# PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic ("***Provider***") and Oklahoma Complete Health, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

## ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary under the applicable Coverage Agreement.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

## ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their

services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide Health Plan with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least 60 days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product unless Provider or Contracted Provider opts into such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-in. Only those Contracted Providers with respect to whom or which such notice is provided shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will provide Provider with at least 30 days' advance written notice of such change. If Provider disputes the change, the Parties will meet in good faith to find a mutually beneficial solution, or either Party may exercise its rights in accordance with Section 7.2.1. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to

exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all

applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts that are directly related to Provider's noncompliance against any amounts due Provider or Contracted Providers from Company or require Provider or the Contracted Provider to reimburse Company for such amounts. Company will provide a copy of the sanctions or penalties to Provider prior to any offsets.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the 5 year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

## ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall timely submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons within 180 days of the date Covered Services were rendered. Contracted Provider , if applicable, shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate will provide written or electronic notice to Provider before using an offset of amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed

by the Payor or Company to the Provider or Contracted Provider as a means to recover an overpayment or payment made in error. Payor or its delegate will not implement the offset if, within 30 days after the date of the notice, Provider refunds the overpayment or payment made in error, or initiates an appeal. The notice shall explain the reason and calculation of the overpayment or payment made in error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

## ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

## ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating

to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third -party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

## ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. Health Plan shall complete these applicable procedures within 60 days after Provider notifies Health Plan of such claim reconsideration and/or claims Dispute. If at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other Party, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including Attachments) in the court record, except this Section 6.2. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

## ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of 2 year(s), after which it will automatically renew for successive terms of 1 year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 120 days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving the other Party written notice of such non-renewal not less than 120 days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily

withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

## ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted

Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third -party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. All amendments must be in writing and counter executed by both Parties, unless Section 8.7.1. is applicable.

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

| To Health Plan at: | To Provider at: |
|---|---|
| Attn: President | Attn: Dale Clayton |
| | Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic |
| Oklahoma Complete Health, Inc. | |
| 7725 W. Reno Ave. [Suite 332] | PO Box 280 |
| Oklahoma City, OK 73127 | Mangum, OK 73554 |
| | dale@cohesivehealthcare.net |

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or

as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.**

**IN WITNESS WHEREOF**, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

| **HEALTH PLAN:** | **PROVIDER:** |
|---|---|
| Oklahoma Complete Health, Inc. | Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic<br>(Legibly Print Name of Provider) |
| Authorized Signature: | Authorized Signature: |
| Print Name: Clayton Franklin | Print Name: |
| Title: President & CEO | Title: |
| Signature Date: | Signature Date: |
| ICM #: ICMProviderAgreement_164043 | Tax Identification Number: 82-2087512 |
| **To be completed by Health Plan only:**<br>Effective Date: | National Provider Identifier: 1033635263<br>Medicare Number: |

**PARTICIPATING PROVIDER AGREEMENT**

**SCHEDULE A**
**CONTRACTED PROVIDER-SPECIFIC PROVISIONS**

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons 24 hours per day, 7 days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If applicable, Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If applicable, Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center) ("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If applicable, Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If applicable, Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If applicable, Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). If applicable, Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

7.3 LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

**PARTICIPATING PROVIDER AGREEMENT**

**SCHEDULE B**
**PRODUCT PARTICIPATION**

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

**List of Product Attachments:**
Attachment A: Medicaid
Attachment B: Medicare
Attachment C: Commercial-Exchange
Attachment D: [Reserved]
Attachment E: [Reserved]

**PARTICIPATING PROVIDER AGREEMENT**

**SCHEDULE C**
**INFORMATION FOR CONTRACTED PROVIDERS**

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to Health Plan hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

## Attachment A: Medicaid

**PRODUCT ATTACHMENT**
**OKLAHOMA MEDICAID PRODUCT (SOONERSELECT)**
**(INCLUDING REGULATORY REQUIREMENTS)**

THIS PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between Oklahoma Complete Health, Inc. ("Health Plan") and Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain Participating 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;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers will be designated and participate as "***Participating Providers***" in the Product described in this Attachment; and

WHEREAS, Health Plan has contracted with the Oklahoma Health Care Authority ("***OHCA***") to be a State Medicaid Care Management Organization to provide Covered Services to Covered Persons in the State's Medicaid program known as SoonerSelect, and such other programs (hereafter referred to as "Medicaid Product") as may be awarded to Health Plan by OHCA.

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 SoonerSelect. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the Medicaid Product. The Medicaid Product includes those programs and health benefit arrangements offered by Health Plan or other Company pursuant to a contract (the "***State Contract***") with the Oklahoma Health Care Authority, or any successor thereto, to provide specified services and goods to covered beneficiaries under the SoonerSelect programs (or additional, ancillary or successor State Medicaid programs thereto), and to meet certain performance standards while doing so. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

Where Company is not the Payor, the rights and responsibilities assigned under this Attachment to Company, Payor, or "Company or Payor" shall be understood to apply to either Company or Payor as applicable under the circumstances and as determined by the terms of the Payor Contract, Regulatory Requirements and/or Company policies and procedures. The phrase "Company or Payor" is not intended to nor shall result in the expansion of any rights on the part of Provider or Contracted Providers or any liabilities on the part of Company or Payor. Nothing in this Attachment shall be construed as conferring any financial or legal liabilities of Payor under any Regulatory Requirements or the Payor Contract to Company or Health Plan. Nothing in this Attachment shall be construed as altering the terms of the Payor Contract, or in a manner that is inconsistent with Regulatory Requirements. The rights and responsibilities that arise under a Payor Contract (including a Governmental Contract)

and that are assigned under this Attachment to Health Plan are understood to be assigned to Company (and references to "Health Plan" will be understood to be references to Company) where Company is a party to the Payor Contract.

2.2 Participation. Unless otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicaid Product as "***Providers***," and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment constitutes the Product Attachment for the Medicaid Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company. To the extent any provision of this Attachment, or any provision of the Agreement as it relates to this Attachment, (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Attachment will become effective as of the Effective Date and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Attachment. Notwithstanding the above, Health Plan may immediately terminate this Attachment upon notice to Provider in the event that the State Contract is terminated or the SoonerSelect program (or any aspect thereof) is no longer authorized by law (i.e., has been vacated by a court of law, CMS has withdrawn federal authority for the program, or the program is the subject of a legislative repeal).

4. Governmental Contract/Regulatory Requirements. **Schedule A** to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicaid Product under the State Contract and the provisions that are required by the State Contract to be included in the Agreement with respect to the Medicaid Product. Schedule B to this Attachment, which is incorporated herein by this reference, sets forth the terms that are applicable to the Medicaid Product under State laws and regulations, and that are required under such laws and regulations to be included in the Agreement with respect to the Medicaid Product. To the extent that a Coverage Agreement is subject to the law cited in the **Schedule B**, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement. Provider shall expressly impose these terms and obligations, in writing, on each of its Contracted Providers, as such term is defined in the Agreement. Health Plan is and shall be a third -party beneficiary of any agreement between Provider and its Contracted Providers with the right to directly enforce these terms and condition upon Contracted Providers. Applicable State agencies have the right to modify, supplement, amend and add to the terms, conditions and obligations set forth in **Schedules A and B**, and Provider shall be bound by such changes

## Attachment A: Medicaid

## SCHEDULE A
## GOVERNMENTAL CONTRACT REQUIREMENTS

This Schedule A sets forth the special provisions that are specific to the Oklahoma SoonerSelect Medicaid , SoonerSelect Children's Program and CHIP Product under the applicable State Contract.

