PROVIDER AGREEMENT

AETNA BETTER HEALTH ADMINISTRATORS, LLC, on behalf of itself and its Affiliates ("Company"), and Mangum City Hospital Authority d/b/a/ Mangum Regional Medical Center, on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:
As of the Effective Date, Provider agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: April 1, 2024 (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider has read and understood this Agreement, has had the opportunity to review it with an attorney of Provider's choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER	**COMPANY**
By:_____	**By:**_____
Printed Name:_____	**Printed Name:**_____
Title:_____	**Title:**_____

FEDERAL TAX I.D. NUMBER: 82-2087512

GROUP NPI NUMBER: 1033635263

As required by Section 8.6 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Provider:

Mangum Regional Medical Center
PO Box 280
Mangum, OK 73554
Attn: Hospital Administrator

Company:

Aetna Medicaid Administrators LLC
c/o Aetna Inc.
4500 E Cotton Center Blvd
Phoenix, AZ 85040
ATTN: Ld Director, Network Management

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations**. Provider agrees that it and all Group Providers will:

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (ii) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) change in the ownership or management of Provider; and (iv) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

1.2 **Provider and Group Provider Contact and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within twenty (20) business days unless Applicable Law requires Company to update its directories in a shorter timeframe, of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Provider objects to a Policy change that will have a significant impact on Provider's administration or operations or will create a material adverse financial impact for Provider, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and eighty (180) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) Subject to Applicable law, to notify Company of any underpayment or payment/claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for

resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Provider with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

1.5 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable Product Addendum(a) and Service and Rate Schedule(s), and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees to pay Facility for Covered Services rendered to Members; and within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company will notify Provider of a new or revised Product Addendum and Service and Rate Schedule.; provided that such addition will not go into effect unless Provider agrees to such addition, in writing, within the time period specified in Company's notice.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination

of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Indemnification**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent, which consent shall not be unreasonably withheld.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution**. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR**

INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT. The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum (the most current version, which may be contained in the Provider Manual)** and any other part of the Agreement, the terms of the State Compliance Addendum will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign

this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Company may amend the agreement for reasons other than Applicable Law by notifying Provider in writing at least sixty (60) days prior to the effective date of the amendment. Hospital may reject the amendment upon Provider's receipt of such notice of amendment, by notifying Company in writing of such rejection within thirty (30) days of notice of such amendment; provided, however, if Company has not received notice of such rejection within that thirty (30) day period, Provider's silence shall constitute acceptance of such amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider: (a) employed by Provider; or (b) who, through a contract or arrangement with Provider, provides services to Members for which Provider is reimbursed under this Agreement or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include "Medicaid Products", as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government

Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products. Furthermore, the Parties understand and agree that if this Agreement is executed prior to execution of a State Contract and/or prior to issuance to Company of Government Approvals, the **State Compliance Addendum (Medicaid Products)** may need to be added to this Agreement after execution. After issuance of the State Contract and/or Government Approvals, Company may, in its discretion: (a) unilaterally amend the Agreement to add the **State Compliance Addendum (Medicaid Products)**; and/or (b) incorporate the **State Compliance Addendum (Medicaid Products)** into the Provider Manual.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Products**. Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the "Medicaid Product(s)"):

A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State.

B. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans: Reimbursement is based upon the contracted location where service is performed and is at a minimum an amount equal to 100% of the State of Oklahoma's Medicaid fee schedule.

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).

C. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).

D. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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Regulatory Compliance Addendum
Governing Oklahoma Medicaid (Provider)

Aetna Better Health of Oklahoma Inc., an Oklahoma corporation ("Company" or "CE") has contracted with the Oklahoma Health Care Authority ("OHCA" or "State Agency" or "Government Sponsor") to provide Medicaid managed care services to Enrollees as part of the SoonerSelect program ("SoonerSelect"). The provisions of this Addendum are required by the State Contract, state or federal law for all of Company's participating providers. Company and Provider entered into that certain provider agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company.

If there is any conflict between the terms of this Addendum and any term of the Agreement, including any Addendums, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, if there is any conflict or ambiguity between any of the terms of the Agreement, including this Addendum, and the State Contract, then the terms of the State Contract shall govern and control. If any requirement in the Agreement or this Addendum is determined by OHCA to conflict with the State Contract, such requirement shall be null and void, and all other provisions shall remain in full force and effect. References to the State Contract are for convenience only.

Each provision contained herein shall apply to Provider only to the extent applicable to the services provided by Provider pursuant to the Agreement.

