part D eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization or Part D Plan Sponsor.

1.20 Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery

of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

1.21 Related Entity: means any entity that is related to the MA organization or Part D Sponsor by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2500 during the contract period.

ARTICLE II
THE PLAN'S OVERSIGHT AND ACCOUNTABILITY

2.0 Oversight by The Plan: The Parties acknowledge and agree that The Plan shall oversee, and ultimately remain responsible and accountable to CMS for, those functions and responsibilities required of The Plan pursuant to Laws and its CMS Contract. The Plan shall provide ongoing monitoring and oversight of all aspects of Group's performance of its obligations under the Agreement, Blue Choice PPO Addendum and this MA PPO Addendum.

2.1 Cooperation with CMS: The Parties acknowledge and agree that either Party's failure to cooperate with CMS or its designees may result in a referral of The Plan and/or Group to law enforcement and/or implementation of other remedial action by CMS, including, without limitation, imposition of intermediate sanctions.

ARTICLE III
COVERED SERVICES

3.0 Provision of Covered Services: Group Participating Provider shall furnish Covered Services to MA PPO Members and otherwise perform other activities under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum in a manner consistent and in compliance with the requirements of all Laws; The Plan's contractual obligations under its Medicare Advantage Contract with CMS; all of The Plan's applicable policies, procedures and guidelines, including, but not limited to, The Plan's compliance plan and such policies, procedures and initiatives for combating fraud, waste and abuse; and professionally recognized standards of health care. Group Participating Provider shall ensure that Covered Services are provided to MA PPO Members in a culturally competent manner, including for those MA PPO Members with limited English proficiency and/or reading skills, diverse cultural and ethnic backgrounds, physical disabilities, and mental disabilities. Group Participating Provider shall discuss all treatment options with MA PPO Members, including the option of no treatment, as well as related risks, benefits and consequences of such options. As applicable, Group Participating Provider shall provide to MA PPO Members instructions regarding follow-up care and training regarding self-care.

3.1 Direct Access to Certain Benefits: Group Participating Provider shall comply with all referral and Preauthorization procedures set forth in the Provider section of The Plan's website at www.bcbsok.com, provided that no referral or prior authorization obligations shall be required for or imposed upon a MA PPO Member 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 for or imposed upon a MA PPO Member to obtain an influenza vaccine or a pneumococcal vaccine.

3.2 Availability: Group Participating Provider shall make necessary and appropriate arrangements with other Participating Providers to ensure that Medically Necessary Covered Services are readily available to MA PPO Members twenty-four (24) hours a day, seven (7) days a week.

3.3 Non-Discrimination: Group Participating Provider shall not deny, limit, or condition coverage or the furnishing of health care services or Benefits, including Covered Services, to MA PPO Members based on any factor related to health status, including, but not limited to, medical condition (including mental and/or physical illness or disability), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability (including conditions arising out of acts of domestic violence).

3.4 Advance Directives: Group Participating Provider shall comply with advance directive requirements in accordance with Laws and shall document in a prominent part of each MA PPO Member's current medical record whether or not such individual has executed an advance directive as required by Laws. Group Participating Provider shall not condition the provision of health care services or benefits, including Covered Services, or otherwise discriminate against any MA PPO Member based on whether or not the individual has executed an advance directive.

ARTICLE IV
RECORDS AND FACILITIES

4.0 Maintenance of Records: Group shall maintain adequate operational, financial, and administrative records, medical and prescription records, contracts, books, files and other documentation involving transactions related to the CMS Contract and/or the administration or delivery of Covered Services to MA PPO Members under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum ("Records"). At minimum, such Records shall be sufficient to enable The Plan to (1) evaluate Group's performance, including accuracy of data submitted to The Plan, and (2) enforce The Plan's rights under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum and in accordance with Laws.

4.1 Inspection of Records: Group and any Downstream Entities, at Group's sole cost and expense, shall provide The Plan, HHS, the Comptroller General, and/or their authorized designees with direct access to audit, evaluate, collect, and inspect all Records, personnel, physical premises, computer and other electronic systems, and facilities and equipment relating to Group's performance under this MA PPO Addendum, including the provision of Covered Services to MA PPO Members. Such direct access will be provided through ten (10) years from the date of the final term of the CMS Contract period or ten (10) years from the date of completion of any audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity, or ten (10) years from the submission of data to CMS to verify for Medical Loss Ratio requirements, whichever is later, or such other time frame as may be required by Laws. Group, at Group's sole cost and expense, will provide all reasonable facilities and assistance for the safety and convenience of the personnel conducting any such auditing, evaluation, collection, and inspection. Group, at Group's sole cost and expense, will provide The Plan with copies of any and all Records audited, evaluated, collected, or inspected, copied, evaluated and/or audited by HHS, the Comptroller General and/or their authorized designees within the timeframe necessary to allow for The Plan's review before production, unless otherwise instructed by the HHS or Comptroller General. Group will notify The Plan immediately by telephone, to be followed with written notice within three (3) business days if it receives any request from HHS, the Comptroller General or their authorized designees for any Records or to inspect Group's premises, physical facilities or equipment or to confer with Group's personnel, and Group will permit The Plan to participate in any such inspection or conference.

ARTICLE V
PRIVACY, SECURITY AND CONFIDENTIALITY

5.0 Protected Health Information: Group shall obtain, analyze, store, transmit and report Protected Health Information, as defined under Laws, in accordance with all Laws. As applicable, Group and any Downstream Entities shall abide by all Laws and The Plan's procedures regarding privacy, confidentiality, and accuracy of MA PPO Members' medical and prescription records and other health and enrollment information, including (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

ARTICLE VI
PAYMENT

6.0 Claims Payment: The Plan shall pay Group for Covered Services rendered to MA PPO Members pursuant to this MA PPO Addendum in accordance with Attachment A to this MA PPO Addendum.

6.1 Claims to Federal Government Prohibited: Group shall not request payment for Covered Services provided under the Agreement, the Blue Choice PPO Addendum or this MA PPO Addendum 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 PPO Addendum, except as may be approved in advance by The Plan and CMS.

6.2 Overpayment: Group shall provide notice to The Plan of any overpayment(s) identified by Group, including duplicate payments, within ten (10) calendar days of identifying such overpayment, and, unless otherwise instructed by The Plan in writing, Group shall refund any amounts due to The Plan within thirty (30) calendar days of identifying such overpayment.

6.3 Notwithstanding the provisions above, in the event of any overpayment, duplicate payment, or other payment in excess of that to which Group is entitled for Covered Services furnished to a MA PPO Member under the Agreement, the Blue Choice PPO Addendum and/or this Blue Cross MA PPO Addendum, The Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due from The Plan to Group.

ARTICLE VII
HOLD HARMLESS

7.0 MA PPO Member Hold Harmless: Group hereby agrees that in no event, including, but not limited to, non-payment by The Plan, insolvency of The Plan, or breach of the Agreement, the Blue Choice PPO Addendum or this MA PPO Addendum by The Plan, shall Group bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against MA PPO Members or persons other than The Plan acting on such MA PPO Member's behalf for fees that are the legal obligation of The Plan. This provision shall not prohibit Group from collecting charges for non-Covered Services or cost-sharing obligations for Covered Services imposed on MA PPO Member pursuant to the terms of such MA PPO Member's MA PPO Plan.

Group further agrees that: (1) this provision shall survive the termination of this MA PPO Addendum regardless of the cause giving rise to termination and shall be construed to be for the benefit of the MA PPO Member; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Group and the MA PPO Member or persons other than The Plan acting on such MA PPO Member's behalf.

7.1 Dual-Eligible Cost-Sharing: Group agrees that, to the extent Group Participating Provider provides Covered Services to MA PPO Members who are eligible for benefits under both the Medicare and Medicaid Programs ("Dual-Eligible Member"), and unless otherwise instructed by The Plan in writing:

7.1.0 Group shall not bill, charge, collect a deposit from or seek compensation, remuneration or reimbursement from or have any recourse against any Dual-Eligible Member for payment of Medicare Part A and/or Part B cost-sharing when the state Medicaid program is responsible for payment of such amounts; furthermore, Group shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan.

7.1.1 Group shall accept payment under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum as payment in full for the Covered Service provided to a Dual-Eligible Member or submit a claim to the state Medicaid source for payment of any cost-sharing amount that is the obligation of the state Medicaid program.

7.2 Dual-Eligible Benefits: Group shall coordinate with The Plan to ensure that Group is informed of Medicare and Medicaid benefits available to Dual-Eligible Members, including cost-sharing obligations of such Dual Eligible Members as well as any applicable eligibility requirements or other rules.

ARTICLE VIII
COMPLIANCE WITH QUALITY IMPROVEMENT AND GRIEVANCE AND APPEAL REQUIREMENTS

8.0 Quality Improvement: Group shall cooperate and comply with The Plan's medical policies as well as MA PPO Plan policies, procedures and programs for quality improvement, performance improvement and medical management, including, as applicable, drug utilization management, medication therapy management, and e-prescribing programs. Such cooperation and compliance shall include, but not be limited to, making all information regarding medical policy, medical management and quality improvement available to The Plan and CMS upon request, and providing to The Plan such data as may be necessary for The Plan to implement and operate any and all quality improvement and medical management programs and credentialing and recredentialing requirements.

8.1 Grievances, Coverage Determinations and Appeals: Group shall cooperate and comply with all requirements of The Plan regarding the processing of MA PPO Member grievances, coverage determinations and appeals relating to such MA PPO Members' MA PPO Plans, including the obligation to provide to The Plan any and all information within the time frame reasonably requested by The Plan to ensure The Plan's compliance with Laws.

ARTICLE IX
DATA COLLECTION

9.0 Data Reporting: Group acknowledges that The Plan collects, analyzes and integrates data relating to the provision of Covered Services to MA PPO Members in order for The Plan to meet its obligations under Laws, including, without limitation, 42 C.F.R. §§ 422.310, 422.516, 423,329, and 423.514, the CMS Contract and The Plan's policies, procedures and programs. Group agrees to provide to The Plan any and all data, without limitation, including encounter data, diagnosis codes, and medical and prescription records, relating to the provision of health care services and benefits, including Covered Services, by Group to MA PPO Members pursuant to the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum as The Plan so requests, and to submit such data to The Plan, or such other party designated by The Plan, in the format and within such time frames as may be prescribed by The Plan. Group agrees that all data Group submits to The Plan under this MA PPO Addendum shall conform to all relevant national standards and to the requirements for equivalent data for Medicare fee-for-service, as applicable.

9.1 Acknowledgement of Data Used to Obtain Payment Under Federal Program: Group acknowledges and agrees that data furnished by Group to The Plan in connection with the provision of Covered Services under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum will be used by The Plan to obtain payment from CMS under the CMS Contract and to support The Plan's participation in the MA and Part D Programs, including submission of bids for renewal of the CMS Contract in future years and for risk-adjusting MA PPO Plan payments from CMS. Furthermore, Group acknowledges and agrees that The Plan and CMS will rely on the accuracy, completeness and truthfulness of any data Group submits to The Plan under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum.

9.2 Certification of Data Accuracy: Group shall, upon request by The Plan, have its CEO or CFO or an individual delegated the authority to sign on behalf of one of these officers and who reports directly to such officer, certify to the accuracy, completeness and truthfulness of all data submitted under the Agreement, the Blue Choice PPO Addendum or this MA PPO Addendum in the form and format set out in Attachment B to this MA PPO Addendum.

9.3 Potential Financial Penalties: The Plan reserves the right to adopt, upon notice to Group, a schedule of financial penalties to be imposed on Group, in The Plan's sole discretion, for Group's failure to comply with the terms and conditions of this section.

ARTICLE X
DELEGATION AND SUBCONTRACTING

10.0 Delegation of Activities: The Parties agree that to the extent that The Plan delegates to Group performance of any function, duty, obligation, or responsibility, including reporting responsibilities, imposed on The Plan under the CMS Contract ("Delegated Activity"):

10.0.0 The Delegated Activity shall be set out in writing, and if such Delegated Activity includes credentialing of MA PPO Network Providers and/or selection of MA PPO Network Providers, such written arrangement shall address The Plan's right to review on an ongoing basis, approve and audit Group's credentialing process and/or right to review on an ongoing basis, approve, suspend and terminate such providers, as applicable;

10.0.1 The Plan shall conduct on-going monitoring and review of Group's performance of the Delegated Activity;

10.0.2 Group's performance of the Delegated Activity shall comply with Laws, the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum; and

10.0.3 Such delegation shall be subject to the requirements of Laws.

10.1 Termination of Delegated Activities: The Parties agree that, with respect to any Delegated Activity delegated to Group, CMS and The Plan may revoke the delegation in whole or in part or specify such other remedies as CMS or The Plan, in its reasonable discretion, deems appropriate, where CMS, in its sole discretion, or The Plan, in its reasonable discretion, determine that Group is not performing such Delegated Activity in a satisfactory manner.

10.2 Subcontracting: Group agrees that The Plan may, at its option and in its sole discretion, outsource various functions of its CMS Contract, including but not limited to marketing, claims processing and membership. The Parties acknowledge that all vendors involved in the provision of a Delegated Activity and MA PPO Providers are considered First Tier or Downstream Entities and that all First Tier and Downstream Entities must comply with all Laws, including all provisions contained in this MA PPO Addendum. Any services performed by Group, or any Downstream Entities, shall be performed in accordance with the contractual obligations established between CMS and The Plan and all applicable, professionally recognized standards of health care. Accordingly, Group, as a First-Tier Entity, agrees that it will not contract with any entity ("Subcontractor") to administer or deliver Covered Services to MA PPO Members unless (1) such arrangement is approved by The Plan in writing in advance; (2) such Subcontractor is specifically obligated, through a written agreement between Subcontractor and The Plan or Subcontractor and Group, to comply with all Laws, including all provisions contained in this MA PPO Addendum; and (3) such written arrangement specifically permits The Plan and CMS to suspend or terminate the subcontractor or take such other remedial action as CMS or The Plan, in its reasonable discretion, deems appropriate, upon determination by CMS, in its sole discretion, or The Plan, in its reasonable discretion, that such Subcontractor is not performing the services satisfactorily.

ARTICLE XI
COMPLIANCE, FRAUD, WASTE, AND ABUSE PROGRAM AND REPORTING

11.0 Compliance Program: Group shall implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that addresses the scope of services under the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum. Such compliance program shall require cooperation with The Plan's compliance plan and policies and shall include, without limitation, the following:

11.0.0 A code of conduct particular to Group that reflects a commitment to preventing, detecting and correcting fraud, waste, and abuse in the administration or delivery of Covered Services to MA PPO Members. The Plan's code of conduct is available upon request.

11.0.1 Compliance training for all employees, Subcontractors, any affiliated party or any Downstream Entity involved in the administration or delivery of Covered Services to MA PPO Members or involved in the provision of Delegated Activities.

11.0.2 Group shall provide general compliance training to employees, Subcontractors, any affiliated party or any Downstream Entity involved in the administration or delivery of Covered Services to MA PPO Members or involved in the provision of Delegated Activities at the time of initial hiring (or contracting) and annually thereafter. Such general compliance training shall address matters related to Group's compliance responsibilities, including, without limitation, (1) Group's code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues; (2) Group's obligations to comply with Laws; (3) common issues of non-compliance in connection with the provision of health care services to Medicare beneficiaries; and (4) common fraud, waste and abuse schemes and techniques in connection with the provision of health care services to Medicare beneficiaries.

11.0.3 Group also shall provide specialized compliance training to personnel whose job function directly relates to the administration or delivery of Covered Services to MA PPO Members on issues particular to such personnel's job function. Such specialized training shall be provided (1) upon each individual's initial hire (or contracting); (2) annually; (3) upon any change in the individual's job function or job requirements; and (4) upon Group's determination that additional training is required because of issues of non-compliance.

