Agenda
Mangum City Hospital Authority
November 28, 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 November 28, 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

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 October 24, 2023 Regular Meeting Minutes as presented.
2. Approve November 13, 2023 Special Meeting Minutes as presented.
3. Approve October 2023 Quality meeting minutes as presented.
4. Approve October 2023 Medical Staff meeting minutes as presented.
5. Approve October 2023 Claims
6. Approve November 2023 Estimated Claims.
7. Approve October 2023 Quality Report.
8. Approve October 2023 Clinic Report.
9. Approve October 2023 CCO Report.
10. Approve October 2023 CEO Report.
11. Approve the following forms, policies, appointments, and procedures previously approved by Corporate Management, on 11/16/23 Quality Committee and on 11/21/23 Medical Staff.
12. Discussion and possible action with regard to accept the Policy & Procedure: 340B Drug Discount Purchasing Program
13. Discussion and possible action with regard to accept the Policy & Procedure: OnCall and Call Back Responsibilities for Radiology
14. Discussion and possible action with regard to accept the Policy & Procedure: Nursing Education Personal Belonging and Valuables

15. Discussion and possible action with regard to accept the Policy & Procedure: Drug Diversion

16. Discussion and possible action with regard to accept the Policy & Procedure: Temporary Absence Release for Patients

17. Discussion and possible action with regard to accept the Policy & Procedure: Temporary Absence Release Form

18. Discussion and possible action with regard to accept the Policy & Procedure: Patient Belongings and Valuables

19. Discussion and possible action with regard to accept the Policy & Procedure: Corporate Patient Belongings List

20. Discussion and possible action with regard to accept the Policy & Procedure: Patient Valuables Record

21. Discussion and possible action with regard to accept the Policy & Procedure: Lost and Found Property Report

22. Discussion and possible action with regard to accept the Policy & Procedure: Lost and Found Log

23. Discussion and possible action with regard to accept the Policy & Procedure: Behavioral Observation Checklist

24. Discussion and possible action with regard to accept the Policy & Procedure: Medication Error and Near Miss Report

25. Discussion and possible action with regard to accept the Policy & Procedure: Intravenous (IV) Extravasation Management and Treatment

26. Discussion and possible action with regard to accept the Policy & Procedure: Appendix A Extravasation Management Strategies

FURTHER DISCUSSION

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

REPORTS

27. October Financial Reports

OTHER ITEMS

28. Discussion and Possible Action to Approve the Siemens Healthineers Agreement with Mangum Regional Medical Center

29. Discussion and Possible Action to Approve the Mangum-BCBSOK Professional Group Agreement/Addendums for Hospital Based Providers

- Blue Advantage PPO Network Addendum to the Blue Traditional Network Participating Group Agreement
- Blue Choice PPO Network Addendum to the Blue Traditional Network Participating Group Agreement
- Blue Plan65 Select Network Addendum to the Blue Traditional Network Participating Group Agreement
- BlueLincs HMO Network Addendum to the Blue Traditional Network Participating Group Agreement
- Blue Traditional Network Participating Group Agreement
- Blue Cross Medicare Advantage (HMO) Addendum to the BlueLincs HMO Network Addendum to the Blue Traditional Network Participating Group Agreement
- Blue Cross Medicare Advantage (PPO) Addendum to the Blue Traditional Network Participating Group Agreement including the Blue Choice PPO Network Agreement
- NativeBlue Network Addendum to the Blue Traditional Network Participating Group Agreement
- Blue Preferred PPO Network Addendum to the Blue Traditional Network Participating Group Agreement including the Blue Choice PPO Network Addendum

30. Discussion and Possible Action to Approve the Equipment Maintenance Agreement between DP Medical Services

31. Discussion and Possible Action to Terminate the agreement with Commercial Medical Electronics Maintenance Agreement and Mangum Regional Medical Center

32. Discussion and Possible Action to Approve the agreement Fiberoptic Endoscopic Evaluation of Swallowing services between Freeborn Dysphagia Associates LLC and Mangum Regional Medical Center

33. Discussion and Possible Action to Approve the addendum to Service Agreement for RevOPS AVID

34. Discussion and possible action to approve the MRMC- HIPAA Security Officer Appointment- Tim Hopen

35. Discussion and possible action regarding the review and approval of RHC patient balances.

36. Discussion and possible to Approve moving forward with a Debit Card linked to the Hospital account instead of a Credit Card

37. Discussion and action to establish a contract for the professional services of a Certified Public Accountant (the “auditor”) for financial and compliance audits for fiscal years 2018, 2019, 2020, 2021, and 2022 for Mangum Regional Hospital and Mangum Regional Medical Center managed by, Cohesive Healthcare Management & Consulting LLC. The last update the board received was November 2022 wherein, the board was advised the audit would soon be done. These audits are to be performed in accordance with generally accepted auditing standards as set forth by the American Institute of Certified Public Accountants, the standards for financial audits set forth in Government Auditing Standards issued by the comptroller General of the United States, and the audit requirements of Title 2 US Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance), including any future changes

or replacement of these requirements applicable to the audit period in question. The completion/status is required for the City of Mangum's annual audit to be complete.

EXECUTIVE SESSION

38. Discussion and possible action to enter into executive session to discuss the approval of medical staff privileges/credentials/contracts for the following providers pursuant to 25 O.S. § 307(B)(1):
    - **Amendment to Professional Services Agreement**-Dr. Barry Davenport
    - **Resignation -** Dr. Gregory Morgan

OPEN SESSION

39. Discussion and possible action in regard to executive session, if needed.

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

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

ADJOURN
Motion to Adjourn

Duly filed and posted at **5:00 p.m. on the 22nd day of November 2023**, by the Secretary of the Mangum City Hospital Authority.

_____
Ally Kendall Secretary

Minutes
Mangum City Hospital Authority Session
October 24, 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 October 24th, 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

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

Motion to approve consent agenda as presented.

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

1. Approve September 26, 2023 regular meeting minutes as presented.
2. Approve August 2023 Quality meeting minutes as presented.
3. Approve September 2023 Medical Staff meeting minutes as presented.
4. Approve September 2023 Claims.
5. Approve September 2023 Clinic Report.
6. Approve September 2023 Quality Report.
7. Approve September 2023 CCO Report.
8. Approve September 2023 CEO Report.
9. 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
Review & Consideration of Approval of Policy & Procedures: Seasonal Influenza
Review & Consideration of Approval of Policy & Procedures: Staff Influenza Vaccine Program

Review & Consideration of Approval of Policy & Procedures: Credit Cardholder Policy with attachments A and B

FURTHER DISCUSSION

None.

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

None.

REPORTS

10. September Financial Reports

September Financials by Dennis Boyd.

Statistics

o The average daily census (ADC) for September 2023 was 8.53 - (Year-To-Date 12.35 vs PY 10.32).

o Year-to-Date Medicare swing bed patient days were only 2,644 as compared to the PY total of 2,230.

Balance Sheet Highlights

o The cash balance as of September 30, 2023, inclusive of both operating & reserves, was $1.66M. This increase of $196K over the August 31, 2023, balance was primarily due to a decrease in payments on AP, which increased by $244K.

o Days cash on hand, inclusive of reserves, was 33.6.

o Net AR decreased by $154K from August. This was primarily volume driven by the decrease in ADC from the prior month of approximately -28%.

o Payments of approximately $1.3M were made on AP (prior 3-month avg was $1.4M).

o Cash receipts were approximately the same as the previous 3 months ($1.5M).

o The Medicare principal balance decreased by $81K due to ERS loan payments. Note that we have estimated a CY payable of over $2M for FY23

at this time that will be adjusted throughout the year based on census and respective costs.

Income Statement Highlights

o Net patient revenue for September was $1.45M which is approximately an increase of $90K over the prior month year-to-date average despite the decrease in ADC.

o Operating expenses, exclusive of interest & depreciation, were reasonably consistent with the prior month year-to-date average ($1.48M vs $1.49M).

o 340B revenues reached a monthly high for FY23 ($20K) — 66% increase. Year-to-date, net profit from this service line has now exceeded $41K.

Additional Notes

o The hospital has experienced material increases in ADC in FY23 as compared to FY22.

These trends are evident & reflected by month on the Admissions, Discharges & Days of Care page within each board packet. The hospital has attempted to mitigate the need to request a Medicare ERS loan throughout the year but has continued to incur recoupments of approximately $86K/month (over $1M annual) related to 2017.

Chairman Vanzant asked Dennis Boyd how much the hospital has in reserve funds, response was "1.6M total cash on hand and reserve funds."

OTHER ITEMS

11. Discussion and Possible Action to Approve the Nuance Licensing Agreement with Mangum Family Clinic

    Motion to approve.

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

12. Discussion and Possible Action to Approve the Mangum-Facility Credit Card-3 different options presented.

    Motion to approve Capital One Credit Card.

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

13. Discussion and Possible Action to Approve -the Mangum and CPSI service agreement.

    Motion to approve.

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

14. Discussion and Possible Action to Approve-the removal of 4 metal trailers on the property.

    Motion to approve.

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

15. Discussion and possible to grant 'view only' access to Mangum's Operating and ARPA accounts with Sovereign Bank for Adrian Brownen.

    Motion to approve.

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

16. Discussion and action to establish a contract for the professional services of a Certified Public Accountant (the "auditor") for financial and compliance audits for fiscal years 2018, 2019, 2020, 2021, and 2022 for Mangum Regional Hospital and Mangum Regional Medical Center managed by, Cohesive Healthcare Management & Consulting LLC. The last update the board received was November 2022 wherein, the board was advised the audit would soon be done. These audits are to be performed in accordance with generally accepted auditing standards as set forth by the American Institute of Certified Public Accountants, the standards for financial audits set forth in Government Auditing Standards issued by the comptroller General of the United States, and the audit requirements of Title 2 US Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance), including any future changes or replacement of these requirements applicable to the audit period in question. The completion/status is required for the City of Mangum's annual audit to be complete.

    City Clerk Erma Mora informed the board that their current consultant requested the audit from the hospital. Erma also states that last year Andrea had informed her the audit was almost complete.

    Tabled until next meeting, request made by Chairman Vanzant

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 6:22pm

Carson Vanzant, Chairman

Ally Kendall, City Clerk

Minutes
Mangum City Hospital Authority Special MeetingSession
November 13, 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 November 13th, 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 5:05pm

ROLL CALL AND DECLARATION OF A QUORUM

PRESENT
Trustee Cheryl Lively
Trustee Michelle Ford
Trustee Carson Vanzant
Trustee Lisa Hopper

ABSENT
Trustee Ronnie Webb

OTHER ITEMS

1. Discussion and possible action with regard to accept the best and most responsible bid for the repairs to the Mangum Regional Medical Center's roof.

   Motion to approve the bid from Monarch for $39,900

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

2. Discussion and possible action with regard to entering into an Extended Repayment Schedule (ERS) Loan for repayment of Medicare debt.

   Trustee Lively questioned why we were applying for the ERS loan when in last months meeting it was stated that the hospital has $1.6M in reserve fund. Dennis Boyd via telephone informed the board that they have $1.6M in total, cash on hand plus reserve fund. Dennis informs the board the monthly payment plan is $86,000/month through March saving the hospital $6,000 in interest.

   Motion to approve.

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

Voting Nay: Trustee Lively

ADJOURN

Chairman Vanzant motion to adjourn at 5:40pm

Duly filed and posted at **5:00 p.m. on the 22nd day of November 2023**, by the Secretary of the Mangum City Hospital Authority.

Carson Vanzant, Chairman

Ally Kendall, 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:	**10/12/2023**	**Time:**	**12:20**	**Recorder: D. Jackson**		**Reporting Period: Sept. 2023**	

Members Present

Chairperson: Dr. C | CEO: Kelly Martinez | dical Representative: Dr C

Name	**Title**	**Name**	**Title**	**Name**	**Title**
Nick Walker	CNO	Danielle Cooper	Bus Office	Tonya Bowen	Lab
Bethany Moore	HR	Kaye via Teams	Credentialing		IT
Jennifer Dryer	HIM	Mark Chapman	Maintenance/EOC	Marla Abernathy	Dietary
Chrissy Smith Chelsea Church/Lynda James	PT Pharmacy	Melissa Tunstall Chasity Howell	Radiology Case Management	Meghan Smith	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 10/12/2023 by 1st Melissa/ 2nd Kelley	
II. REVIEW OF MINUTES			
A. Quality Council Committee	09/14/2023	Committee reviewed listed minutes A-F. Motion to approve minutes as distributed made by Melissa 2nd by Kelley. Minutes A-F approved. Present a copy of the MeetingMinutes at the next Medical Executive Committee and Governing Board meeting.	
B. EOC/ Patient Safety Committee	09/12/2023		
C. Infection Control Committee	09/21/2023		
D. Pharmacy & Therapeutics Committee	06/15/2023		
E. HIM/Credentialing Committee	09/07/2023		
F. Utilization Review Committee	09/08/2023		

Mangum Regional Medical Center
Quality Assurance & Performance Improvement Committee Meeting

III. REVIEW OF COMMITTEE MEETINGS			
A. EOC/Patient Safety	10/10/2023		
B. Infection Control	10/05/2023		
C. Pharmacy & Therapeutics	09/21/2023 [Next meeting 12/2023]		
D. HIM-Credentials	10/05/2023		
E. Utilization Review	10/05/2023		
F. Compliance	07/12/2023 - Next meeting 10/2023		
IV. OLD BUSINESS			
A. Old Business	None		
V. NEW BUSINESS			
A. New Business	Staff Influenza Vaccine Program Seasonal Influenza Form	Chasity/Megan	
VI. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT			
A. Volume & Utilization			
1. Hospital Activity	Total ER – 160 Total OBS pt - 1 Total Acute pt - 13 Total SWB - 8 Total Hospital Admits (Acute/SWB) - 21 Total Hospital DC (Acute/SWB) - 25 Total pt days - 256 Average Daily Census - 9		
2. Blood Utilization	total units administered 11 for the reporting period with no adverse reactions		
B. Care Management			
1. CAH Readmissions	3 for the reporting period - 1) Pt admitted with primary dx Debilitation; Readmitted with secondary dx 2) Pt admitted with primary dx, readmitted with primary dx, readmitted for another dx 3) Pt admitted with primary dx, readmitted with primary dx		
2. IDT Meeting Documentation	9/9 (100%) completed within 24 hours of IDT		
3. Insurance Denials	1 insurance denials for the reporting period – insurance denied In-pt status, pt switched to OBS		

4. IMM Notice	9/9 (100%) notices signed within 2 days prior to discharge		
C. Risk Management			
1. Incidents	6 ER AMA; 1.) pt to the ER for SHOB, diagnostic results discussed with pt as well as the need for transfer, however pt did not want to be transferred and expressed that they no longer want aggressive care. Will follow up with PCP for further options, risk/benefits discussed, pt signed AMA. 2.) Pt to the ER with c/o fall, once in the ER would not allow the provider to preform MSE, provider discussed risks/benefits however pt remained adamant against no exam and leaving. Signed AMA. 3.) Pt to the ER with c/o pain, would not allow provider exam nor would patient speak to the provider, wanted to DC. Risks/benefits discussed, pt signed AMA. 4.) Pt to the ER for c/o not feeling good, treated for findings and pt watched over night. Pt feeling better and refused any further testing/treatment, wanted to DC. Discussed risks/benefits, AMA signed 5.) Pt to the ER or c/o CP, agreeable to testing and treatment, when advised that repeat lab testing was needed pt abruptly declined stating that they were afraid of needles and wanted no further testing. Risks/benefits discussed, AMA signed. 6.) Pt to the ER for c/o N/V/D, exam and dx preformed, provider discussed findings and best course of treatment via admit with pt who is agreeable, all admit information completed by provider who then followed up with pt who decided to DC and not admit for further tx. Risks/benefits discussed, AMA signed. OTHER	AMAs - 1 pt in the ER during the reporting period refused to visit with CM for home assistance, provider advised APD referral for this patient. All AMAs for the reporting period reviewed with CEO/CNO and discussed with Med. Director at Quality - all deemed appropriate care, will monitor OTHER - 1.) Staff educated on need for gentle care with handling due to skin fragility 1.) Visitor event - Visitor met with CEO, explained their side of the story and feelings regarding pt hospitalization. CEO/Visitor discussed both visitor/staff concerns and feelings regarding event both parties came to a mutual agreement on visitation and visitor will come to CEO/CNO with any needs. No complaints voiced during the meeting.	