1. Definitions. Terms used in this Addendum and not defined herein will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract. Terms used in this Addendum that are not otherwise explicitly defined shall be understood to have the definition set forth in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

2. Incorporation of Terms and Conditions. Provider agrees that all applicable terms and conditions set out in the State Contract, any incorporated documents, the solicitation for the State Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Enrollees under this Addendum. (State Contract §1.14.1)

3. Approval of State Contract. Effectiveness of the Agreement is contingent upon approval of the State Contract by the OHCA Board and the Centers for Medicare and Medicaid Services (CMS). If CMS does not approve the State Contract under the terms and conditions, the Agreement and this Addendum, OHCA may terminate the Agreement. (State Contract§ 1.2.3)

4. Termination.

    4.1 Availability of Records. In the event of termination of this Addendum or the Agreement, Provider shall immediately make available to OHCA or its designated representative, in a usable form, any or all records, whether medically or financially related to the terminated Provider's activities undertaken pursuant to this Addendum, and that the provision of such records shall be at no expense to OHCA. (State Contract §1.14.1.11.14.1.1) Moreover, Provider shall cooperate with Company and OHCA to ensure that any Enrollee records and information are provided to Company to facilitate an orderly transition of all Enrollees' care. (State Contract § 1.14.5.2.1)

4.2 Notice of Termination. Notwithstanding anything in the Agreement to the contrary, Health Plan and Provider may terminate this Addendum for cause upon 30 days advance written notice to the other party, and without cause upon 60 days advance written notice to the other party (State Contract §1.14.5.1).

4.3 Immediate Termination. Notwithstanding anything in the Agreement to the contrary, this Addendum may be immediately terminated by Health Plan in the event of the following (State Contract§ 1.14.5.1):

a) To protect the health and safety of Enrollees;
b) Upon conviction of credible allegation of Fraud on the part of Provider;
c) Provider's licenses, certifications and/or accreditations are modified, revoked or in any other way affected to make it unlawful for Provider to provide services under this Addendum;
d) Upon request of OHCA or, if OHCA determines termination is in the best interests of the State, upon direction of OHCA (State Contract § 1.14.1.1 and State Contract § 1.12.6.1);
e) If Provider violates Section 1.24.1.7 of the State Contract (State Contract § 1.12.1.7).
f) DHS or OJA terminates or refuses to re-contract Provider.

4.4 Company's right to deny, refuse to renew or terminate the Agreement shall be in accordance with the terms of the State Contract and any applicable statutes and regulations;

5. Independent Contractor. Provider is not a third-party beneficiary to the State Contract. Provider is an independent contractor performing services as outlined in the State Contract. (State Contract §1.14.1.1)

6. NPI. Providers rendering Covered Services, including Providers ordering or referring a covered service, must have a National Provider Identifier ("NPI"), to the extent such Provider is not an atypical provider as defined by CMS. (State Contract §1.14.1.1)

7. Enrollment in SoonerCare. Provider represents and warrants that it is now, and shall at all times during the term of this Addendum be, enrolled as a contracted provider in good standing in SoonerCare, and Provider shall, upon request of Company or OHCA, provide any and all such documentary evidence, as reasonably required by Company or OHCA, to validate such status in accordance with 42 C.F.R. 438.602(b)(1) and 438.608(b) (State Contract §§1.13.1.4.1 and 1.20.8). In accordance with 42 C.F.R. § 438.602(b)(2), Health Plan may execute this Addendum pending the outcome of the of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to 60 days but will terminate Provider immediately upon notification from the State that Provider cannot be enrolled with SoonerCare, or the expiration of one 60 day period without enrollment of Provider with SoonerCare. (State Contract §1.13.1.4.2)

8. Credentialing and Recredentialing. Provider shall comply with OHCA's and Company's credentialing and re-credentialing processes as set forth in the Agreement and Provider Manual. (State Contract §§ 1.14.1 and 1.14.2) and 42 C.F.R. § 438.214, 42 C.F.R. §§ 438.12(a)(2) and 438.214(b).

9. Enrollee Rights and Responsibilities. Provider shall abide by the Enrollee rights and responsibilities denoted in § 1.12.5.4 of the State Contract and in Company's Enrollee Handbook. (State § Contract 1.14.1.1)

10. Display Notices of Enrollee Rights to Grievances, Appeals and State Fair Hearings. Provider shall display notices in public areas of Provider's facility/facilities in accordance with all State requirements and any subsequent amendments. (State Contract § 1.14.1.1)

11. Physical Accessibility. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3). (State Contract § 1.14.1.1)

12. Interpreter Presence. Provider shall accommodate the presence of interpreters and shall not suggest or require that Enrollees with LEP, or who communicate through sign language, utilize friends or family as interpreters. (State Contract §§ 1.14.1.1 1.12.1.1, and 1.12.1.2).