1. Definitions. For purposes of this Attachment, the following terms have the meanings set forth below. Terms used in this Attachment and not defined below will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract (as defined below). Terms used in this Attachment that are not otherwise explicitly defined shall be understood to have the definition laid out 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.

1.1 "***Act***" means the Social Security Act.

1.2 **"*Adverse Benefit Determination*"** means, pursuant to 42 C.F.R. § 438.400(b):

a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, health care setting, or effectiveness of a covered benefit;

b) The reduction, suspension, or termination of a previously authorized service;

c) The denial, in whole or in part, of payment for a service;

d) The failure to provide services in a timely manner, as defined by OHCA;

e) The failure of Company to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals;

f) For a resident of a Rural Area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the network; or

g) The denial of a Covered Person's request to dispute a financial liability, including Cost Sharing, Copayments, premiums, deductibles, coinsurance and other Covered Person financial liabilities.

1.3 **"*Affiliate*"** means associated business concerns or individuals if, directly or indirectly: (1) either one controls or can control the other; or (2) a third party controls or can control both.

1.4 **"*American Indian/Alaska Native*"** or **"*AI/AN*"** means, pursuant to 42 C.F.R. § 438.14, any individual defined at 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12. This means the individual:

a) Is a member of a Federally recognized Indian Tribe;

b) Resides in an urban center and meets one or more of the four criteria; o Is a member of an Indian Tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the State in which they reside or who is a descendant, in the first or second degree, of any such member;

c) Is an Eskimo or Aleut or other Alaska Native; o Is considered by the Secretary of the Interior to be an Indian for any purpose; or o Is determined to be an Indian under regulations issued by the Secretary;

d) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

e) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

1.5 **"*Appeal*"** means a review of an Adverse Benefit Determination by Company.

1.6 **"*Authorized Representative*"** means a competent adult who has the Covered Person's signed, written authorization to act on the Covered Person's behalf during the Grievance, Appeal, and State Fair Hearing process. The written authority to act shall specify any limits of the representation.

1.7 **'*Behavioral Health Services*"** means a wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse and co-occurring disorders.

1.8 **"*Business Days*"** means Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

1.9 **"Calendar *Days*"** means all seven days of the week, including State of Oklahoma holidays.

1.10 **"*Care Manager*"** means Company's staff primarily responsible for delivering services to Covered Persons s in accordance with its OHCA-approved Risk Stratification Level Framework, and meets the qualifications specified in Section 1.8.4.3 of the State Contract.

1.11 **"*Care Plan*"** means a comprehensive set of actions and goals for the Covered Person developed by the Care Manager based on a Covered Person's unique needs. Company shall develop and implement Care Plans for all Covered Persons with a Special Health Care Need determined through the Comprehensive Assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.8.3 of the State Contract.

1.12 **"*Children*"** means a child under age 19 determined eligible for SoonerCare under 42 C.F.R. § 435.118 or the state's Medicaid expansion CHIP.

1.13 **"*Clinical Practice Guidelines*"** means systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Company shall adopt Clinical Practice Guidelines in accordance with 42 C.F.R. § 438.236, ensuring they are based on valid and reliable clinical evidence or a consensus of Providers in the particular field; consider the needs of Covered Persons; are adopted in consultation with Participating Providers; and are reviewed and updated periodically as appropriate.

1.14 **"*Copayment*"** means a fixed amount that a Covered Person pays for a covered health care service when the Covered Person receives the service.

1.15 **"*Cost Sharing*"** means a State requirement that Covered Persons bear some of the cost of their care through mechanisms such as Copayments, deductibles and other similar charges.

1.16 **"*Covered Person*"** means an Eligible who is enrolled in Company's SoonerSelect plan.

1.17 **"*Covered Services*"** means all Medicaid services provided by Company in any setting, including but not limited to medical care, behavioral health care and pharmacy.

1.18 **"*Critical Incident*"** means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a SoonerSelect program Company Enrollee. Critical Incidents include, but are not limited to, the following when the Covered Person is in the care of a behavioral health inpatient, residential or crisis stabilization unit, in accordance with OAC 317:305-95.39: Suicide death; non-suicide death; death-cause unknown; homicide; homicide attempt with significant medical intervention; suicide attempt with significant medical intervention; allegation of physical, sexual or verbal abuse or neglect; accidental injury with significant medical intervention; use of Restraints/Seclusion (Isolation); AWOL or absence from a mental health facility without permission; or treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

1.19 **"*Days*"** means calendar days unless otherwise specified.

1.20 **"*Disenroll*"** means the removal of a Covered Person from participation in Company's MCO.

1.21 **"*Dual Eligible Individuals*"** means individuals eligible for both Medicaid and Medicare.

1.22 **"*Electronic Visit Verification (EVV) System*"** means an electronic system that documents the time that Providers begin and end the delivery of services to Covered Persons and the location of services. The EVV System shall comply with Section 12006 of the 21st Century Cures Act and associated CMS requirements.

1.23 **"*Eligible*"** means an individual who has SoonerCare coverage.

1.24 **"*Emergency Medical Condition*"** means a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

1.25 **"*Emergency Services*"** means Covered Services that are furnished by a Provider qualified to furnish such services and needed to evaluate, treat, or stabilize an Emergency Medical Condition.

1.26 **"*Encounter Data*"** means information relating to the receipt of any item(s) or service(s) by a Covered Person under this Attachment that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

1.27 **"*Fraud*"** means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

1.28 **"*Grievance*"** means a Covered Person expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Covered Person's rights regardless of whether remedial action is requested. A Grievance includes a Covered Person's right to dispute an extension of time proposed by Company to make an authorization decision.

1.29 **"*Grievance and Appeal System*"** means the processes that Company implements to handle Covered Person Grievances and Appeals of Adverse Benefit Determinations, as well as the processes to collect and track information about them.

1.30 **"*Indian Health Care Provider*"** *or* **"*IHCP*"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

1.31 **"*Indian Tribe*"** has the definition set forth in 25 U.S.C. § 1603.

1.32 **"*Limited English Proficiency*"** *or* **"*LEP*"** means Covered Persons who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP) and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

1.33 **"*Managed Care Organization*"** *or* **"*MCO*"** means a health plan that has a contract with OHCA to participate in the SoonerSelect program and to deliver benefits and services to Covered Persons.

1.34 **"*Medically Necessary*"** means a standard for evaluating the appropriateness of services. Medical necessity, as established under OAC 317:30-3-1, is established through consideration of the following standards:

a) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

b) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the Covered Person's need for the service;

c) Treatment of the Covered Person's condition, disease or injury must be based on reasonable and predictable health outcomes;

d) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the Covered Person, family or medical provider;

e) Services must be delivered in the most cost-effective manner and most appropriate setting; and

f) Services must be appropriate for the Covered Person's age and health status and developed for the Covered Person to achieve, maintain or promote functional capacity or age appropriate growth and development.