	- 1.) Pt was noted to have skin tear during pt care. Unknown cause, pt high risk for skin tears. Area cleaned and dressed. 1.) Visitor event - Visitor in with pt, could be heard speaking to pt loudly with what staff felt could be negative conversation. Staff felt the visitor no longer needed to be present due to their concern for visitor's assumed demeanor towards pt. Visitor did not want to leave and attempted to express feelings to staff, staff remained addiment that visitor needed to leave. GCSD in with another pt and assistance requested in asking visitor to leave. Visitor left with follow up appointment scheduled the next am with CEO		
2. Reported Complaints	1 for reporting period - 1 ER pt spoke with CEO c/o ER nurse being rude to pt. CEO/CNO expressed to pt that staff would be addressed regarding this concern, pt satisfied with this resolution.	CEO/CNO spoke with Nurse regarding c/o rudeness, therapeutic communication advised. Nurse did express that there was a miscommunication during the visit that may be the cause of this concern	
3. Reported Grievances	None for reporting period		
4. Patient Falls without Injury	1 for reporting period - 1 in-pt was being assisted by nursing staff with witnessed fall, pt sitting on buttocks on the floor, staff called for assistance, pt with no injuries noted. Mobility device and fall precautions in place prior to fall. Pt will be assisted x 2 staff for all transfers post-fall for		

	safety		
5. Patient Falls with Minor Injury	None for reporting period		
6. Patient Falls with Major Injury	None for reporting period		
7. Fall Risk Assessment	1 completed post fall for reporting period		
8. Mortality Rate	1 in pt - 1 SWB admitted with pneumonia, during the hospital stay pt continued to decline despite ABT/resp support, family/provider discussed comfort care, family agreeable. Pt expired in-pt.		
9. Deaths Within 24 Hours of Admission	None for the reporting period		
10. Organ Procurement Organization Notification	1 reported deaths with 1 declines for reporting period		
D. Nursing			
1. Critical Tests/Labs	74 for the reporting period		
2. Restraint Use	1 for reporting period – Patient was restrained using bilateral soft wrist and ankle restraints. The patient was violent in nature, attempting to harm self and staff. Documentation was complete and accurate with appropriate observation/monitoring. All measures exhausted in regards to attempting to distract/calm/redirect the patient before and during restraint use. No visible harm noted/documented to patient.		
3. Code Blue	None for the reporting period		
4. Acute Transfers	1 for the reporting period		
5. Inpatient Transfer Forms	1 completed for reporting period		
E. Emergency Department			
1. ED Nursing DC/ Transfer Assessment	20/20 (100%)		

2. ED Readmissions	13 for the reporting period - 1) Pt presented to ED for constipation, returned the next day for the same complaint. 2) Pt diagnosed with ear infection and returned the next day due to non-compliance. 3) Pt was examined for LLE post procedure and was scheduled for a f/u outpatient exam. 4) Pt presented to ED due to ETOH abuse and was d/c home with the plan to f/u with their PCP. 5) Pt was first examined for lower extremity nerve pain, returned a few days later with unrelated cardiac issues. 6) Pt arrived to the ED to be examined for possible UTI. Labs collected, pt did not qualify for admittance with immediate lab results. Other labs were sent out for results. 7, 8, 9, 10, 11) Pt is an alcoholic who fell at home and then calls EMS to bring them to the ED. Depending on the patient's level of intoxication, the patient will allow treatment or choose to leave AMA. 12) Pt fell at home and was examined after small external head injury with appropriate scans completed. Pt returned later in the day with new symptoms r/t fall. 13) The patient fell while at work and only reported injuring an upper extremity. Pt was treated for a sprain after no fx's were noted on film. Pt returned two days later, now complaining of nausea/vomiting and ataxia.	1) The pt's MOC was again educated and to f/u with PCP. 2) Treatment again administered and the patient was again educated on treatment plan. 3) Pt checked in to be seen but decided to leave and drive to see her specialist, they were educated on risks involved. 4) Pt returned the next day, intoxicated again, and stated they were unable to pay copay to see PCP. 5) Pt returned due to cardiac event, treated, and discharged to f/u with her established cardiologist. 6) Pt was admitted for treatment of UTI after send out labs returned. 7, 8, 9, 10, 11) Pt is an alcoholic who is noncompliant with treatment. APS and family are involved with hope to find long term placement for the patient. The patient continues to refuse to allow help or need for long term placement. 12) The patient's scans and neuro assessment did not change. Pt was again provided with education in regards to head injury/concussion post fall. 13) Since the patient did not report hitting their head on the initial visit, full neuro work up was initiated with no deficits and negative imaging. Pt educated on post-fall treatment.	
3. ER Log & Visits	160 (100%)		
4. MSE	20/20 (100%)		
5. EMTALA Transfer Form	14/14 (100%)		
6. Triage	20/20 (100%)		

7. ESI Triage Accuracy	20/20 (100%)		
8. ED Transfers	14 for the reporting period - Patients transferred to Higher Level of Care for: 1.) Psychosis – In-pt psych 2.) Resp failure – ICU 3.) Ileus – Gen Surgery 4.) STEMI – Cardiology 5.) Bowel Obs – Gen Surgery 6.) SI/SH – In-pt psych 7.) DKA – ICU 8.) Bowel Obs – Gen Surgery 9.) STEMI – Cardiology 10.) Weakness – further testing not available at MRMC 11.) Psychosis – In-pt psych 12.) SI/SH – In- pt psych 13.) Unresponsive – ICU 14.) NSTEMI - Cardiology	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	4 for the reporting period		
12. STEMI Care	2 for reporting period - 2 STEMI; 1 delay in airvac notification d/t pt urgent need for b/p management to stabilize pt, 1 delay in transport notification d/t ER nurse with pt for med management during 20 min window, began transport calls at 37 min; no air transport d/t weather, ground x 3 declined d/t no coverage, air transport not available until 0633. Delay in fibrinolytic therapy d/t management of b/p and need for stabilization prior to admin, treated	MOUs in place for multiple facilities. Staff will contiune to document attempts to locate appropropriate facility for patient that has the ability (room availability/staff) to accept patient, pt will be stabilized/treated to all capable efforts of MRMC. Providers will stabilize pt prior to transfer and provide work up based on symptoms. Providers will remain in contact with Cards for delayed transports and	

	once pt stabilized. 1 NSTEMI – pt presented with n/v, denied CP prior to or during visit. Work up with elevated trop, repeat trop remains elevated. Contacted Cards for accepting with additional testing requesting prior to accepting. Treated for initial c/o and transferred once accepted by cards.	defer to Cards recommendations	
13. Chest Pain	9/12 EKG (75%) 3 EKG during the reporting period with time stamp covered by the pt sticker, 2 instances were by RT and 1 by the provider	RT director educated RT staff member and provider that time staff must be visable	
14. ED Departure - (OP-18)	Median time – 105 min		
F. Pharmacy & Medication Safety			
1. After Hours Access	97 for the reporting period		
2. Adverse Drug Reactions	None for reporting period		
3. Medication Errors	3 for the reporting period: 1) Pharmacy tech left one unopened vial of Ativan outside of locked meddispense machine. Found by RN and given to administration, med returned to pharmacy and correct count established with no missing medication. 2) Pharmacy tech did not check if enough insulin was stocked. It was also found that the shipment for the insulin was delayed so the providers should have been notified so they could make appropriate changes. One patient did not receive their long acting insulin, the provider was notified and modifications were made to the patient's MAR. No harm was caused and the patient's glucose remained WNL. 3) Pharmacy tech stocked incorrect dose of Hydralazine in Meddispense, 10 mg instead of 25 mg. This was found when scanning medication for the	1) Procedures in regards to restocking medication, especially high risk medications, reviewed with pharmacy tech. 2) Pharmacy tech educated on need to check insulin stock and review meddispense prior to leaving. 3) Pharmacy tech educated on need to double check medications prior to loading the meddispense. This is also why we scan the patient and then their medications prior to administration!	

	patient and the charge nurse was notified. The correct dose, 25 mg, was then obtained from pharmacy by the charge nurse and administered to the patient.		
4. Medication Overrides	72 for the reporting period - 19 overrides were from the nursing station MedDispense. The remainder 53 were from the ER MedDispense.	CNO will set up education with the nursing staff to wait for order in CPSI prior to pulling medication unless Emergent Situation, to help decrease overrides	
5. Controlled Drug Discrepancies	7 for the reporting period - All discrepancies were from nurses miscounting medications at shift change.		
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		
H. Wound Care Services			
1. Development of Pressure Ulcer	None for the reporting period		
2. Wound Healing Improvement	4/4 (100%) for the reporting period		
3. Wound Care Documentation	100% for initial assessment and discharge assessment documentation completed on time		
I. Radiology			
1. Radiology Films	5 films repeated due to technical error – 106 total for the reporting period; 1 artifact on film, 2 anatomy was clipped, pt was rotated, 1 another body part was obstructing view		
2. Imaging	23 for the reporting period; with 23 consents for CT obtained		
3. Radiation Dosimeter Report	5/5 (100%)		
J. Laboratory			

1. Lab Reports	0 repeated /2156 total for the reporting period 1 processing error - 2 units of platelets received for pt admin. 1 unit was directly admin per orders to pt, the 2nd unit of platelets was put in refrigerator instead of being put on agitator until administration, then administered to patient without incident. Called OBI for clarification on handling and make aware of refrigerated platelets, advised by OBI that they can be refrigerated and not agitated up to 8 hrs, there is potential for decrease in platelet numbers but this handling will not harm patient.	Inservice was done for entire lab on how to handle platelets.	
2. Blood Culture Contaminations	None for the reporting period		
K. Infection Control and Employee Health			
1. Line Events	None for the reporting period		
2. CAUTI's	0 for the reporting period		
3. CLABSI's	0 for the reporting period		
4. Hospital Acquired MDRO's	0 for the reporting period		
5. Hospital Acquired C-diff	0 for the reporting period		
6. HAI by Source	0 for the reporting period		
7. Hand Hygiene/ PPE & Isolation Surveillance	100%		
8. Patient Vaccinations	0 received influenza vaccine / 0 received pneumococcal vaccine		

9. VAE	None for the reporting period		
10. Employee Health Summary	0 employee event/injury,5 employee health encounters (vaccines/testing) 1 reports of employee illness/injury		
L. Health Information Management (HIM)			
1. History and Physicals Completion	20/20 (100%) completed within 24 hrs of admit		
2. Discharge Summary Completion	20/20 (100%) completed within 72 hrs of discharge		
3. Progress Notes (Swing bed & Acute)	Weekly SWB notes – 20/20 (100%) Daily Acute notes – 19 /20 (100%) - 1 missing, provider emailed and chart put in provider box for completion		
4. Swing Bed Indicators	8/8 (100%) SWB social HX completed within 24 hrs/first business day after admit		
5. E-prescribing System	52/52 (100%) of medications were electronically sent this reporting period		
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%) of appropriate orders for admit from Acute to SWB status		
8. Discharge Instructions	20/20 (95%)		
9. Transfer Forms	14/14 (100%) for ER and in-pt transfers to higher level of care for the reporting period		
M. Dietary			

1. Weekly Cleaning Schedules	48/48 (100%)		
2. Daily Cleaning Schedules	390/390 (100%)		
3. Wash Temperature	90/90 (100%)		
4. Rinse Temperature	90/90 (100%)		
N. Therapy			
1. Discharge Documentation	18/18 (100%) completed within 72 hours of discharge		
2. Equipment Needs	9/9 (100%)		
3. Therapy Visits	PT 125– OT 119 - ST 1		
4. Supervisory Log	1 PTA supervisory logs completed for reporting period		
5. Functional Improvement Outcomes	PT 9/9 (100%) – OT 9/9 (100%) – ST 0/0 (100%) - pts discharged during the reporting period with improvement outcomes		
O. Human Resources			
1. Compliance	96% - Annual Licensure; One nurse with license expired in July 67% - CPR; expired x 3 staff 67% ACLS; not required by previous employer HR staff change over during this time period (Aug/Sept)	1.) Nurse taken off schedule until proof of renewal received 2. & 3.) All employees are signed up for BLS/ACLS classes in 10/2023	
2. Staffing	Hired – 1, 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, 2 – Recalls, 1029 items checked out properly		
S. Life Safety			
1. Fire Safety Management	1 fire drills for the reporting period – 24 fire extinguishers checked		
2. Range Hood	Quarterly		
3. Biomedical Equipment	Quarterly		
T. Emergency Preparedness			
1. Orientation to EP Plan	1/1 (100%)		
U. Information Technology			
A. IT Incidents	Aug – 57 Sept – 49		
V. Outpatient			
1. Therapy Visits	42/51 (82%) 6 no show/no call missed visits, 3 visits which patients called and rescheduled.		
2. Discharge Documentation	7/7 (100%) discharge notes completed within 72 hrs of discharge		
3. Functional Improvement Outcomes	3/3 (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	Staff Influenza Vaccine Program Seasonal Influenza Form	Approved 1st Chasity/ 2nd Meghan	
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	Plum 360 Infusion System - ICU Medical Hamilton Medical - Ventilator - HAMILTON - T1		
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			
XII. EDUCATION/TRAINING			
A. Education/ Training	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	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	Approved 02/2023	Approved 02/2023	

(ICRA)			
G. Annual Review of Hazard Vulnerability Analysis (HVA)	Due 10/2023	Reviewed with Melissa EP/Mark	
Department Reports			
A. Department reports			
Other			
A. Other	None		
Adjournment			
A. Adjournment	There being no further business, meeting adjourned by Nick seconded by Melissa at 13:03	The next QAPI meeting will be – tentatively scheduled for 11/09/2023	

Mangum Regional Medical Center
Medical Staff Meeting
Thursday
October 19, 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:

Kelley Martinez, RN, CEO
Chelsea Church, PharmD
Nick Walker, RN, CCO
Chasity Howell, RN, Utilization Review Director
Megan Smith, RN, Infection Control
Lynda James, LPN, Pharmacy Tech
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 12:59 pm by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the September 21, 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. We are increasing our clinic coverage with the addition of Kenna one day a week which is to start at the end of October.
    b. We continue our pursuit of working with the community as an organization.

- Operations Overview
    - We are planning several projects with the staff for the upcoming Holidays. We plan on being active with the community regarding these plans.
    - We are looking to move forward with the floor replacement in the cafeteria. This will take our cafeteria down for a few days. This will not hinder our ability to provide dietary services to our patients.
    - We are continuing to work with EMS to enhance patient care.
    - We have planned several events for the upcoming Holidays for patients, staff and visitors.
    - We are doing audits of accounts to ensure we are capturing all data.
    - We also have a new CFO Adrian Brownen
    - As of January 1, 2024, we are no longer serving the staff for free. Providers will continue to eat free but not staff. We will have a pricing list coming out soon.
    - We are monitoring payments from Managed Care Insurance Companies to ensure we are getting reimbursed.
    - We have seen a late denial for a patient that had been here for several days and after an initial approval. We are appealing.

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

    b. Nursing

Patient Care

- MRMC Education included:
    1. Flu shots will be provided beginning October 1, 2023.
    2. Education provided to staff regarding the indications for continuation of foley catheters.
    3. Education provided to staff for proper care and maintenance of foley catheters.
- MRMC Emergency Department reports one patient Left Without Being Seen (LWBS).
- MRMC Laboratory reports zero contaminated blood culture set.
- MRMC Infection Prevention reports 0 CAUTI's.
- MRMC Infection Prevention report 0 CLABSI.

Client Service

- Total Patient Days decreased with 256 patient days in September as compared to 365 patient days in August. This represents an average daily census of 9. In addition, MRMC Emergency Department provided care to 160 patients in September.
- MRMC Case Management reports 21 Total Admissions for the month of September 2023.
- September 2023 COVID-19 Stats at MRMC: Swabs (9 PCR & 32 Antigen) with 1 Positive.

Preserve Rural Jobs

- MRMC hired one CNA during the month of September.
- All allowable/available positions in regard to nursing staff filled at this time.

Written report remains in minutes.

c. Infection Control

- Old Business
  - a New IP started the first week of September, 2023 and is currently working with Cohesive Corp, IP.
- New Business:
  - a. Employee Influenza Vaccine Program.
- Data:
  - a, N/A
- Policy & Procedures Review:
  - a. Pending Corporate Review of Manual.
- Education/In Services
  - a. N/A
- Updates: No updates at this time.
- Annual Items:
  - a. Completed March 2023

Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Continuing to work on the building. Flooring in Nurses break area and Med Prep room needing replaced – Tile ready for pick up.
b. 15 AMP Receptacles – all 15 AMP Receptacles will be replaced with 20 AMP Receptacles throughout Hospital – replacement has started.
c. Replace all receptacles on generator circuit at Clinic with red receptacles.

d. ER Provider office flooring needing replaced-Tile ready to be picked up.
e. Damaged ceiling tile in patient area due to electrical upgrade-will need more tile to complete.
f. Replace ceiling tile that do not fit properly – will need more tile to complete.
g. North wall in Nurses breakroom in need of repair.
h. Chrome pipe needs cleaned and escutcheons replaced on hopper in ER - - Possibly remove or cover unused hopper.
i. East wall in room 27 needing repair around the A/C unit – complete 8-11-2023.
j. ISO Caddys installed in patient rooms – ISO Caddys on site. Installation will start 9-=/14/2023.
k. Sanitizer brackets – Brackets onsite – Need installed in rooms 17 and 31
l. Phone wire from ceiling in Room 19 – Needs raceway installed-raceway ordered – complete 9/8/2023.
m. Ceramic tile around toilet paper dispenser missing in rest room in Room 17.

i.i.i. New Business
a. EOC, EM and Life Safety Plans will be evaluated and approved in the October EOC meeting.

Written report remains in minutes.

e. Laboratory
i. Tissue Report – None - September, 2023
i.i. Transfusion Report – Approved – September, 2023

f. Radiology
i. There was a total of – 199 X-Rays/CT/US
i.i. Nothing up for approval
i.i.i. Updates:
- We have received the State Permit.

Written report remains in minutes.

g. Pharmacy
i. Verbal Report by Pharmacy Tech.
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 – Was held on 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 – 3
     - 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 – 2
   - Afterhours access was – 94
   - Compliance
     Written report remains in minutes.

k. Utilization Review
   i. Total Patient days for August: 365
   i.i. Total Medicare days for August: 320
   i.i.i. Total Medicaid days for August: 8
   iv. Total Swing Bed days for August: 309
   v. Total Medicare SB days for August: 281
   Written report remains in the minutes.

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

6. New Business
   a. Review & Consideration of Approval of Policy & Procedures: MRMC – Seasonal Influenza
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy - & Procedure: MRMC - Season Influenza Policy.
   b.Review & Consideration of Approval of Policy & Procedure: MRMC – Staff Influenza Vaccine Program
      i.Motion: made by John Chiaffitelli, DO, Medical Director, to approve Policy & Procedure: MRMC - Influenza Vaccine Program Policy.

c.Review & Discussion of Senate Bill 712: Discussion was held over the Senate Bill 712.

7. Adjourn
   a. Dr Chiaffitelli made a motion to adjourn the meeting at 1:31 pm.

_____ _____

Medical Director/Chief of Staff Date

QUALITY MANAGEMENT REPORT

SUMMARY

Current Year 2023
Month : 10

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	#	139.00		138.00	-1.00	1852.00		1466.00	-386.00
00102	Volume & Utilization	Total # of Observation Patients admitted	#			3.00	3.00	6.00		18.00	12.00
00103	Volume & Utilization	Total # of Acute Patients admitted	#	12.00		11.00	-1.00	169.00		142.00	-27.00
00104	Volume & Utilization	Total # of Swing Bed Patients admitted	#	8.00		11.00	3.00	111.00		111.00	
00105	Volume & Utilization	Total Hospital Admissions (Acute & Swing bed)	#	20.00		22.00	2.00	280.00		253.00	-27.00
00106	Volume & Utilization	Total Discharges (Acute & Swing bed)	#	19.00		21.00	2.00	263.00		252.00	-11.00
00107	Volume & Utilization	Total Patient Days (Acute & Swing bed)	#	260.00		263.00	3.00	3612.00		3632.00	20.00
00108	Volume & Utilization	Average Daily Census (Acute & Swing bed)	#	8.00		8.50	0.50	10.00		119.20	109.20
00109	Volume & Utilization	Left Against Medical Advice (AMA)	#	1.00	2.00	4.00	3.00	38.00	2.00	45.00	7.00
		CARE MANAGEMENT									
00201	Care Management	CAH 30 Day Readmission Rate per 100 patient discharges	%	1.00	0.05	0.19	81%	0.07	0.05	0.06	14%
		RISK MANAGEMENT									
00301	Risk Management	Total Number of Events	#	3.00				79.00		2.63	97%
00302	Risk Management	Total number of complaints	#							0.30	
00304	Risk Management	Total number of complaints from ED	#							0.10	
00306	Risk Management	Total number of grievances	#					1.00		0.10	90%
00308	Risk Management	Total number of grievances from ED	#							0.10	
00310	Risk Management	Inpatient falls without injury	#	1.00			100%	22.00		1.10	95%
00312	Risk Management	ED patient falls without injury	#					3.00			100%
00314	Risk Management	Patient falls with minor injury	#	1.00			100%	5.00		0.50	90%
00316	Risk Management	ED patient falls with minor injury	#								
00318	Risk Management	Total number of patient falls with major injury	#					1.00			100%
00320	Risk Management	Total number of ED patient falls with major injury	#								
00323	Risk Management	Inpatient Mortality Rate	%	11.00	0.10	0.00	100%	15.00	0.10	0.00	100%
00325	Risk Management	ED Mortality Rate	%		0.10	0.01		9.00	0.10	0.00	100%
00327	Risk Management	OPO Notification Compliance	%	100.00	1.00	0.50	100%	95.00	1.00	0.94	99%
		NURSING									
00408	Nursing	Total Number of Code Blues during reporting period	#	1.00		1.00	0%	12.00		1.00	92%
00409	Nursing	Total number of CAH patients transferred to tertiary facility	#	1.00		2.00	100%	14.00		1.20	91%
		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	#	5.00		10.00	100%	118.00		10.00	92%

Clinic Operations Report

Mangum Family Clinic

October 2023

Monthly Stats	October 22	October 23
Total Visits	198	206
Provider Prod	133	144
RHC Visits	185	197
Nurse Visits	13	8
Televisit	0	0
Swingbed	0	1

Provider Numbers	RHC	TH	SB
Barnes			
Chiaffitelli			1
Sims	195		
other	2		

Payor Mix	
Medicare	45
Medicaid	81
Self	3
Private	77

Visits per Geography	
Mangum	160
Granite	23
Altus	6
Blair	5

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Visits	167	123	164	166	164	127	148	198	192	206			

Clinic Operations:

- Amy Sims, worked 22 days in October for an avg of 9 pts per day.
- 57 revenue generating referrals to the hospital ancillary depts.
- Amy Sims presented her letter of resignation. Last day, per contract, December 29th.