13. Emergency Services. Emergency Services shall be rendered without the requirement of Prior Authorization. (State Contract § 1.14.1.1)

14. Confidentiality. Provider shall keep all Enrollee information confidential, as defined by State and federal laws, regulations and policy. (State Contract § 1.14.1.1)

15. Records.

    15.1 Maintenance. Provider shall maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Enrollees and their representatives shall be given access to and can request copies of the Enrollees' medical records to the extent and in the manner provided under State or federal law. (State Contract § 1.14.1.1)

    15.2 Record Availability. Provider shall maintain all records related to services provided to Enrollees for a 10-year period (for minors, Provider shall retain all medical records during the period of minority, plus a minimum of 10 years after the age of majority.). In addition, Providers shall make all Enrollees' medical records or other service records available for any quality reviews that may be conducted by Company, OHCA or its designated agent(s) during and after the term of the Agreement. OHCA, its personnel, designees and contractors shall be provided with prompt access to Enrollees' records. Enrollees shall, at all times, have the right to request and receive copies of their medical records and to request they be amended. (State Contract §§ 1.14.1.1 and 1.11.9.1)

16. Professional Standards for Health Records. In accordance with 42 C.F.R. § 438.208(b)(5), Providers furnishing services to Enrollees shall maintain and share Enrollees' health records in accordance with professional standards. (State Contract § 1.14.1.1)

17. Critical Incident Reporting. Consistent with the reporting and tracking system established by Company, Provider shall report adverse or Critical Incidents to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with OAC 317:30-5-95.39(c). Provider shall avail itself of training and take corrective action as needed to ensure compliance with Critical Incident requirements, in the manner and format required in the Reporting Manual. Provider shall ensure that any serious incident that harms or potentially harms a Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated and corrected, in a manner that ensures Company's compliance with State and federal law, including, but not limited to, 42 C.F.R. §§ 482.13(e) through (g); 483.350-.376; and OAC 317:30-5-95.39. Provider shall report abuse, neglect and/or Exploitation to Company within less than one Business Day. Provider shall immediately, but not to exceed 24 hours, take steps to prevent further harm to any and all Enrollees and respond to any emergency needs of Enrollees. Provider shall conduct an internal Critical Incident investigation and submit a report on the investigation as soon as possible, based on the severity of the Critical Incident, to Company, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with the timeframes established by OAC 317:30-5-95.39(c). Provider will cooperate with any investigations and implement any corrective actions as directed by Company and/or OHCA within applicable timeframes. (State Contract § 1.11.9.3)

18. Vaccines for Children. If Provider is eligible for participation in the Vaccines for Children program, Provider shall comply with all program requirements as defined by OHCA. (State Contract § 1.14.1.1)

19. Facility and Record Access for Evaluation, Inspection or Auditing Purposes. Authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Agreement (State Contract § 1.14.1.1). Provider shall, upon request, make available any and all administrative, financial and medical records relating to the delivery of items or services for which State of federal monies are expended, unless otherwise provided by law. Any audit of a Participating Provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2. (State Contract § 1.20.1.4)

20. Release of Information for Monitoring Purposes. Provider shall release to Company any information necessary to monitor Provider's performance on an ongoing and periodic basis. (State Contract § 1.14.1.1)

21. Cost Sharing.

21.1 Enrollee Charges. When the Covered Service provided requires a Co-payment, as allowed by Company, Provider may charge the Enrollee only the amount of the allowed Co-payment, which may not exceed the Co-payment amount allowed by OHCA. Provider shall accept payment made by Company as payment in full for Covered Services, and Provider shall not solicit or accept any surety or guarantee of payment from the Enrollee, OHCA or the State. (State Contract § 1.14.1.1)

21.2 Exemption from Cost Sharing. In accordance with 42 C.F.R. 447.56, Provider shall not seek cost sharing from "Exempt Populations," including, but not limited to, AI/AN Enrollees (State Contract §§1.19.2 and 1.17.3.4) nor for "Exempt Services" as defined in 42 C.F.R. 447.56 (State Contract § 1.19.3)

21.3 Cost Sharing – Payment Reduction. Company will reduce payment to a Provider by the amount of the Enrollee's Cost Sharing obligations, regardless of whether Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, Company shall not reduce payments to Provider, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing. (State Contract § 1.19.4)

21.4 Balance Billing. In accordance with §1932(b)(6) of the Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), Provider agrees to, and agrees that any of its Contracted Providers or subcontractors will, hold harmless Enrollee for the costs of Covered Services, except for any applicable Co-payment amount allowed by OHCA. (State Contract §1.16.1.3)