Also aligning with federal standards, "Medically Necessary services" are no more restrictive than the State Medicaid program including Quantitative (QTL) and Non-Quantitative Treatment Limits (NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures. Company shall cover Medically Necessary services related to the ability for a Covered Person to attain, maintain, or regain functional capacity.

1.35 **"*Non-Participating Provider*"** means a physician or other Provider who has not contracted with or is not employed by Company to deliver services under the SoonerSelect program.

1.36 **"*Non-Urgent Sick Visit*"** means medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of Non-Urgent Sick Visits include cold symptoms, sore throat and nasal congestion. Requires face-to-face medical attention within 72 hours of Covered Person notification of a non-urgent condition, as clinically indicated.

1.37 **"*Oklahoma Health Care Authority*"** *or* **"*OHCA*"** means the single state Agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerSelect program.

1.38 **"*Overpayment*"** means any payment made to a Participating Provider by Company to which the Participating Provider is not entitled or any payment to Company by a state to which Company is not entitled to under Title XIX of the Act and under the SoonerSelect program.

1.39 **"*Participating Provider*"** means a physician or other Provider who has a contract with or is employed by Company to provide services to Covered Persons under the SoonerSelect program. This is the "Provider" in the Agreement between Company and the Participating Provider.

1.40 **"*Patient Centered Medical Home"* *or* *"PCMH*"** means primary care delivery system model that incorporates a managed care component with traditional fee-for-service and incentive payments for medical homes. For the purposes of this Attachment, the term "PCMH" shall be used instead of "primary care provider." PCMH Providers include the provider types listed in Section 1.12.4.1 of the State Contract.

1.41 **"*Pediatric*"** means relating to children from birth through age 21.

1.42 **"*Prior Authorization*"** means a requirement that a Covered Person obtain Company's approval before a requested medical service is provided or before services by a Non-Participating Provider are received. Prior Authorization is not a guarantee of claims payment; however, failure to obtain Prior Authorization may result in denial of the claim or reduction in payment of the claim.

1.43 **"*Protected Health Information*"** means information considered to be individually identifiable health information, as described in 45 C.F.R. § 160.103.

1.44 **"*Provider*"** means a provider that is either a Participating or a Non-Participating Provider.

1.45 **"*Provider-Preventable Conditions*"** means a condition occurring in any inpatient hospital setting, identified by the Secretary under Section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in Section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Also includes a condition occurring in any health care setting that is identified in the State Plan, has been found by OHCA, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Covered Person; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and any surgical or other invasive procedure performed on the wrong patient.

1.46 **"*Rural Area*"** means a county with a population of less than 50,000 people.

1.47 **"*Secretary*"** means the Secretary of the U.S. Department of Health and Human Services.

1.48 **"*SoonerCare*"** means the Oklahoma Medicaid program.

1.49 **"*State*"** means, when not otherwise specified, a government entity or entities within the State of Oklahoma.

1.50 **"*State Contract*"** means the agreement between Company and OHCA whereby Company will provide Medicaid services to Covered Persons and be paid by OHCA as described in the terms therein, and which comprises the State Contract and any addenda, appendices, attachments or amendments thereto.

1.51 **"*State Plan*"** means the agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

1.52 **"*State Fair Hearing*"** means the process set forth in Subpart E of 42 C.F.R. Part 431.

1.53 **"*Subcontractor*"** means an individual or entity that has a contract with Company that relates directly or indirectly to the performance of Company's obligations under the State Contract. Provider is not a Subcontractor by virtue of this Attachment.

1.54 **"*Telehealth*"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telehealth visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

1.55 **"*Third Party Liability (TPL)*"** means all or part of the expenditures for a Covered Person's medical assistance furnished under the OHCA State Plan that may be the liability of a third party individual, entity or program.

1.56 **"*Urgent Care*"** means medical care provided for a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that a reasonably prudent layperson could expect that the absence of medical attention within 24 hours could result in:

a) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) Serious impairment to bodily function; or

c) A serious dysfunction of any body organ or part.

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 Covered Persons under this Attachment. (Model Contract 1.12.2.1)

3. Conflict of Terms. If any requirement in the Agreement is determined by OHCA to conflict with the State Contract, such requirement shall be null and void and all other provisions of the Agreement shall remain in full force and effect. (Model Contract 1.12.2.1)

4. Approval of State Contract. Effectiveness of this Attachment 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, it, and this Attachment, will be considered null and void. (Model Contract 1.1.4)

5. Termination of this Attachment.

5.1 Availability of Records. In the event of termination of this Attachment 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 Attachment, and that the provision of such records shall be at no expense to OHCA. (Model Contract 1.12.2.2) Moreover, Provider shall cooperate with Company and OHCA to ensure that any Covered Person records and information are provided to Company to facilitate an orderly transition of all Covered Persons' care. (Model Contract 1.12.6.2.1)

5.2 Notice of Termination. Notwithstanding anything in the Agreement to the contrary, Health Plan and Provider may terminate this Attachment for cause upon thirty (30) days advance written notice to the other party, and without cause upon sixty (60) days advance written notice to the other party (Model Contract 1.12.6.1).

5.3 Immediate Termination. Notwithstanding anything in the Agreement to the contrary, this Attachment may be immediately terminated by Health Plan in the event of the following:

a) To protect the health and safety of Covered Persons;

b) Upon 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 Attachment;

d) Upon request of OHCA or, if OHCA determines termination is in the best interests of the State, upon direction of OHCA (Model Contract 1.12.2.2 and Model Contract 1.12.6.1); or

e) If Provider violates Section 1.24.1.7 of the State Contract (Model Contract 1.12.1.7).

f) DHS or OJA terminates or refuses to re-contract Provider.

6. 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. (Model Contract 1.12.2.2)

7. NPI. Providers rendering Covered Services, including Providers ordering or referring a covered service, must have an NPI, to the extent such Provider is not an atypical provider as defined by CMS. (Model Contract 1.12.2.2)

8. Enrollment in SoonerCare. Provider represents and warrants that it is now, and shall at all times during the term of this Attachment 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). (Model Contract 1.12.1.4.1 and 1.18.8) In accordance with 42 C.F.R. § 438.602(b)(2), Health Plan may execute this Attachment 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. (Model Contract 1.12.1.4.2)

9. 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. (Model Contract 1.12.2.2 and 1.12.3) and 42 C.F.R. § 438.214, 42 C.F.R. §§ 438.12(a)(2) and 438.214(b).

10. Covered Person Rights and Responsibilities. Provider shall abide by the Covered Person rights and responsibilities denoted in Section 1.11.5.2.4 of the State Contract and in Company's Enrollee Handbook. (Model Contract 1.12.2.2)

11. Display Notices of Covered Person 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. (Model Contract 1.12.2.2)

12. Physical Accessibility. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3). (Model Contract 1.12.2.2)

13. Interpreter Presence. Provider shall accommodate the presence of interpreters and shall not suggest or require that Covered Persons with LEP, or who communicate through sign language, utilize friends or family as interpreters. (Model Contract 1.12.2.2 and 1.11.1.2).