Quality Report:

Improvement Measure	Actual	Goal	Comments
Reg Deficiencies	0	0	10 audited
Patient Satisfaction	13	5	12 Excellent; 1 Good
New Patients	34	10	Good solid numbers
No Show	8.1%	<12%	21
Expired Medications	0	0	None noted.

Outreach:

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

Summary

Very strong month regarding volume. 34 “new patients” and an 8% “no show” rate indicates a well working clinic. As stated, Amy Sims has tendered her resignation and given her 60-day contractual notice. Mangum Clinic is already in the process of finding interim coverage and has started the recruitment process. More to come. Mangum Clinic continues to be dedicated to providing the utmost in quality patient care. The search will continue to find the provider is found.

“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
October 2023

Patient Care

- MRMC Education included:

  1. Flu vaccines administered through the month.

  2. Education regarding EMTALA requirements/documentation.

  3. Hand hygiene education and monitoring by Infection Control.

- MRMC Emergency Department reports no patients Left Without Being Seen (LWBS).
- MRMC Laboratory reports zero contaminated blood culture set(s).
- MRMC Infection Prevention reports 0 CAUTI's.
- MRMC Infection Prevention report 0 CLABSI.

Client Service

- Total Patient Days increased with 263 patient days in October as compared to 256 patient days in September. This represents an average daily census of 9. In addition, MRMC Emergency Department provided care to 138 patients in October.
- MRMC Case Management reports 22 Total Admissions for the month of October 2023.
- October 2023 COVID-19 Stats at MRMC: Swabs (6 PCR & 58 Antigen) with 9 Positive.

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	21	22		22
Swing Bed	14	14	15	5	12	12	10	15	8	11		6
Observation	1	1	1	1	1	1	2	6	0	3		0
Emergency Room	159	119	168	138	148	130	152	154	160	138		210
Lab Completed	2542	2159	2804	1897	2191	1802	1987	2409	2156	2078		2337
Rad Completed	211	185	244	204	192	196	160	184	123	130		214
Ventilator Days	0	0	31	30	7	0	0	0	0	0		0

Preserve Rural Jobs

- MRMC placed one part time CNA to full-time and have placed a need for a part-time CNA.
- All other allowable/available positions regarding nursing staff filled at this time!

Mangum Regional Medical Center

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

Chief Executive Officer Report
October 2023

Operations Overview

- We are looking to get our Strong Mind program up and running. What does this include? We are looking for a Licensed Therapist, the space at the Annex, and we are looking for a van to transport patients to and from the facility. Patients will be at the facility from approximately 10am until 2pm.
- We have been having a monthly potluck for the staff and to observe birthdays.
- We have completed the cafeteria floor and new equipment is in place.
- We are continuing to work with EMS to enhance patient care.
- We continue to have some coding issues, but we are catching those before claims go to insurance companies to ensure we are timely filling and that we have clean claims.
- We continue to look for a Dr. and a Nurse Practitioner for the clinic with Amy Sims turning in her resignation.
- We are also looking for a Part-Time Practitioner for the clinic so we do not have any drop in service after Amy departs us.
- We are starting to do a thorough look at all our contracts to ensure we utilize them and that they are providing the service they say they are.
- Starting January 1, 2024, our cafeteria will no longer be serving lunch to the staff for free. There will be a price list coming soon.
- We do have some PTO changes coming out we are changing from a Max accrual of 336 to 168 total hours.

Mangum Board Meeting Financial Reports
October 31, 2023

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

Mangum Regional Medical Center
Financial Summary
October 31, 2023

	Prior Month	Current Month	**Oct-23** Year-to-Date	**Mthly Avg** Year-to-Date
ADC (Average Daily Census)	**8.53**	**8.48**	**11.96**	**12.0**
Payer Mix % (Acute):				
MCR	44.44%	52.63%	57.46%	
MCR Mgd Care	12.96%	44.74%	12.13%	
All Others	42.59%	2.63%	30.42%	
Total	100.00%	100.00%	100.00%	
Payer Mix % (SWB):				
MCR	84.65%	89.78%	90.87%	
MCR Mgd Care	15.35%	10.22%	9.13%	
All Others	0.00%	0.00%	0.00%	
Total	100.00%	100.00%	100.00%	
Operating margin	(61,821)	(173,615)	(1,666,818)	*(166,682)*
Operating Margin (Current Month vs Mthly Avg)	*104,861*	*(6,933)*		
NPR (Net Patient Revenue)	1,450,237	1,193,166	13,525,499	*1,352,550*
NPR (Current Month vs Mthly Avg)	*97,688*	*(159,384)*		
Operating Expenses	1,534,955	1,379,782	15,349,345	*1,534,934*
Oper Exp (CM vs Mthly Avg)	*20*	*(155,152)*		
NPR % of Oper Exp	**94.5%**	**86.5%**	**88.1%**	
Patient Days	256	263	3,635	*364*
Oper Exp / PPD	$ 5,996	$ 5,246	$ 4,223	
# of Months	**1**	**1**	**10**	
Cash Receipts (rnd)	**1,490,569**	**1,211,980**	**15,375,460**	*1,537,546*
Cash Receipts (CM vs Mthly Avg)	*(46,977)*	*(325,566)*		
Cash as a % of NPR (s/b 100% min)	**102.8%**	**101.6%**	**113.7%**	
Calendar Days	30	31	304	
Operating Exp / Day	$ 51,165	$ 44,509	$ 50,491	
Cash - (unrestricted)	850,824	712,301	712,301	
Days Cash-On-Hand	**16.6**	**16.0**	**14.1**	
Cash - (including restricted)	1,663,013	1,524,490	1,524,490	
Days Cash-On-Hand	**32.5**	**34.3**	**30.2**	
MCR Rec (Pay) - "as stated - but to be adjusted"	(2,761,845)	(2,680,074)		
AP & Accrued Liab	13,452,087	13,467,838		
Accounts Receivable (at net)	1,399,933	1,318,350		

Per AP aging schedule (incl. accruals)	**Sep-23**	**Oct-23**	Net Change
Account Payable - Cohesive	10,687,281	10,287,358	(399,923)
Account Payable - Other	1,872,082	2,287,756	415,674
Total	12,559,363	12,575,114	15,751
Cohesive Loan	5,365,899	5,334,882	(31,017)

Mangum Regional Medical Center
Cash Receipts - Cash Disbursements Summary
October 2023

	Current Month	COVID	Total Less COVID	Year-To-Date	COVID	Year-To-Date Less COVID
Cash Receipts	$ 1,211,980	$ -	$ 1,211,980	$ 15,375,460	$ -	$ 15,375,460
Cash Disbursements	$ (1,345,813)	$ -	$ (1,345,813)	$ (15,196,565)	$ 139,447	$ (15,057,118)
NET	$ (133,833)	$ -	$ (133,833)	$ 178,895	$ 139,447	$ 318,342

November 28, 2023

Board of Directors
Mangum Regional Medical Center

October 2023 Financial Statement Overview

- Statistics
  - The average daily census (ADC) for October 2023 was **8.48** – (Year-To-Date **11.96** vs PY fiscal year end of **9.86**).
  - Year-To-Date Acute payer mix was approximately **70%** MCR/MCR Managed Care combined & consistent with the prior fiscal year end.
  - Year-To-Date Swing Bed payer mix was **91%** MCR & **9%** MCR Managed Care. For the prior year end those percentages were **93% & 7%,** respectively.

- Balance Sheet Highlights
  - The cash balance as of October 31, 2023, inclusive of both operating & reserves, was **$1.52M**. This decrease of **$139K** from September 30, 2023, balance was primarily due to a decrease in patient cash receipts which decreased by **$279K** from the prior month.
  - Days cash on hand, inclusive of reserves, was **30.2** based on October YTD expenses.
  - Net AR decreased by **$82K (6%)** from September (flat & consistent with the ADC).
  - Payments of approximately **$1.35M** were made on AP (prior 3-month avg was **$1.38M**).
  - Cash receipts were **$200K** less than in the previous 3 months **($1.2M vs $1.4M)**.
  - The Medicare principal balance decreased by **$82K** due to ERS loan payments. Note that we have estimated a CY payable of over **$2M** for FY23 at this time that will be adjusted throughout the year based on census and respective costs.

- Income Statement Highlights

    - Net patient revenue for October was **$1.2M** which is approximately a decrease of **$177K** over the prior month year-to-date average due to the decrease in ADC.
    - Operating expenses, exclusive of interest & depreciation, were $1.32M and decreased from the prior month year-to-date average **of $1.45M by $167K (contract labor).**
    - 340B revenues were **$9K** for October & YTD**, $126K**. Net profit from this service line YTD is **$54K**.

- Clinic (RHC) Income Statement Highlights as incurred & projected.
    - Year-To-Date average visits per day = 07.13; Oct 2023 = 08.91.
    - Projected operating revenues (YTD) = $323K
    - Projected operating expenses (YTD) = $724K
    - Projected operating loss (YTD) = -($401K)

- Additional Notes

    - The hospital has experienced material increases in ADC in FY23 as compared to FY22. These trends are evident & reflected by month on the Admissions, Discharges & Days of Care page within each board packet. The hospital has attempted to mitigate the need to request a Medicare ERS loan throughout the year but has continued to incur recoupments of approximately **$86K/month (over $1M annual) related to 2017 alone.**

MANGUM REGIONAL MEDICAL CENTER

Admissions, Discharges & Days of Care

Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	12/31/2023 YTD	12/31/2022 PY Comparison
Admissions												
Inpatient	13	16	19	11	16	12	13	19	13	11	143	138
Swingbed	14	14	15	5	12	7	10	15	8	17	117	95
Observation	0	1	1	1	2	1	2	6	0	3	17	6
	27	31	35	17	30	20	25	40	21	31	277	239
Discharges												
Inpatient	15	16	20	10	16	12	10	18	16	11	144	136
Swingbed	10	11	14	11	6	12	12	14	9	12	111	98
Observation	0	1	1	1	2	1	2	6		3	17	6
	25	28	35	22	24	25	24	38	25	26	272	240
Days of Care												
Inpatient-Medicare	23	31	43	22	35	27	25	39	24	20	289	274
Inpatient-Other	33	29	32	13	19	11	8	21	30	18	214	183
Swingbed-Medicare	371	356	386	289	328	240	222	281	171	202	2,846	2,414
Swingbed-Other	0	2	42	51	30	39	40	28	31	23	286	204
Observation	0	1	1	1	2	1	2	6	0	3	17	6
	427	419	504	376	414	318	297	375	256	266	3,652	3,081
Calendar days	31	28	31	30	31	30	31	31	30	31	304	304
ADC - (incl OBS)	13.77	14.96	16.26	12.53	13.35	10.60	9.58	12.10	8.53	8.58	12.01	10.13
ADC	13.77	14.93	16.23	12.50	13.29	10.57	9.52	11.90	8.53	8.48	11.96	10.12
ER	158	119	169	136	148	132	152	154	162	160	1,490	1,446
Outpatient	176	132	182	141	177	152	171	190	158	165	1,644	2,426
RHC	170	123	167	162	164	125	142	196	159	196	1,604	1,723

MANGUM REGIONAL MEDICAL CENTER
Comparative Balance Sheet - Unaudited
Fiscal Year 2023

	January	February	March	April	May	June	July	August	September	October	Prior Month Variance
Cash And Cash Equivalents	980,584	677,752	684,122	724,967	556,140	627,470	566,073	654,397	850,824	712,301	**(138,523)**
Reserved Funds	-	-	800,000	1,400,000	768,400	968,400	662,189	812,189	812,189	812,189	**-**
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	1,915,345	1,399,933	1,318,350	**(81,583)**
Due From Medicare	74,934	74,956	-	-	-	-	-	-	-	-	**-**
Inventory	243,297	235,738	244,725	260,940	270,700	234,397	228,685	239,652	246,453	247,888	**1,435**
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	1,550,814	1,891,626	1,899,170	**7,545**
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	2,004,456	1,936,608	**(67,849)**
Total Assets	7,311,075	7,055,057	8,160,453	8,786,028	7,703,117	7,373,924	7,006,080	7,180,725	7,205,480	6,926,505	(278,975)
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	12,559,363	12,575,114	**15,751**
AHSO Related AP	892,724	892,724	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	2,761,845	2,680,074	**(81,771)**
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	5,365,899	5,334,882	**(31,017)**
Notes Payable - Other	23,565	23,565	23,565	95,369	88,382	81,409	74,366	67,281	60,197	52,990	**(7,206)**
Alliantz Line Of Credit	-	-	-	-	-	-	-	-	-	-	**-**
Leases Payable	273,074	269,075	265,054	261,011	256,946	280,019	276,961	276,057	275,582	274,465	**(1,117)**
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	21,915,610	21,810,250	(105,361)
Net Assets	(13,358,207)	(13,496,944)	(13,645,584)	(13,792,536)	(14,131,044)	(14,299,723)	(14,486,500)	(14,648,309)	(14,710,130)	(14,883,745)	**(173,615)**
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	7,180,725	7,205,480	6,926,505	(278,975)

Mangum Regional Medical Center
Cash Receipts & Disbursements by Month
November 28, 2023 Board Meeting

2021				2022				2023		
Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Stimulus Funds	Disbursements	Month	Receipts	Disbursements
Jan-21	830,598		695,473	Jan-22	2,163,583		1,435,699	Jan-23	1,290,109	1,664,281
Feb-21	609,151		1,472,312	Feb-22	1,344,463	254,626	1,285,377	Feb-23	1,506,708	1,809,690
Mar-21	910,623	49,461	866,387	Mar-22	789,800		1,756,782	Mar-23	1,915,435	1,109,683
Apr-21	742,500		999,127	Apr-22	1,042,122		1,244,741	Apr-23	2,005,665	1,365,533
May-21	816,551		1,528,534	May-22	898,311		1,448,564	May-23	1,436,542	2,237,818
Jun-21	936,092		1,455,892	Jun-22	1,147,564		1,225,070	Jun-23	1,777,525	1,506,459
Jul-21	1,009,037		1,774,932	Jul-22	892,142		979,914	Jul-23	1,140,141	1,508,702
Aug-21	1,292,886	100,000	2,156,724	Aug-22	890,601		1,035,539	Aug-23	1,600,786	1,352,905
Sep-21	278,972		753,559	Sep-22	2,225,347		1,335,451	Sep-23	1,490,569	1,295,680
Oct-21	1,954,204		1,343,425	Oct-22	1,153,073		1,233,904	Oct-23	1,211,980	1,345,813
Nov-21	1,113,344	316,618	1,800,166	Nov-22	935,865		1,476,384	Nov-23		
Dec-21	1,794,349	305,543	1,325,063	Dec-22	1,746,862		1,073,632	Dec-23		
	12,288,308	771,623	16,171,592		15,229,733	254,626	15,531,057		15,375,460	15,196,565
Subtotal FY 2021	13,059,930			Subtotal FY 2022	15,484,359			Subtotal FY 2023	15,375,460	

Mangum Regional Medical Center
Medicare Payables by Year
November 28, 2023 Board Meeting

`	Original Balance	Balance as of 10/31/2023	Total Interest Paid as of 10/31/2023
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)	**418,537.80**	259,330.77
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)	**(37,253.01)**	
FY23 MCR pay (rec) estimate	2,515,000.00	**2,298,789.00**	
Total	**7,511,072.85**	**2,680,073.79**	**1,182,652.38**