22. Third-Party Liability. Provider shall identify Enrollee Third-Party Liability coverage, including Medicare and long-term care insurance, as applicable; and except as otherwise required, Provider shall seek such Third-Party Liability payment before submitting claims to Company. (State Contract § 1.14.1.1)

23. Claims Submission and Payment. Provider shall comply with all claim submittal obligations of the State Contract. Provider shall promptly submit claims information needed to Company to make payment within six months of the Covered Service being provided to an Enrollee. Health Plan may not impose requirements to file claims within a shorter period. (State Contract 1.14.1.1). Except for those exceptions set forth in § 1.16.5 of the State Contract, resubmitted claims must be filed within an additional six months thereafter. (State Contract §§ 1.16.5 and 1.16.6)

24. Performance-based Provider Payments/Incentive Plans. Performance-based provider payment(s)/incentive plan(s) to which Provider is subject, if any, may be set forth in the Agreement between Company and Provider (including any Amendments, Attachments, Exhibits or Appendices) or the Company's Provider Manual. (State Contract § 1.14.1.1)

25. QM/QI Participation. Provider shall (i) participate in and cooperate with any internal and external Quality Management/Quality Improvement (QM/QI) monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or Company, and Provider shall participate in any corrective action processes taken to improve quality of care. (State Contract § 1.14.1.1)

26. Data and Reporting. Provider shall timely submit of all reports, clinical information and Encounter Data required by Company and OHCA. (State Contract § 1.14.1.1)

27. Clinical Practice Guidelines. Provider and Contracted Providers shall exercise good faith efforts to adopt and utilize the Clinical Practice Guidelines adopted by Company. (State Contract §1.8.5)

28. Indemnify and Hold Harmless. At all times during the term of the Agreement, Provider shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by Provider or Contracted Providers pursuant to the Agreement. (State Contract § 1.14.1.1)

29. Non-discrimination. Provider agrees that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of Company's program or otherwise subjected to discrimination in the performance of the Agreement with Company or in the employment practices of Provider. Provider shall identify Enrollees in a manner which will not result in discrimination against the Enrollee in order to provide or coordinate the provision of Covered Services and shall not use discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment days or preference to private pay patients. (State Contract § 1.14.1.1)

30. Access and Cultural Competency. Provider shall take adequate steps to promote the delivery of services in a culturally competent manner to Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (State Contract § 1.14.1.1)

31. Timely Access to Care. Provider shall comply with State standards for timely access to care and services, as specified in the State Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. §438.206(c)(1)(i). Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, or if Provider serves only Medicaid Enrollees, hours of operation comparable to other State Medicaid populations, in accordance with 42 C.F.R. §438.206(c)(1)(ii). Provider shall comply with any corrective action directed by Company to remedy any failure to comply with timely access to care obligations. (State Contract § 1.13.1.2)

32. Database Screening and Criminal Background Check of Employees. Provider shall comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Enrollees and/or access to Enrollees' PHI. Provider is prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed at Section 1.20.10 of the State Contract, entitled "Prohibited Affiliations and Exclusions." Provider shall conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. Provider shall immediately report to Company any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate this Addendum as provided under State and/or federal law. (State Contract § 1.14.1.1)

33. Prohibited Payments. Provider acknowledges that Company will not pay for an item or service for which payment is prohibited by Section 1903(i) of the Act, including but not limited to, services (State Contract § 1.16.2.4):

33.1 Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

33.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

33.3 Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.

33.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

33.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. (State Contract § 1.7.15)

33.6 Company will suspend any payments to Provider for which the State determines there is a credible allegation of Fraud in accordance with § 1.20.7 of the State Contract, entitled "Suspension of Payments for Credible Allegation of Fraud," and in accordance with 42 C.F.R. § 455.23. (State Contract § 1.16.2.2).

33.7 In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include: in accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), Company will not make any payment to a Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-Preventable Conditions for which payment shall not be made include:

33.8 Health-acquired conditions occurring in any inpatient hospital setting, identified as a health acquired condition by the Secretary of HHS under § 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in § 1886(d)(4)(D)(ii) and (iv) of the Act; other than DVT/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in Pediatric and obstetric patients; and

33.9 Conditions meeting the following criteria:

a) Is identified in the State Plan;

b) Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

c) Has a negative consequence for the Enrollee;

d) Is auditable; and

e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient.