11.0.4 Group shall maintain records of the date, time, attendance, topics, training materials, and results of all training and related testing. Group shall, upon request, provide to The Plan annually and upon request a written attestation certifying that Group has provided compliance training in accordance with this section. Such training shall be subject to The Plan review/prior approval and shall incorporate those provisions that The Plan determines to be important.

11.0.5 Policies and procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and Group's compliance and anti-fraud, anti-waste, and anti-abuse initiatives. Such program shall include implementation and publication to Group's directors, officers, employees, agents and contractors of a compliance hotline, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and Group's anti-fraud, anti-waste, and anti-abuse initiatives;

11.0.6 Annual compliance risk assessments, performed at Group's sole expense. Group shall, upon request, share the results of such assessments with The Plan to the extent any part of the assessment directly or indirectly relates to the Agreement, the Blue Choice PPO Addendum and/or this MA PPO Addendum.

11.0.7 Routine monitoring and auditing of Group's responsibilities and activities with respect to the administration or delivery of Covered Services to MA PPO Members and the Agreement, the Blue Choice PPO Addendum and this Blue Cross MA PPO Addendum. Group hereby represents and warrants to The Plan that Group has an adequate work plan in place to perform such monitoring and audit activities. Group shall take corrective action to remedy any deficiencies found as appropriate.

11.0.8 Upon request, provision of a report to The Plan of the activities of Group's compliance program required by this MA PPO Addendum, including, without limitation, reports and investigations, if any, of alleged failures to comply with laws, regulations, the terms and conditions of the CMS Contract, or the Agreement, the Blue Choice PPO Addendum, or this MA PPO Addendum so that The Plan can fulfill its reporting obligations under Laws. Upon request, Group shall provide to The Plan the results of any audits related to the administration or delivery of Covered services to MA PPO Members. Group shall make appropriate personnel available for interviews related to any audit or monitoring activity.

11.1 Incidents of Suspected Non-Compliance, Fraud, Waste or Abuse: Group shall promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the Agreement, the Blue Choice PPO Addendum, this MA PPO Addendum, and/or the administration or delivery of Covered Services to MA PPO Members ("Incident") and report any such Incident to The Plan as soon as reasonably possible, but in no instance later than thirty (30) calendar days after Group becomes aware of such Incident. Such notice to The Plan shall include a statement regarding Group's efforts to conduct a timely, reasonable inquiry into the Incident, proposed or implemented corrective actions in response to the Incident, and any other information that may be relevant to The Plan in making its decision regarding self-reporting of such Incident.

Group shall cooperate with any investigation by The Plan, HHS or its authorized designees relating to such Incident, and Group acknowledges that its failure to cooperate with any such investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

Group shall cause its Downstream Entities to promptly report to Group, who shall report to The Plan, any Incidents in accordance with this section.

11.2 Compliance Reviews: In addition to any other audits or reviews agreed to pursuant to the Agreement, the Blue Choice PPO Addendum or this MA PPO Addendum, Group shall provide The Plan with access to Group's records, physical premises and facilities, equipment and personnel in order for The Plan, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum.

11.3 Conflicts of Interest: Group shall require any manager, officer, director or employee associated with the administration or delivery of Covered Services to MA PPO Members to sign a conflict of interest statement, attestation or certification at the time of hire and annually thereafter certifying that such individual is free from any conflict of interest in administering or delivering Covered Services to MA PPO Members. Group shall supply the form of such statement, attestation or certification to The Plan upon request.

11.4 Exclusion of Certain Individuals: Group certifies that neither Group nor its employees, any Subcontractor, any affiliated party or any Downstream Entity involved in the provision of a Delegated Activity under this MA PPO Addendum has been: (1) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, state or local) contract or subcontract, (2) listed by a federal governmental agency as debarred, (3) proposed for debarment or suspension or otherwise excluded from federal program participation, (4) been 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; or (5) within a three (3) year period preceding the date of this MA PPO Addendum, had one or more public transactions (federal, state or local) terminated for cause or default.

Group shall check appropriate databases at least annually to determine whether any of Group's employees, Subcontractors or affiliated parties or Downstream Entities involved in the provision of a Delegated Activity under this MA PPO Addendum 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 HHS Office of Inspector General List of Excluded Individuals-Entities (http://exclusions.oig.hhs.gov/), the Healthcare Integrity and Protection Data Bank (http://www.npdb-hipdb.hrsa.gov/), and the General Service Administration List of Parties Excluded from Federal Procurement and Non-procurement Programs (https://www.epls.gov/).

Group acknowledges and agrees that it has a continuing obligation to notify The Plan in writing within seven (7) business days if any of the above-referenced representations change. Group 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 PPO Addendum may be grounds for immediate termination of this MA PPO Addendum, at the sole discretion of The Plan.

11.5 Preclusion List: Group agrees, for all services performed on or after January 1, 2020:

11.5.0 MA PPO Members do not have any financial liability for services, items, or drugs furnished. ordered, or prescribed to the MA PPO Member 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;

11.5.1 After the expiration of the sixty (60) day period specified in §422.222, Group will no longer be eligible for payment from The Plan and will be prohibited from pursuing payment from the MA PPO Member as stipulated by the terms of the CMS Contract per 42 C.F.R. § 422.504(g)(1)(iv); and,

11.5.2 Group will hold financial liability for services, items and drugs that are furnished, ordered, or prescribed after this sixty (60) day period, at which point, Group and the MA PPO Member will have already received notification of the preclusion.

ARTICLE XII
OFF-SHORE OPERATIONS

12.0 Group shall not itself nor directly or indirectly through another person or entity, undertake any functions, activities, or services in connection with the Agreement, the Blue Choice PPO Addendum or this MA PPO Addendum, including without limitation, storage of Medicare Member information, outside of the United States of America without the prior written consent of The Plan.

ARTICLE XIII
TERM AND TERMINATION

In addition to the termination provisions in Article VII of the Agreement, the following provisions shall apply to this MA PPO Addendum:

13.0 Term: The Parties agree that this MA PPO Addendum is effective as stated on the cover page of this MA PPO Addendum and shall remain in effect for the duration of the term of the Agreement and the Blue Choice PPO Addendum unless otherwise terminated according to the terms specified herein.

13.1 Termination Upon Termination of CMS Contract: The Parties agree that this MA PPO Addendum is conditioned upon the CMS Contract and shall terminate automatically upon termination of the CMS Contract. The Plan shall, to the extent practical and feasible, undertake commercially reasonable efforts to advise Group in advance of the termination of the CMS Contract.

13.2 Termination Upon CMS Request: The Parties agree that this MA PPO Addendum shall terminate immediately upon the request of CMS.

13.3 Termination Without Cause: Either Party may terminate this MA PPO Addendum without cause by providing the other Party with advance written notice of termination at least ninety (90) days prior to the effective date of such termination.

13.4 Notice of Termination to MA PPO Members: Upon termination of this MA PPO Addendum for any reason, The Plan, and not Group, shall, as required by Laws, notify MA PPO Members treated by Group in the six (6) months prior to the effective date of the termination of this MA PPO Addendum and Group's participation in the MA PPO Network. Group shall cooperate with and assist The Plan in identifying such MA PPO Members.

13.5 Continuation of Benefits: Upon termination of this MA PPO Addendum for any reason, Group shall continue to provide Covered Services to MA PPO Members through the date of such MA PPO Member's discharge or when medically appropriate alternative care is arranged for the MA PPO Member ("Continuation Services"). Such Continuation Services shall be provided in accordance with the terms and conditions of the

Agreement, the Blue Choice PPO Addendum and this MA PPO Addendum, including, but not limited to, the compensation rates and terms set forth herein, unless the Parties otherwise agree in writing.

13.6 Transition of MA PPO Members: Upon either Party's provision of notice of termination of this MA PPO Addendum to the other Party, Group shall cooperate fully with The Plan and The Plan protocols, if any, in the transfer of MA PPO Members to other MA PPO Providers.

The terms of this section shall survive the termination of this MA PPO Addendum.

ARTICLE XIV
CONFLICT AND PREEMPTION

14.0 Conflict: To the extent any provision of this MA PPO Addendum conflicts with any provision in the Agreement or the Blue Choice PPO Addendum, this MA PPO Addendum shall control with respect to the provision of Covered Services or Group's obligation or duty under the Agreement, the Blue Choice PPO Addendum or this MA PPO Addendum as the same relates to MA PPO Members, MA PPO Plans, or the CMS Contract.

14.1 Preemption: The Parties acknowledge and agree that the standards established by the Medicare Advantage Program and Part D Program supersede any state law or regulation, other than state licensing laws or state laws relating to the solvency of sponsors of MA Plans or Part D Plans, with respect to MA PPO Plans.

ARTICLE XV
AMENDMENT DUE TO LEGAL OR REGULATORY CHANGES

15.0 Amendments: The Parties acknowledge and agree that this MA PPO Addendum shall supersede any previous amendment or addendum to the Agreement or the Blue Choice PPO Addendum regarding the subject matter herein. Further, the Parties agree that this MA PPO Addendum shall automatically be amended as necessary to conform to Laws and to include any additional terms and conditions as CMS and/or The Plan may find necessary and appropriate in order to implement and comply with the requirements of Laws, and any such additional or conforming terms and conditions will be considered incorporated herein, as if fully stated, pending formal amendment.

ARTICLE XVI
COUNTERPARTS

16.0 This MA PPO Addendum may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

ATTACHMENT A
COMPENSATION/CLAIMS SUBMISSION

COMPENSATION.

Group agrees to accept Group's CMS Interim Rate as payment in full for the provision of a Covered Service to an MA PPO Member. Any applicable cost-sharing amount that is the responsibility of the MA PPO Member pursuant to the terms of such MA PPO Member's MA PPO Plan shall be deducted from this Maximum Reimbursement Allowance.

Group must provide official written notice to The Plan of any modification to Group's CMS Interim Rate upon receipt of the notification letter. Changes to Group's CMS Interim Rate will be applied prospectively beginning no later than thirty (30) days after receipt of the notification from Group and will not be applied retroactively. If notification is not received for a twelve-month period, Group's CMS Interim Rate will revert to the CMS All-Inclusive Rate.

If applicable, services that do not have an All-Inclusive Rate posted on the CMS web site will be reimbursed based upon the applicable MA PPO Plan fee schedule in effect at the time the Covered Service is provided, less any applicable Copayments, Coinsurance or Deductible amounts. Payment of compensation shall be in accordance with MA PPO applicable policies and procedures. Such fees shall be payment in full for services rendered except for applicable Copayments, Coinsurance or Deductible amounts. It is acknowledged by the parties that the fee schedule is not updated at the same time as the CMS reimbursement rate update. Changes to the fee schedule shall be applied prospectively beginning on the effective date of the update and will not be applied retroactively.

Both parties acknowledge and agree that certain reductions to Medicare provider payments are mandated pursuant to the Budget Control Act of 2011 and it's 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 PPO Addendum. Accordingly, both parties agree that the rates payable under this MA PPO Addendum shall be adjusted by the amount proportionally equal to any reductions under Sequestration and such other regulatory authority.

CLAIMS SUBMISSION

Group shall submit complete and properly executed claims for a Covered Service to The Plan or its designee within one hundred eighty (180) calendar days of the date the Covered Service is rendered. If Group fails to submit a claim within one hundred eighty (180) calendar days of the date the Covered Service is rendered, Group forfeits the right to payment from The Plan or MA PPO Member.

Claims may be submitted (1) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format, or (2) on a completed version of the applicable CMS claim form.

CLAIMS PAYMENT

The Plan shall make payment on a clean claim, as defined in Laws and/or the Provider section of The Plan's website at www.bcbsok.com, to Group within thirty (30) days of The Plan's receipt of such claim.

ATTACHMENT B
ATTESTATION

THIS ATTESTATION SHALL BE COMPLETED ONLY UPON REQUEST BY THE PLAN

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

_____ has reported to The Plan, for transmission to CMS, and for the period of _____ to _____, all _____ data requested by The Plan available to _____ with respect to the MA PPO Plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to The Plan and/or CMS via this report is accurate, complete, and truthful.

_____
Authorized Signature

_____
Indicate title (CEO, CFO, or delegate)

_____
on behalf of

_____
Name of Group

_____
Date

BlueCross BlueShield of Oklahoma

Blue Advantage PPO℠ Network Addendum to the Blue Traditional℠ Network Participating Group Agreement

This Blue Advantage PPO Network Addendum ("Blue Advantage PPO Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), and the undersigned ("Group"). This Blue Advantage PPO Addendum includes all applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

The undersigned parties hereby agree to the terms and conditions contained in this Blue Advantage PPO Addendum. This Blue Advantage PPO Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
	RICK KELLY
Name of Signatory	Name of Signatory
	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS
Title of Signatory	Title of Signatory
Date Signed	Date Signed

With respect to Blue Advantage PPO Members only, the following terms shall apply:

ARTICLE I
DEFINITIONS

1.0 Blue Advantage PPO Member: Any person described in *Applicability of Agreement* in Article VIII of the Agreement whose designated network is Blue Advantage PPO.

1.1 Blue Advantage PPO Participating Primary Care Physician ("Blue Advantage PPO PCP"): Family and general practitioners, internists, pediatricians and others as approved by The Plan, who are under an agreement with The Plan to render Covered Services to Blue Advantage PPO Members and to be eligible for a Blue Advantage PPO Member to choose as a primary care physician.

1.2 Blue Advantage PPO Participating Provider: A hospital, other health care facility, physician, health care professional or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to Blue Advantage PPO Members.

1.3 Group Participating Primary Care Physician ("Group Participating PCP"): A family or general practitioner, internist, pediatrician, or other as approved by The Plan, who is employed by or under an agreement with Group and eligible for a Blue Advantage PPO Member to choose as a primary care physician.

1.4 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum allowed amount for Covered Services rendered to Blue Advantage PPO Members, as described in Article III.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to Blue Advantage PPO Members the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth in Article III and hold Blue Advantage PPO Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the Blue Advantage PPO Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until The Plan has determined the Maximum Reimbursement Allowance and notified Group as to the amount due from the Blue Advantage PPO Member, if any, under the Blue Advantage PPO Member's Benefit Agreement, Group shall not bill or attempt to collect from the Blue Advantage PPO Member any coinsurance amounts. The total amount collected from The Plan, or administered accounts, and the Blue Advantage PPO Member for copayment, deductible and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Group agrees to promptly refund to the Blue Advantage PPO Member any amounts which may have been collected from the Blue Advantage PPO Member in excess of the Blue Advantage PPO Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the Blue Advantage PPO Member for services denied as not Medically Necessary or Experimental/Investigational/Unproven unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Blue Advantage PPO Member: Group agrees to extend all Covered Services to Blue Advantage PPO Members in accordance with the applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

2.2 Call Coverage: Group agrees to provide coverage for Blue Advantage PPO Members twenty-four (24) hours per day, seven (7) days per week by a Blue Advantage PPO Participating Provider.

2.3 Coordinate Health Care: Group shall coordinate the Blue Advantage PPO Member's health care with the Blue Advantage PPO PCP and/or other specialists or facilities when such care is needed.

2.4 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a Blue Advantage PPO Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Blue Advantage PPO Addendum by The Plan pursuant to Article XI of the Agreement.

2.5 Manage Health Care: Group Participating PCP agrees to manage the total health care of the Blue Advantage PPO Member. This includes, but is not limited to, health supervision, basic treatment, initial diagnosis, management of chronic conditions and preventive health services.

