



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

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

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

Attachment A: Provider Networks

- | | | |
|---------------------------------------|---------------------------------------|-------------------------------|
| A-1: Blue Traditional SM | A-4: Blue Advantage PPO SM | A-7: NativeBlue SM |
| A-2: Blue Choice PPO SM | A-5: BlueLincs HMO SM | A-8: Blue Plan65 Select |
| A-3: Blue Preferred PPO SM | | |

Attachment B: Requirements for Acute Care Hospitals

Attachment C: Reimbursement for Acute Care Hospitals

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

Attachment D: Locations and Ancillary Entities

- | | | |
|---|---|---|
| <input type="checkbox"/> D-1: Ambulance | <input type="checkbox"/> D-4: Home Health | <input type="checkbox"/> D-7: Laboratory |
| <input type="checkbox"/> D-2: Dialysis | <input type="checkbox"/> D-5: Hospice | <input type="checkbox"/> D-8: Skilled Nursing |
| <input type="checkbox"/> D-3: DME/O&P | <input type="checkbox"/> D-6: Infusion | <input type="checkbox"/> D-9: Swing Bed |

Attachment E: Hospital Performance Program

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

BCBS.

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

Facility.

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

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

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

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

Authorized Signature

Rick Kelly

Name of Signatory

Vice President, Provider Network Operations

Title of Signatory

Date Signed

Authorized Signature

Name of Signatory

Title of Signatory

Date Signed

RECITALS

WHEREAS, Facility provides Health Care Services; and

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

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

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

ARTICLE I DEFINITIONS

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

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

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

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

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

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

ARTICLE II OBLIGATIONS OF FACILITY

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

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

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

2.0.0.0 Required quality improvement activities;

2.0.0.1 Methods to identify incidents or patterns;

2.0.0.2 Mechanisms for taking follow-up action; and

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

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

2.0.2 Subcontractors and Designees.

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

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

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

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

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

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

2.10 Covered Person Hold Harmless.

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

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

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

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

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

2.11.0 Coverages.

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

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

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

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

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

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

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

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

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

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

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

2.13 **Utilization Management and Quality Improvement.**

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

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

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

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

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

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

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

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

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

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

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

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

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

2.18 **Notices.**

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

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

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

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

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

2.20 **Audit/Access to Records.**

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

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

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

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

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

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

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

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

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

**ARTICLE III
OBLIGATIONS OF BCBS**

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

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

3.1 **Applicability of Agreement.**

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

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

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

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

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

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

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

ARTICLE IV CONFIDENTIALITY

4.0 Confidential Information Definitions.

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

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

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

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

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

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

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

4.1.3 is independently developed by the Recipient Party.

4.2 Confidentiality Requirements.

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

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

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

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

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

ARTICLE V TERM AND TERMINATION

5.0 **Term and Termination.**

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE VI DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

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

ARTICLE VII GENERAL PROVISIONS

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

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

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

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

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

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

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

**ATTACHMENT A
PROVIDER NETWORKS**

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

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

**ATTACHMENT A-1
BLUE TRADITIONALSM**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

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

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT A-2
BLUE CHOICE PPOSM**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

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

2.1 **Failure to Comply.**

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

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

- 2.2 **Other Provider Networks.** In the event that Facility has not contracted with BCBS to be a Participating Provider in one or more of its other Provider Networks, including but not limited to Blue Preferred PPO, Blue Advantage PPO and BlueLincs HMO, the terms of this Blue Choice PPO Attachment, including the Maximum Reimbursement Allowance described in Attachment C, shall be applicable to any Covered Services rendered to Covered Person enrolled in a Product that utilizes a Provider Network in which Facility does not participate. Facility agrees to hold such Covered Persons harmless from any sums in excess of the Blue Choice PPO Maximum Reimbursement Allowance. This paragraph shall supersede any provision contained in the Blue Traditional Attachment, if applicable, to accept the Blue Traditional Maximum Reimbursement Allowance for any Covered Person whose designated Provider Network is one in which Facility does not participate.