14. Emergency Services. Emergency Services shall be rendered without the requirement of Prior Authorization. (Model Contract 1.12.2.2)

15. Confidentiality. Provider shall keep all Covered Person information confidential, as defined by State and federal laws, regulations and policy. (Model Contract 1.12.2.2)

16. Records.

16.1 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. Covered Persons and their representatives shall be given access to and can request copies of the Covered Persons' medical records to the extent and in the manner provided under State or federal law. (Model Contract 1.12.2.2)

16.2 Record Availability. Provider shall maintain all records related to services provided to Covered Persons for a ten year period (For minors, Provider shall retain all medical records during the period of minority, plus a minimum of ten years after the age of majority.) In addition, Providers shall make all Covered Persons' 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 Covered Persons' records. Covered Persons shall, at all times, have the right to request and receive copies of their medical records and to request they be amended. (Model Contract 1.12.2.2 and 1.10.9.1)

17. Professional Standards for Health Records. In accordance with 42 C.F.R. § 438.208(b)(5), Providers furnishing services to Covered Persons shall maintain and share Covered Persons' health records in accordance with professional standards. (Model Contract 1.12.2.2)

18. 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, DHS, and the Covered Person'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. Provider shall ensure that any serious incident that harms or potentially harms a Covered Person'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 Covered Persons and respond to any emergency needs of Covered Persons. 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, DHS, and the Covered Person'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. (Model Contract 1.10.10)

19. 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. (Model Contract 1.12.2.2)

20. 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 this Attachment. (Model Contract 1.12.2.2) 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. (Model Contract 1.18.1.4)

21. 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. (Model Contract 1.12.2.2)

22. Cost Sharing.

22.1 Covered Person Charges. When the Covered Service provided requires a Copayment, as allowed by Company, Provider may charge the Covered Person only the amount of the allowed Copayment, which may not exceed the Copayment 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 Covered Person, OHCA or the State. (Model Contract 1.12.2.2)

22.2 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 Covered Persons (Model Contract 1.17.2, and 1.15.3.4) nor for "Exempt Services" as defined in 42 C.F.R. 447.56 (Model Contract 1.17.3)

22.3 Cost Sharing – Payment Reduction. Company will reduce payment to a Provider by the amount of the Covered Person'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. (Model Contract 1.17.4)

22.4 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 Covered Person for the costs of Covered Services, except for any applicable Copayment amount allowed by OHCA. (Model Contract 1.14.1.3)

23. Third Party Liability. Provider shall identify Covered Person 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. (Model Contract 1.12.2.2)

24. Claims Submission and Payment. Provider shall promptly submit claims information needed to Company to make payment within six months of the Covered Service being provided to a Covered Person. (Model Contract 1.12.2.2) Except for those exceptions set forth in Section 1.14.4.2.1 of the Model Contract, resubmitted claims must be filed within an additional six months thereafter. (Model Contract 1.14.4.2.1)

25. Performance-based Provider Payments/Incentive Plans. Performance-based provider payment(s)/incentive plan(s) to which Provider is subject, if any, are set forth in the Compensation Schedule of the Agreement (Model Contract 1.12.2.2)

26. QM/QI Participation. Provider shall (i) participate in and cooperate with any internal and external 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. (Model Contract 1.12.2.2)

27. Data and Reporting. Provider shall timely submit of all reports, clinical information and Encounter Data required by Company and OHCA. (Model Contract 1.12.2.2)

28. Clinical Practice Guidelines. Provider and Contracted Providers shall exercise good faith efforts to adopt and utilize the Clinical Practice Guidelines adopted by Company. (Model Contract 1.7.4)

29. 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. (Model Contract 1.12.2.2)

30. 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 Covered Persons in a manner which will not result in discrimination against the Covered Person in order to provide or coordinate the provision of Covered Services, and shall not use discriminatory practices with regard to Covered Persons such as separate waiting rooms, separate appointment days or preference to private pay patients. (Model Contract 1.12.2.2)

31. Access and Cultural Competency. Provider shall take adequate steps to promote the delivery of services in a culturally competent manner to Covered Persons, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (Model Contract 1.12.2.2)

32. 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 Covered Persons, 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 these timely access to care obligations. (Model Contract 1.12.1.2)

33. 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 Covered Persons and/or access to Covered Persons' Protected Health Information. 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 1.18.10 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 Attachment as provided under State and/or federal law. (Model Contract 1.12.2.2)

34. 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:

a) 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.

b) 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).

c) 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.

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

e) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan. (Model Contract 1.6.17)

35. Prohibited Affiliations and Exclusions. Provider acknowledges that Company, in accordance with 42 C.F.R. § 438.214(d)(1), 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), 438.808(b)(2) and § 1903(i)(2) of the Act; (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), 438.610(a) and § 1903(i)(2) of the Act; 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) 438.610(b) and 1903(i)(2) of the Act. 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 Federal Acquisition Regulation 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), 438.610(a) and § 1903(i)(2) of the Act; 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), 438.610(b), and § 1903(i)(2) of the Act. Provider warrants and represents to Company that it does not fall within any of the prohibited affiliations and exclusions described in this paragraph. (Model Contract 1.18.10) Health Plan may immediately terminate this Attachment 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 Section 1.18.10 of the State Contract. 1.14.2.3

36. Provider Right to Support Covered Person Grievance/Appeal. Company will take no punitive action against Provider in the event that Provider either requests an expedited resolution or supports a Covered Person's Appeal. (Model Contract 1.12.2.3)

37. Prohibited Payments. Company will suspend any payments to Provider for which the State determines there is a credible allegation of Fraud in accordance with Section 1.18.7 of the State Contract, entitled "Suspension of Payments for Credible Allegation of Fraud," and in accordance with 42 C.F.R. § 455.23. (Model Contract 1.14.2.2). 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:

a) Health- acquired conditions occurring in any inpatient hospital setting, identified as a health acquired condition by the Secretary of DHHS 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 Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients; and

b) Conditions meeting the following criteria:

- Is identified in the State Plan;
- 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;
- Has a negative consequence for the Covered Person;
- Is auditable; and
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient. (Model Contract 1.14.2.4)

38. Provider Preventable Conditions - Reporting. Provider shall promptly report to Company all Provider Preventable Conditions associated with claims for payment or Covered Person treatments for which payment would otherwise be made. (Model Contract 1.21.2.12)

39. 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 a Covered Person 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 Covered Person (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 Covered Person to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408 that the Adverse Benefit Determination is upheld. A Covered Person, 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 Covered Person is requesting an expedited resolution, a Covered Person'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 Covered Person with filing Grievances and Appeals including: provision of reasonable assistance to Covered Persons in (i) completing Grievance or Appeals forms; (ii) taking other procedural steps related to the Grievance or Appeal; (iii) making available Covered Person 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) (Model Contract 1.16.1.4) Covered Person has the right to request continuation of the benefits that Company seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes, although the Covered Person may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds Company's determination that is adverse to the Covered Person. (Model Contract 1.16.1.2.1) Providers shall not be allowed to request continuation of benefits as an Authorized Representative of the Covered Person, as specified in 42 § 438.420(b)(5).