2.6 Primary Care Services: Group Participating PCP agrees to personally provide to Blue Advantage PPO Members the full range of primary care services which are Medically Necessary.

2.7 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified for Blue Advantage PPO Members who have such requirements in their Benefit Agreement in accordance with Article VI of the Agreement.

ARTICLE III
MAXIMUM REIMBURSEMENT ALLOWANCES

3.0 Maximum Reimbursement Allowances: Except as set forth below, the Maximum Reimbursement Allowance for Covered Services rendered to Blue Advantage PPO Members shall be as set forth in the Agreement.

3.0.0 Conversion Factors: For Covered Services rendered to Blue Advantage PPO Members, the applicable conversion factors are set forth below:

Provider Type	All Codes
Chiropractor, Optometrist & Physician	$35.00
Anesthesiologist Assistant, Certified Registered Nurse Anesthetist, Nurse Practitioner, Physician Assistant & Psychologist	$28.86
All Other Health Care Professionals	$22.60

3.0.1 Anesthesia Rates: For Covered Services rendered to Blue Advantage PPO Members, the applicable anesthesia rates are set forth below:

Provider Type	Anesthesia Rate
Physician	$39.00
Certified Registered Nurse Anesthetist	$33.15
Anesthesiologist Assistant	$29.64

ARTICLE IV
TERM AND TERMINATION

In addition to the termination provisions in Article XI of the Agreement, the following provision shall apply to this Blue Advantage PPO Addendum:

4.0 Contract Period: This Blue Advantage PPO Addendum shall be effective as stated on the cover page of this Blue Advantage PPO Addendum and shall continue until the earlier of (1) termination of all agreements between Group and The Plan or (2) termination of only this Blue Advantage PPO Addendum between Group and The Plan in accordance with the termination provisions of the Agreement.

Refer to cover page for effective date and signatures.

BlueCross BlueShield of Oklahoma

Blue Choice PPO[SM] Network Addendum to the Blue Traditional[SM] Network Participating Group Agreement

This Blue Choice PPO Network Addendum ("Blue Choice PPO Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), and the undersigned ("Group"). This Blue Choice PPO Addendum includes all applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

The undersigned parties hereby agree to the terms and conditions contained in this Blue Choice PPO Addendum. This Blue Choice PPO Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
Name of Signatory	RICK KELLY Name of Signatory
Title of Signatory	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS Title of Signatory
Date Signed	Date Signed

With respect to Blue Choice PPO Members only, the following terms shall apply:

ARTICLE I
DEFINITIONS

1.0 Blue Choice PPO Member: Any person described in *Applicability of Agreement* in Article VIII of the Agreement whose designated network is Blue Choice PPO.

1.1 Blue Choice PPO Participating Primary Care Physician ("Blue Choice PPO PCP"): Family and general practitioners, internists and pediatricians who are contracted by The Plan to be eligible for a Blue Choice PPO Member who subscribes to the Point of Service Program to choose as a primary care physician.

1.2 Blue Choice PPO Participating Provider: A hospital, other health care facility, physician, health care professional or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to Blue Choice PPO Members.

1.3 Group Participating Primary Care Physician ("Group Participating PCP"): A family or general practitioner, internist, pediatrician, or other as approved by The Plan, who is under an agreement with The Plan to be eligible for a Blue Choice PPO Member to choose as a primary care physician.

1.4 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum amount allowed for Covered Services rendered to Blue Choice PPO Members, as described in Article III.

1.5 Point of Service ("POS") Program: The written agreement entered into by The Plan and a group's representative or with individuals referencing Blue Choice PPO PCP and other Blue Choice PPO Participating Providers, under which The Plan provides, indemnifies, or administers health care benefits.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to Blue Choice PPO Members the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth in Article III and hold Blue Choice PPO Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the Blue Choice PPO Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until The Plan has determined the Maximum Reimbursement Allowance and notified Group as to the amount due from the Blue Choice PPO Member, if any, under the Blue Choice PPO Member's Benefit Agreement, Group shall not bill or attempt to collect from the Blue Choice PPO Member any coinsurance amounts. The total amount collected from The Plan, or administered accounts, and the Blue Choice PPO Member for copayment, deductible and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Group agrees to promptly refund to the Blue Choice PPO Member any amounts which may have been collected from the Blue Choice PPO Member in excess of the Blue Choice PPO Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Applicability of Reimbursement: In the event that Group has not separately contracted with The Plan for its other networks, including but not limited to Blue Preferred PPO, BlueLincs HMO or Blue Advantage PPO, the terms of this Blue Choice PPO Addendum, including the Maximum Reimbursement Allowance described herein, shall be applicable to any Covered Services rendered to a Member whose designated network is one in which Group does not participate. Group agrees to hold such Member harmless from any sums in excess of the Blue Choice PPO Maximum Reimbursement Allowance. This paragraph shall supersede any provision contained in the Agreement, if applicable, to accept the Blue Traditional Maximum Reimbursement Allowance for any Member whose designated network is one in which Group does not participate.

2.0.1 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the Blue Choice PPO Member for services denied as not Medically Necessary or Experimental/Investigational/Unproven unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Blue Choice PPO Member: Group agrees to extend all Covered Services to Blue Choice PPO Members in accordance with the applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

2.2 Call Coverage: Group agrees to provide coverage for Blue Choice PPO Members twenty-four (24) hours per day, seven (7) days per week by a Blue Choice PPO Participating Provider.

2.3 Coordinate Health Care: Group shall coordinate the Blue Choice PPO Member's health care with the Blue Choice PPO PCP and/or other specialists or facilities when such care is needed.

2.4 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a Blue Choice PPO Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Blue Choice PPO Addendum by The Plan pursuant to Article XI of the Agreement.

2.5 Manage Health Care: Group Participating PCP agrees to manage the total health care of the Blue Choice PPO Member. This includes, but is not limited to, health supervision, basic treatment, initial diagnosis, management of chronic conditions and preventive health services.

2.6 Primary Care Services: Group Participating PCP agrees to personally provide to Blue Choice PPO Members the full range of primary care services which are Medically Necessary.

2.7 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified for Blue Choice PPO Members who have such requirements in their Benefit Agreement in accordance with Article VI of the Agreement.

ARTICLE III
MAXIMUM REIMBURSEMENT ALLOWANCES

3.0 Maximum Reimbursement Allowances: Except as set forth below, the Maximum Reimbursement Allowance for Covered Services rendered to Blue Choice PPO Members shall be as set forth in the Agreement.

3.0.0 Conversion Factors: For Covered Services rendered to Blue Choice PPO Members, the applicable conversion factors are set forth below:

Provider Type	E&M Codes	All Other Codes
Physician & Optometrist	$37.96	$47.06
Chiropractor	$35.75	$44.55
Certified Registered Nurse Anesthetist	$31.27	$38.87
Anesthesiologist Assistant, Nurse Practitioner, Physician Assistant & Psychologist	$28.81	$35.76
Speech Therapist	$26.11	$32.28
Dietician	$24.20	$30.17
Physical/Occupational Therapist	$23.81	$29.69

Provider Type	E&M Codes	All Other Codes
Audiologist, LADC, LCSW & LPC	$21.62	$26.72

3.0.1 Anesthesia Rates: For Covered Services rendered to Blue Choice PPO Members, the applicable anesthesia rates are set forth below:

Provider Type	Anesthesia Rate
Physician	$52.00
Certified Registered Nurse Anesthetist	$44.00
Anesthesiologist Assistant	$39.52

ARTICLE IV
TERM AND TERMINATION

In addition to the termination provisions in Article XI of the Agreement, the following provision shall apply to this Blue Choice PPO Addendum:

4.0 Contract Period: This Blue Choice PPO Addendum shall be effective as stated on the cover page of this Blue Choice PPO Addendum and shall continue until the earlier of (1) termination of all agreements between Group and The Plan or (2) termination of only this Blue Choice PPO Addendum between Group and The Plan in accordance with the termination provisions of the Agreement.

Refer to cover page for effective date and signatures.

BlueCross BlueShield of Oklahoma

BlueLincs HMO℠ Network Addendum to the Blue Traditional℠ Network Participating Group Agreement

This BlueLincs HMO Network Addendum ("BlueLincs HMO Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and among GHS Health Maintenance Organization, Inc., d/b/a BlueLincs HMO ("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 ("HCSC"), and the undersigned medical group, whose members are duly licensed by the State of Oklahoma and authorized to practice as physicians and health care professionals ("Group"). This BlueLincs HMO Addendum includes and incorporates all applicable terms and conditions of the Agreement currently in effect between Group and Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan").

The undersigned parties hereby agree to the terms and conditions contained in this BlueLincs HMO Addendum. This BlueLincs HMO Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUELINCS HMO, A SUBSIDIARY OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
Name of Signatory	RICK KELLY Name of Signatory
Title of Signatory	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS Title of Signatory
Date Signed	Date Signed

With respect to BlueLincs HMO Members only, the following terms shall apply:

ARTICLE I
DEFINITIONS

1.0 BlueLincs HMO Member: A person enrolled and eligible to receive Benefits for Covered Services pursuant to the terms of a Benefit Agreement which requires Covered Services be received from BlueLincs HMO Participating Providers.

1.1 BlueLincs HMO Network: Includes all Participating Providers under an agreement with BlueLincs HMO.

1.2 BlueLincs HMO Participating Physician: A physician under an agreement with BlueLincs HMO as an independent contractor who is a duly licensed Doctor of Medicine, Osteopathy, or other healing art profession defined and authorized by Oklahoma statutes, licensed to practice medicine, surgery, or other procedures and provide services within the scope of such license**,** and who is in good standing with the Oklahoma State Board of Medical Licensure and Supervision, Oklahoma Board of Osteopathic Examiners, or other Oklahoma Board of Physician Examiners appropriate to the specified healing art profession.

1.3 BlueLincs HMO Participating Primary Care Physician ("BlueLincs HMO PCP"): Family and general practitioners, internists, pediatricians, and others as approved by BlueLincs HMO, who are under an agreement with BlueLincs HMO to be eligible for a BlueLincs HMO Member to choose as a primary care physician.

1.4 BlueLincs HMO Participating Provider: A hospital, other health care facility, physician, health care professional or other provider of medical services, equipment or supplies, under an agreement with BlueLincs HMO to provide Covered Services to BlueLincs HMO Members.

1.5 Group Participating Primary Care Physician ("Group Participating PCP"): A BlueLincs HMO credentialed physician under an agreement with or employed by Group who is a duly licensed Doctor of Medicine, Osteopathy, or other healing art profession defined and authorized by Oklahoma statutes, licensed to practice in the field of family or general practice, pediatrics or internal medicine, and who is in good standing with the Oklahoma State Board of Medical Licensure and Supervision, Oklahoma Board of Osteopathic Examiners, or other Oklahoma Board of Physician Examiners appropriate to the specified healing art profession.

1.6 Maximum Reimbursement Allowance: The amount established by BlueLincs HMO as the maximum amount allowed for Covered Services rendered to BlueLincs HMO Members, as described in Article IV.

1.7 Non-Network Provider: Any health care provider not under an agreement with BlueLincs HMO to provide services to BlueLincs HMO Members.

1.8 Out of Network Requests: The process BlueLincs HMO Participating Providers follow to obtain authorization from BlueLincs HMO when a BlueLincs HMO Member needs specific Medically Necessary services which are unavailable within his/her network.

1.9 Provider Referral: A provider documented referral process that does not require approval by BlueLincs HMO.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Minimum Number of BlueLincs HMO Members: Group Participating PCPs shall accept new BlueLincs HMO Members until each Group Participating PCP has at least three hundred (300) BlueLincs HMO Members. Notice of intent to close a Group Participating PCP's practice to new and/or established BlueLincs HMO Members after three hundred (300) BlueLincs HMO Members must be given in writing to BlueLincs HMO at least ninety (90) days prior to Group Participating PCP's desired effective date.

2.1 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to BlueLincs HMO Members the lesser of Group's Usual Charge or BlueLincs HMO's Maximum Reimbursement Allowance set forth in Article IV and hold BlueLincs HMO Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the BlueLincs HMO Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until BlueLincs HMO has determined the Maximum Reimbursement Allowance and notified Group of the amount due from the BlueLincs HMO Member, if any, under the BlueLincs HMO Member's Benefit Agreement, Group shall not bill or attempt to collect from the BlueLincs HMO Member any coinsurance amounts. The total amount collected from BlueLincs HMO, or administered accounts, and the BlueLincs HMO Member for copayment, deductible and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or BlueLincs HMO's Maximum Reimbursement Allowance. Group agrees to promptly refund to the BlueLincs HMO Member any amounts which may have been collected from the BlueLincs HMO Member in excess of the BlueLincs HMO Member's responsibility as shown on BlueLincs HMO's provider claims summary.

2.1.0 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the BlueLincs HMO Member for services denied as not Medically Necessary or Experimental/ Investigational/Unproven unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.2 Account Data: Group shall provide to BlueLincs HMO all identifying information for Group and/or Group Participating Provider, including name, address, phone number, office hours, and tax identification number. At least sixty (60) days' advance notice to BlueLincs HMO is required for changes in account data of Group and/or Group Participating Provider.

2.3 BlueLincs HMO Member Acceptance: Group shall accept BlueLincs HMO Members so long as Group is accepting members of other managed care carriers.

2.4 BlueLincs HMO Members: Group agrees to extend all Covered Services to BlueLincs HMO Members in accordance with the applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

2.5 Call Coverage: Group agrees to provide for Medical Emergency telephone service twenty-four (24) hours a day, seven days a week for BlueLincs HMO Members with Medical Emergency health conditions, including arrangements to assure coverage of a BlueLincs HMO Member/patient after hours, or when Group Participating Provider is otherwise absent, consistent with administrative requirements. Covering arrangement will be with a BlueLincs HMO Participating Physician or Health Care Professional or a physician or health care professional who has otherwise been approved by BlueLincs HMO. It will be the responsibility of Group to notify BlueLincs HMO or to keep BlueLincs HMO informed of covering physician arrangements.

2.6 Communication with the BlueLincs HMO PCP: If a Group Participating Provider renders services to a BlueLincs HMO Member for whom the Group Participating Provider is not the BlueLincs HMO PCP, Group agrees to provide a written report of services rendered to the BlueLincs HMO PCP for inclusion in the BlueLincs HMO Member's medical records within fourteen (14) days of completing the course of treatment.

2.7 Discontinuing Care: If Group discontinues providing care for a BlueLincs HMO Member, Group will provide the BlueLincs HMO Member and BlueLincs HMO sixty (60) calendar days advance written notice of Group's discontinuance of care, and must continue to provide care for such BlueLincs HMO Member during such sixty (60) calendar day period or until the BlueLincs HMO Member selects a new provider.

2.8 Drug Formulary Use: Group agrees to promote the use of the Blue Cross and Blue Shield of Oklahoma Drug Formulary and comply with Prior Authorization when required. The Blue Cross and Blue Shield of Oklahoma Drug Formulary is available in the Provider section of the website at www.bcbsok.com under Pharmacy Program.

2.9 Enrollment: All BlueLincs HMO Members will either select or be assigned a BlueLincs HMO PCP to provide primary care services. The following shall apply to Group Participating PCPs:

2.9.0 If BlueLincs HMO determines a Group Participating PCP is unable to meet the access standards defined in the Agreement, BlueLincs HMO may limit or terminate the assignment of new enrollment to that Group Participating PCP and may proceed to assign BlueLincs HMO Members to other BlueLincs HMO PCPs as necessary.

