BlueCross BlueShield of Oklahoma

Participating Ancillary Provider Agreement
BlueTraditional, BlueChoice PPO and BluePreferred Networks
Ambulance Transport Services

This Participating Ancillary Provider Agreement for the BlueTraditional, BlueChoice PPO and BluePreferred Networks for Ambulance Transport Services ("Agreement") is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, and its subsidiaries and affiliates ("The Plan"), and the undersigned, a provider of Ambulance Transport Services ("Ancillary Provider").

As of the date executed, this Agreement includes the following:

☒ Participating Ancillary Provider Agreement	OKANCBT 03-01-16
☒ Attachment A, Locations of Ancillary Provider	OKANCBT A-ANC 03-01-16
☒ Attachment B, Ancillary Services and Billing Requirements	OKANCBT B-AMB 03-01-16
☒ Attachment C, Maximum Reimbursement Allowances	OKANCBT C-AMB 03-01-16
☒ Attachment D, Utilization Management	OKANCBT D-AMB 05-01-11
☒ Attachment E, Appeals and Grievance Procedures	OKANCBT E-ANC 03-01-16

Any notice given pursuant to the terms and provisions of this Agreement shall be sent as follows:

Notice to Ancillary Provider:

Contact Name: Ryan Lawson
Contact Title: Major
Address: 220 South 1st Street
City, State ZIP: Broken Arrow, OK 74012
Email: rlawson@brokenarrowok.gov

Notice to The Plan:

Network Management
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, OK 74102-3283

The undersigned hereby agree to the terms and conditions contained in this Agreement. This Agreement shall be effective beginning on the first day of the month following execution by The Plan.

City of Broken Arrow dba Broken Arrow Fire Dept.	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
Name of Ancillary Provider	
☒ Authorized Signature	Authorized Signature
Name of Signatory	JOSEPH R. CUNNINGHAM, M.D. Name of Signatory
Title of Signatory	DIVISIONAL SENIOR VP HEALTH CARE DELIVERY, AND CHIEF MEDICAL OFFICER Title of Signatory
Date Signed	Date Signed

ARTICLE I – DEFINITIONS

1.0 Ancillary Services: Those services, supplies, products, accommodations and care customarily provided by or available from Ancillary Provider, including those identified on Attachment B.

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

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

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

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

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

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

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

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

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

1.9 HCPCS: The Centers for Medicare and Medicaid Services' ("CMS") Common Procedure Coding System which consists of Level 1 Current Procedural Terminology (CPT), Level 2 National Codes, and Level 3 Local Codes. References to HCPCS include codes set forth in subsequent revisions of the coding system.

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

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

1.12 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum allowed amount for Covered Services rendered to the Member as described on Attachment C.

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

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

1.15 Medical Review: A review of claims and medical records by The Plan to determine which services are Medically Necessary.

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

1.16.0 in accordance with generally accepted standards of medical practice;

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

1.16.2 not primarily for the convenience of the Member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

1.17 Member: Any person eligible to receive Ancillary Services pursuant to the terms of The Plan's underwritten or administered contracts, which includes access to one or more of The Plan's provider networks, including Medicare supplemental coverage, or any person covered under Benefit Agreements underwritten or administered by other Blue Cross and/or Blue Shield Plans or a participant of a group utilizing The Plan's networks, as described herein, excluding Medicare program beneficiaries.

1.18 MyHealth Access Network ("MyHealth"): MyHealth Access Network is an Oklahoma non-profit health information network that provides secure, online access to patients' community-wide medical data.

1.19 MyHealth Participating Provider: A hospital, other health facility, physician, health care professional or other provider of medical services, equipment or supplies, who is eligible and is a participant in the MyHealth Access Network.

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

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

1.22 Preauthorization: The process of requiring Participating Providers to obtain authorization prior to rendering specific services as outlined on Attachment D.

1.23 Predetermination: A voluntary request submitted to The Plan prior to rendering services using the Predetermination Request Form located on The Plan's website at www.bcbsok.com. The purpose of a Predetermination request is to determine whether a specific service, including services that may be considered Experimental/Investigational/Unproven, is Medically Necessary. A Predetermination is not a guarantee of Benefits or a substitute for the Preauthorization process.