40. Overpayments to Providers. Provider shall utilize Company's established mechanism for reporting overpayments. Provider shall report overpayments within thirty (30) 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. (Model Contract 1.18.11.2 and 1.18.11.1)

41. Retroactive Dual Eligibility. Dual Eligible Individuals are excluded from SoonerSelect program enrollment. Covered Persons who become Dual Eligible Individuals will be Disenrolled as of their Medicare eligibility effective date. In the event that a Covered Person 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. (Model Contract 1.5.9)

42. Electronic Visit Verification ("***EVV***"). If Provider provides services subject to EVV, Provider shall participate in Company's EVV system. (Model Contract 1.19.1.1)

43. Encounter Data. Provider shall cooperate with and 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 Covered Persons. Provider shall submit Encounter Data and claims data in sufficient detail to support detailed utilization and tracking and financial reporting. (Model Contract 1.19.4.1 and 1.19.4.2)

44. 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 Attachment and upon Provider's request, of a paper copy of the Provider Manual(s).

45. Health Information Exchange ("***HIE***"). If Provider has a CMS-certified Electronic Health Records (EHR) system, Provider shall connect to the State HIE for the purpose of bi-directional health data exchange. If Provider does not have a certified EHR, Provider shall use the State HIE provider portal to query patient data for enhanced patient care, and shall sign a participation agreement with the State HIE and sign up for direct secure messaging services and portal access so that clinical information can be shared securely with other providers in Provider's community of care. Provider shall engage with the State HIE for the purpose of connecting its EHR system to the HIE to share Provider's patient electronic records. If Provider is a hospital, long term care facility or an emergency department, Provider shall send electronic patient event notifications of a patient's admission, discharge, and/or transfer ("***ADT***") to the state HIE. (Model Contract 1.19.4.4)

46. Compliance with Law.

46.1 Changes in Law/Interpretation of Laws. The Parties to this Attachment 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 Attachment 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 Attachment, the Parties shall be mutually bound by the amended requirements in effect at any given time following the Effective Date of this Attachment. The explicit inclusion of some statutory and regulatory duties in this Attachment shall not exclude other statutory or regulatory duties. All questions pertaining to the validity, interpretation and administration of this Attachment 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 Attachment is found to be in violation of State or federal statutes, that portion shall be stricken from this Attachment and the remainder of this Attachment and Agreement shall remain in full force and effect.

46.2 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:

- Title VI of the Civil Rights Act of 1964;
- The Age Discrimination Act of 1975;
- The Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- The Americans with Disabilities Act of 1990 as amended;
- Section 1557 of the Patient Protection and Affordable Care Act (ACA);
- Healthcare Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2;
- Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2;

- Oklahoma Electronic Information Technology Accessibility (EITA) Act (Oklahoma 2004 HB 2197) regarding information technology accessibility standards for persons with disabilities;
- Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
- Oklahoma Worker's Compensation Act, 85A O.S. §1 *et seq.*;
- 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;
- Title 317 of the Oklahoma Administrative Code ("OAC");
- 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
- Deceptive Trade Practices; Unfair Business Practices.

46.3 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; and/or (iv) have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding.

46.4 Covered Persons' 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 Covered Persons' rights, and shall ensure that its employees and Contracted Providers observe and protect those rights. (Model Contract 1.1.24)

47. Patient Centered Medical Homes ("*PCMHs*"). The following provisions shall apply if Provider is a PCMH. (Model Contract 1.12.2.4.1)

a) Provider shall deliver primary care services and follow-up care;

b) Provider shall utilize and practice evidence-based medicine and clinical decision supports;

c) Provider shall make referrals for specialty care and other covered services and, when applicable, work with Company to allow Covered Persons to directly access a specialist as appropriate for a Covered Person's condition and identified needs;

d) Provider shall maintain a current medical record for the Covered Person;

e) Provide shall use health information technology to support care delivery;

f) Provider shall provide care coordination in accordance with the Covered Person's Care Plan, as applicable based on Company's Risk Stratification Level Framework, and in cooperation with the Covered Person's Care Manager;

g) Provider shall insure coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;

h) Provider shall engage active participation by the Covered Person and the Covered Person's family, authorized representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;

i) Provider shall provide access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;

j) Provider shall 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

k) Provider shall participate in continuous quality improvement and voluntary performance measures established by Company and/or OHCA.

l) Provider shall maintain medical records documenting all referrals of Covered Persons.

m) Provider shall meet the following "Appointment Time" obligations for the applicable Provider-type category (Model Contract 1.12.4.1 and 1.12.4.2):

| Service Category | Appointment Time |
|---|---|
| Adult PCMH<br>Pediatric PCMH | • Not to exceed 30 days from date of the Covered Person's request for routine appointment.<br>• Within 72 hours for Non-Urgent Sick Visits.<br>• Within 24 hours for Urgent Care.<br>• Each PCMH 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 Covered Person's request for routine appointment.<br>• Within 72 hours for Non-Urgent Sick Visits.<br>• Within 24 hours for Urgent Care.<br>Maternity Care:<br>• First Trimester – Not to exceed 14 Calendar Days<br>• Second Trimester – Not to exceed seven Calendar Days<br>• Third Trimester – Not to exceed three Business Days |
| Adult Specialty<br>Pediatric Specialty | • Not to exceed 60 days from date of the Covered Person's request for routine appointment.<br>• 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 benefit package. (Model Contract 1.12.4.3)

48. Behavioral Health Providers. The following provisions shall apply if Provider is a behavioral health provider.

a) Provider shall provide inpatient psychiatric services to Covered Persons and schedule the Covered Person for outpatient follow-up or continuing treatment prior to discharge from the inpatient setting with the outpatient treatment occurring within seven (7) Calendar Days from the date of discharge.

b) Provider shall complete the OHCA Customer Data Core (CDC) form located at http://www.odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the Model Contract;

c) Provider shall provide treatment to pregnant Covered Persons 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 Covered Person releases to share clinical information and Covered Person 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. (Model Contract 1.12.2.4.2)

e) Provider shall meet the following "Appointment Time" obligations (Model Contract 1.12.4.4):

| **Service Category** | **Appointment Time** |
|---|---|
| Adult Mental Health<br>Adult Substance Use<br>Pediatric Mental Health<br>Pediatric Substance Use | • Not to exceed 30 days from date of the Covered Person's request for routine appointment.<br>• Within seven days of hospitalization.<br>• Within 24 hours for Urgent Care. |

f) If requested by the Covered Person 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. (Model Contract 1.12.4.4)

49. 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 Covered Persons. 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. (Model Contract 1.12.2.4.3)

**Attachment A: Medicaid**

## SCHEDULE B
## 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 Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, 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 a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, a Covered Person 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 a Covered Person 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 ninety (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 ninety (90) days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than ninety (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 Covered Persons confined on the date of insolvency in an inpatient facility, and for pregnant Covered Persons, until Covered Person's discharge from inpatient facilities, Covered Person'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 ninety (90) days from the date of notice for a Covered Person 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 Covered Persons 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 (6) 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, § 6993.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))

## Attachment A: Medicaid

**EXHIBIT 1**
**COMPENSATION SCHEDULE**
**FACILITY AND PROFESSIONAL SERVICES**
**RURAL HEALTH CLINIC**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

**Outpatient Services**. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Payor's Medicaid fee schedule. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

Health acknowledges the SoonerCare Reimbursement Notice, OHCA PRN 2019-09, updating RHC methodology effective July 1, 2019, RHCs have the option to be paid using an alternative payment methodology (APM) if the RHC elects. RHC services paid using the APM are reimbursed at the rate indicated on the facilities periodic rate notification letter from the Medicare Fiscal Intermediary. In order to receive this rate, a RHC must agree to the APM and forward a copy of the facilities' periodic rate notification letter for its most recent full cost reporting year from the fiscal intermediary to the Health Plan within 30 days of receipt. The APM rate a facility receives will not be less than prospective payment system (PPS). There is no retroactive cost settlement.