34. Prohibited Affiliations and Exclusions.

34.1 Provider acknowledges that Company may not contract with Providers excluded from participation in federal health care programs, and may not contract for the provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly: (i) with an individual convicted of crimes described in § 1128(b)(8)(B) of the Act, in accordance with 42 C.F.R. § 438.808(a), and 438.808(b)(2); (ii) with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-

procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(a); or (iii) with any individual or entity that is excluded from participation in any federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(b). Moreover, Company may not employ or contract, directly or indirectly, for the furnishing of health care, services: (i) with any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is, debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(a); or (ii) with any individual or entity that is excluded, or would provide those services through an individual or entity who is excluded, from participation in any federal health care program under § 1128 or 1128A of the Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(b). Provider warrants and represents to Company that it does not fall within any of the prohibited affiliations and exclusions described in this paragraph. (State Contract §1.20.10). Health Plan may immediately terminate this Addendum in the event that Provider comes within any such prohibition or exclusion. Provider shall not receive any payment hereunder using Medicaid funds for services or items as provided in §1.20.10 of the State Contract. (State Contract § 1.20.10.3)

34.2 No person who has been involved in any manner in the development of this State Contract while employed by the State of Oklahoma shall be employed by the Company to fulfill any of the services provided under the State Contract, in accordance with 74 O.S. § 85.42(B) (State Contract § 1.20.10.3)

34.3 Provider acknowledges that Company may not contract with: (i) any such person or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal, state, local department, or agency; (ii) any such person or entity that has been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract; or for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property within three years of the Health Plan's contract with the person or entity; (iii) any such person or entity that is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in the previous paragraph; or (iv) Any such person or entity that has had one or more public (federal, state, or local) contracts terminated for cause or default within three years of the Health Plan's contract with the person or entity. (State Contract § 1.20.10.3)

35. Off-Shoring. In accordance with 42 C.F.R. § 438.602(i), Company shall not enter into any subcontract for the performance of any duty under this State Contract in which such services are to be transmitted or performed outside of the United States nor will any claims be paid by Company to a Network Provider, out-of-Network Provider, Subcontractor, or financial institution located outside of the U.S. The purchase of offshore services is expressly prohibited. (State Contract § 4.5.1)

36. Provider Right to Support Enrollee Grievance/Appeal. Company will take no punitive action against Provider in the event that Provider either requests an expedited resolution or supports an Enrollee's Appeal. (State Contract § 1.14.1.2)

37. Provider Preventable Conditions - Reporting. Provider shall promptly report to Company all Provider Preventable Conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (State Contract § 1.23.1.18)

38. Grievances and Appeals System. Provider acknowledges that it has received the following information regarding Company's Grievance and Appeals system. In accordance with 42 C.F.R. §§ 438.402 and 438.228(a), Company operates an Enrollee Grievances and Appeals System to handle Appeals of an Adverse Benefit Determination and Grievances. In accordance with the requirements of 42 C.F.R. § 438.402, Company's Grievances and Appeals System allows a Enrollee (or his or her Authorized Representative) to file a Grievance with Company, either orally or in writing, at any time, and to subsequently to request an Appeal with Company, with the ability for the Enrollee to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld. An Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 Calendar Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to Company, which may be filed either orally or in writing. Unless the Enrollee is requesting an expedited resolution, an Enrollee's oral request for an Appeal must be followed by a written, signed request for an Appeal, with the filing date being the date that the oral request for Appeal was made. Company will make assistance available to the Enrollee with filing Grievances and Appeals including: provision of reasonable assistance to Enrollees in (i) completing Grievance or Appeals forms; (ii) taking other procedural steps related to the Grievance or Appeal; (iii) making available Enrollee care support staff; (iv) providing auxiliary aids and services upon request, such as providing interpreter services; and (v) providing toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 C.F.R. 438.406(a). An Enrollee may be represented by an Authorized Representative, may present evidence and testimony, may make legal and factual arguments and the Company shall make Enrollee's case file available to the Enrollee at no charge. Enrollee has the right to request a State Fair Hearing by filing a request within 120 Days after receiving notice that the Adverse Benefit Determination has been upheld on Appeal. Enrollee has the right to request continuation of the benefits that Company seeks to reduce or terminate during an Appeal or State Fair Hearing filing., Providers shall not be allowed to request continuation of benefits as an Authorized Representative of the Enrollee, as specified in 42 § 438.420(b)(5). (State Contract § 1.18 et. seq.)