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

1.25 Usual Charge: The fee most commonly charged by Ancillary Provider for services provided to most patients.

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

ARTICLE II – AGREEMENTS OF ANCILLARY PROVIDER

2.0 Accept Reimbursement: Ancillary Provider agrees to accept as payment in full the lesser of Ancillary Provider's charges for Covered Services or The Plan's Maximum Reimbursement Allowance described in Attachment C. Until The Plan has determined the Maximum Reimbursement Allowance and notified Ancillary Provider as to the amount due from the Member, if any, under the Member's Benefit Agreement, Ancillary Provider shall not bill or collect from the Member any coinsurance amounts. Ancillary Provider may collect deductibles, copayments, or amounts for Noncovered Services unless prohibited by law. The total amount collected from The Plan, or administered accounts, and the Member for deductible, copayment, and coinsurance, but not including Noncovered Services, may not exceed the lesser of Ancillary Provider's charges for Covered Services or The Plan's Maximum Reimbursement Allowance. Ancillary Provider shall refund to Member any amounts which may have been collected from the Member in excess of the Member's responsibility as shown on The Plan's Explanation of Claims Submission when issued.

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

2.0.1 Written Waiver: Ancillary Provider shall not bill or attempt to collect from Member for Ancillary Services denied as not Medically Necessary or Experimental/Investigational/Unproven, unless Ancillary Provider has obtained a Written Waiver prior to rendering services. (A Written Waiver is not required for services rendered by ambulance transport providers.) A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Ancillary Provider Information: Ancillary Provider shall complete and provide to The Plan the Ancillary Provider Credentialing Application, along with all required documentation prior to the effective date of this Agreement. At least thirty (30) days' advance notice to The Plan is required for changes to the information submitted on the Ancillary Provider Credentialing Application.

2.2 Claims Submission: Ancillary Provider shall submit claims to The Plan in accordance with Article IV, Billing Requirements.

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

2.4 Eligibility Verification: Ancillary Provider accepts the responsibility of verifying the identity, eligibility and coverage of the patient or Member applying for Benefits. If Ancillary Provider does not verify the identity, eligibility and coverage of the patient or Member applying for Benefits, Ancillary Provider assumes the risk that the claim may be denied by The Plan, or if The Plan pays Benefits in error, The Plan may recoup payment pursuant to the Right of Recovery section in Article II.

2.5 Equal Treatment of Members: Ancillary Provider agrees to provide Covered Services to Member in the same manner, promptness and equal in quality as those services that are provided to all other patients of Ancillary Provider, without regard to age, race, sex, national origin, health status, economic status, veteran status, disability, or religious conviction.

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

2.7 Liability Insurance: Ancillary Provider, at its sole expense, agrees to maintain insurance for the professional liability and comprehensive general liability risk at all times while this Agreement is in effect. For Ambulance Transport, the minimum requirements are $1,000,000 per occurrence and $1,000,000 aggregate. For Durable Medical Equipment and/or Medical Supplies and/or Orthotics and Prosthetics, the minimum requirements are $500,000 per occurrence and $1,000,000 aggregate. For all other Ancillary Providers, the minimum requirements are $1,000,000 per occurrence and $3,000,000 aggregate. Ancillary Provider will provide proof of insurance upon request of The Plan. From time to time, The Plan may revise the limits for minimum coverage. Should such arrangements change during the term of this Agreement, Ancillary Provider must notify The Plan in writing within thirty (30) days. Failure of Ancillary Provider to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article X of this Agreement.

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

2.8 Licenses and/or Certifications: As it applies to its specialty, Ancillary Provider shall maintain in good standing while this Agreement is in effect a valid and unrestricted license, as applicable, specific to the provision of the Ancillary Services in the State of Oklahoma, and if required, a valid Drug Enforcement Administration (DEA) number with unrestricted privileges, and a valid and unrestricted Bureau of Narcotics and Dangerous Drugs (BNDD) certificate. If Ancillary Provider is certified by Medicare, Ancillary Provider must be in good standing with Medicare and be free from any state and/or federal

sanctions during the past five (5) years. Further, Ancillary Provider shall maintain good professional standing with any board, organization or body that certifies, credentials or accredits Ancillary Provider in connection with the provision of Ancillary Services. Refer to Attachment B for more specific requirements.

2.9 Network Participation: Ancillary Provider will be a Participating Provider in the networks identified on Attachment B.