Health Plan agrees to comply with the updated RHC methodology and reimburse Provider according to the most current periodic rate notification letter for its most current cost reporting year received from CMS Fiscal Intermediary. Provider's failure to provide a copy of the rate notification letter within 30 days of receipt may result in a reduction in payments by Health Plan.

**Outpatient Default**. If there is no established payment amount on the Medicaid fee schedule for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made

to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Encounter Updates. Updates to Contracted Provider-specific Encounter rates shall become effective ("Encounter Update Effective Date") as of the later of: (i) the first day of the month following thirty (30) days after Payor receives notification from Contracted Provider of such Encounter rate update as evidenced by the facilities' most current periodic rate modification letter from the Medicare Fiscal Intermediary; or (ii) the effective date of such code updates, as determined by the State. Claims processed prior to the Encounter Update Effective Date shall not be reprocessed to reflect any Encounter rate updates. Provider shall supply Health Plan their facilities' updated periodic rate modification letter within 30 days of receipt from CMS Fiscal Intermediary.

4. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

5. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

6. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

7. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service: (i) is required to identify each date of service; and (ii) must contain modifiers as identified in the Provider Manual. Applicable modifiers should be placed in the first modifier field for claims payment.

8. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

9. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

10. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means the Group's charges that qualify as Medically Necessary Covered Services and are eligible for reimbursement under the Plan.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

**Attachment A: Medicaid**

**EXHIBIT 2**
**COMPENSATION SCHEDULE**
**PROFESSIONAL SERVICES**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicaid fee schedule.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically

stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

6. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

## Attachment A: Medicaid

### EXHIBIT 3
### COMPENSATION SCHEDULE
### CRITICAL ACCESS HOSPITAL SERVICES

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

**Inpatient Services**. The maximum compensation for Covered Services rendered to a Covered Person during an inpatient stay shall be the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicaid fee schedule. Such payment shall be inclusive of all services rendered.

**Outpatient Services**. The maximum compensation for outpatient Covered Services is the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for outpatient Covered Services is the lesser of (i) Allowable Charges; or (ii) 100% of the Medicaid fee schedule. Such payment shall be inclusive of all services rendered.

***Additional Provisions:***

1. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

2. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

3. Application of 72-Hour Rule. Payments made to any Contracted Provider for inpatient Covered Services shall constitute payment for all such Contracted Provider's charges relating to a Covered Person's pre-admission testing and procedures occurring within seventy-two (72) hours prior to an admission, including, but not limited to, charges for laboratory services, pathology services, radiology services, and medical/surgical supplies. If the admitting hospital is a CAH, the payment window policy does not apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window. The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.

4. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

5. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

6. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

7. Provider-Based Billing. Provider-Based Billing (as defined herein) will not be reimbursed under this Compensation Schedule as they are included as part of the compensation for professional fees under this Agreement. Neither the Payor nor Covered Person shall be responsible for such Provider-Based Billing. "Provider-Based Billing" are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and include but are not limited services billed using Revenue Codes 0510-0519.

8. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

9. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

10. Encounter Payment. Encounter is defined as the same treatment for the same diagnosis in the same treatment setting without being discharged, released, or transferred within the same 48 hour period.

11. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.

## Attachment B: Medicare

### MEDICARE PRODUCT ATTACHMENT
### (INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered into as of the Effective Date of the Agreement by and between Oklahoma Complete Health, Inc. ("***Health Plan***") and Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain provider agreement, including all Attachments, 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; and

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers will be designated and participate as "Participating Providers" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Medicare Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: Medicare Product (which is sometimes referred to in this Attachment as this *"**Product**"*). The term "***Medicare Product***" refers to those programs and health benefit arrangements offered by Health Plan or another Company in connection with one or more of the following Medicare product types that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof) on its own or jointly with a State that administers or regulates such program or plan (each a "Medicare Product Type"): a non-Dual Eligible Special Needs Plan Medicare Advantage plan ("***MA Plan***"); a Medicare Advantage prescription drug plan ("***MA-PD Plan***"); a Dual Eligible Special Needs Plan ("***DSNP Plan***"); a Capitated Financial Alignment Demonstration ("***MMP Plan***") plan or program (e.g., a plan or program adopted or established under the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments); or other Medicare Product Types. The Medicare Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a Medicare Product. The Medicare Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Product. Provider acknowledges that it will participate in each Medicare Product Type for which a Compensation Schedule(s) is attached to this Medicare Product Attachment.

2.2 Participation. Except as otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicare Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medicare Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual).

Provider acknowledges that all or certain of Health Plan's duties with respect to the Medicare Product may be delegated to a Company, a Payor or their delegates. Neither Health Plan, Company nor any Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels and/or Medicare Product Types, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Medicare Product Type.

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule(s) for the Medicare Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicare Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicare Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. CMS Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicare Product under a Governmental Contract.

5. Compensation Schedule. This Section sets forth or describes the Compensation Schedule(s) applicable to the various Medicare Product Types.

5.1 Schedule. The Compensation Schedule for the Medicare Product at any given time is the lesser of (i) the Allowable Charges for the particular Covered Service, or (ii) the appropriate amount for such Covered Service under the Company's fee schedule in effect on the date of service for the Medicare Product. Upon Provider's reasonable written request from time to time the Company will provide Provider with a representative sample of the fees then in effect under the Company's fee schedule applicable to the Medicare Product.

5.2 Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in the Medicare Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

## Attachment B: Medicare

## SCHEDULE A
## CMS REGULATORY REQUIREMENTS

This Schedule sets forth required provisions that are applicable to all Medicare Product Types under this Medicare Product Attachment.

1. **DEFINITIONS**. The following terms shall be defined as set forth below as used in this Medicare Product Attachment. Capitalized terms not otherwise defined in this Schedule shall be defined as set forth in the Agreement or elsewhere in the Medicare Product Attachment.

1.1 ***Capitated Financial Alignment Demonstration Program*** means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 ***Clean Claim*** means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 ***CMS*** means Centers for Medicare and Medicaid Services.

1.4 ***CMS Contract*** means the contract between Health Plan or a Payor and CMS, or among Health Plan or a Payor, CMS and the State, that governs the terms of Health Plan's or Payor's participation in a Medicare Plan.

1.5 ***Completion of Audit*** means completion of audit by HHS, the Government Accountability Office, or their designees of a Medicare Advantage Organization, First Tier, Downstream or Related Entity.

1.6 ***Covered Persons*** means those individuals who are enrolled in a Medicare Plan.