2.9.1 BlueLincs HMO and Group recognize that a physician/patient relationship is a personal relationship and that circumstances may arise under which relationships between a particular BlueLincs HMO Member and a particular Group Participating PCP may become unsatisfactory to one or the other. In such a case, Group will continue providing service to the BlueLincs HMO Member while accommodating the BlueLincs HMO Member's choice and transition to another Group Participating PCP or BlueLincs HMO PCP.

2.10 Health Education Programs: Group agrees to ensure that Group Participating PCPs encourage BlueLincs HMO Member participation in various health education and health maintenance programs offered by and through BlueLincs HMO to promote achieving and maintaining a healthy lifestyle to the BlueLincs HMO Members.

2.11 Hold Harmless: As required of all Oklahoma participating providers by the Oklahoma Insurance Department, Group agrees that, in no event, including but not limited to nonpayment by BlueLincs HMO, BlueLincs HMO's insolvency or breach of this BlueLincs HMO Addendum, shall Group bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against BlueLincs HMO Members or persons other than BlueLincs HMO for Covered Services provided pursuant to this BlueLincs HMO Addendum. This provision will not prohibit collection of any applicable copayments or deductible billed in accordance with the terms of the BlueLincs HMO Member's Benefit Agreement.

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

Group 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.

2.12 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a BlueLincs HMO Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify BlueLincs HMO of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to BlueLincs HMO may result in termination of this BlueLincs HMO Addendum by BlueLincs HMO pursuant to Article XI of the Agreement.

2.13 Noncovered Services: In the event that Group Participating Provider shall provide Noncovered Services, Group Participating Provider shall, prior to rendering such Noncovered Services, (a) inform the BlueLincs HMO Member that (1) the service(s) to be provided are not covered; (2) BlueLincs HMO will not pay for or be liable for said services; (3) the BlueLincs HMO Member will be financially liable for such services, and (b) obtain a Written Waiver as defined in the Agreement. Such Written Waiver must specifically

identify the services for which the BlueLincs HMO Member or his or her representative agrees to be financially responsible and must be executed before Group Participating Provider renders such services.

2.14 Preventive Care Services: Group agrees to ensure that Group Participating PCPs render preventive care services and health improvement education to BlueLincs HMO Members during each office visit and document such in the BlueLincs HMO Member's records.

2.15 Primary Care Services: Group agrees to ensure that Group Participating PCPs provide to BlueLincs HMO Members the full range of primary care services which are Medically Necessary and manage the BlueLincs HMO Member's total health care program. This includes health supervision, basic treatment, initial diagnosis, management of chronic conditions and preventive health services. Group Participating PCPs will also coordinate health care with specialists or institutions when such care is needed, including Prior Authorization of appropriate referrals.

2.16 Sanctions for Non-Compliance: Failure of Group to comply with any or all of the provisions of this BlueLincs HMO Addendum may result in nonpayment for services provided and/or termination of this BlueLincs HMO Addendum as provided in Article XI of the Agreement and Article VI of this BlueLincs HMO Addendum. Group may not bill or collect from the BlueLincs HMO Member for the aforementioned services.

2.17 Transfer of BlueLincs HMO Members: In order to facilitate continuity of the BlueLincs HMO Member's care, Group agrees to coordinate with BlueLincs HMO when the BlueLincs HMO Member transfers to another provider, including provision of copies of the BlueLincs HMO Member's medical/clinical records, at no charge to BlueLincs HMO or the BlueLincs HMO Member.

2.18 Utilization Management: Group agrees to comply with utilization management requirements as set forth in Article V of this BlueLincs HMO Addendum and ensure that Prior Authorization is obtained or verified as required by the BlueLincs HMO Member's Benefit Agreement in accordance with Article V of this BlueLincs HMO Addendum and Article VI of the Agreement.

ARTICLE III
AGREEMENTS OF BLUELINCS HMO

3.0 Allow Group Participating PCPs to Limit BlueLincs HMO Members: BlueLincs HMO agrees to limit BlueLincs HMO Member selection of Group Participating PCPs to three hundred (300) BlueLincs HMO Members each if so directed by Group. Notice of Group Participating PCP's desire to limit BlueLincs HMO Members must be given to BlueLincs HMO ninety (90) days prior to the desired effective date. Group may not limit BlueLincs HMO Member selection until a minimum of three hundred (300) BlueLincs HMO Members have selected a Group Participating PCP.

3.1 Provide BlueLincs HMO Member Listing: Upon request, BlueLincs HMO agrees to furnish Group with an eligibility listing for each Group Participating PCP which shows current BlueLincs HMO Members, level of Benefits, and physician selection.

3.2 Reimbursement: BlueLincs HMO agrees to pay Group in accordance with the reimbursement provisions set forth in Article IV to this BlueLincs HMO Addendum for Covered Services provided to the BlueLincs HMO Member as of the effective date of this BlueLincs HMO Addendum. This reimbursement shall be applicable to all services arranged, provided and billed by Group. BlueLincs HMO shall deduct any copayment, deductible or coinsurance amounts required by the applicable Benefit Agreement from payment due to Group.

ARTICLE IV
MAXIMUM REIMBURSEMENT ALLOWANCES

4.0 Maximum Reimbursement Allowances: Except as set forth below, the Maximum Reimbursement Allowance for Covered Services rendered to BlueLincs HMO Members shall be as set forth in the Agreement.

4.0.0 Conversion Factors: For Covered Services rendered to BlueLincs HMO Members, the applicable conversion factors are set forth below:

Provider Type	All Codes
Chiropractor, Optometrist & Physician	$35.00
Anesthesiologist Assistant, Certified Registered Nurse Anesthetist, Nurse Practitioner, Physician Assistant & Psychologist	$28.86
All Other Health Care Professionals	$22.60

4.0.1 Anesthesia Rates: For Covered Services rendered to BlueLincs HMO Members, the applicable anesthesia rates are set forth below:

Provider Type	Anesthesia Rate
Physician	$39.00
Certified Registered Nurse Anesthetist	$ 33.15
Anesthesiologist Assistant	$29.64

4.1 BlueLincs HMO Members Over 65: Services for BlueLincs HMO Members age sixty-five (65) and older will be reimbursed at the Medicare fee schedule in effect as of the date of service.

ARTICLE V
UTILIZATION MANAGEMENT

5.0 Purpose of the Utilization Management Program: BlueLincs HMO and Group recognize the need to deliver quality health care services in an efficient manner and mutually agree to develop and maintain an appropriate utilization and quality management program for all BlueLincs HMO Members.

5.1 Prior Authorization: Group agrees to ensure the following:

5.1.0 Group Participating PCPs: For Group Participating PCPs, Group agrees to obtain Prior Authorization or ensure that Prior Authorization is obtained in accordance with BlueLincs HMO's utilization management guidelines and protocols and BlueLincs HMO Member Benefits descriptions. These services may include but are not limited to: all inpatient hospital admissions; certain outpatient services; home health or hospice services; genetic testing; and advanced imaging services. For specific Prior Authorization requirements, Group shall call the number on the back of the BlueLincs HMO Member's identification card. Group shall follow the process set forth in Article VI of the Agreement to obtain or verify Prior Authorization.

5.1.1 Other Group Participating Providers: When an initial Provider Referral of a BlueLincs HMO Member is made to a Group Participating Provider for a specific diagnosis, Group agrees to obtain Prior Authorization or ensure that Prior Authorization is obtained for any additional services related to the treatment of that diagnosis in accordance with BlueLincs HMO's utilization management guidelines and protocols and BlueLincs HMO Member Benefits descriptions. These services may include but are not limited to: all inpatient hospital admissions; certain outpatient services; home health or hospice services; genetic testing; and advanced imaging services. For specific Prior Authorization requirements, Group shall call the number on the back of the

BlueLincs HMO Member's identification card. Group shall follow the process set forth in Article VI of the Agreement to obtain or verify Prior Authorization.

5.2 Referral Requirements:

5.2.0 Provider Referrals: Group agrees to the following:

(a) Group Participating PCPs: Group Participating PCPs shall ensure that all required Provider Referrals and/or Out of Network Requests are completed when such care is needed by a BlueLincs HMO Member. Except in a Medical Emergency or when authorized in advance by BlueLincs HMO, Group Participating PCPs shall refer BlueLincs HMO Members to BlueLincs HMO Participating Providers only.

(b) Other Group Participating Providers: When an initial Provider Referral of a BlueLincs HMO Member is made to a Group Participating Provider for a specific diagnosis, the Group Participating Provider shall ensure that all subsequent Provider Referrals and/or Out of Network Requests relating to treatment of the diagnosis that led to the initial referral are completed. Except in a Medical Emergency or when authorized in advance by BlueLincs HMO, Group Participating Providers shall refer BlueLincs HMO Members to BlueLincs HMO Participating Providers only.

5.2.1 Out of Network Requests: Group Participating Providers are required to refer BlueLincs HMO Members to BlueLincs HMO Participating Providers unless, in Group Participating Provider's best medical judgment, there is no BlueLincs HMO Participating Provider who can provide the Medically Necessary services needed for a BlueLincs HMO Member. The Group Participating Provider may submit an Out of Network Request when a BlueLincs HMO Member needs Medically Necessary services which are unavailable within his/her network by contacting BlueLincs HMO's Prior Authorization Department as set forth in Article VI of the Agreement. Non-Network Providers must be approved by BlueLincs HMO prior to ordering services on behalf of the BlueLincs HMO Member. The Group Participating Provider shall also provide complete information on authorized care or services to the out of network provider to whom the BlueLincs HMO Member is being referred.

5.3 Other Utilization Review Requirements: Group agrees to work with BlueLincs HMO in conducting utilization review activities to ensure the appropriateness and Medical Necessity of services provided to BlueLincs HMO Members in the following areas:

5.3.0 Extended Duration of Services: Hospital or other inpatient stays and extensions of outpatient services in which the patient's duration of services may exceed regional norms for the average duration of services for patients with the same or related conditions.

5.3.1 Diagnostic Admissions: Hospital or other inpatient stays in which the patient could have safely and effectively received diagnostic services and treatment without having been admitted.

5.3.2 Inpatient Ancillary Services: Hospital or other inpatient stays in which the ancillary services provided to the patient were neither Medically Necessary nor consistent with the patient's diagnosis.

5.3.3 Weekend Admissions: Hospital or other inpatient stays in which the patient is admitted on Friday or Saturday or Sunday and receives no active course of treatment over the weekend.

5.3.4 Unnecessary Stays or Days: Hospital or other inpatient stays in which the patient receives no active course of treatment throughout part or all of the stay, or any treatment rendered which could have been provided in an outpatient or other setting without jeopardizing the effectiveness of the treatment or the safety of the patient.

5.3.5 Quality Assurance: Quality of care assessment using BlueLincs HMO established standards or criteria.

5.4 Failure to Comply with Prior Authorization: Failure of Group to comply with BlueLincs HMO's Prior Authorization requirements may result in nonpayment for services provided. As noted in Article XI of the Agreement, BlueLincs HMO reserves the right to terminate this BlueLincs HMO Addendum if Group fails to comply with the utilization review requirements as defined in this Article.

5.5 Services Not Medically Necessary: Payment will be denied for services provided by Group that BlueLincs HMO determines to be not Medically Necessary or Experimental/Investigational/Unproven. Such denied charges may not be collected from the BlueLincs HMO Member.

ARTICLE VI
TERMINATION OF THE BLUELINCS HMO ADDENDUM

In addition to the termination provisions in Article XI of the Agreement, the following shall apply to this BlueLincs HMO Addendum:

6.0 Contract Period: This BlueLincs HMO Addendum shall be effective as stated on the cover page of this BlueLincs HMO Addendum and shall continue until the earlier of (1) termination of all agreements between Group and The Plan or (2) termination of only this BlueLincs HMO Addendum between Group and BlueLincs HMO in accordance with Article XI of the Agreement.

6.1 Enrollment Assignments: In the event either party gives notice of intent to terminate or not to renew this BlueLincs HMO Addendum, BlueLincs HMO may limit or terminate new enrollment assigned to Group Participating PCPs as of the date of the termination notice and may proceed to transfer BlueLincs HMO Members to other BlueLincs HMO Participating Providers.

6.2 Notification of BlueLincs HMO Members: In the event Group or a Group Participating PCP or BlueLincs HMO shall terminate participation under this BlueLincs HMO Addendum in accordance with Article XI of the Agreement, BlueLincs HMO shall notify the BlueLincs HMO Members assigned to Group Participating PCPs within thirty (30) days of receipt of the termination notice if applicable.

Refer to cover page for effective date and signatures.

BlueCross BlueShield of Oklahoma

Blue Preferred PPO℠ Network Addendum to the Blue Traditional℠ Network Participating Group Agreement including the Blue Choice PPO℠ Network Addendum

This Blue Preferred PPO Network Addendum ("Blue Preferred PPO Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), and the undersigned ("Group"). This Blue Preferred PPO Addendum includes all applicable terms and conditions of the Agreement and the Blue Choice PPO Network Addendum (the "Blue Choice PPO Addendum") currently in effect between Group and The Plan.

The undersigned parties hereby agree to the terms and conditions contained in this Blue Preferred PPO Addendum. This Blue Preferred PPO Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
	RICK KELLY
Name of Signatory	Name of Signatory
	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS
Title of Signatory	Title of Signatory
Date Signed	Date Signed

With respect to Blue Preferred PPO Members only, the following terms shall apply:

ARTICLE I
DEFINITIONS

1.0 Blue Preferred PPO Member: Any person described in *Applicability of Agreement* in Article VIII of the Agreement whose designated network is Blue Preferred PPO.

1.1 Blue Preferred PPO Participating Provider: A hospital, other health care facility, physician, health care professional or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to Blue Preferred PPO Members.

1.2 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum amount allowed for Covered Services rendered to Blue Preferred PPO Members, as described in Article III.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to Blue Preferred PPO Members, the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth in Article III and hold Blue Preferred PPO Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the Blue Preferred PPO Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until The Plan has determined the Maximum Reimbursement Allowance and notified Group as to the amount due from the Blue Preferred PPO Member, if any, under the Blue Preferred PPO Member's Benefit Agreement, Group shall not bill or attempt to collect from the Blue Preferred PPO Member any coinsurance amounts. The total amount collected from The Plan, or administered accounts, and the Blue Preferred PPO Member for copayment, deductible and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Group agrees to promptly refund to the Blue Preferred PPO Member any amounts which may have been collected from the Blue Preferred PPO Member in excess of the Blue Preferred PPO Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Applicability of Reimbursement: In the event that Group has not separately contracted with The Plan for its other networks, including but not limited to BlueLincs HMO or Blue Advantage PPO, the terms of this Blue Preferred PPO Addendum, including the Maximum Reimbursement Allowance described herein, shall be applicable to any Covered Services rendered to a Member whose designated network is one in which Group does not participate. Group agrees to hold such Member 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 Addendum, if applicable, to accept the Blue Choice PPO Maximum Reimbursement Allowance for any Member whose designated network is one in which Group does not participate.

2.0.1 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the Blue Preferred PPO Member for services denied as not Medically Necessary or Experimental/Investigational/ Unproven unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Blue Preferred PPO Member: Group agrees to extend all Covered Services to Blue Preferred PPO Members in accordance with the applicable terms and conditions of the Agreement and the Blue Choice PPO Addendum currently in effect between Group and The Plan.

2.2 Call Coverage: Group agrees to provide coverage for Blue Preferred PPO Members twenty-four (24) hours per day, seven (7) days per week by a Blue Preferred PPO Participating Provider.

2.3 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a Blue Preferred PPO Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Blue Preferred PPO Addendum by The Plan pursuant to Article XI of the Agreement.

2.4 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified for Blue Preferred PPO Members who have such requirements in their Benefit Agreement in accordance with Article V of the Agreement.