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

2.11 No Solicitation: Ancillary Provider, for itself and on behalf of all of its contracted and subcontracted providers, shall not engage in activities, directly or indirectly, whether written, verbal or electronic, to solicit, influence, encourage or induce or attempt to solicit, influence, encourage or induce: (i) any Member to disenroll from health plans offered by The Plan, or; (ii) any potential Member to refrain from enrolling in health plans offered by The Plan, or; (iii) any Member or potential Member to enroll for health benefits with any other health benefit plan or insurer, which activities include, but are not limited to:

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

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

(c) using or disclosing to any third party The Plan's membership lists acquired during the term of this Agreement unless previously authorized in writing by The Plan, which authorization shall be within The Plan's sole discretion and in strict adherence to all privacy laws;

(d) sending or posting on any social media website any communication, whether written or electronic, directed to or publicly accessible by Members, which falsely disparages or casts a negative light on The Plan; or

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

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

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

2.12.0 any action against any of its licenses, certification or accreditation;

2.12.1 any legal or government action initiated against Ancillary Provider, its employee(s), agent(s) or owner(s) which affects this Agreement, including but not limited to, any action for professional negligence, fraud, violation of any law, or against any license.

Failure of Ancillary Provider to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article X of this Agreement.

2.13 Notification of Incorrect Payments: Ancillary Provider agrees to notify The Plan of receipt of any incorrect payment of which it is aware, including underpayments, duplicate payments, or overpayments. Overpayments shall not be refunded to the Member until The Plan has determined who is entitled to such funds.

2.13.0 Corrected Claims: Corrected claims shall be submitted within eighteen (18) months following The Plan's adjudication of the original claim. The Plan will initiate its recovery efforts within eighteen (18) months after the payment to Ancillary Provider by sending Ancillary Provider written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made.

2.14 Offices, Locations, or Entities: The terms of this Agreement, including all applicable addendums to this Agreement, shall be in effect for all offices, locations, or entities owned, operated or utilized by Ancillary Provider and listed on Attachment A.

2.14.0 Changes in Offices, Locations or Entities: Subsequent to the effective date of this Agreement, Ancillary Provider shall notify The Plan in writing of any additional offices, locations, or entities owned, operated, or utilized by Ancillary Provider in addition to the one(s) identified on Attachment A . The Plan shall determine, in its sole discretion, whether to add these offices, locations, or entities to this Agreement. Ancillary Provider shall also notify The Plan of any changes to its offices, locations or entities, including but not limited to changes in corporate entity name, changes or additions to tax identification number or NPI, changes or additions to scope of services, or closings, in writing at least thirty (30) days prior to such change. Failure of Ancillary Provider to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article X of this Agreement. The Plan will make one of the following determinations at The Plan's sole discretion:

(a) If The Plan determines that an additional office, location, or entity will be added to this Agreement, any services provided at the additional office, location, or entity shall be subject to the terms of this Agreement from the time said services began to be provided at the additional office, location, or entity.

(b) If The Plan determines that an additional office, location, or entity will not be added to this Agreement, all services at the additional office, location, or entity shall be determined to be out of network unless the office, location, or entity enters into a separate agreement with The Plan. If the additional office, location, or entity is not added to this Agreement and does not enter into a separate agreement with The Plan, Ancillary Provider must notify the Member as required by state law.

2.14.1 Failure to Provide Information Regarding Additional Offices, Locations, or Entities: Ancillary Provider's failure to timely provide or disclose information required by this Section may result in The Plan terminating this Agreement effective immediately or effective on a date chosen by The Plan. In addition, should Ancillary Provider fail to provide timely notice pursuant to Section 2.14.0, The Plan may exercise its options as set forth in 2.14.0 (a) or 2.14.0 (b).

2.15 Other Billing or Service Arrangements: Ancillary Provider is not permitted to allow another entity or individual to bill or submit claims for reimbursement to The Plan under its Agreement with The Plan for services that are performed by Ancillary Provider, or are required to be billed by Ancillary Provider under this Agreement. "Under arrangement" billing and other similar billing or service arrangements are not permitted by The Plan. "Under arrangement" billing occurs when an ancillary provider provides services and a hospital or other entity bills for the services under its agreement with The Plan. Except as otherwise set forth in this Agreement or unless approved by The Plan in writing, Ancillary Provider is not permitted to bill for services that are provided by another entity or provider.

2.16 Pass-Through Billing: Pass-through billing is not permitted by The Plan. Pass-through billing occurs when Ancillary Provider requests and bills for a service, but the service is not actually performed by Ancillary

Provider. Ancillary Provider shall not bill for these services unless otherwise specifically approved by The Plan in writing. Such approval shall be specific to services or service lines and the manner in which such services shall be billed.