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

MTD					YTD			
Actual	Budget	Variance	% Change		Actual	Budget	Variance	% Change
245,590	186,753	58,837	32%	Inpatient revenue	2,651,204	1,871,194	780,010	42%
1,128,584	705,378	423,206	60%	Swing Bed revenue	12,051,154	6,651,728	5,399,426	81%
618,323	581,052	37,271	6%	Outpatient revenue	5,959,558	5,878,203	81,354	1%
178,118	157,684	20,434	13%	Professional revenue	1,663,857	1,592,018	71,839	5%
2,170,615	1,630,867	539,748	33%	Total patient revenue	22,325,772	15,993,142	6,332,630	40%
820,169	225,498	594,671	264%	Contractual adjustments	5,308,294	2,110,676	3,197,618	152%
-	-	-	#DIV/0!	Contractual adjustments: MCR Settlement	2,680,967		2,680,967	#DIV/0!
157,280	109,920	47,359	43%	Bad debts	811,011	1,077,938	(266,927)	-25%
977,449	335,419	642,030	191%	Total deductions from revenue	8,800,273	3,188,614	5,611,659	176%
1,193,166	1,295,448	(102,282)	-8%	Net patient revenue	13,525,499	12,804,528	720,971	6%
3,737	3,618	119	3%	Other operating revenue	30,958	36,171	(5,213)	-14%
9,265	57,180	(47,915)	-84%	340B REVENUES	126,069	554,013	(427,944)	-77%
1,206,168	1,356,246	(150,078)	-11%	Total operating revenue	13,682,527	13,394,712	287,814	2%
				Expenses				
429,806	366,482	63,324	17%	Salaries and benefits	4,067,769	3,601,965	465,805	13%
157,258	142,010	15,248	11%	Professional Fees	1,457,515	1,404,957	52,558	4%
248,085	433,230	(185,145)	-43%	Contract labor	3,684,914	4,248,424	(563,510)	-13%
117,485	110,104	7,380	7%	Purchased/Contract services	1,336,739	1,081,078	255,661	24%
225,000	225,000	-	0%	Management expense	2,250,000	2,250,000	-	0%
63,012	88,585	(25,573)	-29%	Supplies expense	957,291	870,234	87,057	10%
29,191	29,926	(735)	-2%	Rental expense	300,947	297,104	3,843	1%
16,761	16,788	(28)	0%	Utilities	183,579	167,885	15,695	9%
52	1,219	(1,167)	-96%	Travel & Meals	10,852	12,081	(1,229)	-10%
9,927	12,129	(2,202)	-18%	Repairs and Maintnenance	117,590	120,936	(3,345)	-3%
12,384	12,596	(212)	-2%	Insurance expense	114,148	125,955	(11,807)	-9%
11,484	21,829	(10,345)	-47%	Other Expense	217,182	218,227	(1,045)	0%
6,909	33,672	(26,763)	-79%	340B EXPENSES	82,039	330,201	(248,163)	-75%
1,327,353	1,493,571	(166,218)	-11%	Total expense	14,780,564	14,729,045	51,519	0%
(121,185)	(137,325)	16,140	-12%	EBIDA	(1,098,038)	(1,334,333)	236,295	-18%
-10.0%	-10.1%	0.08%		EBIDA as percent of net revenue	-8.0%	-10.0%	1.94%	
4,265	4,276	(11)	0%	Interest	71,801	72,922	(1,121)	-2%
48,164	48,039	125	0%	Depreciation	496,979	477,749	19,231	4%
(173,615)	(189,640)	16,026	-8%	Operating margin	(1,666,818)	(1,885,003)	218,185	-12%
-	-	-		Other	-	-	-	
-	-	-		Total other nonoperating income	-	-	-	
(173,615)	(189,640)	16,026	-8%	Excess (Deficiency) of Revenue Over Expenses	(1,666,818)	(1,885,003)	218,185	-12%
-14.39%	-13.98%	-0.41%		Operating Margin %	-12.18%	-14.07%	1.89%	

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

	January	February	March	April	May	June	July	August	September	October	YTD
Inpatient revenue	**248,170**	**273,130**	**272,704**	**168,264**	**292,654**	**256,424**	**217,685**	**346,918**	**329,664**	**245,590**	2,651,204
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**	**971,812**	**1,128,584**	12,051,154
Outpatient revenue	**569,774**	**479,203**	**655,242**	**450,232**	**596,547**	**566,829**	**643,187**	**672,465**	**707,757**	**618,323**	5,959,558
Professional revenue	**165,566**	**172,559**	**183,040**	**122,822**	**164,587**	**152,378**	**159,248**	**182,030**	**183,508**	**178,118**	1,663,857
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	2,192,741	2,170,615	22,325,772
Contractual adjustments	**(121,100)**	**19,061**	**(134,294)**	**(23,053)**	**1,539,024**	**831,011**	**916,605**	**836,330**	**624,540**	**820,169**	5,308,294
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**	**117,963**	**157,280**	811,011
Total deductions from revenue	437,792	438,520	797,799	798,060	1,588,972	872,957	969,988	1,176,234	742,503	977,449	8,800,273
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	1,450,237	1,193,166	13,525,499
Other operating revenue	**643**	**481**	**1,746**	**782**	**4,037**	**14,751**	**920**	**1,035**	**2,826**	**3,737**	30,958
340B REVENUES	**17,199**	**11,534**	**9,264**	**6,654**	**7,518**	**25,149**	**6,901**	**12,515**	**20,071**	**9,265**	126,069
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	1,473,134	1,206,168	13,682,527
	89.8%	89.9%	90.2%	89.8%	78.5%	86.4%	86.8%	89.1%	94.5%	86.5%	88.1%
Expenses											
Salaries and benefits	**361,005**	**411,948**	**411,789**	**381,508**	**403,854**	**366,863**	**401,488**	**441,681**	**457,827**	**429,806**	4,067,769
Professional Fees	**149,199**	**131,495**	**159,564**	**139,183**	**153,226**	**141,955**	**140,784**	**141,126**	**143,727**	**157,258**	1,457,515
Contract labor	**467,147**	**361,407**	**425,232**	**351,293**	**409,120**	**355,927**	**361,836**	**396,420**	**308,448**	**248,085**	3,684,914
Purchased/Contract services	**107,498**	**115,260**	**160,858**	**144,976**	**166,564**	**132,525**	**102,698**	**144,927**	**143,947**	**117,485**	1,336,739
Management expense	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	**225,000**	2,250,000
Supplies expense	**85,209**	**77,055**	**109,037**	**83,909**	**96,572**	**145,554**	**92,679**	**108,407**	**95,857**	**63,012**	957,291
Rental expense	**25,693**	**25,335**	**22,200**	**40,587**	**37,323**	**28,670**	**21,353**	**36,558**	**34,038**	**29,191**	300,947
Utilities	**19,305**	**20,759**	**20,147**	**17,598**	**17,253**	**19,058**	**18,169**	**15,749**	**18,780**	**16,761**	183,579
Travel & Meals	**721**	**1,537**	**2,377**	**1,470**	**2,279**	**1,610**	**101**	**170**	**535**	**52**	10,852
Repairs and Maintnenance	**14,713**	**10,390**	**11,618**	**10,943**	**11,837**	**10,109**	**12,289**	**10,891**	**14,871**	**9,927**	117,590
Insurance expense	**13,940**	**13,997**	**5,518**	**6,394**	**12,379**	**12,386**	**12,384**	**12,384**	**12,384**	**12,384**	114,148
Other	**14,963**	**25,844**	**14,797**	**47,046**	**32,512**	**22,132**	**23,495**	**8,940**	**15,970**	**11,484**	217,182
340B EXPENSES	**9,702**	**6,242**	**5,693**	**5,170**	**7,268**	**13,332**	**5,975**	**10,877**	**10,871**	**6,909**	82,039
Total expense	1,494,096	1,426,270	1,573,830	1,455,077	1,575,186	1,475,120	1,418,248	1,553,130	1,482,254	1,327,353	14,780,564
EBIDA	$ (72,701)	$ (79,303)	$ (89,736)	$ (89,352)	$ (283,290)	$ (113,390)	$ (132,198)	$ (107,762)	$ (9,120)	$ (121,185)	$ (1,098,038)
EBIDA as percent of net revenue	-5.1%	-5.9%	-6.0%	-6.5%	-21.9%	-8.3%	-10.3%	-7.5%	-0.6%	-10.0%	-8.0%
Interest	**10,509**	**9,096**	**8,824**	**7,659**	**7,489**	**7,125**	**6,414**	**5,883**	**4,536**	**4,265**	71,801
Depreciation	**58,070**	**50,338**	**50,080**	**49,942**	**47,728**	**48,164**	**48,164**	**48,164**	**48,164**	**48,164**	496,979
Operating margin	$ (141,280)	$ (138,737)	$ (148,640)	$ (146,952)	$ (338,508)	$ (168,680)	$ (186,776)	$ (161,810)	$ (61,821)	$ (173,615)	$ (1,666,818)
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)	(161,810)	(61,821)	(173,615)	(1,666,818)
Operating Margin % (excluding other misc. rever	-9.94%	-10.30%	-10.02%	-10.76%	-26.20%	-12.39%	-14.52%	-11.20%	-4.20%	-14.39%	-12.18%

	10/31/2023	"Annualized"
On-Site Visits -->	1,518	1,822
On-Site Visit / Bus Day -->	7.13	7.03

Mangum Family Clinic

Ten Months Ended 10/31/2023

Description	YTD FS Per General Ledger	Eliminate Rev Deduct & Other Inc	Adj Rev Deduct to RHC Calc	Cost Report Allocations	10 RHC Financial Statements	FY 2023 "Annualized" RHC Financial Statements
Gross Patient Revenue	190,454	-	-	-	190,454	228,545
Less: Revenue deductions	204,163	(204,163)	132,982	-	132,982	159,579
Net Patient Revenue	394,617	(204,163)	132,982	-	323,437	388,124
Other Income (if any)	2,548	(2,548)	-	-	-	-
Operating revenue	397,165	(206,711)	132,982	-	323,437	388,124
Operating Expenses:						
Salaries	117,540	-	-	-	117,540	141,049
Benefits	-	-	-	-	-	-
Prof Fees	161,980	-	-	34,601	196,581	235,898
Contract Labor	1,056	-	-	-	1,056	1,267
Purch Serv	60,028	-	-	-	60,028	72,033
Supplies	5,328	-	-	-	5,328	6,393
Rent	23,469	-	-	-	23,469	28,162
Utilities	8,848	-	-	-	8,848	10,618
Repairs	752	-	-	-	752	902
Other	4,242	-	-	-	4,242	5,091
Insurance	2,157	-	-	-	2,157	2,588
Travels & Meals	4,586	-	-	-	4,586	5,503
Management Fee Direct Exp	(0)	-	-	115,403	115,403	138,484
Critical Access Hospital Overhead Allocation (a)	-	-	-	184,113	184,113	220,936
Total Operating Expenses	389,985	-	-	334,117	724,102	868,924
Net Income (loss)	**7,180**	**(206,711)**	**132,982**	**(334,117)**	**(400,665)**	**(480,800)**

MGMT Fee Allocation est. 2023	1 months	11,540	
IP Rounding allocation based on 8/31/22 IRR estimate	8 months	27,681	213.07
CAH Overhead Allocation - from Chris based on last filed cost report -------->	12 months	220,936	477.01
Total allocation ------->		260,157	
			(263.94)

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	10/31/2023	9/30/2023	8/31/2023	7/31/2023
ALCO SALES & SERVICE CO	Patient Supplies	299.80	-	-	-	299.80	-	-	-
AMERICAN HEART ASSOCIATION INC	Supplies	-	-	-	-	-	242.22	-	-
AMERICAN PROFICIENCY INSTITUTE	Lab Supplies	-	-	-	-	-	50.00	-	-
ANESTHESIA SERVICE INC	Patient Supplies	-	-	-	-	-	914.14	2,510.17	
APEX MEDICAL GAS SYSTEMS, INC	Supplies	-	-	-	-	-	-	-	900.00
ARAMARK	Linen Services	12,051.80	3,012.95	-	-	15,064.75	20,394.52	23,729.74	26,588.50
ASPEN INSPECTION SERVICES	Repairs/maintenance	-	-	-	-	-	-	300.00	-
AT&T	Fax Service	-	-	-	-	-	-	2,413.05	4,380.33
AVANAN, INC.	COVID Capital	-	-	-	16,800.00	16,800.00	16,800.00	16,800.00	16,800.00
BARRY DAVENPORT	1099 Provider	-	-	-	-	-	-	-	4,320.00
BIO-RAD LABORATORIES INC	Lab Supplies	1,568.45	-	-	-	1,568.45	1,550.42	1,550.42	1,842.22
BRIGGS HEALTHCARE	Supplies	-	-	-	-	-	-	-	32.64
CARNEGIE EMS	Patient Transport Svs	4,740.00	-	-	-	4,740.00	8,550.00	8,550.00	7,150.00
CARNEGIE TRI-COUNTY MUN. HOSP	Pharmacy Supplies	-	-	-	-	-	-	9,869.76	-
CDW-G LLC	Supplies	-	-	-	3,059.84	3,059.84	3,059.84	3,059.84	3,059.84
CITY OF MANGUM	Utilities	-	-	-	-	-	-	8,048.85	8,940.17
CliftonLarsonAllen LLP	Audit firm	-	-	-	-	-	-	-	6,300.00
COHESIVE HEALTHCARE MGMT	Mgmt Fees	225,000.00	225,000.00	517.50	896,960.38	1,347,477.88	1,253,494.64	1,195,925.60	1,026,206.55
COHESIVE HEALTHCARE RESOURCES	Payroll	187,969.16	451,000.32	478,323.01	3,673,661.68	4,790,954.17	5,216,906.53	5,145,201.55	5,204,553.00
COHESIVE MEDIRYDE LLC	Patient Transportation Service	-	-	-	-	-	-	794.75	2,948.75
COHESIVE STAFFING SOLUTIONS	Agency Staffing Service	130,266.77	312,367.41	440,450.01	3,265,841.81	4,148,926.00	4,216,879.78	4,755,205.67	4,858,389.89
COMMERCIAL MEDICAL ELECTRONICS	Quarterly Maintenance	-	-	-	-	-	-	2,450.00	4,900.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	-	-	2,000.00	17,980.95	19,980.95	21,980.95	23,980.95	25,980.95
CPSI	EHR Software	-	-	-	-	-	6,132.00	4,411.00	3,112.00
CURBELL MEDICAL PRODUCTS INC	Supplies	-	-	-	-	-	-	-	128.66
DELL FINANCIAL SERVICES LLC	Server Lease	-	-	-	-	-	-	590.96	1,314.97
DIAGNOSTIC IMAGING ASSOCIATES	Radiology Purch Svs	2,150.00	-	-	-	2,150.00	4,550.00	10,750.00	4,300.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	6,165.00	6,962.64	-	343,786.52	356,914.16	351,591.55	356,591.55	398,621.67
DR W. GREGORY MORGAN III	1099 Provider	-	-	-	-	-	-	4,766.67	4,766.67
eCLINICAL WORKS, LLC	RHC EHR	6,000.00	-	-	-	6,000.00	2,875.50	-	2,875.50
EMD MILLIPORE CORPORATION	Lab Supplies	-	-	-	-	-	-	5,831.05	5,831.05
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	-	-	-	-	-	-	2,928.00	2,928.00
FEDEX	Shipping	-	-	-	-	-	145.66	84.71	171.79
FIRSTCARE MEDICAL SERVICES, PC	1099 Provider	-	-	-	-	-	-	-	10,259.90
FORVIS LLP	Finance Purch Svs(Formerly BKD)	6,642.00	-	-	-	6,642.00	-	-	2,487.13
FOX BUILDING SUPPLY	Repairs/maintenance	(151.19)	-	-	-	(151.19)			
GEORGE BROS TERMITE & PEST CON	Pest Control Service	-	-	-	-	-	760.00	320.00	320.00
GRAINGER	Maintenance Supplies	273.73	-	-	-	273.73	967.83	-	1,945.24
GREER COUNTY CHAMBER OF	Advertising	-	-	-	-	-	-	900.00	900.00
HAC INC	Dietary Supplies	-	-	-	-	-	-	591.89	804.43
HEALTH CARE LOGISTICS	Pharmacy Supplies	-	100.38	-	-	100.38	-	2,473.18	3,208.38
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	-	-	-	-	-	1,050.00	-	1,050.00
HENRY SCHEIN	Lab Supplies	-	-	-	-	-	-	-	2,824.61
HILL-ROM COMPANY, INC	Rental Equipment	-	-	-	-	-	-	-	2,470.95
ICU MEDICAL SALES INC.	Supplies	-	-	-	-	-	-	-	1,000.00
HSI	Materials Purch svs	-	-	-	-	-	2,500.00	-	-
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	-	-	-	-	-	-	204.30	306.45
INQUISEEK LLC	RHC purch svs	-	-	-	225.00	225.00	225.00	225.00	225.00
INSIGHT DIRECT USA INC.	IT Minor Equipment	-	-	-	1,007.36	1,007.36	1,007.36	1,007.36	1,007.36
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	-	-	-	-	-	691.17	656.41	2,283.95
JIMALL & KANISHA' LOFTIS	Rent House	-	-	-	-	-	-	-	850.00
KCI USA	Rental Equipment	-	-	-	-	-	-	234.96	2,356.43

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	10/31/2023	9/30/2023	8/31/2023	7/31/2023
KING GUIDE PUBLICATIONS INC	Advertising	-	-	-	-	-	100.00	100.00	100.00
LABCORP	Lab purch svs	-	-	-	-	-	-	2,135.18	4,883.20
LAMPTON WELDING SUPPLY	Patient Supplies	-	-	-	-	-	-	-	2,849.75
LANGUAGE LINE SERVICES INC	Translation service	-	-	-	-	-	130.00	260.00	390.00
LOCKE SUPPLY	Plant Ops supplies	663.80	-	-	-	663.80	-	-	235.21
MANGUM STAR NEWS	Advertising	-	-	-	-	-	-	-	145.50
MARK CHAPMAN	Employee Reimbursement	-	-	-	-	-	-	-	531.57
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	-	-	-	-	-	11,904.45	20,321.61	5,982.44
MEDLINE INDUSTRIES	Patient Care/Lab Supplies	-	-	-	-	-	3,125.41	18,533.28	14,525.73
MYHEALTH ACCESS NETWORK, INC	Compliance purch svs	-	-	-	-	-	758.92	758.92	758.92
NATIONAL RECALL ALERT CENTER	Safety and Compliance	-	-	-	-	-	-	1,290.00	1,290.00
NEXTIVA, INC.	Phone Svs	-	-	-	-	-	-	-	2,167.62
NUANCE COMMUNICATIONS INC	RHC purch svs	-	-	-	-	-	246.00	369.00	369.00
OFMQ	Quality purch svs	-	-	-	-	-	350.00	350.00	700.00
OHERI	Education/Training	-	-	-	-	-	-	-	325.00
OKLAHOMA BLOOD INSTITUTE	Blood Bank	6,475.90	-	-	-	6,475.90	10,217.80	11,788.30	10,010.40
OPTUM	Pharmacy Supplies	-	114.95	-	-	114.95	-	-	-
ORTHO-CLINICAL DIAGNOSTICS INC	Lab purch svs	-	-	-	1,203.96	1,203.96	1,203.96	1,203.96	1,203.96
PARA REV LOCKBOX	CDM purch svs	-	-	-	-	-	6,827.00	6,827.00	6,827.00
PHARMA FORCE GROUP LLC	340B purch svs	-	-	-	-	-	-	-	608.36
PHARMACY CONSULTANTS, INC.	PHARMACY CONSULTANTS, INC.	-	-	-	-	-	2,530.00	-	3,491.43
PHILADELPHIA INSURANCE COMPANY	OHA Insurance	-	-	-	-	-	-	2,116.00	2,116.00
PHILIPS HEALTHCARE	Supplies	-	-	-	-	-	-	504.88	504.88
PIPETTE COM	Lab maintenance	-	-	-	-	-	-	-	216.00
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	-	-	-	-	-	-	359.76	359.76
PORT53 TECHNOLOGIES, INC.	Software license	-	-	-	-	-	200.88	200.88	200.88
PRESS GANEY ASSOCIATES, INC	Purchased Service	738.48	-	-	-	738.48	738.48	1,448.44	2,158.52
PUCKETT DISCOUNT PHARMACY	Pharmacy Supplies	-	-	-	-	-	-	4.00	62.80
PURCHASE POWER	Postage Fees	-	-	-	-	-	100.00	-	132.76
RADIATION CONSULTANTS	Radiology maintenance	-	-	-	-	-	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	-	-	25,000.00	-	25,000.00	29,780.00	20,670.00	20,670.00
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance	-	-	-	-	-	770.00	-	-
SBM MOBILE PRACTICE, INC	1099 Provider	-	-	-	-	-	-	-	6,800.00
SCHAPEN LLC	Clinic Rent	-	-	-	-	-	-	-	1,750.00
SHERWIN-WILLIAMS	Supplies	-	-	-	(11.78)	(11.78)	(11.78)	(11.78)	(11.78)
SHRED-IT USA LLC	Secure Doc disposal service	2,544.75	-	-	-	2,544.75	2,384.32	4,984.78	2,480.83
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract	-	-	-	-	-	12,600.00	12,600.00	12,600.00
SIZEWISE	Rental Equipment	-	2,473.50	-	-	2,473.50	2,473.50	4,604.00	3,914.48
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	-	-	-	-	-	1,735.00	5,205.00	5,205.00
SOMSS LLC	1099 Provider	-	-	-	-	-	-	-	6,400.00
SPACELABS HEALTHCARE LLC	Telemetry Supplies	-	-	-	-	-	-	405.98	1,242.08
SPARKLIGHT BUSINESS	Cable service	445.94	-	-	-	445.94	-	451.94	445.94
STANDLEY SYSTEMS LLC	Printer lease	-	-	-	-	-	2,245.75	4,301.14	2,314.94
STAPLES ADVANTAGE	Office Supplies	-	-	-	-	-	298.94	-	1,588.47
STERICYCLE INC	Waste Disposal Service	-	-	-	-	-	-	3,255.57	233.27
STRYKER INSTRUMENTS	Patient Supplies	-	-	-	-	-	-	-	-
SUMMIT UTILITIES	Utilities	-	-	-	-	-	32.33	843.30	834.20
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies	-	-	-	-	-	1,755.00	4,950.00	3,195.00
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	3,285.00
TRS MANAGED SERVICES	Agency Staffing-old	-	-	-	63,463.18	63,463.18	78,989.68	103,999.01	125,027.51