ARTICLE III
MAXIMUM REIMBURSEMENT ALLOWANCES

3.0 Maximum Reimbursement Allowances: Except as set forth below, the Maximum Reimbursement Allowance for Covered Services rendered to Blue Preferred PPO Members shall be as set forth in the Agreement.

3.0.0 Conversion Factors: For Covered Services rendered to Blue Preferred PPO Members, the applicable conversion factors are set forth below:

Provider Type	E&M	All Other
Physician & Optometrist	$35.54	$43.77
Chiropractor	$33.31	$41.27
Certified Registered Nurse Anesthetist	$29.21	$36.08
Anesthesiologist Assistant, Nurse Practitioner, Physician Assistant & Psychologist	$27.94	$34.47
Speech Therapist	$24.49	$30.09
Dietician	$22.55	$27.95
Physical/Occupational Therapist	$22.18	$27.50
Audiologist, LADC, LCSW & LPC	$20.29	$24.90

3.0.1 Anesthesia Rates: For Covered Services rendered to Blue Preferred PPO Members, the applicable anesthesia rates are set forth below:

Provider Type	Anesthesia Rate
Physician	$47.00
Certified Registered Nurse Anesthetist	$40.00
Anesthesiologist Assistant	$35.72

ARTICLE IV
TERM AND TERMINATION

In addition to the termination provisions in Article XI of the Agreement, the following provision shall apply to this Blue Preferred PPO Addendum:

4.0 Contract Period: This Blue Preferred PPO Addendum shall be effective as stated on the cover page of this Blue Preferred PPO Addendum and shall continue until the earlier of (1) termination of all agreements between Group and The Plan or (2) termination of only this Blue Preferred PPO Addendum between Group and The Plan in accordance with the termination provisions of the Agreement.

Refer to cover page for effective date and signatures.

BlueCross BlueShield of Oklahoma

NativeBlue℠ Network Addendum to the Blue Traditional℠ Network Participating Group Agreement

This NativeBlue Network Addendum ("NativeBlue Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), and the undersigned ("Group"). This NativeBlue Addendum includes all applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

The undersigned parties hereby agree to the terms and conditions contained in this NativeBlue Addendum. This NativeBlue Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
	RICK KELLY
Name of Signatory	Name of Signatory
	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS
Title of Signatory	Title of Signatory
Date Signed	Date Signed

With respect to NativeBlue Members only, the following terms shall apply:

ARTICLE I
DEFINITIONS

1.0 Group Participating Primary Care Physician ("Group Participating PCP"): A family or general practitioner, internist, pediatrician, or other as approved by The Plan, who is employed by or under an agreement with Group and eligible for a NativeBlue Member to choose as a primary care physician.

1.1 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum allowed amount for Covered Services rendered to NativeBlue Members, as described in Article III.

1.2 NativeBlue Member: A Member whose designated network is NativeBlue. All NativeBlue Members are required to be employees or an eligible Member of a Tribal Business Entity.

1.3 NativeBlue Participating Primary Care Physician: Family and general practitioners, internists, pediatricians and others as approved by The Plan, who are under an agreement with The Plan to render Covered Services to NativeBlue Members and to be eligible for a NativeBlue Member to choose as a primary care physician.

1.4 NativeBlue Participating Provider: A hospital, other health facility, physician, health care professional or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to NativeBlue Members.

1.5 Tribal Business Entity: 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. A Tribal Business Entity may be a wholly owned subsidiary of one or more Tribal Business Entities.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to NativeBlue Members the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth in Article III and hold NativeBlue Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the NativeBlue Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until The Plan has determined the Maximum Reimbursement Allowance and notified Group of the amount due from the NativeBlue Member, if any, under the NativeBlue Member's Benefit Agreement, Group shall not bill or attempt to collect from the NativeBlue Member any coinsurance amounts. The total amount collected from The Plan, or administered accounts, and the NativeBlue Member for copayment, deductible and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Group agrees to promptly refund to the NativeBlue Member any amounts which may have been collected from the NativeBlue Member in excess of the NativeBlue Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the NativeBlue Member for services denied as not Medically Necessary or Experimental/Investigational/Unproven unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Call Coverage: Group agrees to provide coverage for NativeBlue Members twenty-four (24) hours per day, seven (7) days per week by a NativeBlue Participating Provider.

2.2 Coordinate Health Care: Group shall coordinate the NativeBlue Member's health care with the NativeBlue Participating Primary Care Physician and/or other specialists or facilities when such care is needed.

2.3 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a NativeBlue Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this NativeBlue Addendum by The Plan pursuant to Article XI of the Agreement.

2.4 Manage Health Care: Group Participating PCP agrees to manage the total health care of the NativeBlue Member. This includes, but is not limited to, health supervision, basic treatment, initial diagnosis, management of chronic conditions and preventive health services.

2.5 NativeBlue Member: Group agrees to extend all Covered Services to NativeBlue Members in accordance with the applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

2.6 Primary Care Services: Group Participating PCP agrees to personally provide to NativeBlue Members the full range of primary care services which are Medically Necessary.

2.7 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified for NativeBlue Members who have such requirements in their Benefit Agreement in accordance with Article VI of the Agreement.

ARTICLE III
MAXIMUM REIMBURSEMENT ALLOWANCES

3.0 The basis for reimbursement for Covered Services provided to NativeBlue Members will be the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth below. Reimbursement shall be made according to The Plan's medical policies and reimbursement guidelines pertaining to subjects such as multiple surgical procedures, surgical assistance, global surgical services, coding and unbundling.

3.1 Maximum Reimbursement Allowances: Maximum Reimbursement Allowances for Covered Services provided to NativeBlue Members shall be based on base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and multiplied by the applicable percentage set forth in the sections below. Services for which a Medicare reimbursement rate is not available will be reimbursed in accordance with The Plan's fee schedule in effect as of the date of service. For purposes of this NativeBlue Addendum, the Medicare reimbursement rate only establishes the Maximum Reimbursement Allowance. All provisions of the Agreement remain applicable. The Maximum Reimbursement Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments. Any changes to the Medicare reimbursement amount will be implemented by The Plan within thirty (30) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

3.1.0 RBRVS: The Maximum Reimbursement Allowances for RBRVS shall be as set forth above in 3.1, except the applicable percentage shall be as set forth in the table below:

Provider Type	Percentage of CMS Physician Allowance
Physicians, Chiropractors & Optometrists	103%
All Other Health Care Professionals	88%

3.1.1 Anesthesia: The Maximum Reimbursement Allowances for anesthesia services shall be as set forth above in 3.1, except the applicable percentage shall be as set forth in the table below:

Provider Type	Percentage of CMS Physician Allowance
Physicians, Chiropractors & Optometrists	103%
All Other Health Care Professionals	88%

3.1.2 Durable Medical Equipment: The Maximum Reimbursement Allowances for durable medical equipment and supplies shall be as set forth above in 3.1, except the applicable percentage shall be seventy-five percent (75%).

3.1.3 Pathology/Laboratory: The Maximum Reimbursement Allowances for pathology/laboratory services shall be as set forth above in 3.1, except the applicable percentage shall be seventy-five percent (75%).

3.1.4 Pharmaceutical Products: The Maximum Reimbursement Allowances for pharmaceutical products shall be as set forth above in 3.1, except the applicable percentage shall be one hundred percent (100%).

3.2 Discontinued or Unrecognized Codes: If Centers for Medicare and Medicaid Services ("CMS") does not recognize or reimburse for a specific code or discontinues use of a specific code, The Plan may not reimburse for the unrecognized or discontinued code or The Plan may reimburse in accordance with The Plan's fee schedule in effect as of the date of service. The Plan may also make a determination to bundle services or pay for services using an alternative or more specific code.

3.3 Rounding: If any calculation set forth in Article III results in numbers positioned more than two (2) places to the right of the decimal, The Plan will round to the nearest penny.

3.4 Written Report: The Plan will not reimburse, nor may Group collect from the NativeBlue Member, any amounts for Professional Services unless such services have been rendered to an identifiable individual patient and are supported by a written report.

ARTICLE IV
TERM AND TERMINATION

In addition to the termination provisions in Article XI of the Agreement, the following provision shall apply to this NativeBlue Addendum:

4.0 Contract Period: This NativeBlue Addendum shall be effective as stated on the cover page of this NativeBlue Addendum and shall continue until the earlier of (1) termination of all agreements between Group and The Plan or (2) termination of only this NativeBlue Addendum between Group and The Plan in accordance with the termination provisions of the Agreement.

4.1 Termination by The Plan: In addition to termination pursuant to Contract Period, in the event The Plan determines that applicable laws, rules, regulations, statutes, orders, or standards, as are adopted, amended, or issued from time to time, of the United States of America, the states or any department or agency thereof, including but not limited to the Centers for Medicare and Medicaid Services and the Indian Health Service ("Laws"), render material obligations of this NativeBlue Addendum or the NativeBlue plans unenforceable or commercially unreasonable, or require additional material obligations in order to implement and comply with the requirements of such Laws, then The Plan may terminate this NativeBlue

Addendum upon notice to Group as soon as is feasible but in no event less than ninety (90) days prior to the effective date of the termination.

Refer to cover page for effective date and signatures.

BlueCross BlueShield of Oklahoma

Blue Plan65 Select℠ Network Addendum to the Blue Traditional℠ Network Participating Group Agreement

This Blue Plan65 Select Network Addendum ("Blue Plan65 Select Addendum") to the Blue Traditional Network Participating Group Agreement ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), and the undersigned ("Group"). This Blue Plan65 Select Addendum includes all applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

The undersigned parties hereby agree to the terms and conditions contained in this Blue Plan65 Select Addendum. This Blue Plan65 Select Addendum shall be effective beginning on _____

MANGUM FAMILY CLINIC	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Group	
Authorized Signature	Authorized Signature
Name of Signatory	RICK KELLY Name of Signatory
Title of Signatory	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS Title of Signatory
Date Signed	Date Signed

With respect to Blue Plan65 Select Members only, the following terms shall apply:

ARTICLE I
DEFINITIONS

1.0 Blue Plan65 Select Member: Any person eligible to receive Professional Services pursuant to the terms of a Blue Plan65 Select Benefit Agreement.

1.1 Blue Plan65 Select Participating Provider: A hospital, other health care facility, physician, health care professional or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to Blue Plan65 Select Members.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to Blue Plan65 Select Members the lesser of Group's Usual Charge or the Medicare Part B allowable charge. Medicare Part B deductible and coinsurance amounts which would ordinarily be owed by the Blue Plan65 Select Member will be paid directly to Group by The Plan on behalf of the Blue Plan65 Select Member. Group shall not bill or attempt to collect any amounts directly from the Blue Plan65 Select Member except for those services not covered by Medicare Part B. The Plan will not reimburse, nor may Group collect from the Blue Plan65 Select Member, any amounts for Professional Services unless such services have been rendered to an identifiable individual patient and are supported by a written report. Group agrees to promptly refund to the Blue Plan65 Select Member any amounts which may have been collected from the Blue Plan65 Select Member in excess of the Blue Plan65 Select Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the Blue Plan65 Select Member for services denied as not Medically Necessary or Experimental/Investigational/Unproven unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Blue Plan65 Select Member: Group agrees to extend all Covered Services to Blue Plan65 Select Members in accordance with the applicable terms and conditions of the Agreement currently in effect between Group and The Plan.

2.2 Call Coverage: Group agrees to provide coverage for Blue Plan65 Select Members twenty-four (24) hours per day, seven (7) days per week by a Blue Plan65 Select Participating Provider.

2.3 Coordinate Health Care: Group shall coordinate the Blue Plan65 Select Member's health care with the Primary Care Physician and/or other specialists or facilities when such care is needed.

2.4 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a Blue Plan65 Select Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Blue Plan65 Select Addendum by The Plan pursuant to Article XI of the Agreement.

2.5 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified for Blue Plan65 Select Members who have such requirements in their Benefit Agreement in accordance with Article VI of the Agreement.

ARTICLE III
TERM AND TERMINATION

In addition to the termination provisions in Article XI of the Agreement, the following provision shall apply to this Blue Plan65 Select Addendum:

3.0 Contract Period: This Blue Plan65 Select Addendum shall be effective as stated on the cover page of this Blue Plan65 Select Addendum and shall continue until the earlier of (1) termination of all agreements between Group and The Plan or (2) termination of only this Blue Plan65 Select Addendum between Group and The Plan in accordance with the termination provisions of the Agreement.

Refer to cover page for effective date and signatures.

Sysmex America, Inc., 577 Aptakisic Road, Lincolnshire, IL 60069
Tel: 888.879.7639 Option 4, Email: servicecontracts@sysmex.com

Service Agreement Quotation

Bill to: 2001010882 (2001010882)	Ship to: 2004019079
MANGUM REGIONAL MEDICAL CENTER PO BOX 280 Mangum, OK 73554	**Sales Region: MOUNTAIN WEST** MANGUM CITY HOSPITAL AUTHORITY 1 Wickersham St Mangum, OK 73554

Service Agreement #	Effective Dates of Coverage:
51016281	11/17/2023 to 11/16/2024

To confirm your acceptance of this Service Agreement please return this quotation along with a copy of your Purchase Order to ServiceContracts@sysmex.com.

Billing Frequency Selection (Circle)			
Annually	Bi-Annually	Quarterly	Monthly

If a billing frequency is not selected, your invoice will default to annual.

OPTIONAL INFORMATION

GPO Designation	
Equipment Purchase Quotation #	
Equipment Sales Agreement Date	

Covered Equipment

Equipment Model	Serial Number	Effective Coverage Dates	Description of Service	Unit Price per Year	Term Price
XN-550	13401	11/17/2023 to 11/16/2024	BeyondCare Remote	$8,439.00	$8,439.00
				TOTAL:	**$8,439.00**

Please return this quotation along with a copy of your Purchase Order to servicecontracts@sysmex.c

Sysmex America, Inc. ("Sysmex") reserves the right to withdraw the offer to provide Service at the rates contained herein and require an appointment on a time and materials basis to provide any Service necessary to the Equipment to meet Sysmex Equipment specifications prior to entering into any future agreement for Service.

For Hematology Equipment Only:
Pricing for Service is based on Customer's equipment sales agreement, Master Agreement or Group Purchasing Organization ("GPO") Agreement. By submission of a purchase order, Customer agrees the terms and conditions of the agreement between Sysmex and Customer under which the applicable equipment was acquired (the "Equipment Sales Agreement") apply to this Service Agreement. In the event no Equipment Sales Agreement exists between Sysmex and Customer and a GPO Agreement including terms for service is applicable to the parties, the GPO Agreement terms and conditions for Service shall apply. In the event (i) there is no applicable Equipment Sales Agreement and/or GPO Agreement; or (ii) the Equipment Sales Agreement and/or GPO Agreement do not contain terms relating to Service, the Sysmex Terms and Conditions for Service at www.sysmex.com/service_tnc_na_eng shall apply. Notwithstanding the foregoing, by submission of a purchase order Customers that have acquired Sysmex equipment from a Sysmex authorized distributor ("Distributor Customers") agree the Terms and Conditions for Service at www.sysmex.com/service_tnc_na_eng, including, but not limited to, the terms for Distributor Customers apply to this Service Agreement.

For Urinalysis Equipment Only:
By submission of a purchase order, Customer agrees the terms and conditions of the agreement between Sysmex and Customer under which the applicable equipment was acquired (the "Equipment Sales Agreement") apply to this Service Agreement. In the event no Equipment Sales Agreement exists between Sysmex and Customer the Sysmex Terms and Conditions for Service at www.sysmex.com/service_tnc_na_eng shall apply. Notwithstanding the foregoing, in the event an agreement for service is in place between Customer and a third party or Sysmex has accepted assignment of an agreement between Customer and a third party (each a "Third Party Agreement"), the terms and conditions of the Third Party Agreement shall apply until such Third Party Agreement is terminated, by expiration or otherwise. Customer acknowledges and agrees in no event will this Service Agreement Quotation extend the term of any Third Party Agreement, and upon termination of any Third Party Agreement Sysmex and Customer must mutually agree upon the terms and conditions of any agreement for Service.