2.17 Policies and Procedures: Ancillary Provider agrees to abide by The Plan's operational policies and procedures and medical policies as set forth in this Agreement, and as described in the Provider section of The Plan's website at www.bcbsok.com.

2.18 Preauthorization Requirements: It is the responsibility of Ancillary Provider to ensure The Plan is contacted and Preauthorization is obtained or verified in accordance with Attachment D, attached to and considered a part of this Agreement.

2.19 Predetermination: Ancillary Provider is not required to obtain Preauthorization for those Members who do not have mandatory Preauthorization requirements in their Benefit Agreement. However, if Ancillary Provider elects to do so, it may submit a Predetermination request for such Members' admissions or outpatient services. Refer to www.bcbsok.com for more information and a form for requesting Predetermination.

2.20 Provider Directories: Ancillary Provider agrees to permit The Plan, on at least an annual basis, to publish, distribute and disseminate Ancillary Provider's name and address as a Participating Provider in provider directories in paper or electronic form.

2.21 Provision of Records: Ancillary Provider agrees to furnish, without charge upon request, all information reasonably required by The Plan to verify and substantiate the provision of Ancillary Services and the charges for such services. Ancillary Provider shall continue to provide such requested information for a period of two (2) years after the termination of this Agreement (or for such other period as may be required by network accreditation organizations as applicable). The Plan may be billed by Ancillary Provider for subsequent requests for the same information at a rate not to exceed twenty-five cents (25¢) per page. Ownership and access to records of Member shall be controlled by applicable law. Failure of Ancillary Provider to provide such information within the time period designated by The Plan in the request may result in termination of this Agreement by The Plan pursuant to Article X of this Agreement.

2.22 Record Maintenance: Ancillary Provider shall maintain medical records for Members to whom services are rendered in accordance with federal, state and local laws and regulations, and comply with the Medical Records Documentation and Confidentiality Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

2.23 Records Review: Ancillary Provider will allow The Plan to conduct reviews and audits, including assessment of medical records completeness, utilization, quality of care, billing practices, equipment maintenance, general office environment, and management of other practice areas of concern to The Plan. On-site reviews may be conducted during Ancillary Provider's regular business hours. Such access shall continue to be allowed for a period of two (2) years after the termination of this Agreement. Failure of Ancillary Provider to provide such information within the time period designated by The Plan in the request may result in termination of this Agreement by The Plan pursuant to Article X of this Agreement.

2.24 Release: Ancillary Provider shall obtain and maintain a written authorization from each Member treated by Ancillary Provider, pursuant to which the Member authorizes Ancillary Provider and The Plan to obtain, release, and use medical information regarding the Member and the care and treatment provided to the Member in connection with the services and responsibilities of each party under this Agreement or any program administered by The Plan. Ancillary Provider shall provide to The Plan, upon request, a copy of the Member's release.

2.25 Right of Recovery:

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

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

2.25.1 In accordance with Oklahoma law, when The Plan has Preauthorized a service **and** Ancillary Provider has verified the Member's or patient's eligibility within four (4) days of the service, The Plan will not deny benefits or offset against future payments any amounts previously reimbursed unless:

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

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

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

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

2.25.2 When amounts have been reimbursed in error, other than as described in Section 2.25.0, and 2.25.1, such amounts may also be offset against future payments due Ancillary Provider from The Plan. The Plan will initiate its recovery efforts within eighteen (18) months after the payment to Ancillary Provider by sending Ancillary Provider written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Ancillary Provider will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset.

2.25.3 The Plan shall not be prohibited from requesting a refund or retracting a payment outside the time frames set forth in this Section if:

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

(b) Ancillary Provider has otherwise agreed to make a refund.

In limited circumstances, The Plan's contractual obligations to its self-funded employer groups may require an adjustment or offset due to an audit that has covered a period that is outside the limitation periods specified above.

2.26 Scope of Services: Ancillary Provider agrees to render Covered Services to Members, within the scope of its license (if applicable) and consistent with Ancillary Provider's education, training, and experience, who

are patients identified as requiring, by reason of injury or illness, the intensity of care and level of care which is reasonable, necessary, and appropriate for the Member.