VENDOR NAME	DESCRIPTION	0-30 Days	31-60 Days	61-90 Days	OVER 90 Days	10/31/2023	9/30/2023	8/31/2023	7/31/2023
ULINE	Patient Supplies	-	-	-	-	-	-	-	1,103.30
ULTRA-CHEM INC	Housekeeping Supplies	-	-	-	-	-	-	-	353.89
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	-	-	-	-	-	1,161.47	2,486.53	4,502.12
US MED-EQUIP LLC	Swing bed eq rental	-	-	-	-	-	1,154.20	-	1,474.79
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	1,600.00	5,655.00	-	-	7,255.00	13,655.00	5,130.00	5,130.00
WELCH ALLYN, INC.	Supplies	-	-	-	-	-	-	(628.66)	(628.66)
WORTH HYDROCHEM	semi-annual water treatment	-	-	-	482.00	482.00	482.00	482.00	-
Grand Total		**595,444.39**	**1,006,687.15**	**946,290.52**	**8,287,745.90**	**10,836,167.96**	**11,329,072.42**	**11,843,072.41**	**11,939,730.05**
			Reconciling Items:		Conversion Variance	13,340.32	13,340.32	13,340.32	13,340.22
					AP Control	12,748,174.36	12,967,260.42	12,722,455.85	12,819,113.49
					Accrued AP	719,663.51	484,826.47	486,089.34	173,464.20
AHSO Related AP	**Description**	**10/31/2023**			AHSO Related AP	(892,723.76)	(892,723.76)	(892,723.76)	(892,723.76)
ADP INC	QMI Payroll Service Provider	4,276.42			**TOTAL AP**	**12,575,114.11**	**12,559,363.13**	**12,315,821.43**	**12,099,853.93**
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**							

District / Sales Office

SIEMENS HEALTHCARE DIAGNOSTICS INC.

Attn: Casey Hampton Tucker
Phone: 984-281-7881
Fax: 919-869-2694
Email: casey.hamptontucker@siemens-healthineers.com

Sold To

#0000002498
MANGUM REGIONAL MEDICAL CENTER
1 WICKERSHAM ST
MANGUM, OK 73554-9117

Bill To

#0000149707
QUARTZ MOUNTAIN HEALTHCARE SYSTEM
ONE WICKERSHAM DR
MANGUM, TX 73554

Payer

#0000149707
QUARTZ MOUNTAIN HEALTHCARE SYSTEM
ONE WICKERSHAM DR
MANGUM, TX 73554

Siemens Healthcare Diagnostics Inc. is pleased to submit the following proposal for service and maintenance described herein at the stated prices and terms. Subject to your acceptance of the terms and conditions on the face and general terms and conditions Document hereof.

Item #	Product Name	Functional Location	Serial Number	Performance Plan	Contract Duration	Standard Pricing	Annual Pricing	Partial Year Price	Net Price
1*	SYSMEX CA-660	400-571381	14184	Plus (8am-5pm, M-F)	11/18/2023 - 11/17/2025	$7,516	$3,895	$0	$7,790.00
Total Contract Price									$7,790.00

Terms of payment: Net 30 days from invoice date. Past due payment is subject to 1.5% interest charge per month.

Customer's Acceptance

(By) (Signature)

Name and Title

Acceptance Date _____

Siemens Healthcare Diagnostic Inc.

(By) (Signature)

Casey Hampton Tucker - DX Inside Sales Representative

Name and Title

Customer P.O. #_____ (If your organization does not require a PO for payment, please initial here and provide written confirmation.)
Customer P.O. #_____ (enter P.O. # for contract billing;)
_____ (Initial if P.O. is required but will be issued prior to warranty expiration)
Standing P.O. #_____ (for T&M charges outside of the contract)

Please review payment frequency as listed in the exhibit. If a different frequency is required, please indicate here.
( ) Annual ( ) Quarterly ( ) Monthly

Agreement becomes effective upon customer signature and Siemens acceptance. Customer's acceptance acknowledges receipt and agreement to Terms and Conditions set forth on all pages of this proposal.

Please return Signed Performance Plan Quote and PO (Hardcopy PO preferred) back to Casey Hampton Tucker by phone number 984-281-7881 at email casey.hamptontucker@siemens-healthineers.com or fax number 919-869-2694.

You will not be invoiced until the start date of the term of this quote. If your facility is tax exempt, please include a copy of your exemption certificate with your signed quote and purchase order

Exhibit A

Item #1:

Equipment	SYSMEX CA-660		
Equipment Location	MANGUM REGIONAL MEDICAL CENTER - #0000002498		
Address	1 WICKERSHAM ST MANGUM OK 73554-9117		
Functional Location: 400-571381	**Serial Number:** 14184	**Payment Frequency:** Annual	
Performance Plan Type: Plus (8am-5pm, M-F)	**Contract Start:** 11/18/2023	**Contract End:** 11/17/2025	**Annual Price:** USD 3,895.00
Catalog Number: 10713266		**GPO Pricing VIZIENT**	

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Contract Period or as indicated:	Contract Period
Principal Coverage Period (PCP)	8:00 am - 5:00 pm Monday through Friday, excluding holidays
Planned Maintenance	8:00 am - 5:00 pm Monday through Friday, excluding holidays
On-Site Applications Support	8:00 am - 5:00 pm Monday through Friday, excluding holidays
Technical Phone Support	Included
On-Site Response Objective	Next Business Day
Labor	Included
Travel	Included
Updates	Included
General Spare Parts Coverage	Included
teamplay Fleet	Included
Smart Remote Services	Included

Siemens shall use commercially reasonable efforts to meet the specified CSE on-site response time objective, however some on-site response times may be delayed due to travel time or other factors.

No further Options or Alternatives are included in the above listed equipment.

Glossary

Deliverables	Description
Principal Coverage Period (PCP)	Hours defined in Exhibit A during which agreed-upon on-site services are provided. Principal Coverage Period is independent of Technical Phone Support hours, Planned Maintenance hours, and On-Site Applications Support hours.
Planned Maintenance	Hours defined in Exhibit A during which preventive services are carried out in accordance with the equipment's specific maintenance plan. This includes: tracking and scheduling of required maintenance tasks; exchange of wear and tear parts according to maintenance plan; care measures; adjustments to factory specifications; verification of specified performance and functionality; documentation and detailed protocol of system condition.
On-Site Applications Support	Hours defined in Exhibit A during which the Technical Applications Specialists provide on-site services. On-Site Applications Support includes: assay troubleshooting at the request of the Field Service Representative or Remote Services Center, required training associated with mandatory updates, and Siemens assay additions. On-Site Applications Support that are excluded from the service agreement are: additional and repeat training post-implementation, relocation of equipment, revalidation of assays, lot rollovers, and linearity studies. IT support and customization is also excluded unless covered by a separate Professional Services agreement.
Technical Phone Support	Direct access to technical specialists at the Siemens Remote Services Center for fast diagnosis and technical support. Technical Phone Support is included for Siemens customers with a current service agreement, with coverage hours varying by product. Access to a technical specialist is not guaranteed outside of coverage hours.
On-Site Response Objective	Siemens shall use commercially reasonable efforts to meet the specified Field Service Representative on-site response time objective defined in Exhibit A, in accordance with the defined Principal Coverage Period, once a dispatch notification has been created by Customer Care Center. Some on-site response times may be delayed due to travel time or other factors. For urgent situations in which instrument is not operational (i.e. unable to produce certain results) every effort will be made to dispatch a Field Service Representative to the account site within that day's PCP (see Exhibit A). On-Site Response Objective does not apply to On-Site Applications Support by a Technical Applications Specialist.
Labor	Unlimited coverage of on-site labor by a Field Service Representative during the Principal Coverage Period indicated. On-site service performed outside of the Principal Coverage Period or services provided that are not included in the service agreement will be billed at the current prevailing tiered labor rates.
Travel	Travel time for a Field Service Representative to and from Customer's site is included with the service agreement.
Updates	Modifications or reliability enhancements to equipment in the form of mandatory updates (safety and performance-related update instructions), to be scheduled during the defined Principal Coverage Period. Includes all necessary parts, labor, and training associated with the mandatory update. Necessary associated training will be scheduled during normal business hours (8:00 am - 5:00 pm Monday - Friday), excluding holidays. Does not include enhancements to the operating systems or additional functionality.
General Spare Parts Coverage	Replacement of standard spare parts, as defined in the Replacement Parts Section of the Service Agreement Terms and Conditions. Excludes parts defined as consumable parts, customer replaceable parts, or customer supplies in the Operator's Guide, as well as reagents. Excludes non-Siemens parts unless specifically identified in Exhibit A. Also excludes certain parts, components, and peripherals, as found in the Exclusions Section of the Service Agreement Terms and Conditions.
teamplay Fleet	teamplay Fleet is a teamplay digital health platform solution that enables you to streamline the management of your fleet from Siemens Healthineers and to optimize your asset performance holistically, 24/7, and from any browser capable device. With its broad range of features, teamplay Fleet offers you a clear overview of your equipment data, helping to maintain and optimize your asset performance while keeping your equipment cybersecure and allowing you to make sound decisions about the future of your fleet.

Deliverables	Description
Smart Remote Services	Smart Remote Services (SRS) – the efficient and comprehensive infrastructure for medical equipment-related remote services – combines high-tech medical engineering with state-of-the-art information technology. Services, which formerly required on-site visits, are now available via data transfer. Atellica Connectivity Manager or syngo Lab Connectivity Manager software is required to faciliate the delivery of Smart Remote Services. Siemens Healthineers uses SRS to remotely diagnose, troubleshoot, and support Siemens instruments, automation systems, and middleware products. Not available on all Siemens systems.

Siemens Healthcare Diagnostic, Inc. General Terms and Conditions

1. Initial Condition of Equipment
This service agreement ("Agreement") is entered into by Siemens Healthcare Diagnostics Inc. ("Siemens Healthineers") on the premise that equipment covered by this Agreement ("Equipment") is presently operating in accordance with the manufacturer's specifications as of the date of this Agreement.
Where service has not been provided by Siemens Healthineers under warranty or contract for greater than sixty (60) days preceding the date of this Agreement, Equipment condition is subject to verification by Siemens Healthineers at Customer's expense.
Any and all repairs performed by Siemens Healthineers to restore the Equipment performance to manufacturer's specifications or that are outside of the scope of this Agreement will be invoiced at Siemens Healthineers then-current rates for labor, travel and parts.
Verification is waived by Siemens Healthineers where Siemens Healthineers service, or service by a Siemens Healthineers- authorized service provider, has been provided under warranty or contract within sixty (60) days of the date of this Agreement.

2. Term.
Siemens Healthineers will provide the services detailed herein for the term set forth on Exhibit A beginning on the Contract Start date and continuing through the Contract End date for each piece of Equipment (“Term”). Any services provided by Siemens Healthineers after the expiration of the Term shall be billed to Customer on a time and material basis at Siemens Healthineers’ then current rates unless Siemens Healthineers and Customer renew this Agreement or enter into a subsequent service agreement for the applicable Equipment. Siemens Healthineers reserves the right not to renew service coverage for older equipment or software at Siemens Healthineers sole discretion.

3. Siemens Healthineers Service
Subject to the terms of this Agreement and with reasonable promptness, Siemens Healthineers or its authorized service provider will repair those Equipment malfunctions which occur notwithstanding that the Equipment is being operated in accordance with the instruction manual for such Equipment. A service call shall be considered complete when Siemens Healthineers, or its authorized service provider, demonstrates by an appropriate test procedure that the Equipment is operating in accordance with the manufacturer's specifications for such Equipment. Siemens Healthineers, or its authorized service provider, shall provide to Customer a copy of the "Field Service Report" detailing the work performed by Siemens Healthineers' field service representative, or its authorized service provider. Siemens Healthineers may require that the Equipment be returned to the repair facility for service.
As consideration for the service provided hereunder, Customer shall pay Siemens Healthineers the specified fees. Customer is also responsible for the payment of any sales and use tax on the service and any service parts furnished hereunder.

4.Service Parts
Unless otherwise provided elsewhere in this Agreement, all service parts are furnished on an exchange basis and the parts removed become the property of Siemens Healthineers. Siemens Healthineers will supply at its own expense, necessary parts, except consumables, provided replacement of the parts is required because of normal wear and tear or otherwise deemed necessary by Siemens Healthineers and further provided that the Siemens Healthineers-manufactured parts are available from the factory. All Parts will be new, standard parts, or used, reworked or refurbished parts that comply with applicable performance and reliability specifications. Exchange parts removed from the Equipment shall become the property of Siemens Healthineers unless such exchange parts constitute "hazardous wastes", "hazardous substances", "special wastes" or other similar materials, as such terms are defined by any federal, state or local laws, rules or regulations, in which case, at the option of Siemens Healthineers, the exchange parts shall remain the property of the Customer and shall be disposed of by the Customer in strict compliance with all applicable laws, rules and regulations. For a list of excluded parts not covered by this Agreement, please refer to Section 5 (o) of this Agreement below.

5. Exclusions
Service does not include any work and related travel, labor and parts required to repair Equipment malfunctions resulting from Customer's failure to provide suitable operating conditions or to adequately furnish all facilities required by the manufacturer's installation manual.

In addition, service required to correct malfunctions resulting from the following is excluded from this Agreement:
(a) Failure on the part of Customer to maintain the Equipment in accordance with the routine maintenance requirements set forth in any manuals for such Equipment;
(b) Damage caused by Customer error, misuse, abuse, or operation outside of conditions prescribed in the Equipment instruction manual or damage caused by use for a purpose other than for which is was designed;
(c) Improper use or storage or other external cause, including service or modifications not performed by Siemens Healthineers or its authorized service provider;
(d) Damage incurred during the transportation of the Equipment not supervised by Siemens Healthineers or its authorized representative;
(e) Damage caused by repair, service, or alteration made or attempted by any parties other than Siemens Healthineers or Siemens Healthineers' authorized service provider without Siemens Healthineers' prior written consent;
(f) Acts of God including flood, earthquake, tornado, hurricanes and other natural or man-made disasters;
(g) Acts of war, vandalism, sabotage, arson and civil commotion;
(h) Electrical surges and sprinkler damage, or;
(i) Use of supplies, disposables, consumables or reagents not recommended in writing by the Equipment manufacturer, or accessories which the Equipment manufacturer has not specifically designated in writing as compatible with the Equipment;
(j) Customer owned instrument de-installation, decontamination, re-installation;
(k) Rebuilding of any Equipment software or IT environment damage resulting from a cyberattack.
Siemens Healthineers service also excludes the following:
(l) Furnishing of batteries, fuses, lamps, hoses, tubing, filters, disconnected fittings, electrodes, computer software, test patterns, calibration standards, report forms, printers, printer paper, pen styli, ink pens, or hollow cathode;
(m) Service which is unreasonable for Siemens Healthineers or its authorized service provider to render because of unauthorized alterations or attachments to the Equipmen;.
(n) System peripherals such as uninterruptable power sources. (Applies to Centaur, Immulite, and Atellica Products.);
(o) Parts defined as 'Supplies', 'Supplies list', 'Supplies and Replacement Parts', 'Consumables and Accessories', 'Orderable Parts', or 'Customer Replaceable Parts' within the Operator's Guide, Instructions for Use, or Operating Manual (all of which can be found in the Document Library at <https://doclib.Siemens Healthineers-healthineers.com/home>).
Service calls made by Siemens Healthineers, or its authorized service provider, and any related travel, labor and parts required to correct Equipment malfunctions resulting from causes set forth above shall be invoiced by Siemens Healthineers to Customer at Siemens Healthineers' then-current rates.

6. Planned Maintenance (PM)
Planned maintenance will be carried out according to the manufacturer's recommended schedule. Planned maintenance generally includes checking mechanical and electrical safety, lubrication, functional testing and adjusting for optimum performance as specified in the detailed planned maintenance work plan. Planned maintenance will be performed during normal business hours (M-F, 8AM to 5PM), and excluding holidays, unless mutually agreed otherwise.

7. Warranty
Siemens Healthineers warrants that Equipment service rendered by Siemens Healthineers, or its authorized service provider, to the Customer hereunder shall be performed in a workmanlike manner, consistent with industry standards. If the service performed does not result in the Equipment performing in accordance with the manufacturer's specifications, Siemens Healthineers shall repeat such service until the Equipment performs in accordance with the manufacturer's specifications. The foregoing express warranty and remedy are exclusive and there are no other warranties expressed or implied.
THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE ARE HEREBY DISCLAIMED BY SIEMENS HEALTHINEERS.