39. Overpayments to Providers. Provider shall utilize Company's established mechanism for reporting overpayments. Provider shall return overpayments within 60 Days after the date on which the Overpayment was identified and shall notify Company in writing of the reason for the Overpayment. Provider acknowledges that if an Overpayment is identified by OHCA rather than by Company, OHCA may recover the Overpayment directly from Provider, or OHCA may require Company to recover and send the Overpayment to OHCA as directed by the OHCA Program Integrity and Accountability Unit. (State Contract §1.20.11.6)

40. Retroactive Dual Eligibility. Dual Eligible Individuals are excluded from SoonerSelect Program enrollment. Enrollees who become Dual Eligible Individuals will be disenrolled as of their Medicare eligibility effective date. In the event that an Enrollee becomes retroactively Medicare eligible, Company will recover any claims payments made to Provider during the months of retroactive Medicare eligibility. Provider shall submit the claim to Medicare for reimbursement in such instances. (State Contract § 1.6.10)

41. Electronic Visit Verification. If Provider provides services subject to EVV, Provider shall participate in Company's EVV system. (State Contract § 1.21.2)

42. Encounter Data. Provider shall cooperate with Company's Encounter Data submittal requirements and shall submit required Encounter Data in accordance with Company's automated Encounter Data system, and Provider shall accept and use the State-assigned Provider IDs for Encounter Data submissions and shall accept and use the State eMPI/Medicaid IDs for Enrollees. Provider shall submit complete Encounter Data and claims data timely and in sufficient detail to support detailed utilization and tracking and financial reporting. (State Contract §§ 1.21.7 et. seq.)

43. Provider Reconsiderations and Provider Appeals. Provider acknowledges: (A) receipt from Company of the link to Company's website containing, among other things, the Provider Manual(s) detailing, among other things, the policies and procedures for (i) Company's reconsideration of decisions adverse to Provider; and (ii) Provider appeals of such adverse decisions; and (B) the availability to Provider, at the time of entering into this Addendum and upon Provider's request, of a paper copy of the Provider Manual(s). Provider shall comply with such policies and procedures in pursuing Reconsiderations and Appeals. Appeals of Company decisions adverse to the Provider shall be made in writing within 30 Calendar Days. (State Contract § 1.15.6)

44. Health Information Exchange ("***HIE***"). Provider shall comply with 63 O.S. §§ 1-133, and all subsequently promulgated rules, relating to participation in the State's SDE-HIE for the submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery. Encounter Data will include servicing provider data as required by 42 CFR § 438.242(c) (State Contract § 1.21.8)

45. Compliance with Law.

45.1 Changes in Law/Interpretation of Laws. The Parties to this Addendum acknowledge that Medicaid managed care plans are highly regulated by federal statutes and regulations. The Parties further acknowledge that any and all references to Code of Federal Regulation (C.F.R.) citations and other statutes and regulations applicable to Medicaid managed care, are to those in effect on October 15, 2020. The Parties acknowledge and expect that changes may occur over the term of this Addendum regarding federal or State Medicaid statutes and regulation and State statutes and rules governing health insurers and the practice of health care professions. In the event any indicated C.F.R. citation, federal or State Medicaid statute or regulation or State statute or rule governing health insurers and the practice of health care professions or related requirements are amended during the term of this Addendum, the Parties shall be mutually bound by the amended requirements in effect at any given time following the effective date of this Addendum. The explicit inclusion of some statutory and regulatory duties in this Addendum shall not exclude other statutory or regulatory duties. All questions pertaining to the validity, interpretation and administration of this Addendum shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed. If any portion of this Addendum is found to be in violation of State or federal statutes, that portion shall be stricken from this Addendum and the remainder of this Addendum and Agreement shall remain in full force and effect. (State Contract § 1.2.20.5)

45.2 Compliance with Specific Laws. In accordance with 42 C.F.R. § 438.3(f)(1), Provider shall comply, and shall ensure that its officers, employees, Contracted Providers, Subcontractors and their respective Affiliates comply, with all applicable federal and State laws, regulations, rules, policies and guidance including but not limited to:

a) Federal requirements within 42 C.F.R. §§ 438.1, et seq., as applicable to MCOs
b) Title VI of the Civil Rights Act of 1964;
c) The Age Discrimination Act of 1975;
d) The Rehabilitation Act of 1973;
e) Title IX of the Education Amendments of 1972 (regarding education programs and activities);
f) The Americans with Disabilities Act of 1990 as amended;
g) Section 1557 of the Patient Protection and Affordable Care Act (ACA);
h) Health Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2 (HIPAA);
i) Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2 MHPAEA);
j) Oklahoma Electronic and Information Technology Accessibility (EITA) Act (Oklahoma 2004 House Bill (HB) 2197) regarding information technology accessibility standards for persons with disabilities;

k) Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, et seq
l) Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
m) Oklahoma Worker's Compensation Act, 85A O.S. §§ 1 *et seq.*;
n) 74 O.S. §§ 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225 or 230 as applicable to Company's entity) purchased with monies received from OHCA pursuant to the State Contract;
o) Title 317 of the Oklahoma Administrative Code ("OAC");
p) Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and
q) Deceptive Trade Practices; Unfair Business Practices. (State Contract § 1.2.20.5)