Hospital Vendor Contract Summary Sheet

1. ☒ **Existing Vendor** ☐ **New Vendor**

2. **Name of Contract: Service Agreement Quotation**

3. **Contract Parties: SYSMEX /MRMC**

4. **Contract Type Services: BeyondCare Remote for XN-550 (Lab Analyzer)**

5. **Impacted Hospital Departments:** Laboratory (Hematology)

6. **Contract Summary:** Total Coverage: Unlimited troubleshooting/repair visits during normal business hours (Monday - Friday, 8am - 5pm). All necessary spare parts replaced free of charge. BeyondCare Remote monitors all of our quality controls. We are also able to print and view reports from this program. If there are any issues with the Hematology analyzer it will alert service to come out.

7. **Cost: $8439.00 / YR (This is paid annually)**

8. **Term:** 11/17/2023 to 11/16/2024

9. **Termination Clause:** Either Party may terminate this Agreement without cause at any time by submitting a fifteen (15) calendar day written termination notice.

10. **Other: none**

Pharma Force Group LLC
Software as a Service Agreement

This Software as a Service Agreement (the "Agreement") is entered into as of _October 2, 2023 (Date) between **Pharma Force Group LLC ("PharmaForce")**, a Delaware corporation, with offices located at 4300 S. US Hwy 1, Ste 203-329, Jupiter, FL 33477 and _MANGUM REGIONAL MEDICAL CENTER("Customer"), with offices at _1 Wickersham St, Mangum, OK 73554_____.

1. **Definitions**
   1. "Service" shall mean the online business application, "PharmaForce," that Customer is authorized to access pursuant to the Agreement.
   2. "Customer Data" shall mean any data, information, or other materials of any nature whatsoever, provided to PharmaForce by Customer in the course of implementing and/or using the Service.
   3. "Electronic Communications" shall mean any transfer of signs, signals, text, images, sounds, data or intelligence of any nature transmitted in whole or part electronically.
   4. "Seat(s)" means a unique login for each general access user.
   5. "Term" means any Initial Term and/or Renewal Term as defined in this Agreement.

2. **Product**
   PharmaForce will provide Customer with the Service and any new features that augment or enhance the current business application. PharmaForce shall host the Service and may update the content, functionality, and user interface of the Service from time to time in its sole discretion and in accordance with the Agreement.

3. **Services**
   PharmaForce is a 340B Third Party Administrator. As a third party administrator, PharmaForce determines the eligibility of claims and dispensations for 340B based upon the entity's data and applied configurations. PharmaForce splits orders to the specific account types dependent on the accumulation, configuration logic, pharmacy requirements and the specific solution. PharmaForce is responsible for the following services: (1) load Customer's necessary data to perform Contract Pharmacy and Split Billing administration within the PharmaForce application; (2) establish interface connections between Covered Entity, Wholesalers, Pharmacies, and PharmaForce; (3) remotely guide the Customer Super Users through configuring their 340B program through the PharmaForce User Interface; (4) provide ongoing remote super users training as needed; (5) option to provide onsite support in the event of a HRSA Audit with only expenses paid by Customer.

4. **Customer Responsibilities**
   The Customer is responsible for the following: (1) where applicable, connect PharmaForce with Customer's IT teams for interfaces; (2) where interfaces are not applicable, acquire all necessary data for each Customer setup, leveraging templates provided by PharmaForce; (3) provide Super Users to be trained by a PharmaForce team. The Super Users will then train new users of the system; (4) determine the 340B configuration settings within PharmaForce; (5) perform acceptance testing and determining Go Live readiness and date; (6) participate, when requested by PharmaForce, in government auditing & compliance activities

5. **Reservation of Rights and Ownership**
   PharmaForce reserves all rights not expressly granted to you in this License. The Service is protected by copyright and other intellectual property laws and treaties. PharmaForce or its suppliers own the title, copyright, and other intellectual property rights in the Service. Customer is paying for access to the Service, the Service is not sold. The Agreement does not grant Customer any rights to trademarks or service marks of PharmaForce.

6. **Use Rights**

Subject to the terms and conditions of the Agreement, PharmaForce grants to Customer during the Term of the Agreement the non-exclusive, non-transferable (except in connection with an assignment under Section 18 - Miscellaneous) and, subject to the terms of this Agreement, terminable right to use the Service and to display content solely for Customer's internal business operations, provided such operations shall not include service bureau use, outsourcing, renting, or time-sharing the Service. Customer acknowledges and agrees that the rights granted herein do not constitute a concurrent user license and that the rights granted to Customer are provided to Customer on the condition that Customer does not (and does not allow any third party to) copy, modify, create a derivative work of, reverse engineer, reverse assemble, disassemble, or decompile the Service or any part thereof or otherwise attempt to discover any source code, modify the Service in any mann.er or form, or use unauthorized modified versions of the Service, including (without limitation) for the purpose of building a similar or competitive product or service or for the purpose of obtaining unauthorized access to the Service. Customer is expressly prohibited from sublicensing use of the Service to any third parties. Customer acknowledges and agrees that PharmaForce shall own all rights, title and interest in and to all intellectual property rights in the Service. Except as provided in this Agreement, the access granted to Customer does not convey any rights in the Service, express or implied, or ownership in the Service or any intellectual property rights thereto. Any rights not expressly granted herein are reserved by PharmaForce.

7. **License from Customer**

Subject to the terms and conditions of the Agreement, Customer grants PharmaForce the non- exclusive, non-transferable (except in connection with an assignment under Section 18 Miscellaneous) license to copy, store, record, transmit, maintain, display, view, print, or otherwise use Customer Data to the extent necessary to provide the Service to Customer. In connection with its provision of the Service and access to certain Customer Data, PharmaForce will comply with applicable requirements of law relating to Protected Health Information (PHI), and in connection therewith, will enter into a separate Business Associate agreement with Customer attached hereto as Exhibit A (the "Business Associate Agreement"). Customer agrees that the license to Customer Data shall survive the termination of the Agreement for one year, solely for the purpose of storing backup Customer Data at an offsite storage facility. Customer agrees that PharmaForce and its affiliates may collect and use technical information gathered as part of the product support services provided to Customer, if any, related to the Service. PharmaForce may use this information solely to improve our products or to provide customized services or technologies to Customer and will not disclose this information in a form that personally identifies Customer.

8. **Term, Fees and Payments**

Term and Termination

This Agreement will commence on the date set forth above and shall continue for an Initial Term of thirty-six (36) months ("Initial Term"). Upon completion of the Initial Term, the Agreement shall automatically renew for successive twelve (12) month periods ("Renewal Terms"), unless terminated by either party providing a minimum of thirty (30) days written notice of intent to terminate this Agreement.

Termination. Customer may terminate this Agreement at any time for any reason with a thirty (30) days prior notice of its intention.

Fees

Contract Pharmacy Administration - Fees per unique covered entity ID to individual pharmacy location combination are the greater of $2.00 for every Approved 340B claim or the minimum fee of $500 per month. These fees are inclusive of specialty or non-specialty claims adjudicated within the store location. Fees begin based on the earliest claim filled date.

In-House Retail / Outpatient Pharmacy- Fees per unique covered entity ID to individual pharmacy location combination are the greater of $2.00 for every Approved 340B claim or the minimum fee of $500 per month. These fees are inclusive of specialty or non-specialty claims adjudicated within the store location. Fees begin based on the earliest claim filled date.

Specialty Pharmacies Administration - Fees per unique covered entity ID to individual pharmacy location combination are the greater of $50.00 for every Approved 340B claim or the minimum fee of $500 per month. The minimum fee will only be applied if at least one approved claim is found during that month. If no approved claims are found across any of the Specialty Contract Pharmacy Chain stores in a given month, then a minimum fee of $500 will be applied for that month for that pharmacy chain. Fees begin based on the earliest claim filled date.

Contract Pharmacy-Mail Order Administration - Fees per unique covered entity ID to individual pharmacy location combination are the greater of $2.00 for every Approved 340B claim or the minimum fee of $500 per month. The minimum fee will only be applied if at least one approved claim is found during that month. If no approved claims are found across any of the Mail Order Contract Pharmacy Chain stores in a given month, then a minimum fee of $500 will be applied for that month for that pharmacy chain. Fees begin based on the earliest claim filled date.

Home Infusion - Fees per unique covered entity ID to individual pharmacy location combination are the greater of $50.00 for every Approved 340B claim or the minimum fee of $500 per month. Fees begin based on the earliest claim filled date.

Claim Processing Fee – Fees per claim reviewed by PharmaForce are $0.03 per claim per unique Pharmacy to Covered Entity combination. If Pharmacy charges a Gateway Fee, those gateway fees will be charged monthly to Customer beginning on the earliest claim filled date.

Cash/340B Drug Discount Program Cards (340B Cards)- Fees are $4.00 for every claim adjudicated via the 340B Cards or the minimum fee of $500 per month. These fees are incremental to the PharmaForce fees for identifying approved 340B claims. These fees will only be applied when requested by Customer to initiate the program.

Referral Capture Service – The Full Service option fee will be the amount of 20% of the Net Savings for any referral captured claim during the time of this contract. The Self Service option fee will be the amount of 12% of the Net Savings for any referral captured claim during the time of this contract. The Net Savings Amount is calculated as the total amount collected by the pharmacy minus the pharmacy dispensing fee. This Service Fee is applicable to both the original prescriptions identified and the subsequent refills. Upon contract termination, any prescriptions originally identified by the PharmaForce Referral Capture service will continue to incur fees and be billed for the remainder of the prescription over the next 12 months. This includes refills for the same product, written by the same providers for the same patients as originally identified by the PharmaForce Referral Capture service.

Item #	Description:	Self-Service	Full Service

1	Access to PharmaForce's Referral Claims Manager platform.	X	X
2	Establish interfaces to import encounter, referral, and claims files into the RCM platform.	X	X
3	Processing of encounter file, referral file, and non-captured referral claims.	X	X
4	Access to the RCM's fax outbound & inbound features along with fax forwarding of patient progress notes.	X	X
5	Application support and assistance as needed by users.	X	X
6	PharmaForce will provide assistance in developing a referral policy if CE does not have one in place.		X
7	Review each claim that meets established criteria and review the EMR to ensure each claim meets compliance requirements.		X
8	If an internal referral, document referral date in the RCM for HRSA audit tracking.		X
9	Request progress notes for external referrals from outside specialty clinics in order to "close the loop" for a referral claim.		X
10	Forward/upload the progress notes received into the CE's EMR for clinical care and documentation.		X
11	Approve the claim and refills in the Referral Claims Manager platform. (approval indicator is needed to transmit to our Contract Pharmacy Application for replenishment)		X
12	Provide detailed reporting to Customer on all claims re-qualified to 340B, including detailed, auditable points of data, as documented by PharmaForce during the routine audit of Customer EMR.		X
13	Provide summary reporting to Customer on PharmaForce work, including total additional revenue collected for month, number of patient records audited, number of prescriptions re-qualified to 340B, and year-to-date revenue and other statistics.		X
14	Full HRSA audit support in case one of the referral claims is selected for a HRSA audit		X

340B Home Delivery - PharmaForce will receive a service fee in the amount of 10% of the net savings amount for 340B approved claims filled by the mail-order pharmacy partnered with PharmaForce to provide the service. The net savings amount is calculated as the total payment received by the pharmacy for the relevant claim minus the pharmacy dispensing fee. Although these fees are incremental to the PharmaForce fees for identifying approved 340B claims, PharmaForce will waive the Contract Pharmacy Administration minimum fees and Claim Processing Fee associated with this mail-order pharmacy for the first three months as this service is being established. These fees are separate from any fees associated with the contracted mail-order pharmacy (i.e. dispense fees). These fees will only be applied when requested by Customer to initiate the program.

Mixed Use Split Billing - Fees per mixed use hospital pharmacy leveraging the split billing Service is based on the hospital's number of licensed beds. Monthly fees are as follows depending on licensed bed size; Up to 299 licensed beds $1250, 300 to 499 licensed beds $1750 per month, 500 licensed beds or more $2250 per month. Fees begin in the month when the first live purchase order was submitted.

Expenses and Service Fees
Customer shall pay all fees as set forth above. Customer will also reimburse PharmaForce for any and lodging expenses reasonably and necessarily incurred in the performance of any services onsite for the Customer, upon prior approval by Customer. In the event PharmaForce is requested or required to facilitate the flow of funds owed to Customer by Contracted Pharmacy, PharmaForce shall be entitled to a service fee no greater than 2% of the total amount being transferred from Contract Pharmacy.

Payment Terms
Service Fees and Expenses are due within thirty (30) days from the date of invoice. Service Fees are billed in arrears, beginning with the applicable Go-Live Date. All invoices not disputed within 60 days of receipt of such invoice will be deemed accepted. Payment is due notwithstanding the non-performance of any obligations of any third parties, including under any contract pharmacy arrangement. All payments to PharmaForce are to be made in U.S. currency and are transmitted electronically.

Late Payments
Any late payments shall be subject to a service charge equal to 0.5% of the amount due (calculated on a monthly basis) or the maximum amount allowed by law, whichever is less. In the event that PharmaForce incurs any costs, including reasonable attorney's fees, for efforts in collecting overdue fees from Customer, Customer agrees to pay such costs. Customer further agrees to pay all foreign, federal, state, and local taxes, if applicable, to Customer's access to, use, or receipt of the Service. If Customer is late in payment and is actively using the Service, PharmaForce reserves the right to discontinue access to the Service 60 days after payment was due, until such time that Customer remits payments due in full. Discontinuation of Service access does not release Customer of obligation to remit payments, both overdue and future, for the duration of the Agreement.

9. **Warranties**
PharmaForce warrants that the Service will conform to and perform in accordance with all generally available documentation and specifications relating to the Service. Except as set forth herein, PharmaForce provides the service "AS IS" and "WHERE IS" with no warranties of any kind.

10. **Confidentiality**
Customer and PharmaForce shall maintain the confidentiality of any other information or data which the other party designates or which a party knows or has reason to believe is proprietary, in at least the same manner as the party maintains the confidentiality of its own proprietary information ("Confidential Information"). Confidential Information includes, but is not limited to, technical and non-technical information materials, processes, ideas, and techniques, information pertaining to finances, processes, customers, clients, employees, students, fees, rates, accounting data, statistical data, marketing, research and development plans, projects, and findings, business plans, and the terms of any contracts. Each party's standard of care for maintaining the confidentiality and security of Confidential Information shall be no less than is reasonable for the kind and type information involved. Each party may use Confidential Information only as permitted hereunder. Neither party shall disclose or provide any Confidential Information to any third-party and shall take necessary measures to prevent any unauthorized disclosure by its affiliates, employees, agents, contractors, or consultants including by completing appropriate individual nondisclosure agreements. The receiving party acknowledges that unauthorized disclosure or use of the disclosing party's Confidential Information may cause the disclosing party irreparable harm, and the receiving party agrees to give the disclosing party written notice of any such event as soon as commercially reasonable upon discovery of such, and to take all legal means to minimize any loss or damage due to any such event. Accordingly, each party agrees that the other party shall have the right to seek immediate injunctive relief for any breach of this section by the other, which shall be in addition to any other rights and remedies that it may have available.