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT A-3
BLUE PREFERRED PPOSM**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

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

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT A-4
BLUE ADVANTAGE PPOSM**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

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

2.1 **Failure to Comply.**

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

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

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT A-5
BLUELINCS HMOSM**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

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

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

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

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT A-7
NATIVEBLUESM**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

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

2.1 **Failure to Comply.**

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

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

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT A-8
BLUE PLAN65 SELECT**

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

**ARTICLE I
COVERED SERVICES**

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

**ARTICLE II
PAYMENT**

- 2.0 **Claims Payment.** BCBS will pay Facility for Covered Services rendered to Blue Plan65 Select Covered Persons under this Agreement, including the Attachments. Facility agrees to accept as payment in full the lesser of (i) Facility’s billed charges for Covered Services or (2) the Maximum Reimbursement Allowance set forth on Attachment C for Covered Services rendered to Blue Plan65 Select Covered Persons. Facility agrees to hold such Blue Plan65 Select Covered Persons harmless from any sums in excess of the Maximum Reimbursement Allowance. BCBS will reimburse Facility directly for any Cost Share amounts that are applicable to such Medicare Part B Covered Services.

2.1 **Failure to Comply.**

- 2.1.0 **Health Care Services That Are Not Medically Necessary.** If the Health Care Services are determined to be not Medically Necessary or Experimental, Investigational or Unproven, payment will be denied. Except where otherwise provided by applicable Law, the denied amounts may not be collected from the Blue Plan65 Select Covered Person unless a waiver has been executed prior to rendering Health Care Services.

- 2.1.1 **Health Care Services That Are Medically Necessary.** If the Health Care Services are determined to be Medically Necessary, but Facility failed to comply with the Prior Authorization requirements set forth in this Agreement and the Policies and Procedures, then the amount due to Facility from BCBS will be reduced by five hundred dollars (\$500.00) per Claim. This five hundred dollar (\$500.00) sanction may not be collected from the Blue Plan65 Select Covered Person.

**ARTICLE III
TERM AND TERMINATION**

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

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

**ATTACHMENT B
REQUIREMENTS FOR ACUTE CARE HOSPITALS**

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

**ARTICLE I
DEFINITIONS**

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

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

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

ARTICLE II OBLIGATIONS OF FACILITY

2.0 **Changes in Services.** Facility shall provide BCBS with at least sixty (60) days' Notice prior to any material change in the services available at any Facility Location listed on Attachment D, including, but not limited to, the cessation or material reduction of any of the following services: emergency room, ambulatory surgery, inpatient services, and neonatal and delivery.

2.1 **Credentialing and Recredentialing Notices.** Notwithstanding anything in this Agreement to the contrary, credentialing-related correspondence, including notices of termination for failure to recredential, will be sent to the credentialing address on Facility's most recent credentialing application received by BCBS.

2.2 **Locations and Ancillary Entities.** This Agreement and the rights, duties, and obligations of BCBS set forth herein apply to Facility operating on the Main Campus under Facility's NPI, and to the Locations and Ancillary Entities specifically listed on Attachment D to this Agreement as of the effective date of this Agreement. No other Location or Ancillary Entity existing on the effective date is included in this Agreement, and the terms and conditions of this Agreement shall not be deemed to apply to any Location or Ancillary Entity other than those listed on Attachment D.

2.2.0 **Notification of Sale, Closure or Address Change.** Facility shall notify BCBS in writing of the sale, closing or change of address of any Location or Ancillary Entity included on Attachment D at least thirty (30) days prior to such change or within five (5) business days of the closing date of the transaction if the Location or Ancillary Entity is being sold.

2.2.1 **New Locations and Ancillary Entities.** Facility agrees to notify BCBS in writing and provide information requested by BCBS regarding any new Location or Ancillary Entity, acquired or opened after the effective date of this Agreement, which is not listed on Attachment D. Such notice shall occur as soon as possible but at least sixty (60) days prior to rendering Covered Services to any Covered Person, or within five (5) business days of the closing date of the transaction if the Location or Ancillary Entity is being acquired.

2.2.1.0 **Denials for New Locations and Ancillary Entities.** BCBS may in its sole discretion deny a proposed addition to Attachment D if (i) Facility fails after request to provide information satisfactory to BCBS regarding the addition; (ii) a proposed Location or Ancillary Entity fails to meet BCBS's credentialing requirements, as applicable; or (iii) Facility is unable to resolve other concerns specified by BCBS to BCBS's satisfaction.

2.2.2 **Amendments to Attachment D.** Any changes to the information contained on Attachment D must be made expressly in a written amendment to Attachment D and cannot under any circumstances be deemed to have occurred in the absence of such amendment.

2.2.3 **Reimbursement for Locations/Ancillary Entities.** Reimbursement for Covered Services rendered at a Location will be as expressly set forth on Attachment C of this Agreement for each identified Location unless otherwise indicated on Attachment D. Claims for services, items, procedures and/or surgeries rendered at Off-Campus Locations must contain the appropriate modifiers, as required under *Modifiers* in Article III of this Attachment B. Under no circumstances will reimbursement applicable to Facility on the Main Campus under Facility's NPI be deemed to apply to an Off-Campus Location. Reimbursement for Covered Services rendered by an Ancillary Entity will be as set forth in the applicable sub-attachment to Attachment D.