2.27 Support Quality Improvement Programs: Ancillary Provider agrees to cooperate with the quality improvement activities of The Plan. This includes, but is not limited to, providing, at no charge, medical records of selected Members to The Plan for purposes of quality improvement. Ancillary Provider shall continue to provide such requested information for a period of two (2) years after the termination of this Agreement. All such quality improvement activities of The Plan are considered to be confidential and will not be released to any other party except where required by applicable state or federal laws.

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

2.28 Termination of Participation by Ancillary Provider:

2.28.0 In the event Ancillary Provider shall terminate, without cause, participation under this Agreement, at least ninety (90) days advance written notice is required to be provided to The Plan.

2.28.1 Ancillary Provider agrees to coordinate with The Plan on the transfer to another Participating Provider the care of its Members, including providing copies of medical/clinical records at no cost to the Member or The Plan. Notwithstanding the fact that Ancillary Provider chooses to terminate participation under this Agreement, a Member may choose to continue an ongoing course of treatment with Ancillary Provider. In such case, the following procedures shall apply:

(a) During a transitional period of up to ninety (90) days from the date The Plan received notice of Ancillary Provider's termination, such continuing care shall be treated by The Plan as being provided by and the responsibility of Ancillary Provider under the terms set forth herein. Reimbursement will be based on the Maximum Reimbursement Allowance.

(b) For Members who (1) have a degenerative and disabling condition or disease, or (2) are terminally ill, Ancillary Provider shall continue to provide Covered Services, under the terms set forth herein, for up to ninety (90) days from the date the notice to the Member has been given. Reimbursement will be based on the Maximum Reimbursement Allowance.

2.29 Utilization Management: Ancillary Provider agrees to cooperate in utilization management activities and obtain Preauthorization for Members having such requirements in their Benefit Agreement (refer to Attachment D).

2.30 Verification of Credentials: Ancillary Provider will cooperate with The Plan, or other entity to which The Plan has delegated responsibility for credentialing, in the initial and ongoing verification of credentials for all locations included in this Agreement. Ancillary Provider will report all disciplinary actions, changes in participation in Medicare or Medicaid programs, changes in licensure, and/or any changes to the information submitted on Ancillary Provider's initial or recredentialing application (if applicable) to The Plan in writing at least thirty (30) days prior to the date of change. Ancillary Provider further agrees to ensure that all employees and contracted staff who provide direct patient care maintain current licensure and certification. Ancillary Provider shall allow appropriate representatives of The Plan, or other entity to which The Plan has delegated responsibility for credentialing, access to such documentation upon reasonable request.

ARTICLE III – AGREEMENTS OF THE PLAN

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

3.1 Explanation of Claims Submission: The Plan agrees to notify Ancillary Provider and the Member of appropriate deductible, coinsurance, and noncovered amounts that may, if applicable, be collected from the Member.

3.2 Member Identification: The Plan agrees to provide appropriate Member identification.

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

3.4 Provider Directories: The Plan agrees to include Ancillary Provider's name in The Plan's current written and/or electronic listing of Participating Providers.

3.5 Provide Timely Compensation: Unless otherwise permitted by law, The Plan agrees to process all Properly Filed Claims for Covered Services provided to Member within thirty (30) days from the date of The Plan's receipt. If upon receipt of a claim, The Plan determines it is not a Properly Filed Claim, written notice shall be given to Ancillary Provider within thirty (30) days of receipt of the claim. Upon receipt of the additional information or corrections to make the claim a Properly Filed Claim, the claim shall be processed by The Plan within thirty (30) days, unless otherwise permitted by law. Payment shall be considered made when it is placed in the United States mail or on the date the electronic payment is sent. If payment is due but not made within forty-five (45) days from receipt of a Properly Filed Claim, it shall bear simple interest at the rate of ten percent (10%) per year. The Plan shall pay interest only on claims for services rendered to Members whose Benefit Agreements are underwritten by Blue Cross and Blue Shield of Oklahoma.

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

3.7 Reimbursement: The Plan agrees to reimburse Ancillary Provider in accordance with Attachment C for Covered Services provided to Member as of the effective date of this Agreement. This reimbursement shall be applicable to all services arranged, provided, and billed by Ancillary Provider. Unless prohibited by law, The Plan shall deduct any copayments, coinsurance and deductible amounts required by the applicable Benefit Agreement from payment due Ancillary Provider.