8. Equipment Retrofit
Siemens Healthineers, or its authorized service provider, may make changes in the design or construction of Siemens Healthineers equipment without incurring any obligation hereunder to make such changes to the Equipment covered by this Agreement. Customer shall, however, allow Siemens Healthineers, or its authorized service provider, at Siemens Healthineers' expense, to retrofit components or make design changes which improve Equipment reliability but do not adversely affect Equipment performance.

9. Trained and Key Operators
Customer agrees that only operators who can independently demonstrate the ability to identify hardware and perform all

daily tasks required for sample processing, including all maintenance activities (“Trained Operators”), will operate the system for the life of the agreement. Untrained users operating the system shall be deemed a material default of this Agreement. Customer must be able to document training and provide to Siemens Healthineers upon request.
Customer shall also designate a Trained Operator who is capable of performing basic troubleshooting tasks and acts as an educational resource for the other Trained Operators (”Key Operator”). The Key Operator shall be made available to Siemens Healthineers, or its authorized service provider, to describe Equipment malfunctions to Siemens Healthineers representatives by telephone and who shall be qualified to perform simple adjustments and corrections as requested by Siemens Healthineers representative. Failure to designate a Key Operator or to perform Customer maintenance as specified in the Equipment instruction manual shall be deemed a material default of the Agreement and may result in a service call invoiced by Siemens Healthineers at its then-current standard rates for service, travel, labor and parts, if necessary to resolve an issue that could have been resolved by a Key Operator.

10. OSHA
Customer shall provide Siemens Healthineers' field service representative, or its authorized service provider, with facilities at Customer's location which shall be adequate for Siemens Healthineers or its authorized service provider to perform the services contemplated by this Agreement and comply with the regulations of the Secretary of Labor promulgated under the Occupational Safety and Health Act of 1970 as amended.

11. Access to Books and Records
The obligation under this Section 11 is undertaken pursuant to and to the extent required by Section 952 of the Omnibus Reconciliation Act of 1980 ("Act") which is applicable to parties furnishing services with a value or cost of $10,000 or more over a twelve-month period. Upon written request any time during a four-year period after furnishing the services, Siemens Healthineers shall make available to the Secretary of The Department of Health and Human Services, the U.S. Comptroller General, and their authorized representatives, this Agreement and all books, documents, and records necessary to verify the nature and extend of the cost of such services. If Siemens Healthineers provides any service through a subcontract with a related organization, such subcontract shall contain a provision similar to this Section 11 required by the Act.

12. Payment Terms
Payment is due thirty (30) days from invoice date. Notwithstanding anything to the contrary contained herein, this Agreement may be terminated immediately upon written notice by Siemens Healthineers to Customer for nonpayment. Any service calls made after the date of such termination shall be invoiced at Siemens Healthineers' then-current standard rates for service, travel, labor and parts.
After the first year of the term of the Equipment coverage period set forth in the Agreement, Siemens Healthineers may increase the Annual Agreement Price no more than once every twelve (12) months based upon the percentage increase in the Consumer Price Index for All Urban Consumers, U.S. City Average, All Items ("CPI"), as published by the United States Department of Labor, Bureau of Labor Statistics. The percentage increase in the CPI shall be measured over the period since the commencement of the Agreement (in the case of the first price increase) or since the effective date of the last price increase (in the case of any subsequent price increases). Siemens Healthineers shall provide the Customer with no less than thirty (30) days written notice of any price increase.

13. Limitation of Liability and Indemnification
(a) Limitation of Liability. In no event shall Siemens Healthineers' liability hereunder exceed the actual loss or damage sustained by Customer, up to the purchase price paid to Siemens Healthineers for the service giving rise to such loss or damage, however, liability for intentional misbehavior and personal injury will not be limited. SIEMENS HEALTHINEERS SHALL NOT BE LIABLE TO CUSTOMER FOR ANY LOSS OF USE, REVENUE OR ANTICIPATED PROFITS, COST OF SUBSTITUTE SERVICE (UNLESS OTHERWISE AGREED TO BY SIEMENS HEALTHINEERS), OR LOSS OF STORED, TRANSMITTED OR RECORDED DATA. NEITHER PARTY SHALL BE LIABLE TO THE OTHER PARTY FOR ANY INDIRECT, INCIDENTAL, UNFORESEEN, SPECIAL, PUNITIVE, EXEMPLARY, OR CONSEQUENTIAL DAMAGES ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT. The limitations of Siemens Healthineers' liability contained herein shall apply to Siemens Healthineers and Siemens Healthineers' employees, agents and subcontractors performing under this Agreement, regardless of whether such liability is based on breach of contract, tort, strict liability, breach of warranties, failure of essential purpose or otherwise, and even if Siemens Healthineers or its employees, agents or subcontractors are advised of the likelihood of such damages.
The limitations of Customer's liability set forth herein do not affect Customer's liability for Claims (as defined herein) arising out of the negligent or wrongful acts or omissions of Customer, its employees or agents in connection with this Agreement, to the extent set out in this Agreement. The limitations of Siemens Healthineers' liability set forth herein do

not affect Siemens Healthineers' liability for Claims for personal injury arising as a result of Siemens Healthineers' negligence or product defect, to the extent set out in this Agreement.
THE FOREGOING IS A SEPARATE, ESSENTIAL TERM OF THIS AGREEMENT AND SHALL BE EFFECTIVE UPON THE FAILURE OF ANY REMEDY, EXCLUSIVE OR NOT.
(b) General Indemnification. Each party agrees to indemnify and hold the other party and its employees, directors, officers and agents (collectively, the "Indemnitees") harmless from and against any and all third party claims and associated liabilities, obligations, damages, judgments, penalties, causes of action, costs and expenses (including, without limitation, reasonable attorney's fees) imposed upon or incurred by or asserted against any of the Indemnitees ("Claims") for bodily injuries (including death) or damages to or loss of real or tangible personal property, to the extent that any such Claim arises out of the negligent or wrongful acts or omissions of the indemnifying party, its employees or agents in connection with this Agreement, provided that the Indemnitee provides the indemnifying party with prompt notice of the Claim, reasonable cooperation in the defense and/or settlement of the Claim and is given all right and power to defend and/or settle such Claim.
The obligations of indemnity shall survive the expiration or termination of the Agreement.

14. Force Majeure
Neither party shall be responsible for delay or nonperformance caused by circumstances beyond such party's reasonable control.

15. Default and Termination
Customer shall be in default under this Agreement upon: (i) a failure by Customer to make any payment due Siemens Healthineers within ten (10) days of receipt of notice from Siemens Healthineers that the payment was not made within the applicable payment period; (ii) a failure by Customer to perform any other obligation under this Agreement within thirty (30) days of receipt of notice from Siemens Healthineers; (iii) a failure by Customer to grant Siemens Healthineers access to the Equipment as set forth in this Agreement; (iv) a failure by Customer to notify Siemens Healthineers the Equipment is in need of remedial maintenance or to permit Siemens Healthineers to inspect, repair or adjust the Equipment as deemed necessary by Siemens Healthineers or at any time during the term of this Agreement in order to keep the Equipment operating in material compliance with the written specifications; (v) a failure by Customer to maintain the Equipment in accordance with the manufacturer’s written specifications; (vi) a failure by Customer to purchase from Siemens Healthineers all necessary service parts and labor that are excluded from coverage under this Agreement; (vii) a default by Customer or any affiliate of the Customer under any other obligation to or agreement with Siemens Healthineers or any assignee of the foregoing (including but not limited to, a promissory note, lease, rental agreement, license agreement or purchase contract); or (viii) the commencement of any insolvency, bankruptcy or similar proceedings by or against the Customer (including any assignment by Customer for the benefit of creditors).
Upon the occurrence of any event of default hereunder, Siemens Healthineers may, in addition to any and all other remedies available under law, elect to: (i) immediately cease providing services under this Agreement and any and all other agreements between the parties, or suspend any training courses or educational offerings provided under this Agreement, until the default is cured or corrected; (ii) terminate this Agreement, in which case Customer shall pay to Siemens Healthineers (a) all amounts due under this Agreement through the effective date of termination, (b) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement from the date of termination through the scheduled expiration of the term of this Agreement, and (c) all costs and expenses of collection, including without limitation reasonable attorneys’ fees and court costs incurred by Siemens Healthineers as a result of the Customer’s default; (iii) void any and all warranties for the Equipment that has been affected by the use of unauthorized replacement parts and/or Customer or third-party labor; and/or (iv) commence collection actions (including court actions) for all sums due under this Agreement. All rights and remedies available to Siemens Healthineers hereunder, by law or equity, shall be cumulative and there shall be no obligation for Siemens Healthineers to exercise a particular remedy.
In the event that Customer cures all defaults hereunder, then prior to resumption of the Equipment maintenance services under this Agreement, Siemens Healthineers may inspect the Equipment to determine if it is in good operating condition. Such inspection shall be charged to the Customer at Siemens Healthineers’ per-call rates and terms then in effect. Any repairs or adjustments which Siemens Healthineers determines are required due to: (i) the use of any non-Siemens Healthineers parts; (ii) the repair or service of the Equipment by the Customer or any third party during the suspension of services by Siemens Healthineers; or (iii) any of the exclusions from coverage set forth in Section 5 of this Agreement, shall be charged to the Customer at Siemens Healthineers’ rates and terms then in effect and shall include charges for parts, with all such repairs or adjustments to be completed prior to the resumption of service under this Agreement.

16. Additional Terms and Conditions for Smart Remote Services

(a) Applicable Equipment Upkeep and Maintenance. The services provided by Siemens Healthineers permit improvements in anticipating maintenance and other issues that may arise in connection with Applicable Equipment and, consequently, can improve scheduling of appropriate service. THE SERVICES THAT THE SOFTWARE PERMITS SIEMENS HEALTHINEERS TO PROVIDE ARE NOT A SUBSTITUTE FOR, OR SERVE TO DIMINISH IN ANY WAY, CUSTOMER'S DUTY TO EXERCISE APPROPRIATE DILIGENCE AND CARE IN OPERATING AND MAINTAINING THE APPLICABLE EQUIPMENT(S). CUSTOMER ACKNOWLEDGES THAT CUSTOMER IS RESPONSIBLE TO PERFORM ALL ROUTINE AND PERIODIC MAINTENANCE CHECKS AND PROCEDURES ON THE APPLICABLE EQUIPMENT(S) AND THAT CUSTOMER RETAINS THE DUTY TO FOLLOW ALL APPROPRIATE PROCEDURES AND SAFEGUARDS TO THE SAME EXTENT AS THOUGH THE SOFTWARE WERE NOT INSTALLED AND SIEMENS HEALTHINEERS WERE NOT PROVIDING THE SERVICES

(b) Remote Diagnostics. Customer shall provide Siemens Healthineers with both on-site and remote access to the Equipment. The remote access shall be provided through the Customer network as is reasonably necessary for Siemens Healthineers to provide services under this Agreement. Remote access will be established through a high speed internet based connection to Siemens Healthineers Data Center utilizing Applicable Equipment requirements. Customer hereby acknowledges Siemens Healthineers may require remote access in order to provide services under this Agreement. In the event that Customer fails to provide or maintain the remote access connection, then Siemens Healthineers shall have the option to terminate this Agreement. Customer declining or being unable to remote troubleshoot with Siemens Healthineers may result in a service visit invoiced by Siemens Healthineers at then-current rates for travel and labor.

(c) System Monitoring. Siemens Healthineers provides services for remote monitoring of certain Siemens Healthineers Equipment used by Customer and described in a Supplement hereto ("Applicable Equipment"). In connection with such services, Siemens Healthineers uses certain Smart Remote Services software (“SRS”), a persistent online connection between Siemens Healthineers or its affiliates and the Applicable Equipment to monitor the performance of Applicable Equipment and deliver updates and patches to permit Siemens Healthineers‘ monitoring of the performance of the Applicable Equipment anonymously ("SRS Connection“). SRS is installed on the analyzer computer or server, and works within a domain environment, workgroup, or on a standalone system.

In the event that Customer fails to provide or maintain the SRS Connection for the Applicable Equipment, then Siemens Healthineers shall have the option to terminate this Agreement and any applicable Supplements or Schedules hereto. In addition, any Uptime Performance Guarantee or Availability Commitment of the Equipment (if applicable) shall be void if the SRS Connection is not provided and available 24 hours per day, 7 days a week.

For the purposes of this SRS Connection Section, ‘Security Concept’ means Siemens Healthineers IT security concept, which can be found under the following link or which Siemens Healthineers will send to Customer upon request: https://marketing.webassets.siemens-healthineers.com/5d482f2bbdceb7e4/c407ea6ab7d6/CS_SRS_Security_Concept_V9_HOOD05162003276144.pdf.

'Technical Data‘ means information available through the SRS Connection and may include: (i) application logfiles, errors occurred, device properties, quality control (technical status information); (ii) configuration, software versions, patches, licenses, network settings, device service history (asset and configuration data); (iii) sequences of performance of various tasks, used applications/licenses and interactions with the application (utilization data); (iv) the reagents and consumables loaded onto the Applicable Equipment; (v) any other data explicitly agreed; and in each case not related to an identified or identifiable natural person. ‘Smart Technical Data’ means correlated Technical Data derived from the Applicable Equipment to support prediction of Equipment service requirements. ‘Cyberthreat’ means any circumstance or event with the potential to adversely impact the Equipment via unauthorized or unlawful access, damage and/or destruction, disclosure of information, modification, corruption or alteration of information, and/or denial of service rendering the Equipment unavailable or inoperable. ‘EoS’ means End of Support, the date Siemens Healthineers notifies Customer that the service parts and any other services for the Equipment are no longer available. ‘Insignificant’ means a categorization of a Vulnerability the exploitation of which, taking into account the individual Equipment attributes and/or the respective operating environment, is not reasonably expected and/or would not result in a foreseeable impairment of the Equipment’s secure operation or provide access to personal information. ‘IT Security’ means safeguarding the uninterrupted operation of the Equipment against interference caused by exploited Vulnerabilities, as well as the availability, confidentiality and integrity of data and information created, stored, and/or transmitted by the Equipment. ‘Patch(es)’ means an Equipment and operating system (OS) update that addresses security vulnerabilities within the Equipment. ‘Vulnerability’ means a weakness in the Equipment that could be exploited by a Cyberthreat and are assigned a significance level in accordance with FDA Post-Market Guidance for Cybersecurity of Medical Devices. Siemens Healthineers and its affiliates are authorized to access, maintain, repair, calibrate, update or patch the Applicable Equipment that is the object of the SRS Connection or provide remote training in every case through the SRS Connection and use any Technical Data collected via the SRS Connection for the aforementioned purposes. If the Applicable Equipment hereunder is covered by a warranty period or extended service plan, then Siemens Healthineers, its affiliates and other companies engaged by Siemens Healthineers are also authorized to carry out through the SRS Connection additional system monitoring services supported by the covered Equipment.

(d) Access to Data and Use of Data. Customer hereby irrevocably permits Siemens Healthineers and its affiliates to use for their own business, product surveillance, research or development purposes (e.g. determine trends of usage products and services, improvement of products, services and software), for facilitating and advising on continued and sustained use of products and services, substantiation of aggregated product and services marketing claims and for benchmarking purposes, without restrictions in terms of time, transferability, replication, location or content: (i) Technical Data that is collected via the SRS Connection; and (ii) Smart Technical Data that is collected via the SRS Connection from the Applicable Equipment during a running commercial relationship between the parties.
(e) Customer Obligations for SRS Connection.
(i) Customer shall permit the SRS Connection to be established by connecting the Applicable Equipment either directly or through a gateway or networked computer at Customer's own expense to a secured telecommunications link via a broadband connection and Customer shall bear the cost of any technical requirements for any such connection that is not a part of the Applicable Equipment (e.g. establishing a broadband connection);
(ii) Customer shall support Siemens Healthineers in protecting against cyber threats by implementing and continuously maintaining a holistic, state-of-the-art security concept protecting Customer's IT infrastructure;
(iii) Customer shall not connect Equipment to the SRS Connection that does not comply with state-of-the-art security policies or is otherwise approved by Siemens Healthineers;
(iv) Customer shall not use the SRS Connection in a way that impairs or disrupts the integrity of the SRS Connection or Siemens Healthineers IT infrastructure; and
(v) Customer shall not transmit any data containing viruses, Trojan horses or other programs that may damage or impair the SRS Connection or Siemens Healthineers IT infrastructure.
(f) Customer's Cybersecurity Obligations. In order to protect the Equipment against Cyberthreats, Customer shall implement and continuously maintain a holistic, state-of-the-art security program for its IT infrastructure, including regular network scanning, provided however, that:
(i) network scanning or penetration testing shall not be performed during clinical use of the Equipment and should optionally be scheduled, with Siemens Healthineers' assistance, during equipment downtime;
(ii) the system configuration and/or IT Security controls of the Equipment as stated in the MDS2 and/or Security Whitepaper provided or made available by Siemens Healthineers at, or prior to, the time of delivery must not be modified;
(iii) if during the deployment of the Equipment Vulnerabilities are identified by Customer, Customer shall align with Siemens Healthineers regarding the severity of the Vulnerabilities taking into account the individual Equipment attributes and intended operating environment and shall not refuse acceptance of the Equipment, if the Vulnerability is classified as 'low' by Siemens Healthineers using the Common Vulnerability Scoring System ("CVSS"); and
(iv) Siemens Healthineers' initial response to Customer's inquiry on a Vulnerability will be within fifteen (15) days. Siemens Healthineers will evaluate all Vulnerabilities using CVSS and FDA's definition of "controlled" and "uncontrolled" Vulnerabilities and will make such evaluations available to Customer. Siemens Healthineers will periodically release Patches depending on the age of the device and Equipment version. If Siemens Healthineers determines the Vulnerability to be critical and uncontrolled, Siemens Healthineers will communicate this determination to Customer within thirty (30) days and utilize commercially reasonable efforts to have a mitigation (workaround, patch, etc.) available within sixty (60) days of Siemens Healthineers' determination of an uncontrolled Vulnerability. Unless otherwise specified, no patches may be loaded by Customer. In the event of a Vulnerability that is reasonably determined by Customer to constitute an emergency (meaning that the Managed Equipment must be taken out of clinical use until the Vulnerability is remedied) needing an expedited response, Siemens Healthineers will collaborate with Customer to jointly determine the most prudent action necessary in light of the circumstances.
(v) Customer is responsible for preventing unauthorized access to the Equipment licensed to Customer, including but not limited to changing passwords and other protective settings from their default values to individual ones. The Equipment shall only be connected to an enterprise network or the internet if and to the extent such a connection is authorized by Siemens Healthineers in the instructions for use and only when appropriate security measures (e.g., firewalls, network Customer authentication and/or network segmentation) are in place.
(vi) USB-storage media and other removable storage devices shall only be connected to the Equipment if and to the extent such connection is authorized by Siemens Healthineers in the instructions for use and only when the risk of a malware infection of the Equipment is minimized through malware scanners or other appropriate means.
(vii) The Equipment undergoes regular development to further improve its IT Security. Siemens Healthineers strongly recommends that Equipment updates be applied as soon as they are available and that the latest Equipment versions are used by Customer. The latter might include the purchase of upgrades of hardware and Equipment by Customer; provided however, updates to remedy uncontrolled Vulnerabilities and/or clinical performance based on the Equipment Specification will be provided without additional charge. Use of Equipment versions that are no longer supported, and failure to apply the latest updates/upgrades may increase Customer's exposure to Cyberthreats.
(viii) Customer shall notify Siemens Healthineers without delay in case of suspected or actual Cyberthreats or Vulnerabilities of the Equipment. Disclosure by Customer of such information to third parties during the immediately