1.7 ***Covered Services*** means those services which are covered under a Medicare Plan.

1.8 ***Downstream Entity*** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.9 ***First Tier Entity*** means any party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.10 ***HHS*** means the United States Department of Health and Human Services.

1.11 ***Medicare Advantage Program*** means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.12 ***Preclusion List*** means the CMS-compiled list of individuals and entities that -

a. Meet all of the following requirements: (i) The individual or entity is currently revoked from Medicare under 42 § 424.535. (ii) The individual or entity is currently under a reenrollment bar under 42 § 424.535(c). (iii) CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the

Medicare program. In making this determination under (iii), CMS considers the following factors: (A) The seriousness of the conduct underlying the individual's or entity's revocation. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program. (C) Any other evidence that CMS deems relevant to its determination; or

b. Meet both of the following requirements: (i) The individual or entity has engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable had they been enrolled in Medicare. (ii) CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under (ii), CMS considers the following factors: (A) The seriousness of the conduct involved. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; and (C) Any other evidence that CMS deems relevant to its determination. *42 C.F.R. § 422.2*

1.13 ***Related Entity*** means any entity that is related to Health Plan by common ownership or control and (1) performs some of Health Plan's management functions under contract or delegation; (2) furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Health Plan at a cost of more than $2,500 during a contract period.

1.14 ***State*** means one or more applicable state governmental agencies of the State of Oklahoma, unless otherwise defined in an Attachment for the purposes of that Attachment.

2. **COVERED SERVICES**. Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Medicare Product Attachment.

3. **SUBCONTRACTOR OBLIGATIONS**. To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Medicare Product Attachment.

4. **GOVERNMENT RIGHT TO INSPECT**.

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Medicare Product Attachment or from the date of Completion of Audit, whichever is later. *42 C.F.R. §§ 422.504 (i)(2)(i) and (ii), 423.505(i)(2)(i) and (iv).*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Medicare Product Attachment directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii), 423.505(i)(2)(ii) and (iii).*

5. **PRIVACY, CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS**. Provider shall comply with all privacy, confidentiality and accuracy requirements with respect to Covered Person record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) safeguarding the privacy of any information that identifies a particular Covered Person and, as applicable, having procedures that specify (i) for what purposes the information is used within the organization; and (ii) to whom and for what purposes it discloses the information outside the organization; (3) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (4) maintaining the records and information in an accurate and timely manner; and (5) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §§422.504(a)(13). 422.118 and 423.136*

6. **HOLD HARMLESS**.

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of Payor. *42 C.F.R. §§422.504(i)(3)(i), 422.504(g)(1)(i), 423.505(i)(3)(i) and 423.505(g)(1)(i).*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Health Plan or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. **COMPLIANCE WITH CMS CONTRACT**. Provider shall perform its obligations under this Medicare Product Attachment in a manner consistent with and in compliance with Health Plan's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §§422.504(i)(3)(iii), 423.505(i)(3)(iii).*

8. **PROMPT PAYMENT**. Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Compensation Schedule Exhibit(s) to this Medicare Product Attachment. Any Clean Claim shall be paid within 30 days of receipt by Health Plan, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, as designated by Provider or such Downstream Entity, as applicable. *42 C.F.R. §422.520(b)(1) and (2)*

9. **EFFECT OF PRECLUSION LIST**. Provider acknowledges and agrees that Payor may not pay, directly or indirectly, on any basis, for items or services furnished to a Covered Person by any individual or entity that is excluded by the HHS Office of the Inspector General or is included on the Preclusion List. Provider acknowledges and agrees that, after the expiration of the 60-day period specified in 42 C.F.R. § 422.222: (i) Provider will no longer be eligible for payment from Payor and will be prohibited from pursuing payment from the Covered Person as stipulated by the terms of the contract between CMS and the Payor per 42 C.F.R. § 422.504(g)(1)(iv); and (ii) Provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point Provider will have already received notification of the preclusion. *42 C.F.R. §§422.224; 422.504(g)(1)(v)*

10. **COMPLIANCE WITH FEDERAL AND STATE LAWS**. Health Plan, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §§422.504(i)(4)(v), 423.505(i)(4)(iv)*

11. **DELEGATION OF DUTIES**. In the event that Health Plan delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Medicare Product Attachment shall be subject to the prior written approval of Health Plan or Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

11.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement of Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

11.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or Payor determine that such parties have not performed satisfactorily.

11.3 Health Plan or Payor will monitor the performance of the parties on an ongoing basis.

11.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Health Plan, or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

11.5 If Health Plan or Payor delegates the selection of providers, contractors, or subcontractors, Health Plan or Payor retains the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. §§ 422.504(i)(4) and (5), and 423.505(i).*

12. **NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS**. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

13. **SERVICE AVAILABILITY**. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

14. **CULTURAL COMPETENCE**. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

15. **FOLLOW-UP CARE**. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

16. **ADVANCE DIRECTIVES**. Provider shall comply with Health Plan's and Payor's policies and procedures concerning advance directives. *42 C.F.R. §422.128(b)(1)(ii)(E).*

17. **PROFESSIONALLY RECOGNIZED STANDARDS OF CARE**. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

18. **CONTINUATION OF BENEFITS**. Provider shall provide Covered Services as provided in the Agreement and this Medicare Product Attachment: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

19. **PHYSICIAN INCENTIVE ARRANGEMENTS**. If Provider is a physician or physician group, neither Payor nor Health Plan shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider agrees that, if Health Plan or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). *42 C.F.R. §422.208.*

20. **INFORMATION DISCLOSURES TO CMS**. Provider shall cooperate with Health Plan and Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

21. **NOTICE OF PROVIDER TERMINATIONS**. Health Plan shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

22. **RISK ADJUSTMENT DATA**. Provider shall provide to Health Plan risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4)*. Upon Health Plan's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

23. **COMPLIANCE WITH HEALTH PLAN POLICIES AND PROCEDURES**. Provider shall comply with Health Plan's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Health Plan's request, consult with Health Plan regarding Health Plan's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b)*. Provider shall comply with Health Plan's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

24. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION**. In the event Health Plan suspends or terminates this Medicare Product Attachment with respect to Provider or any physicians employed or contracted with Provider, Health Plan shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Health Plan, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

25. **NOTICE OF WITHOUT CAUSE TERMINATION**. Health Plan and Provider must provide a minimum of sixty (60) days written notice, or such longer period specified in this Agreement, to each other before terminating this Medicare Product Attachment without cause. *42 C.F.R. §422.202(d)(4)*.