11. **Indemnification**

PharmaForce shall indemnify and defend Customer from and against any damages, losses, liab judgments, fines, penalties, costs and expenses (including reasonable attorney's fees) arising out of or relating to any claim, demand, investigation, action, suit or proceeding made or brought against Customer by a third party alleging that any Service infringes or misappropriates such third party's intellectual property rights (a "Claim"), provided Customer (a) promptly notifies PharmaForce in writing of the Claim; and (b) gives PharmaForce sole control of the defense and settlement of the Claim; provided that PharmaForce may not enter into any settlement that adversely effects Customer without Customer's prior written consent. Upon receiving notice of such a Claim related to the Service, PharmaForce may, at its discretion, and at no cost to Customer, (i) modify the Service so it is no longer alleged to infringe or misappropriate, without breaching any of the warranties above; (ii) obtain a license for Customer's continued use of the Service in accordance with this Agreement. The above defense and indemnification obligations do not apply to the extent (i) the Claim arises from the use or combination of the Service or any part thereof with software, hardware, data, or processes not provided by PharmaForce, if our Services or use thereof would not infringe without such combination; or (ii) the Claim arises from Customer's use of the Service in violation of this Agreement, the applicable documentation or applicable Order Forms. This Section states PharmaForce's sole liability to, and Customer's exclusive remedy against, the other party for any type of claim described in this Section.

12. **Disclaimer of Liability**

Except for liability arising out of Section 11 (Indemnification) or the Business Associate Agreement, the parties agree that in no event shall either party be liable to anyone for incidental, consequential, punitive, special or exemplary damages, or indirect damages of any type or kind (including loss of data, revenue, profits, use or other economic advantage), arising from breach of warranty or breach of contract, or negligence, or any other legal cause of action arising from or in connection with the Agreement.

13. **Limitations of Liability**

Subject to the last sentence of this Section, the maximum liability of either party to any person, firm or corporation whatsoever arising out of or in the connection with any license, use or other employment of the Service, whether such liability arises from any claim based on breach or repudiation of contract, breach of warranty, tort, or otherwise, shall in no case exceed the equivalent of two (2) times the amount paid by Customer to PharmaForce in the twelve (12) months preceding the applicable claim. The essential purpose of this provision is to limit the potential liability of the parties arising from the Agreement. The parties acknowledge that the limitations set forth in this Section are integral to the amount of consideration levied in connection with granting access to the Service and that, were PharmaForce to assume any further liability other than as set forth herein, such consideration would of necessity be set substantially higher. Certain states and/or jurisdictions do not allow the exclusion of implied warranties or limitations of liability for incidental or consequential damages, so the exclusions set forth above may not apply to Customer. The limitation of liability set forth in this section shall apply to (i) any indemnity obligations set forth in this Agreement, and (ii) the Business Associate Agreement.

14. **Service Availability**

A Service Level Agreement specific for this Service is defined in Exhibit B.

15. **Support**

A Service Level Agreement specific for this Service will be defined in Exhibit B.

16. **Termination**

In the event of a material breach of the Agreement, either party may terminate the Agreement if the breaching party fails to cure such breach within 30 days of that party being notified in writing of the breach. In addition, Customer may terminate this Agreement in accordance with Exhibit A. Upon termination or expiration of this Agreement, Customer shall have no rights to continue use of the Servi

17. **Insurance**

At all times during the Term of this Agreement, PharmaForce shall abide by the insurance requirements set forth in Exhibit C.

18. **Miscellaneous**

This Agreement shall inure to benefit and bind the parties hereto, their successors and assigns, but neither party may assign the Agreement without written consent of the other, except such consent is not required to the successor of all or substantially all of the assignor's business or assets. The Agreement does not create any joint venture, partnership, agency or employment relationship between the parties, although PharmaForce reserves the right to disclose that Customer is a user of the Service; provided that such disclosure may not imply any endorsement of the Service by Customer. This Agreement (and any Exhibits hereto) represent the entire agreement of the parties and supersedes all prior discussions and/or agreements between the parties and is intended to be the final expression of the Agreement. It shall not be modified or amended except in writing signed by both parties. In the event of an express conflict between the terms of this Agreement and the terms of any Exhibit, the verbiage of the Agreement controls. This Agreement shall be governed in accordance with the laws of the State of Pennsylvania and any controlling U.S. federal law. Any disputes, actions, claims or causes of action arising out of or in connection with this Agreement (or the Service) shall be subject to the exclusive jurisdiction of the state and federal courts located in Pennsylvania. If any provision is held by a court of competent jurisdiction to be contrary to law, such provision shall be limited or eliminated to the minimum extent necessary so that the Agreement shall otherwise remain in full force and effect unless the provisions held invalid or unenforceable will substantially impair the benefits to either party of the remaining portions of the Agreement. Furthermore, the parties hereto shall cooperate to amend the invalid or unenforceable provision to most closely approximate the original intent of the provision while making it acceptable to the applicable court. In the event of any litigation of any controversy or dispute arising out of or in connection with this Agreement, its interpretations, its performance, or the like, the prevailing party shall be awarded reasonable attorneys' fees and/or costs. Neither party shall be liable for any loss or delay resulting from any force majeure event, including, but not limited to, acts of God, fire, natural disaster, terrorism, labor stoppage, war or military hostilities, criminal acts of third parties, and any payment date or delivery of Service date shall be extended to the extent of any delay resulting from any force majeure event. Sections 4, 5, 8, 9 and 14 shall survive the termination or expiration of this Agreement.

19. **Severability**

Each section of this Agreement is severable from this Agreement and, if a court of competent jurisdiction declares one or more provisions or parts unenforceable, the remaining provisions shall remain in full force and effect unless the provisions or parts held invalid or unenforceable will substantially impair the benefits to either party of the remaining portions of the Agreement. Furthermore, the parties hereto shall cooperate to amend the invalid or unenforceable provision or part to most closely approximate the original intent of the provision while making it acceptable to the applicable court.

THE PARTIES ACKNOWLEDGE THAT THEY HAVE READ THIS AGREEMENT, UNDERSTAND IT AND AGREE TO BE BOUND BY ITS TERMS, AND THE PERSON SIGNING ON BEHALF OF EACH HAS BEEN AUTHORIZED TO DO SO.

ACKNOWLEDGED AND AGREED:

Pharma Force Group LLC	MANGUM REGIONAL MEDICAL CENTER _____
By: _____	By: _____
Name: **Daniel Dimitri**	Name: _____
Title: **CEO**	Title: _____
Date: _____	Date: _____

Exhibit A

Business Associate Agreement

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is made as of the October 2, 2023, ("Effective Date") by and between **Mangum Regional Medical Center** ("Covered Entity") and **Pharma Force Group LLC** ("Business Associate").

RECITALS

A. Covered Entity and Business Associate are parties to a **Software as a Service** Agreement dated **October 2, 2023** (the "Services Agreement") pursuant to which Business Associate provides certain services to the Covered Entity and, in connection with those services, the Covered Entity discloses to Business Associate certain individually identifiable protected health information ("PHI") that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the American Recovery and Reinvestment Act of 2009 ("ARRA") and the associated regulations, 45 CFR Parts 160 and 164 (the "Privacy Rule"), as amended from time to time.

B. The parties desire to comply with the HIPAA standards for the privacy and security of PHI of patients of the Covered Entity.

NOW, THEREFORE, for and consideration of the recitals above and the mutual covenants and conditions contained herein, the parties enter into this Agreement to provide a full statement of their respective responsibilities.

SECTION 1 - Definitions

1.01 Reference to HIPAA Rules.

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.02 Specific definitions.

(a) Business Associate. "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 **Pharma Force Group LLC**, on behalf of itself and its affiliates.

(b) Covered Entity. "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 **Mangum Regional Medical Center.**

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

SECTION 2 - Obligations and Activities of Business Associate

2.01 Performance of Services Agreement. Business Associate agrees to not use or disclose PHI other than as permitted or required by the Services Agreement or as required by law.

2.02 Safeguards for Protection of PHI. Business Associate agrees to use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other as provided for by the Services Agreement and this Agreement.

2.03 Mitigation of Harm of Unauthorized Use or Disclosure. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.04 Reporting of Unauthorized Use or Disclosure. As soon as practicable, but in no event later than ten (10) days, Business Associate agrees to report to Covered Entity in writing any use or disclosure of PHI not provided for by the Services Agreement or this Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware. Such report shall contain:

(a) A brief description of what happened, including the date of the unauthorized access or use of PHI and the date of the discovery of the unauthorized access or use of PHI;

(b) A description of the type of unsecured PHI that was involved in the unauthorized access or use;

(c) Any recommended steps the individual whose PHI was inappropriately disclosed should take to protect themselves from the potential harm; and

(d) A brief description of what the Business Associate is doing to investigate the unauthorized access or use of PHI.

Business Associate will report such incidents to the Covered Entity's Privacy Officer. Business Associate will, subject to the approval of the Covered Entity, provide breach notifications to affected individuals, the HHS Office for Civil Rights (OCR), and potentially the media, on behalf of the Covered Entity. If the Covered Entity elects to be responsible for all required notifications, the Business Associate shall reimburse the Covered Entity for the costs associated with the notifications. Such costs will be paid to Covered Entity by Business Associate within thirty (30) days of receipt of an itemized invoice from the Covered Entity.

2.05 Use of Subcontractors. Business Associate agrees, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, to contract with any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate whereby such subcontractors agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

2.06 Access to PHI. Business Associate shall make available PHI in a designated record set to the Covered Entity, or as directed by the Covered Entity to an individual or the individual’s designee, for inspection and copying within ten (10) days of a request by Covered Entity as necessary to satisfy the Covered Entity’s obligations under 45 CFR 164.524.

2.07 Amendment by Business Associate. Business Associate agrees to make any amendment(s) to PHI in a designated record set as directed or agreed to by the Covered Entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy Covered Entity’s obligations under 45 CFR 164.526, within thirty (30) days of receipt of a request from Covered Entity.

2.08 Documentation of Disclosures. Business Associate agrees to maintain and make available the information required to provide an accounting of disclosures to the Covered Entity, or as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity’s obligations under 45 CFR 164.528. Business Associate shall provide such information to the Covered Entity within ten (10) days of a request by Covered Entity.

2.09 Compliance with Patient Right Provisions of Privacy Rule. To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).

2.10 Opportunity to Object. Business Associate agrees that, if it has a legal obligation to disclose any PHI, it will notify the Covered Entity as soon as reasonably practical after it learns of such obligation, and in any event within a time sufficiently in advance of the proposed release date such that Covered Entity's rights would not be prejudiced, as to the legal requirement pursuant to which it believes the PHI must be released. If the Covered Entity objects to the release of such PHI, Business Associate will allow the Covered Entity to exercise any legal rights or remedies the Covered Entity might have to object to the release of PHI, and Business Associate agrees to provide such assistance to Covered Entity, at Covered Entity's expense, as Covered Entity may reasonably request in connection therewith.

2.11 Access to Books and Records. Business Associate agrees to make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

SECTION 3 - Permitted Uses and Disclosures by Business Associate

3.01 Services Agreement. Business Associate may use or disclose PHI as necessary to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in the Services Agreement, provided that such use or disclosure would not violate the HIPAA Rules if done by the Covered Entity.

3.02 Other Permitted Uses and Disclosures.

(a) Business Associate may use or disclose PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c).

(b) Business Associate may use or disclose PHI as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Covered Entity’s minimum necessary policies and procedures.

(d) Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity, except for the specific uses and disclosures set forth below.

SECTION 4 – Obligations of Covered Entity

4.01 Inform of NPP. The Covered Entity shall notify Business Associate of any limitation(s) in the Covered Entity's notice of privacy practices under 45 CFR 164.520, to the extent that such limitation may affect Business Associate’s use or disclosure of PHI.

4.02 Notification of Revocation. The Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate’s use or disclosure of PHI.

4.03 Notification of Restriction. The Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that the Covered Entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.

4.04 Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the HIPAA Regulations

if done by Covered Entity, except as permitted pursuant to the provisions of Sections 2(b), 2(c), 2(d) and 2(e) of this BAA.

4.05 Notice of Amendments. Covered Entity shall notify Business Associate of any amendments made by an Individual to Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.526, to the extent that Business Associate relies or could foreseeably rely on such amended Protected Health Information. Covered Entity shall provide such notice no later than fifteen (15) days prior to the effective date of the change.

4.06 Notice of Potential Problems. Covered Entity shall provide notice to Business Associate of any pattern of activity or practice of Business Associate that Covered Entity believes constitutes a material breach or violation of Business Associate's obligation under the Underlying Agreement or Agreement or other arrangement within five (5) calendar days of discovery and shall meet with Business Associate to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

4.07 Notification of Security Incidents. Covered Entity shall immediately notify Business Associate of any Security Incidents or other security issues/concerns with Covered Entity's environment, including, but not limited to, ransomware, where Business Associate performs services. Provided, however, that Covered Entity shall not be required to report an immaterial incident consisting solely of an unsuccessful attempt to improperly access Electronic PHI that is stored in an information system under its control.

4.08 Privacy/Security. Covered Entity shall ensure that it follows all generally accepted industry practices for privacy and security of its systems, including, but not limited to, the requirement for complex passwords, unique user ids, password resets, and the timely granting of systematic access and termination of said access when notified. Further, Covered Entity shall only provide to Business Associate access to the minimum necessary PHI required to perform the services under the Agreement.

SECTION 5 - Term and Termination

5.01 Term. This Agreement shall become effective on the Effective Date and shall terminate on the same date that the Service Agreement terminates, or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner. In addition, certain provisions and requirements of this Agreement shall survive its expiration or other termination in accordance with Section 7.04 herein.

5.02 Termination for Cause. The Covered Entity may immediately terminate this Agreement and any related Service Agreement if the Covered Entity makes the determination that the Business Associate has breached a material term of this Agreement, provided an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Service Agreement if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity, except that the Covered Entity will immediately terminate this Agreement and the Service Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

5.03 Obligations of Business Associate Upon Termination. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from the Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

(a) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(b) Return to the Covered Entity or, if agreed to by the Covered Entity, destroy, the remaining PHI that the Business Associate still maintains in any form;

(c) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

(d) Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at Section 3.02(e) and (f) above which applied prior to termination;

(e) Return to Covered Entity or, if agreed to by Covered Entity, destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities; and;

(g) Obtain or ensure the destruction of PHI created, received, or maintained by any of the Business Associate's subcontractors.

SECTION 6 – Indemnification and Disclaimer

6.01 Indemnification. Business Associate shall indemnify, defend and hold Covered Entity and its [parent corporation] and affiliates, their directors, officers, agents, servants, and employees (collectively "the Indemnitees") harmless from and against all claims, causes of action, liabilities, judgments, fines, assessments, penalties, damages, awards or other expenses of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, incurred by the Indemnitees and relating to or arising out of breach or alleged breach of the terms of this Agreement, or a violation of the HIPAA Rules, by Business Associate.

Covered Entity shall indemnify, defend and hold Business Associate and its parent corporation and affiliates, their directors, officers, agents, servants, and employees (collectively "the Indemnitees") harmless from and against all claims, causes of action, liabilities, judgments, fines, assessments, penalties, damages, awards or other expenses of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, incurred by the Indemnitees and relating to or arising out of breach or alleged breach of the terms of this Agreement, or a violation of the HIPAA Rules, by Covered Entity.

6.02 Disclaimer. COVERED ENTITY MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE HIPAA RULES WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

SECTION 7 - Miscellaneous

7.01 Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

7.02 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law. This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties.