following sixty (60) day period requires prior written consent by Siemens Healthineers.
(ix) If Siemens Healthineers provides a Patch via SRS or for download, Customer shall promptly install the Patch in accordance with the respective installation instructions given by Siemens Healthineers.
(e) Siemens Healthineers Cybersecurity Obligations. In order to protect the Equipment against Cyberthreats, Siemens Healthineers shall implement and continuously maintain a holistic, state-of-the-art security program for its IT infrastructure, including regular network scanning. In the event that Siemens Healthineers becomes aware of a Vulnerability that Siemens Healthineers does not classify as Insignificant, it shall make available Patches until EoS, until the termination of this Agreement, or up to ten (10) years following Equipment delivery, whichever occurs first, provided that Customer's Equipment version is the most recent or at least the penultimate version at the given time, except in the case of third-party Equipment where the respective Equipment provider does not have a Patch available, Siemens Healthineers will use commercially reasonable efforts to make a mitigation available for the Vulnerability within 120 days following Siemens Healthineers becoming aware of such Vulnerability. In the case of third-party Equipment, Siemens Healthineers will make the Patch available to Customer without undue delay after such Patches are made available by Siemens Healthineers' licensors and Siemens Healthineers performs the required testing and validating on the applicable Equipment. Depending on the severity of the Vulnerability as determined by Siemens Healthineers (after consultation with Customer), Siemens Healthineers may elect to provide the Patch at the time and as part of upcoming routine updates. If the Equipment is connected to SRS and Customer enables remote distribution of the Patch via SRS, or if Patches are made available for download, the Patches shall be free of charge. However, if the Patch needs to be installed on site by Siemens Healthineers, Siemens Healthineers may charge Customer for the expenses (time and material) resulting from the installation. For the sake of clarity; (i) safety, uncontrolled Vulnerability and clinical performance Updates are mandatory and will be provided without additional charge to Customer regardless of contract status, and will be implemented by Siemens Healthineers regardless of who may otherwise be servicing the Equipment; and (ii) all other Updates are non-mandatory ("Refinement Updates") and are not performed unless requested by Customer and may be chargeable (e.g., travel, labor, and sometimes charges for parts) depending on Update.
NOTWITHSTANDING THE FOREGOING, SIEMENS HEALTHINEERS ASSUMES NO LIABILITY WHATSOEVER FOR DAMAGE TO THE EXTENT SUCH DAMAGE IS CAUSED BY THE FOLLOWING:
(i) Customer's intrusive IT Security testing;
(ii) unauthorized modification of the system configuration or IT Security controls of the Equipment;
(iii) the installation of Patches which are not authorized by Siemens Healthineers;
(iv) Customer delaying the self-installation of Patches made available by Siemens Healthineers via SRS or for download;
(v) Hacker attacks, Cyberthreats or related preventative measures; or
(vi) Failure to perform and maintain adequate backups of Customer's data.
(f) SRS Limited Warranty. Unless explicitly otherwise regulated, the SRS Connection is provided "as is" and Siemens Healthineers does not provide Customer with any warranty or guarantee regarding the availability, performance or quality of the SRS Connection. Siemens Healthineers will not provide an SRS Connection if: (i) the provision is prevented by any impediments arising out of national or international foreign trade or custom requirements or any embargoes or other sanctions; or (ii) there is a defect, malfunction or other problem with the telecommunications network; or (iii) there is a defect, malfunction, insufficient configuration or other problem with Customer`s infrastructure.
(g) Update of Terms and Security Concept. Siemens Healthineers shall setup the technical and organizational process for the SRS Connection and IT infrastructure used by Siemens Healthineers for the establishment of the SRS Connection according to the Security Concept. Siemens Healthineers shall be entitled to modify and/or update the terms of this SRS Connection Section 16. SRS Connection and/or the Security Concept to reflect technical progress, changes in law and the further development of its offerings. Such modifications and/or updates shall not jeopardize the quality and execution of the SRS Connection. Siemens Healthineers shall inform Customer of changes by giving Customer at least thirty (30) days prior written notice. Siemens Healthineers will provide Customer with access to the updated terms and conditions.
(h) Certification of SRS. The Siemens Healthineers service organization shall maintain a certified information security management system for the purposes of the SRS Connection. In this regard, Siemens Healthineers shall be subject to regular external audits by independent third parties. The scope and details of the certification are determined in the current Security Concept.
(i) SRS Connection Termination. Siemens Healthineers shall be entitled to suspend the SRS Connection with immediate effect if Customer is in breach of the terms contained herein or if Siemens Healthineers, acting reasonably, is of the opinion that the SRS Connection to one or more of Customer's Equipment contains a risk for the security and performance of the IT infrastructure used by Siemens Healthineers.
(j) SRS Intellectual Property. Siemens Healthineers (and its licensors, where applicable) will retain all intellectual property rights relating to the Applicable Equipment, including improvements thereto, including any improvements derived from Technical Data or Smart Technical Data, as well as any suggestions, ideas, enhancement requests,

feedback, recommendations or other information provided by Customer which are hereby assigned to Siemens Healthineers.

17. Independent Contractor
Nothing in this Agreement shall confer upon any person other than the Parties and their respective successors and assigns any rights, remedies, obligations, or liabilities whatsoever. The Parties agree that they are independent contractors and not agents of each other.

18. Software Updates
Siemens Healthineers may require Customer to update Siemens Healthineers' proprietary software or the Equipment operating system in order to perform services under this Agreement. Siemens Healthineers reserves the right to provide Customer an EOS Announcement (as defined below) with respect to the Equipment software. In the event the Customer does not update or replace the software in accordance with Siemens Healthineers' direction within twelve (12) months from the EOS Announcement date, Siemens Healthineers may, at its option, (i) cancel this Agreement or (ii) remove any affected Software or Equipment from coverage under this Agreement, with a corresponding adjustment of the annual agreement price. Siemens Healthineers will use commercially reasonable efforts to provide service or parts on a time and materials basis only, at Siemens Healthineers' rates and terms then in effect, for any Software subject to an EOS Announcement. Nothing in this Agreement shall in any way grant to Customer any right to or license in any diagnostic service software utilized by Siemens Healthineers in servicing the Equipment. In the event Customer's failure to update or replace the Equipment software in accordance with this Section results in a service call that could have been avoided by performing such software update or replacement, Siemens Healthineers may invoice Customer for such service call at Siemens Healthineers' rates and terms then in effect.

19. End Of Support
Notwithstanding anything to the contrary contained herein, in the event that Siemens Healthineers makes a general announcement that it will no longer offer service agreements for an item of Equipment, software, or components thereof, or provide a particular service agreement option or feature, whether due to the unavailability of spare parts or otherwise (an "EOS Announcement"), then upon no less than twelve (12) months prior written notice to the Customer, Siemens Healthineers may remove any affected Equipment, software, components, options or features from coverage under this Agreement, with a corresponding adjustment of the Annual Agreement Price. In addition, at the end of this twelve (12) month period, the Customer may either remove the affected Equipment, software, components, options or features from coverage under this Agreement or request that Siemens Healthineers provide service or parts on a time and materials basis only, at Siemens Healthineers' rates and terms then in effect, for any Equipment, software, components, options or features subject to an EOS Announcement.

20. Removal of Equipment from Coverage
Customer may remove Equipment from coverage under this Agreement at any time upon no less than thirty (30) days prior written notice to Siemens Healthineers if the use of the Equipment is permanently discontinued and the Equipment is removed from service. There is no fee for this cancellation. Prorated credit will be issued for any advance payments made by the Customer for the period after the effective date of removal (based on the notice requirement). In addition, if the Customer sells or otherwise transfers any of the Equipment to a third party and the Equipment remains installed and in use at the same location, but such third party does not assume the obligations of the Customer under this Agreement or enter into a new service agreement with Siemens Healthineers with a term at least equal to the unexpired term of this Agreement, then the Customer may terminate this Agreement with respect to such Equipment upon no less than thirty (30) days prior written notice to Siemens Healthineers, in which case the Customer shall pay to Siemens Healthineers: (i) all amounts due under this Agreement through the effective date of termination (based on the notice requirement); and (ii) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement for such Equipment from the date of termination through the scheduled expiration of the term of this Agreement.

21. Excluded Provider
Siemens Healthineers certifies that Siemens Healthineers, its employees, agents or representatives providing services hereunder are not suspended or excluded from participation in any federal health care programs, as defined under 42.U.S.C. § 1320a-7b(f), or any form of state Medicaid program (collectively, "Government Payor Programs"). Siemens Healthineers hereby represents and warrants that Siemens Healthineers is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Siemens Healthineers

hereby agrees to promptly notify Customer of any exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that Siemens Healthineers is excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that Siemens Healthineers is in breach of this provision, then Customer may terminate this Agreement upon written notice to Siemens Healthineers.

22. Corporate Compliance
Each of the Parties acknowledges that it has adopted its own corporate compliance program and code of conduct with which it expects its officers, directors, employees and agents to comply, and that it is responsible for monitoring and enforcing observance of its own compliance program and taking prompt action to resolve any non-compliance. A copy of each Party's compliance program and code of conduct is available upon request.

23. Miscellaneous
This Agreement sets forth the entire agreement and understanding between Siemens Healthineers and Customer regarding service of the Equipment. Customer may not assign this Agreement, or any right or obligation arising out of this Agreement, without the express written consent of Siemens Healthineers, which shall not be unreasonably withheld. This Agreement shall not be modified except by a writing making reference hereto, expressing the plan or intention to modify same, and executed by duly authorized representatives of both parties. Any term or condition contained in a Customer purchase order relating to service supplied hereunder shall be null and void. This Agreement shall be governed and construed in accordance with the laws of the State of Illinois without reference to conflicts of law provisions. Each party will send any required notices to the other party by registered or certified mail or by recognized overnight courier service. All notices will be sent to the applicable party at the address set forth herein. A party may designate an alternate address for notices by giving written notice thereof in accordance with the provisions of this Section.

24. Additional Customer Obligations for Professional Services Agreements (DOES NOT APPLY TO EVERY SERVICE AGREEMENT)
Siemens Healthineers and Customer agree that in the event this Agreement includes the provision of professional services (Bronze/Silver/Gold/Platinum, collectively “Professional Services”) as detailed on Exhibit A of this Agreement, the following additional terms shall apply:
In the event of a termination before the expiration of the initial Term of post-installation Professional Services, either for default or in accordance with Section 15. Default and Termination herein, Customer shall pay Siemens Healthineers the full remaining balance for the Professional Services provided hereunder as detailed on Exhibit A of this Agreement.
In the event Customer fails to pay the full remaining balance for the Professional Services as detailed in Section 24 (a) above, Siemens Healthineers reserves the right to disable any and all functionality for the Equipment or software that was developed for Customer as part of the Professional Services detailed in this Agreement.

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract:** Siemens Healthineers
3. **Contract Parties: MRMC/Siemens Healthineers**

4. **Contract Type Services:** Equipment service and maintenance.

5. **Impacted Hospital Departments: Lab**

6. **Contract Summary: This agreement will allow MRMC to have service and maintenance Monday through Friday from 8am to 5pm. This contract is for 2yrs. And is paid annually.**

7. **Cost: $3,895 x2 =$7,516.00**

8. **Prior Cost: $3,895 a year**

9. **Term: The term of the Agreement shall expire on November 17, 2025.**

10. **Termination Clause: Capitalized terms that are not otherwise defined herein shall have the same meaning as they do in the Original Agreement.**

Removal of Equipment from Coverage Customer may remove Equipment from coverage under this Agreement at any time upon no less than thirty (30) days prior written notice to Siemens Healthineers if the use of the Equipment is permanently discontinued and the Equipment is removed from service. There is no fee for this cancellation. Prorated credit will be issued for any advance payments made by the Customer for the period after the effective date of removal (based on the notice requirement). In addition, if the Customer sells or otherwise transfers any of the Equipment to a third party and the Equipment remains installed and in use at the same location, but such third party does not assume the obligations of the Customer under this Agreement or enter into a new service agreement with Siemens Healthineers with a term at least equal to the unexpired term of this Agreement, then the Customer may terminate this Agreement with respect to such Equipment upon no less than thirty (30) days prior written notice to Siemens Healthineers, in which case the Customer shall pay to Siemens Healthineers: (i) all amounts due under this Agreement through the effective date of termination (based on the notice requirement); and (ii) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement for such Equipment from the date of termination through the scheduled expiration of the term of this Agreement.

11. **Other:**

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 Regional Medical Center	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 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℠ Network Addendum to the Blue Traditional℠ 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 Regional Medical Center	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

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 REGIONAL MEDICAL CENTER	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.

BlueCross BlueShield of Oklahoma

Blue Traditional[SM] Network Participating Group Agreement

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

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.

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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, and The Plan shall determine, in its sole discretion, whether to add the new office, location, or entity to this Agreement.

(a) If The Plan determines that the additional office, location, or entity will not be added to this Agreement, all services at the additional office, location, or entity shall be determined to be out of network unless the office, location, or entity enters into a separate agreement with The Plan. If the additional office, location, or entity is not added to this Agreement and does not enter into a separate agreement with The Plan, Group must notify the Member in advance of receiving services at that location that the location is out of network.

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 Remote Access to Electronic Health Records: If Group is able to provide electronic access, Group must establish an agreement with The Plan to enable designated staff access to Group's electronic health record (EHR) system when The Plan is required to conduct regulatory audits such as the Initial Validation Audits (IVA) Department of Health and Human Services' Risk Adjustment Data Validation (HHS-RADV) program, the Healthcare Effectiveness Data and Information Set (HEDIS), and other reviews performed by The Plan. This does not eliminate Group's responsibility to provide records when requested by The Plan.

2.29 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.

2.30 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.

2.31 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 this Attachment V 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

NativeBlue[SM] Network Addendum to the Blue Traditional[SM] 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 REGIONAL MEDICAL CENTER	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 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 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 Regional Medical Center	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 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

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

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 medical group, whose members are duly licensed by the State of Oklahoma and authorized to practice as a physician or health care professional ("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 Groups
- ☑ Attachment A, Compensation/Claims Submission
- ☑ 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 Regional Medical Center	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 Centers for Medicare and Medicaid Services ("CMS"): means the agency within the Department of Health and Human Services that administers the Medicare program.

1.1 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

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

1.3 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.

1.4 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.

1.5 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.

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

1.7 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.

1.8 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.

1.9 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.

1.10 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.

1.11 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.

1.12 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.

1.13 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.

1.14 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.

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

1.16 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.

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

1.18 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.

1.19 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.

1.20 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 BlueLimcs 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 as payment in full for the provision of a Covered Service to a MA HMO Member the lesser of (1) billed charges, or (2) one hundred percent (100%) of the reimbursement rate posted on the Centers for Medicare and Medicaid Services (CMS) web site (www.cms.hhs.gov) for all procedures for which CMS has a reimbursement rate in effect at the time the Covered Service is provided, less 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. Services that do not have a reimbursement 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

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 medical group, whose members 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 Groups
- ☑ Attachment A, Compensation/Claims Submission
- ☑ 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 Regional Medical Center	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

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

1.1 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

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

1.3 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.

1.4 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.

1.5 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.

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

1.7 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.

1.8 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.

1.9 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.

1.10 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.

1.11 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.

1.12 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.

1.13 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.

1.14 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.

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

1.16 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.

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

1.18 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.

1.19 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.

1.20 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 as payment in full for the provision of a Covered Service to a MA PPO Member the lesser of (1) billed charges, or (2) one hundred percent (100%) of the reimbursement rate posted on the Centers for Medicare and Medicaid Services (CMS) web site (www.cms.hhs.gov) for all procedures for which CMS has a reimbursement rate in effect at the time the Covered Service is provided, less 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. Services that do not have a reimbursement 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

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 Regional Medical Center	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.

EQUIPMENT MAINTENANCE AGREEMENT

between

DP MEDICAL SERVICES

AND

MANGUM REGIONAL MEDICAL CENTER

MANGUM, OK

It is agreed that DP Medical Services will provide MANGUM REGIONAL MEDICAL CENTER, hereafter called the FACILITY, with the services described below under the following terms and conditions.

FULL SERVICE BIOMED AGREEMENT (NEW)

(EXCLUDING PARTS)

WE OFFER SERVICE ON THE FOLLOWING EQUIPMENT:

BIOMEDICAL / ANESTHESIA.

A. EQUIPMENT COVERED UNDER THIS BIOMED AGREEMENT:

1). All Electro medical devices listed on Facility provided Inventory Listing.
2). Preventative Maintenance and Electrical Safety testing on all applicable On-Site Equipment
3). On-Site Repair Services **Monday - Friday 8am-5pm**

B. CONTRACT TERM:

The term of this agreement shall be for one (1) year commencing on January 1, 2024, and expiring on January 1 2025. Thereafter this agreement automatically renews each year, unless canceled by either party with a 30 day written notice.

C. COST:

QUARTERLY COST FOR BIOMED INSPECTIONS:

1) Biomed Inspections	$1,750.00	$7,000.00 Yearly

Does not include replacement parts or PM Kits. Shop repairs billed at $150.00 per hour. Non-Scheduled service calls will be billed at $150.00 per hour for labor and drive time will be billed at Zone C rate of $500.00 round trip. Emergency repairs after hours and holidays will be billed at $200.00 and drive time will be billed at $750.00.

D. PURCHASE ORDER:

Invoices for the equipment maintenance services provided within the scope of this Agreement will be submitted at the payment frequency specified in Section D. Please indicate the FACILITY purchase order number that these invoices will reference:#_____

TERMS AND CONDITIONS

E. EQUIPMENT COVERED UNDER THIS AGREEMENT:
DP Medical Services agrees to include in its equipment maintenance program the equipment listed (on the attached medical equipment inventory or on the face of this Agreement), hereafter called the EQUIPMENT. All listed items will be included in a preventive maintenance and/or electrical safety program, which is described in Sections H and I of this Agreement. Documentation of all services shall be maintained on file at the FACILITY.