26. **COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS**. Health Plan and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and

the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

27. **FEDERAL FUNDS**. Provider acknowledges that payments Provider receives from Health Plan or Payor to pursuant to this Medicare Product Attachment are, in whole or part, from Federal funds. Therefore, Provider and any of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

28. **EXCLUDED PERSONS/PROGRAM INTEGRITY**. Provider warrants to Health Plan and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Health Plan and Payor any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8)*. Provider shall promptly notify Health Plan and Payor in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

29. **COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS**. Provider shall cooperate and comply with all applicable State, federal Health Plan and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Health Plan and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. **OFFSHORE SUBCONTRACTORS**. In addition to the applicable requirements of Section 11 of this Medicare Product Attachment, Provider shall disclose to Health Plan in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *CMS Health Plan Management System Memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. **SCOPE AND CONFLICTS**. Nothing in this Medicare Product Attachment shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Medicare Product Attachment. In the event of any conflict between this Medicare Product Attachment and any provision of the Agreement, the provisions of this Medicare Product Attachment shall govern. In the event that any provision of this Medicare Product Attachment conflicts with the provisions of any statute or regulation applicable to Health Plan, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. **TERMINATION**. This Medicare Product Attachment shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. This Medicare Product Attachment may be further terminated by Health Plan immediately upon written notice to Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid or is listed on the Preclusion List.

## Attachment B: Medicare

**EXHIBIT 1**
**COMPENSATION SCHEDULE**
**MA PLAN/MA-PD PLAN/DSNP PLAN**
**FACILITY AND PROFESSIONAL SERVICES**
**RURAL HEALTH CLINIC**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

**Outpatient Services**. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is 100% of the Medicare encounter rate in effect on the date of service. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

4. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

5. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

6. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

7. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

8. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

4. **Encounter** means a face-to-face encounter between a Contracted Provider's patient and a health care professional for services that qualify to be paid as a PPS encounter.

**Attachment B: Medicare**

**EXHIBIT 2**
**COMPENSATION SCHEDULE**
**MA PLAN/MA-PD PLAN/DSNP PLAN**
**PROFESSIONAL SERVICES**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicare fee schedule in effect on the date of service.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which

the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

5. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

**Attachment B: Medicare**

**EXHIBIT 3**
**COMPENSATION SCHEDULE**
**MA PLAN/MA-PD PLAN/DSNP PLAN**
**CRITICAL ACCESS HOSPITAL SERVICES**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

**Inpatient Services**. The maximum compensation for inpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient critical access hospital Covered Services is 100% of the Medicare Per Diem in effect on the date of service. Such payment shall be inclusive of all services rendered.

**Swing-bed.** The maximum compensation for inpatient swing-bed Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient swing-bed Covered Services is 100% of the Medicare Per Diem in effect on the date of service. Such payment shall be inclusive of all services rendered.

**Outpatient Services**. The maximum compensation for outpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for outpatient critical access hospital Covered Services is 100% of the Medicare Cost-to-Charge Ratio in effect on the date of service. Such payment shall be inclusive of all services rendered.

***Additional Provisions:***

1. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

2. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

3. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

4. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

5. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

6. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

7. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

8. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.

## Attachment C: Commercial-Exchange

## PRODUCT ATTACHMENT
## (INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered between Oklahoma Complete Health, Inc. ("Health Plan") and Provider.

WHEREAS, Health Plan and Provider entered into that certain Participating 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 or other Downstream Entities participate in certain Products offered by or available from or through a Company; and

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment, and will be considered to be and will be governed under this Product Attachment as Downstream Entities as defined in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Commercial-Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement.

1.1. "***Commercial-Exchange Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, health insurance exchange, except those excluded by Health Plan. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2. "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3. "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4. "***Emergency***" or "***Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.5. "***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.6. "***State***" means the State of Oklahoma, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Commercial-Exchange Product. This Product Attachment constitutes the "Commercial-Exchange Product Attachment" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial-Exchange Product.

3. Participation. Except as otherwise provided in this Product Attachment or the Agreement, all Contracted Providers under the Agreement will participate as Participating Providers in this Commercial-Exchange Product, and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers, to comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

4. Attachments. This Product Attachment includes, at Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person, and the Compensation Schedule(s) for the Commercial-Exchange Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Commercial-Exchange Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial-Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1. Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2. CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3. Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4. Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

**Attachment C: Commercial-Exchange**

## SCHEDULE A
## 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 Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, 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 a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OK-1 Hold Harmless. In the event Payor fails to pay for Covered Services in accordance with the Agreement, a Covered Person 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 a Covered Person 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 ninety (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 ninety (90) days' advance written notice of such termination. Health Plan's rights to terminate the Agreement for cause upon less than ninety (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 Covered Persons confined on the date of insolvency in an inpatient facility, and for pregnant Covered Persons, until Covered Person's discharge from inpatient facilities, Covered Person'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 ninety (90) days from the date of notice for a Covered Person 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 Covered Persons 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 (6) 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, § 6993.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))

**Attachment C: Commercial-Exchange**

**EXHIBIT 1**
**COMPENSATION SCHEDULE**
**FACILITY AND PROFESSIONAL SERVICES**
**RURAL HEALTH CLINIC**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

**Outpatient Services**. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is 120% of the Medicare encounter rate in effect on the date of service. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor

may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

4. Encounter Updates. Updates to Contracted Provider-specific Encounter rates shall become effective ("Encounter Update Effective Date") as of the later of: (i) the first day of the month following thirty (30) days after Payor receives notification from Contracted Provider of such Encounter rate updates; or (ii) the effective date of such code updates, as determined by the State. Claims processed prior to the Encounter Update Effective Date shall not be reprocessed to reflect any Encounter rate updates.

5. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

6. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

7. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

8. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

9. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

10. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

**Attachment C: Commercial-Exchange**

**EXHIBIT 2**
**COMPENSATION SCHEDULE**
**PROFESSIONAL SERVICES**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the lesser of: (i) Allowable Charges; or (ii) 120% of the Medicare fee schedule in effect on the date of service.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan

will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

5. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

**Attachment C: Commercial-Exchange**

**EXHIBIT 3**
**COMPENSATION SCHEDULE**
**CRITICAL ACCESS HOSPITAL SERVICES**

**Mangum City Hospital Authority dba Mangum Regional Medical Center and Mangum Family Clinic**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

**Inpatient Services**. The maximum compensation for inpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient critical access hospital Covered Services is 165% of the Medicare Per Diem. Such payment shall be inclusive of all services rendered.

**Outpatient Services**. The maximum compensation for outpatient critical access hospital Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule the Allowed Amount for outpatient critical access hospital Covered Services is 145% of the Medicare Cost-to-Charge Ratio. Such payment shall be inclusive of all services rendered.

***Additional Provisions:***

1. Disproportionate Share Hospital ("DSH"), Direct Graduate Medical Education ("GME"), Indirect Medical Education ("IME") or any other "add-on." Notwithstanding anything to the contrary contained herein, in no event will the Contracted Rate, Allowable Charges or any other cost calculations hereunder include DSH, GME, IME or any other "add-on" for any inpatient admission.

2. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

3. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

4. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

5. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

6. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

7. Provider-Based Billing. Provider-Based Billing (as defined herein) will not be reimbursed under this Compensation Schedule as they are included as part of the compensation for professional fees under this Agreement. Neither the Payor nor Covered Person shall be responsible for such Provider-Based Billing. "Provider-Based Billing" are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and include but are not limited services billed using Revenue Codes 0510-0519.

8. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

9. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

10. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If CMS has no published fee amount or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be 50% of Allowable Charges.

11. Encounter Payment. Encounter is defined as the same treatment for the same diagnosis in the same treatment setting without being discharged, released, or transferred within the same 48 hour period.

12. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

***Definitions:***

1. **Allowable** Charges means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.