45.3 Deceptive Trade Practices Violations. Provider represents and warrants that neither Provider nor any of its Subcontractors: (i) have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §§ 751 *et seq.*; (ii) have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding; (iii) have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violation; or (iv) have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding. (State Contract § 1.2.20.5)

45.4 Enrollees' Rights. In accordance with 42 C.F.R. § 438.100(a)(2), Provider shall comply with any applicable federal and State laws that pertain to Enrollees' rights and shall ensure that its employees and Contracted Providers observe and protect those rights. (State Contract § 1.2.20.5)

46. Primary Care Providers ("***PCP***"). The following provisions shall apply if Provider is a PCP. (State Contract §1.14.1.3). Provider shall:

a) deliver primary care services and follow-up care;
b) utilize and practice evidence-based medicine and clinical decision supports;
c) screen Enrollees for behavioral health disorders and conditions;
d) make referrals for Behavioral Health Services, specialty care and other covered services and, when applicable, work with Company to allow Enrollees to directly access a specialist as appropriate for an Enrollee's condition and identified needs;
e) maintain a current medical record for the Enrollee;
f) use health information technology to support care delivery;
g) provide care coordination in accordance with the Enrollee's Care Plan, as applicable based on Company's Risk Stratification Level Framework, and in cooperation with the Enrollee's Care Manager;
h) ensure coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;
i) engage active participation by the Enrollee and the Enrollee's family, Authorized Representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;
j) provide access to medical care 24 hours per day, 7 days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;
k) provide enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
l) participate in continuous quality improvement and voluntary performance measures established by Company and/or OHCA.
m) maintain medical records documenting all referrals of Enrollees.

n) meet the following "Appointment Time" obligations for the applicable Provider-type category (State Contract §§ 1.14.3.1and 1.14.3.2):

Service Category	Appointment Time
Adult PCP Pediatric PCP	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. • Each PCP shall allow for at least some same-day appointments to meet acute care needs.
OB/GYN	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. Maternity Care: • First Trimester – Not to exceed 14 Calendar Days • Second Trimester – Not to exceed seven Calendar Days • Third Trimester – Not to exceed three Business Days
Adult Specialty Pediatric Specialty	• Not to exceed 60 Days from date of the Enrollee's request for routine appointment. • Within 24 hours for Urgent Care.

For purposes of the "Appointment Time" chart above, "Specialty" includes, but is not limited to, the following specialty provider-types: anesthesiologist assistants; physician (MD/DO) specialists and subspecialists to provide specialty care services as required in the benefit package; audiologists; nutritionists; opticians; optometrists; podiatrists; and therapists to provide specialty care services as required in the SoonerSelect Program benefit package. (State Contract §1.14.3.3)

47. Behavioral Health Providers. The following provisions shall apply if Provider is a behavioral health provider.
   a) Provider shall provide inpatient psychiatric services to Enrollees and schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven Calendar Days from the date of discharge.
   b) Provider shall complete the ODMHSAS Customer Data Core form located at odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the State Contract;
   c) Provider shall provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.
   d) Provider agrees that Company will obtain the appropriate Enrollee releases to share clinical information and Enrollee health records with community-based behavioral health Providers, as requested, consistent with all State and federal confidentiality requirements and in accordance with Company policy and procedures. (State Contract §1.14.1.3.2)
   e) Provider shall meet the following "Appointment Time" obligations (State Contract §1.14.3.4):

Service Category	Appointment Time
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	• Not to exceed 30 Days from date of the Enrollee's request for routine appointment. • Within seven Days for residential care and hospitalization. • Within 24 hours for Urgent Care.

f) If requested by the Enrollee and to the extent possible for OHCA-defined services that are reimbursable through Telehealth, Provider shall provide for the delivery of Behavioral Health Services via Telehealth. (State Contract §1.14.3.4)

48. Laboratory Testing Sites. The following provisions shall apply if Provider is a laboratory testing site. Provider shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration, along with a CLIA identification number. Provider understands that Company will maintain a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Enrollees. Any Provider performing laboratory tests is required to be certified under CLIA. OHCA will continue to update the Provider file with CLIA information, which Provider acknowledges will make laboratory certification information available to Company on the Medicaid Provider file. (State Contract §1.14.1.3.3)