F. PREVENTIVE MAINTENANCE AND/OR ELECTRICAL SAFETY INSPECTIONS:
DP Medical Services will perform preventive maintenance and/or electrical safety inspections on the EQUIPMENT identified in Section A in accordance with JCAHO and State Department of Health Services' requirements. These services will be performed during the specified hours stated on the face of this Agreement, excluding holidays.
DP Medical Services follows all manufacturers' recommended preventive maintenance procedures, as well as those set forth by the American Society for Hospital Engineering, and all applicable regulatory agencies.

G. REPAIR SERVICES
DP Medical Services is available 24 hours a day, 7 days a week for repair of the EQUIPMENT identified in Section A. Telephone response time to emergency repair services, when a DP Medical technician is not already on-site, will be within two (2) hours. The EQUIPMENT will be repaired in a timely manner in order to keep downtime to a minimum.
Repairs specifically not covered under this Agreement include the following (1)Repairs due to failure of EQUIPMENT component or due to improper maintenance provided by a source other than DP Medical Services(2)Repairs due to failure of the FACILITY'S steam, water electrical or other utility Supply systems (3) Repairs due to operator neglect misuse or abuse (4) Repairs due to any documented circumstance beyond the control of DP Medical (5) EQUIPMENT overhauls, rebuilds, compressors, upgrades, relocation (6) Repairs to equipment not listed on the attached EQUIPMENT inventory (7) Repairs exceeding 50% of current market value of the EQUIPMENT (8) Pre-Existing conditions

H. PARTS, MATERIALS, AND CONSUMABLES:
Replacement parts or other materials are not included, unless otherwise indicated.
The FACILITY agrees to assist DP Medical Services in obtaining replacement parts and materials from suppliers who have policies of selling parts only to end-users.
Not included in this Agreement are consumable items such as batteries, glass, electrodes, paper, magnetic tapes, patient leads, cables, fiberoptics and similar items that the FACILITY would use during normal operation, unless otherwise indicated.

I. TEST EQUIPMENT AND WORK SPACE:
DP Medical Services will provide all necessary test equipment in order to fulfill the maintenance obligations of this Agreement. Routine calibration and certification of this test equipment by an outside laboratory to those standards set forth by the National Institute of Standards and Technology.
The FACILITY will provide DP Medical Services technical staff with sufficient working space in order to accommodate the day-to-day requirements of this Agreement.

J. INSURANCE:
DP Medical Services maintains an adequate level of Comprehensive Liability and Workers' Compensation Insurance coverage on all of its employees. A certificate of insurance will be provided to the FACILITY upon request.

K. CHANGES AND CANCELLATIONS:
Changes to the terms and conditions of this Agreement whether such changes are due to the quantity or types of items covered, equipment, service level, or pricing (increase and/or decrease), must be agreed to in writing by authorized representative of both DP Medical Services and the FACILITY. This agreement is cancelable by either party with a 30 day written notice.

L. NOTICES:
Notices or correspondence regarding the above agreement shall be sent to the following DP Medical Services:

DP MEDICAL SERVICES 23630 E. 700 Rd. Wagoner, Ok. 74467 918-237-5028 dpmedical@mail.com

DATE OFFERED_____ **DATE ACCEPTED**_____

_____ _____
DP MEDICAL SERVICES **MANGUM REGIONAL MEDICAL CENTER**

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract:** Equipment Maintenance Agreement
3. **Contract Parties: MRMC/DP Medical Services**

4. **Contract Type Services:** Equipment service and maintenance.

5. **Impacted Hospital Departments: Hospital**

6. **Contract Summary: This agreement will allow MRMC to have service and maintenance available 24 hours a day 7 days a week for repairs on equipment.**

7. **Cost: $7,000.00/year**

8. **Prior Cost: $9,800.00/ year**

9. **Term: 1 year**

10. **Termination Clause:** Can be terminated by either party with a 30-day written notice.

11. **Other:**

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract:** Fiberoptic Endoscopic Swallowing Services
3. **Contract Parties: MRMC/Freeborn Dysphagia Associates LLC**

4. **Contract Type Services:** Service Agreement

5. **Impacted Hospital Departments: Patient Care**

6. **Contract Summary:** Evaluation of oropharyngeal swallowing capabilities

7. **Cost: $325.00/evaluation and $225.00/trip**

8. **Prior Cost: none**

9. **Term: 2 year with auto renew at the end of term for 2 more years**

10. **Termination Clause:** Can be terminated by either party with a 30-day written notice.

11. **Other:**

Agreement to Provide
Fiberoptic Endoscopic Evaluation of Swallowing Services

Agreement made this _____ day of November, 2023, by and between Mangum Regional Medical Center, with its principal place of business at 1 Wickersham Dr., Mangum, Oklahoma, 73554(hereinafter referred to as "Contractor") and Freeborn Dysphagia Associates, LLC, with its principal place of business at 18550 144th St, Lexington, OK 73051 (hereinafter referred to as "FDA").

WHEREAS, FDA provides services to the general public in an independent capacity;

WHEREAS, FDA is specifically in the business of providing Speech-Language-Swallowing Pathology assessment, rehabilitative services, consultation, including Fiberoptic Endoscopic Evaluation of Swallowing assessments (collectively referred to as "FEES Services");

NOW, THEREFORE, in consideration of the foregoing premises and of the mutual covenants contained herein, and further good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **Scope of Services**
FDA agrees to provide FEES Services directly to one or more designated third party recipients of those services ("Recipient") in Contractor's care. Such services include a) instrumental evaluation of the Recipient's oropharyngeal swallowing capabilities, and b) recommendations to Contractor's physicians, or designated personnel, regarding suitable management of demonstrated swallowing difficulties, including exercises, compensatory strategies, altered food and liquid consistencies and other interventions deemed appropriate for the Recipient. Such services shall comply with applicable federal and state laws and regulations. The parties contemplate that a Recipient will typically receive a single FEES evaluation unless Contractor expressly requests FDA to conduct re-evaluations.

2. **Doctor Order/Script**
For each FEES Services ordered under this Agreement, Contractor agrees to provide FDA with confirmation of the physician order prior to any procedure. Such order shall also serve as written confirmation of the direction from Contractor to FDA.

3. **Payment**
In consideration of FDA providing such services, Contractor agrees to pay FDA upon the following terms and conditions:

a. Contractor shall pay FDA three hundred twenty-five dollars ($325.00) for each evaluation and/or re-evaluation;

b. Contractor shall also pay a trip charge based on the location of the Contractor's facility. If multiple residents are evaluated at the same Contractor's facility on the same trip, only one trip charge will be charged. Trip charge is $225.00.

c. If FDA arrives at the Facility as scheduled and is unable to complete the test because of the resident's change of condition, cancellation without notice, or documentation not in place (physician's order and consent), FDA shall be compensated one hundred dollars ($100.00) in lieu of the standard fee, as noted in (a).

d. FDA shall invoice Contractor monthly for all FEES Services it has provided in the preceding month. Payment is expected within thirty (30) days of Contractor's receipt of said invoice; *FDA shall invoice Contractor within 24 hours of the completion of services rendered. Payment is expected within (30) days of Contractor's receipt by said invoice.*

e. Invoices that have not been paid within 30 days of the initial FDA billing date may be subject to accrued interest at an annual rate of 18%.

4. **Disputed Claims and Bills**
In the event of any dispute regarding any claim or bill submitted by Contractor for FDA's services, FDA agrees to provide the Contractor with any and all documents and records concerning the disputed matter that the Contractor deems reasonable and necessary. In the case of an investigation by any fiscal or state agency involved in processing payment of claims, FDA hereby agrees to cooperate with the investigation of any disputed claims or bill, should FDA be so directed by the Contractor upon the FDA's receipt of proper notification. In addition, the Contractor hereby agrees to grant any agency involved in processing the claim the right to discuss the status of the claims with FDA.

5. **Confidential Information**
Both parties acknowledge that all activities within this Agreement are subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-91, as amended, and all implementing regulations, and each agrees to comply with said requirements. All information pertaining to any Recipient that is obtained by FDA in the performance of FDA's work, as well, as any information, data, documents, or reports generated by FDA, shall be treated as confidential.

6. **Medical Waste**
Contractor agrees to be responsible for disposal of all medical waste, which attends FEESs Services and hereby certifies that it will do so in accordance with applicable federal and state laws and regulations regarding the disposal of such waste. FDA agrees to cooperate with Contractor to disposing of all medical waste that it generates.

7. **Relationship of Parties**
The parties hereto understand and intend that FDA is an independent contractor to Contractor and that no employment or agency relationship is established by this Agreement. Contractor is to issue to FDA a 1099 at the conclusion of each tax year. No monies will be deducted from Contractor's payment for purposes of income withholding or social security purposes and Contractor shall not otherwise be liable for employer contributions of same. FDA shall be responsible for payment of all taxes including federal, state, and local taxes arising out of FDA activities, including by way of illustration but not limitation, federal and state income taxes,

social security tax, unemployment insurance taxes, and other taxes or business license fees as required.

8. **Service to Others**
FDA may provide services to others during the term of this Agreement provided that it does not interfere with its obligations and performance hereunder.

9. **FDA Personnel**
It is expressly understood by the parties that FDA shall be solely responsible for payment of compensation to the personnel actually providing FEES Services to a Contractor Recipient and, if applicable, Worker's Compensation insurance, premium "overtime" pay, FICA, FUTA, income tax withholding or other payments and benefits which may be applicable to such personnel.

10. **Equipment**
FDA shall provide the necessary tools, equipment or materials to be used in the delivery of FEES services.

11. **Insurance**
Before performing services under this Agreement, FDA will obtain, at its own expense, for itself and its personnel, Comprehensive General Liability insurance coverage. Such coverage shall include liability insurance for professional errors and omissions of its service personnel.

12. **Termination of Agreement**
This agreement shall continue to force for two (2) years following the date first written above. The parties shall renew it automatically upon the same terms and conditions, unless either party provides written notice to the other of not less than sixty (60) days prior to termination date of its desire to terminate the Agreement. Prior to any annual renewal of this Agreement, FDA expressly reserves the right to renegotiate the financial terms and conditions it sets for FEES Services. The foregoing notwithstanding, this Agreement otherwise may be terminated at any time by either party by providing written notice to the other of not less than thirty (30) days prior to the actual termination date.

13. **Governing Law**
This Agreement shall be governed by, and construed in accordance with, the Laws of the State of Oklahoma. A litigation arising from, related to, or concerning this agreement shall be brought solely in the state courts of Oklahoma located in Cleveland County.

14. **Attorney's Fees and Costs**
Should either party to the Agreement prevail in an action brought against the other related to or arising out of this Agreement, the losing party shall reimburse the prevailing party for its reasonable attorney's fees and costs in connection with such proceeding.

15. **Severability**
Each provision of the Agreement shall be considered severable such that if any one provision or clause conflicts with existing or future applicable law, or may not be given full effect because of

such law, this shall not affect any other provision of the Agreement which can be given effect without the conflicting provision of clause.

16. **Entire Agreement**
This Agreement and any attachments or exhibit hereto represent the entire agreement and understanding of the parties and any modification thereof shall not be effective unless contained in writing signed by both parties. Any prior agreements have been merged into this Agreement.

17. **Antidiscrimination Policy**
FDA shall provide all services under this agreement without unlawful discrimination on the basis of race, color, religion, sex, national origin, ancestry, or disability.

IN WITNESS WHEREOF, the parties here to have caused this contract to be executed in their corporate names by duly authorized officers in duplicate originals, one of which is retained by each of the parties, the day and year first above written.

Freeborn Dysphagia Associates, LLC (FDA)
Dba Heart of Oklahoma Speech and Swallow Services

By: _____ Date: _____
Kristina A. Freeborn, MA, CCC-SLP
CEO and Speech/Language Pathologist

Mangum Regional Medical Center
1 Wickersham Drive
Mangum, Oklahoma 73554

By: _____ Date: _____
(Administrator)

Addendum to SERVICE AGREEMENT

This addendum is made to the SERVICE AGREEMENT ("Agreement") signed by Client and Cohesive RevOps Integration Management LLC. ("RevOps"), and _____ ("Client" or "Provider"). Except where noted herein, all terms in the Agreement shall remain in full force and effect. This addendum shall not impact or change the terms of the prior signed agreement or addendums except as specifically addressed herein.

By signing below Client acknowledges that Client has read the contract addendum and agrees to abide by its respective terms.

The parties hereby cause this Addendum to be executed by their duly authorized representatives effective as of the date signed by RevOps.

Client		RevOps Integration Management, LLC.	
Company:			
Signature:		Signature:	
Print Name:		Print Name:	Michael A. Hill
Title:		Title:	
Date:		Date:	

Addendum

Whereas RevOps developed a software tool (AVID) to assist clients in identifying and confirming insurance coverage for patients registered as self-pay. RevOps is willing to provide the service for no cost to Client on the below terms.

The following **Schedule – AVID Insurance Verification Software Services** is added to the Agreement:

The AVID Services:

The AVID services may be canceled by either party on a one (1) business day advance notice in writing (including by email between officers of the respective companies).

Self-Pay Monitoring Software Service

RevOps shall provide a Self-Pay Accounts Monitoring software service. The service is for Client or RevOps billing team to pull a list of self-pay patients from Client's system and utilize the AVID software tool to check for insurance coverage (both commercial and non-commercial). The check is performed over different time periods, to help to reduce the number of claims where coverage exists from reaching Past Timely Filing status and to expedite collections. The service shall seek to find active insurance for accounts in a financial class currently designated as Self Pay. On a timeline defined by RevOps, these accounts will be exported from the Client's system using a custom reporting tool. These accounts will then be loaded into RevOps's insurance eligibility database, which is an automated software module that will run daily, select accounts from the aforementioned database, and check commercial and Medicaid payers to find active insurance. Payers are checked

at regular intervals. The active insurance accounts will be stored and tracked in a central database and a RevOps proprietary tool will be used to track claim filing work. RevOps staff will use the Provider's practice management system to file the claims for the patients where coverage was found. RevOps will perform analysis on the results to find and learn from any patterns and data associations to further improve the rate of finding active insurance.

RevOps shall charge an incremental fee of 0.0% (only its regular billing fees) of the Net Cash Collections on these specific claims where insurance is identified and billed thereafter. As a complimentary add-on service, RevOps shall define the frequency of the software inquiries and which payers are searched to maintain a cost-effective service.

Client acknowledges:

- That patients registered as self-pay, where insurance is found, will have claims billed to their payers and Client authorizes RevOps to file such claims with the insurance payer for any such Self-Pay account extracted from Client's practice management system.
- That the service is subject to the policies of individual payers and other service providers that may be changed or discontinued at any time with or without notice to RevOps or Client.
- That RevOps shall have no liability related to this service or the discontinuation of it at any time due to payer changes or other circumstances, including RevOps's determination that the service is not cost-effective for RevOps to maintain.

USAGE LIMITATIONS

This Addendum only gives you some rights to use the results of the Insurance Verification Services, and RevOps reserves all other rights. As between the parties, RevOps retains all rights, titles, and interest, including, without limitation, all intellectual property rights in and to the software underlying the service. Client agrees to not:

- show the service to RevOps's competitors or potential competitors;
- use the service for purposes other than those identified in the Agreement or Addendums;
- sell or resell the services outside Client's organization;
- otherwise commercially exploit or make the service available to any third party;
- interfere with or disrupt the integrity or performance of the RevOps software cloud platform or the data contained therein;
- use the service in violation of any applicable laws or regulations; or
- attempt to gain unauthorized access to the RevOps software cloud platform or related systems or networks.

The AVID services do not include Medicaid Redetermination or other business cases for which the tool might be used. The use of the tool for any other business case shall require a separate addendum and pricing.

Additional Terms:

EXCLUSIVE REMEDY/LIMITATION OF LIABILITY: IN NO EVENT SHALL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY INDIRECT, SPECIAL, PUNITIVE, EXEMPLARY, INCIDENTAL, OR CONSEQUENTIAL DAMAGES (INCLUDING LOSS

OF PROFIT OR BUSINESS), HOWSOEVER ARISING, WHETHER UNDER CONTRACT, TORT, OR ANY OTHER LEGAL OR EQUITABLE THEORY, EVEN IF INFORMED ABOUT THE POSSIBILITY OF THE SAME. IN NO EVENT WILL THE REVOPS PARTIES' AGGREGATE LIABILITY ARISING OUT OF OR RELATED TO THIS AGREMENT FOR ANY DAMAGES TO CLIENT OR TO ANY OTHER ENTITY REGARDLESS OF THE FORM OF ACTION, WHETHER BASED ON CONTRACT, INDEMNITY, TORT, NEGLIGENCE, STRICT LIABILITY, PRODUCTS LIABILITY, OR ANY OTHER LEGAL OR EQUITABLE THEORY, EVER EXCEED $25,000 OR THE TOTAL FEES PAID DURING AN AVERAGE THREE MONTH PERIOD, WHICHEVER IS LESSER.

WARRANTY LIMITATION: OTHER THAN AS EXPRESSLY SET FORTH IN THIS AGREEMENT, REVOPS DOES NOT MAKE ANY EXPRESS OR IMPLIED WARRANTIES, CONDITIONS, OR REPRESENTATIONS TO CLIENT, WITH RESPECT TO THE SOFTWARE, HARDWARE, DOCUMENTATION, OR ANY SERVICES PROVIDED HEREUNDER OR OTHERWISE REGARDING THIS AGREEMENT, WHETHER ORAL OR WRITTEN, EXPRESS, IMPLIED OR STATUTORY. WITHOUT LIMITING THE FOREGOING, ANY IMPLIED WARRANTY OR CONDITION OF MERCHANTABILITY, THE IMPLIED WARRANTY AGAINST INFRINGEMENT, AND THE IMPLIED WARRANTY OR CONDITION OF FITNESS FOR A PARTICULAR PURPOSE ARE EXPRESSLY EXCLUDED AND DISCLAIMED.

All other terms of the Master Service Agreement shall remain the same.

Hospital Vendor Contract Summary Sheet

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

2. **Name of Contract:** RevOps
3. **Contract Parties: MRMC/Cohesive RevOps Integration Management LLC**

4. **Contract Type Services:** Service Agreement Coding and Billing

5. **Impacted Hospital Departments: Hospital**

6. **Contract Summary:** This addendum adds a new service to the current agreement**.** This service uses a software tool to check for insurance coverage of patients.

7. **Cost: $0**

8. **Prior Cost:**

9. **Term:**

10. **Termination Clause:** Can be terminated by either party with a 1 business day written notice.

11. **Other:**