7.03 Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

7.04 Survival. The respective rights and obligations of Business Associate and Covered Entity under the provisions of Sections 2.01, 2.02, 2.03, 2.04, 2.10, 5.03 and 6.01, to the extent applicable, shall survive termina-

of this Agreement indefinitely. In addition, Sections 2.06 and 2.07 shall survive termination of this Agreement, provided that the Covered Entity determines that the PHI being retained pursuant to Section 5.03 herein constitutes a Designated Record Set.

7.05 No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

7.06 Notices. Any notices to be given hereunder to a Party shall be made via U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below.

If to Business Associate, to:

Pharma Force Group LLC
4300 S. US Hwy 1, Ste 203-329
Jupiter, FL 33477

If to Covered Entity, to:

_____
_____
_____

Each party named above may change its address and that of its representative for notice by the giving of notice of the change in the manner provided above.

In addition, Covered Entity shall provide the phone number and email address for the following contacts:

Privacy Officer:
Security Officer:
Compliance Officer:

7.07 Counterparts; Facsimiles. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies of this document shall be deemed to be originals.

7.08 Governing Law. The laws of the State of Oklahoma shall govern the interpretation of this Agreement and shall apply in any lawsuit or other dispute arising out of this Agreement, without regard to conflict of laws provisions.

IN WITNESS WHEREOF, the parties have hereunto set their hands effective the Effective Date first above written.

COVERED ENTITY	BUSINESS ASSOCIATE
By: _____	By:_____
Print Name: _____	Print Name: _____

Print Title: _____ Print Title: _____

Date: _____ Date: _____

Exhibit B

1. Service Availability

"Uptime". PharmaForce guarantees an uptime of 99.99% for the PharmaForce application If the actual availability of the Service is less than 99.99% in any two of four consecutive months, then, in addition to all other remedies available to Customer, Customer may terminate the Agreement on written notice to PharmaForce with no liability, obligation or penalty to Customer by reason of such termination.

2. Service Levels

The standard Support Help Desk will be available Monday – Friday, 8:00 am EST – 8 00 pm EST. An emergency after hours hotline number is available and monitored 24hrs per day seven days per week. Response times are based on assigned severity level of the issue. Service requests can be submitted either by calling into our Support Help Desk, or through the Customer Support portal within PharmaForce. All support requests will be reviewed by the support representative who will make the final determination of level of severity.

A confirmation of receipt will be issued within 15 minutes of completion.

Initial contact by a support representative will occur based on the following severity levels:

1. ***Critical*** - A problem or issue that has halted operation or has a catastrophic impact on business.
    - **Resolution Handling** – After initial call into the Support Help Desk, a support agent will be assigned to the request and troubleshooting will begin within 1 hour.

Note: To ensure immediate response, customers should call all Critical issues directly to the support line.

2. ***Severe*** – The problem has a significant impact on business and/or an important feature is unavailable.
    - **Resolution Handling – Upon receipt of the initial service request,** a support agent will be assigned to your request within 24 hours. Follow up communication from the assigned agent will occur within 48 hours.

3. ***Standard*** – The problem has a minor impact on business. Operations are not adversely affected.
    - **Resolution Handling –** Upon receipt of the initial service request, a support agent will be assigned to your request within 48 hours. Follow up communication from the assigned agent will occur within 72 hours.

4. ***Low*** – The problem is considered to be an inconvenience. No impact on normal business operations or a work-around is available.
    - **Resolution Handling** – Upon receipt of the initial service request, a support agent will be assigned to your request within 48 hours. Follow up communication from the assigned agent will occur within 72 hours. Issues deemed low, will be added to a future release with expected release date communicated to the customer.

5. ***Exceptions*** – If the reported issue is to be incorporated into the next Product Release and the customer has been notified of the status, additional follow up will be deferred until a release date has been determined.

Exhibit C

PharmaForce will maintain during the term of this Agreement the following insurance in at least the amounts below specified.

(a) Commercial General Liability insurance written on occurrence basis with the following limits:

General Aggregate Limit	$2,000,000
Products/Completed Operations	$2,000,000 aggregate
Personal Injury and Adv. Injury Limit	$1,000,000 ea. person/organization
Bodily Injury & Property Damage Limit	$1,000,000 each occurrence
Fire Damage	$300,000 (any one fire)
Medical Expense	$15,000 (any one person)

No exclusions for: Product/Completed Operations; Contractual Liability; Independent Contractors; Personal & Advertising Injury.

(b) Automobile Liability: Any Auto Owned, Hired and Non-Owned

Combined Single Limit for Bodily Injury & Property Damage	$1,000,000 ea. accident/aggregate

(c) Excess "Umbrella" Liability $2,000,000 ea. occurrence/aggregate

The umbrella coverage shall be no more restrictive than underlying coverage.

(d) Workers' Comp. & Employers Liability Statutory Coverage as required by law

(e) Network Security and Privacy Liability insurance in an amount not less than $2,000,000 occurrence/aggregate with deductible/retention of not more than $50,000, unless otherwise approved by Customer, covering PharmaForce and its subcontractors engaged in such activities for network and privacy risks including coverage for unauthorized access, failure of security, breach of privacy perils, wrongful disclosure of information, as well as event management costs and regulatory defense.

Quotation

Your Service Sales Representative
Devon Holgate
Phone: 412-406-4424
Fax:
devon.holgate@bayer.com

Issue PO to:
Bayer HealthCare LLC
1 Bayer Drive
Indianola, PA 15051

Q-00069749 | 8/29/2023

Prepared for
Mangum Regional Medical Center

1 Wickersham St
Mangum, OK 73554

Service types
DirectCARE Basic (DCB)
All pricing is in USD

GPO

GPO pricing applied
PREMIER RADIOLOGY T1-T4

Valid until
10/28/2023

Summary

What's Here:

// This document presents an agreement tailored to the specific needs of your facility.

// The information that follows will provide a detailed overview of the service agreement you have selected.

What's Next:

☐ Please review this quotation in full to ensure it accurately reflects your request.

☐ Fully execute the agreement by completing the Acceptance and Billing section on the final page and returning the signed agreement along with your purchase order to your Inside Sales Representative for processing.

Quotation

Your Service Sales Representative
Devon Holgate
Phone: 412-406-4424
Fax:
devon.holgate@bayer.com

Bayer HealthCare LLC
1 Bayer Drive
Indianola, PA 15051

Q-00069749 | 8/29/2023

Prepared for	GPO pricing applied	Price quote valid until
Mangum Regional Medical Center	**PREMIER RADIOLOGY T1-T4**	10/28/2023

Program Details

DirectCARE Basic* (DCB)

The following items are available 8 AM - 5 PM M-F:
- Bayer EPM™
  - Calibration per OEM specifications and procedures
  - Software updates
  - EPM™ certified part replacements
  - Complete inspection and safety testing
- Onsite service by a Bayer certified field engineer
- Hardware system coverage

Also included:
- Enhanced access to the myRadiologySolutions customer portal
- 24/7 Technical Support
- VirtualCARE® Remote Support

*Please see additional details of your service program in the attached terms and conditions

This Service Program meets CMS requirements for hospital equipment maintenance accreditation.

Medrad® Stellant FLEX CT Injection System

Catalog Number	Serial No.	Location	PMs	Effective Date	Expires 9/7/2024	Expires 9/7/2025	Expires 9/7/2026
DCB-FLEX	120485		3	9/8/2023	$4,633.77	$4,633.77	$4,633.77
Subtotals for Medrad® Stellant FLEX CT Injection System					**$4,633.77**	**$4,633.77**	**$4,633.77**

Subtotal for DCB	**Per-year costs**	**$4,633.77**	**$4,633.77**	**$4,633.77**
	Cumulative costs	**$4,633.77** One-year agreement	**$9,267.54** Two-year agreement	**$13,901.31** Three-year agreement

- *Cost is pro-rated*

Total, all plans	**Per-year costs**	**$4,633.77**	**$4,633.77**	**$4,633.77**
	Cumulative cost	**$4,633.77** Year One	**$9,267.54** Year Two	**$13,901.31** Year Three

Billing Plan

To aid your planning, here is a schedule for your service agreement invoices.

Invoices		Total
	$13,901.31 Due: On Receipt of PO	
		$13,901.31

All Pricing is in U.S. Currency.

Quotation

Your Service Sales Representative
Devon Holgate
Phone: 412-406-4424
Fax:
devon.holgate@bayer.com

Bayer HealthCare LLC
1 Bayer Drive
Indianola, PA 15051

Q-00069749 | 8/29/2023

Prepared for	GPO pricing applied	Price quote valid until
Mangum Regional Medical Center	**PREMIER RADIOLOGY T1-T4**	10/28/2023

Comments

VirtualCARE Remote Support Acknowledgement

Please note, VirtualCARE is not applicable for Provis, Vistron or Veris equipment.

I acknowledge VirtualCARE Remote support as an entitlement of our Bayer service coverage and agree to the install at the time of Bayer's next service visit.

IT Contact Name
Type or write name

Phone
(000) 000-0000

Email
Type or write email address

Customer Approver Name
Type or write name

Customer Approver Title
Type or write title

Customer Approver Signature
X
Please print and sign

Date
MM/DD/YY

☐ I would like to opt out of VirtualCARE Remote Support.

Quotation

Your Service Sales Representative
Devon Holgate
Phone: 412-406-4424
Fax:
devon.holgate@bayer.com

Bayer HealthCare LLC
1 Bayer Drive
Indianola, PA 15051

Q-00069749 | 8/29/2023

Prepared for	GPO pricing applied	Price quote valid until
Mangum Regional Medical Center	**PREMIER RADIOLOGY T1-T4**	10/28/2023

Acceptance

Your signature below indicates your acceptance of this Agreement, including the terms and conditions included as part of this document. Please complete the information below, along with your Purchase Order referencing Quote # Q-00069749, and email this form to your Bayer Service Sales Representative, Devon Holgate at devon.holgate@bayer.com

If pricing and terms of this order are based on your current Group Purchasing Organization (GPO) affiliation, any change to your current affiliation may require a new quote or updated terms and pricing.

Payment terms

30 days due net

Address

1 Wickersham St
Mangum, OK 73554

Billing Information

Write your preferred billing address below.

Customer Contact

Service Coverage

☐ One Year ☐ Two Years ☐ Three Years

Additional Customer Comments

PO#

Type or write PO number

PO Amount

Type or write PO amount

Customer Approver

Type or write customer name

Customer Approver Title

Type or write customer title

Customer Approver Signature

X

Please print and sign

Date

MM/DD/YYYY

Inside Sales Representative Signature

X

Please print and sign

Date

MM/DD/YYYY

All Pricing is in U.S. Currency.

Quotation

Your Service Sales Representative
Devon Holgate
Phone: 412-406-4424
Fax:
devon.holgate@bayer.com

Bayer HealthCare LLC
1 Bayer Drive
Indianola, PA 15051

Q-00069749 | 8/29/2023

Prepared for	GPO pricing applied	Price quote valid until
Mangum Regional Medical Center	**PREMIER RADIOLOGY T1-T4**	10/28/2023

Bayer Product Terms and Conditions

Please click on the relevant product name below to review terms and conditions

SERVICES
- DirectCARE
  - DirectCARE Basic

All Pricing is in U.S. Currency.

Service Order Agreement

Tariffed Services & Non-tariffed Services

Company Name:	Mangum Regional Medical Center	Service Order Number:	
Contact Name:	Chad Lampson	Sales Rep:	James Coy
Contact Number:	405.652.0764	Date:	9.14.2023
Email:	clampson@chmcok.com		

SERVICE SUMMARY	FD Fiber	Term Length:	36 Month
Requested Service Date:	8/30/20223	Services:	FD Fiber
Purchase Order Number:		Delivery Mechanism:	FD Network

CUSTOMER INFORMATION / SERVICE SITE

Customer Business Name:	*Mangum Regional Medical Center*					Main Phone:	
Company Federal ID #:						Main Fax:	
Service Address:	1 Wickersham Dr	City:	Mangum	State:	OK	Zip:	73554
Billing Address:		City:		State:		Zip:	

Bill Options: ☑ Paper ☐ Email: If multiple locations: ☑ One Bill ☑ Separate Bills

For Internal Use Only | CAS Number: | Site Number:

MONTHLY CHARGES

Discription	Cost Per Unit		Quantity		Total
WebEx Calling Telecom Recovery Fee	$ 3.16	X	8		$ 25.28
WebEx Calling Professional License	$ 13.50	X	19		$ 256.50
WebEx Calling Workspace License	$ 9.50	X	46		$ 437.00
	$ -	X			$ -
	$ -	X			$ -
			Total Monthly Charges		$ 718.78

Installation

Discription	Cost Per Unit		Quantity		Total
WebEx Calling Implementation Professional License	$ 45.00	X	19		$ 855.00
WebEx Calling Implementation Workspace License	$ 45.00	X	46		$ 2,070.00
Cisco 8851 IP Phone	$ 225.00	X	2		$ 450.00
Cisco 8800 KEM Audio Expansion Module	$ 165.00	X	2		$ 330.00
Cisco 6851 IP Phone	$ 100.00	X	46		$ 4,600.00
Audio Codes 124 with smart net and hardware	$ 2,075.00	X	2		$ 4,150.00
			Total Install Charges		$ 12,455.00

By signing this order form, Customer agrees to pay all charges incurred on Customer's FirstDigital Telecom's ("FirstDigital") account, including any applicable federal, state, or local use, excise, sales, privilege taxes, duties, or similar liabilities, by the stated due date and to adhere to all of the terms and conditions as set forth at www.firstdigital.com/legal and in FirstDigital's applicable tariffs, if any, and promotional offerings and the terms and conditions included with this Service Order Agreement, which FirstDigital terms and conditions and applicable tariffs are hereby incorporated by reference. Customer also authorizes FirstDigital to obtain any credit information necessary and/or customer proprietary network information, necessary to provision FirstDigital Service and to establish this FirstDigital account, and authorizes release of said information by any and all third parties to FirstDigital. Further, the undersigned represents that he/she is authorized to approve and accept the responsibility of the terms and conditions herein. Customer understands that, pursuant to tariff, number assignments are not guaranteed, and should not be relied on before service is activated. Customer understands there is a charge for changing Preferred (InterLATA and/or IntraLATA long distance Carrier(s)).

Authorized Signature:	_____	Title	_____
Customer Name:	_____	Date	_____
Company Name:	_____	Name:	_____
FirstDigital Signature	_____	Date	_____

Hospital Vendor Contract Summary Sheet

1. ☐ **Existing Vendor** ☒ **New Vendor**

2. Name of Contract:
- FirstDigital Service Order Agreement

3. Contract Parties:
- Mangum Regional Medical Center and FirstDigital

4. Contract Type Services: Service Agreement

a. Impacted Hospital Departments: Nursing, Patient Care Areas

5. Contract Summary:
- 36 month Service Agreement between FirstDigit and Mangum Regional Medical Center to offer phone service for the facility and patients.
-

6. Cost: $718.78/Month

7. Prior Cost: 2167.62/month

8. Term: Will remain effective for 36 months

a. Termination Clause: None.

9. Other:

RESOLUTION NO. 2023-0926

A RESOLUTION OF THE BOARD OF TRUSTEES FOR THE MANGUM CITY HOSPITAL AUTHORITY REMOVING AUTHORIZED SIGNATURES ON THE HOSPITAL ACCOUNTS AND ADDING ADDITIONAL AUTHORIZED SIGNATURES ON HOSPITAL ACCOUNTS

Be it Resolved, by the Board of Trustees for the Mangum City Hospital Authority:

§ 1. That the following authorized signers should be removed as authorized signers from the Hospital Accounts:

ANDREA SNIDER

Passed and Approved by the Board of Trustees for the Mangum City Hospital Authority, this 26TH day of September 2023.

_____

_____, chairperson

ATTEST:

_____

Secretary