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

**ARTICLE III
BILLING REQUIREMENTS**

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

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

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

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

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

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

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

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

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

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

3.7.0 Medical Necessity or lowest cost setting determinations.

3.7.1 Bill/Claim validation determinations of coding accuracy.

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

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

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

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

3.9 **Claims Timely Filing.** Facility will submit Clean Claims to BCBS for any and all services rendered to Covered Persons at Facility's billed charges and in accordance with the billing requirements set forth in this Article.

3.9.0 **Original Claims.** Claims will be submitted within one hundred eighty (180) days of the date of discharge or date of service, or within one hundred eighty (180) days of the primary payer's dated provider Claims summary. Claims will be accepted beyond the one hundred eighty (180) day period if the Covered Person's Coverage Agreement allows a longer timely filing period. Claims which are not submitted within the timely filing requirements herein will not be honored and Facility agrees not to bill BCBS or the Covered Person for Health Care Services associated with such Claims.

3.9.1 **Corrected Claims.** Corrected Claims will be accepted by BCBS up to twelve (12) months following BCBS's adjudication of the original Claim.

3.10 **Impermissible Billing.** Notwithstanding *Include All Charges* in Sections 3.3.2 and 3.3.4 above, BCBS does not permit pass-through billing, billing for Non-Patients, splitting Claims, billing under arrangements with other Health Care Providers ("Under-arrangement" billing), or billing practices where a Health Care Provider or entity submits Claims by or for another Health Care Provider not otherwise provided for in the Health Care Provider's agreement with BCBS or as further described in Policies and Procedures. Only Health Care Services provided to Covered Persons physically present, either in person or appropriately via telemedicine, at locations listed on Attachment D are eligible to be Covered Services. Health Care Services provided not in accordance with this provision shall be the responsibility of Facility.

3.11 **Notification of Incorrect Payments.** Notwithstanding *Corrected Claim*, above, Facility agrees to notify BCBS of receipt of any incorrect payment of which it is aware, including underpayments, duplicate payments, or overpayments, within twelve (12) months of the original Claim process date. This obligation survives termination of the Agreement. Overpayments shall not be refunded to the Covered Person until BCBS has determined who is entitled to such funds. Facility agrees BCBS will be permitted to deduct overpayments (whether discovered by Facility or BCBS) from future payments made by BCBS, along with an explanation of the credit action taken.

3.12 **Professional Services.** Facility may not bill for Professional Services on a UB-04 Claim form. If charges for Professional Services are included on a UB-04 Claim form, and subsequent revisions, those charges will not be included in the calculation of the Maximum Reimbursement Allowance.

3.13 **Reference Lab.** Facility is not permitted to bill or submit lab Claims for reimbursement to BCBS under this Agreement for services provided to a patient who is not physically present at Facility, including billing and/or submitting Claims for laboratory services provided on samples or specimens where the patient was not present at the Facility at the time of collection of the sample/specimen, unless the sample or specimen was collected by a provider located within the county where Facility is located or a contiguous county and delivered or shipped to Facility for processing.

3.14 **Report Other Insurance.** Facility will report to BCBS any fact of which it or its agents have knowledge which indicates that the condition requiring services to the Covered Services arises

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

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

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

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

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

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

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

**ATTACHMENT C
REIMBURSEMENT FOR ACUTE CARE HOSPITALS**

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

**ARTICLE I
DEFINITIONS**

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

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

ARTICLE II REIMBURSEMENT

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

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

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

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

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

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

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

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

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

3.1 **Hospital Services.**

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

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

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

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

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

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

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

4.1 **Hospital Services.**

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

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

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

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

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

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

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

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

5.1 **Hospital Services.**

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

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

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

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

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

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

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

6.1 **Hospital Services.**

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

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

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

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

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

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

7.1 **Hospital Services.**

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

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

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

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

**ARTICLE VIII
REIMBURSEMENT FOR THE NATIVEBLUE NETWORK**

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

8.1 **Hospital Services.**

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

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

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

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

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

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

9.1 **Hospital Services.**

9.1.0 **Inpatient.**

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

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

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

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

9.1.1 **Outpatient.**

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

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

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

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

**ATTACHMENT D
LOCATIONS AND ANCILLARY ENTITIES**

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

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

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