50. Pharmacy Providers. In accordance with OAC 535:15-3-9, any pharmacy located outside the State of Oklahoma providing pharmacy services to Oklahoma residents must be licensed by the Oklahoma State Board of Pharmacy. Additionally, the pharmacist in charge must also be licensed by the Oklahoma State Board of Pharmacy. (State Contract § 1.14.3.5)

STATE LAW REGULATORY REQUIREMENTS

This schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Enrollees enrolled in or covered by this Product may be set forth in the Provider Manual or another Addendum. To the extent that a Coverage Agreement, or an Enrollee, is subject to the law cited in the parenthetical at the end of a provision on this Schedule B, such provision will apply to the rendering of Covered Services to an Enrollee with such Coverage Agreement, or to such Enrollee, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, an Enrollee shall not be liable to Participating Provider for any sums owed by Payor. Neither Participating Provider nor the agent, trustee or assignee of Participating Provider may maintain an action at law against an Enrollee to collect sums owed by Payor. (OKLA. STAT. ANN. tit. 36, § 6913.D)

OK-2 Termination.

(a) If Provider terminates the Agreement or Participating Provider voluntarily chooses to discontinue participation with respect to a particular Product, Provider or Participating Provider will give Company written notice by the longer of 90 days or the number of days set forth in the Agreement prior to such termination. (OKLA. STAT. ANN. tit. 36, § 6913.F; OKLA. ADMIN. CODE 365:40-5-71(4)(C))

(b) If Health Plan terminates the Agreement without cause, Health Plan will give Provider at least 90 days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than 90 days' advance notice are set forth in the Agreement (OKLA. ADMIN. CODE 365:40-5-71(1).

OK-3 Continuation of Care.

(a) If Payor becomes insolvent, Participating Provider shall provide services for the duration of the period after Payor's insolvency for which premium payment has been made, for Enrollees confined on the date of insolvency in an inpatient facility, and for pregnant Enrollees, until Enrollee's discharge from inpatient facilities, Enrollee's delivery and discharge if pregnant, and/or expiration of benefits under the Coverage Agreement. (OKLA. STAT. ANN. tit. 36, § 6913.E.2; OKLA. ADMIN. CODE 365:40-5-72(b))

(b) Following termination, Participating Provider will continue to provide services, at the terms and price under the Agreement, for up to 90 days from the date of notice for an Enrollee who: (i) has a degenerative and disabling condition or disease; (ii) has entered the third trimester of pregnancy; or (iii) is terminally ill. With respect to Enrollees that have entered the third trimester of pregnancy, terminated Participating Provider shall continue to provide services, at the terms and price under the Agreement, through at least six weeks of postpartum evaluation. (OKLA. ADMIN. CODE 365:40-5-71(4)(A).

(c) If Company or Payor authorizes such continuation of care, Participating Provider will: (i) accept reimbursement set forth in the Agreement as payment in full, (ii) adhere to the quality assurance requirements and provide necessary medical information regulated to such care, and (iii) otherwise adhere to applicable policies and procedures regarding references, and obtaining preauthorization and treatment plan approval, from the Company or Payor. (OKLA. ADMIN. CODE 365:40-5-71(4)(d).

OK-4 Delegation of Claims Processing. If Company has delegated its claims processing functions to Provider, Provider shall comply with the requirements of applicable Oklahoma law, including without limitation Chapter 40, Subchapter 5, Part 23 of the Insurance Department Regulations. (OKLA. ADMIN. CODE 365:40-5-127(d))

OK-5 Network Lease. Participating Provider expressly authorizes Company to sell, lease and otherwise transfer information regarding the payment or reimbursement terms of the Agreement, and acknowledges that Participating Provider has received prior adequate notification of such other contracting parties. (OKLA. STAT. ANN. tit. 36, §§ 1219.3.B; 7302.B)

OK-6 Indemnification. If the Agreement requires indemnification by Participating Provider, such indemnification will not apply, to the extent required by law, with respect to liability imposed by the Oklahoma Managed Health Care Reform and Accountability Act. (OKLA. STAT. ANN. tit. 36, § 6593.E).

OK-7 Contract Disclosures. Participating Provider acknowledges and agrees that the Agreement (including the Provider Manual) discloses the following:

(a) the mailing address, including a physical address, where claims are to be sent for processing whether it be the address of the Payor, a delegated claims processor, or any other entity, including a clearing house or a repricing company designated by the Payor to receive claims;

(b) the telephone number to which Participating Provider's questions and concerns regarding claims may be directed; and

(c) the mailing address, including physical address, of any separate claims processing centers for specific types of services, if applicable. (OKLA. ADMIN. CODE 365:40-5-127(a)).