ARTICLE IV – BILLING REQUIREMENTS

4.0 Balance Billing: Ancillary Provider agrees to collect amounts from the Member only for Ancillary Services not covered by the applicable Benefit Agreement, unless otherwise mandated by federal law, and for copayments, coinsurance and deductible amounts required by the applicable Benefit Agreement. Unless otherwise mandated by federal law, Ancillary Provider may collect from Member at time of service the applicable copayment and deductible. However, until The Plan has determined the Maximum Reimbursement Allowance and notified Ancillary Provider of the amount due from Member, if any, Ancillary Provider shall not bill the Member. Ancillary Provider agrees that any amounts which may have been collected from Member in excess of the Member's responsibility shall be refunded within thirty (30) days of receipt of The Plan's Explanation of Claims Submission.

4.1 Claim Filing: Ancillary Provider shall submit Properly Filed Claims for Covered Services provided to Members at Ancillary Provider's Usual Charge in The Plan's designated format (refer to Attachment B). Ancillary Provider must submit all claims within one hundred eighty (180) days after the date of service or within one hundred eighty (180) days after the primary payor's dated Explanation of Claims Submission, and look to The Plan for payment except for coinsurance, deductible, and noncovered amounts unless otherwise mandated by federal law. Claims will be accepted beyond the one hundred eighty (180) day period if the Member's Benefit Agreement allows a longer timely filing period. Claims which are not submitted within the later of either the above one hundred eighty (180) day period or the timely filing

requirements of the Member's Benefit Agreement will not be honored and Ancillary Provider agrees not to bill The Plan or Member for services associated with such claims.

4.1.0 Deleted or Invalid Codes: If a claim is received containing codes which have been deleted or which have become invalid for the dates of service on the claim, the claim will be returned for appropriate coding.

4.1.1 Multiple Services in a Single Day: Ancillary Provider shall submit all Covered Services rendered for a day on the same claim. If a service is not included on the original claim, Ancillary Provider shall submit a corrected claim which includes all Covered Services rendered. Failure to submit all charges on the same claim may result in The Plan rejecting the claim.

ARTICLE V – REIMBURSEMENT

5.0 Applicability of Reimbursement: The lesser of Ancillary Provider's charges for Covered Services or The Plan's Maximum Reimbursement Allowance as described in Attachment C shall be paid for Covered Services provided to all persons included in the definition of "Member" and as described in Section 9.2 of this Agreement, unless the terms of a separate network participation agreement and/or addendum supersedes. Ancillary Provider agrees to hold such individuals harmless from any sums in excess of the Maximum Reimbursement Allowance.

5.1 Changes in CPT-4/HCPCS Codes/ICD-10 Diagnosis Codes: Codes established subsequent to the effective date of this Agreement will be assigned a Maximum Reimbursement Allowance determined in a manner consistent with Maximum Reimbursement Allowances of comparable CPT-4/ HCPCS/ICD-10 Diagnosis Codes. The assigned pricing will be provided to Ancillary Provider.

5.2 Maximum Reimbursement Allowances: Maximum Reimbursement Allowances for Covered Services provided to Member will be as described on Attachment C.

5.3 Report Other Insurance: Ancillary Provider will report to The Plan any fact of which it or its agents have knowledge which indicates that the condition requiring Ancillary Services to the Member arises from any employment related or occupational injury or disease, or may be compensated under any State or Federal Worker's Compensation or Employer's Liability law, or that the Member has other insurance in effect which may provide Benefits.

ARTICLE VI – QUALITY IMPROVEMENT

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

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

6.1.0 Scope and objective of the quality improvement activities;

6.1.1 Methods to identify incidents or patterns;

6.1.2 Mechanisms for taking follow-up action; and

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

ARTICLE VII – PROVIDER AUDIT

7.0 Audit: Ancillary Provider agrees to allow The Plan, or its designated representatives, access to the Member's patient account records as well as any correspondence of other parties concerned with the services provided to Member. The purpose of Provider Audit is to verify billing information, verify that The Plan's reimbursement was made in accordance with the provisions of this Agreement, identify cases for potential Coordination of Benefits (COB), worker's compensation, and other party liability. Provider Audit will be scheduled during Ancillary Provider's business office's regular work hours and in conjunction with Medical Review when possible. Such access shall continue to be allowed for a period of two (2) years after the termination of this Agreement.

7.1 Claim Review: The Plan reserves the right to audit claim payments on an individual or aggregate basis, regardless of whether such payment or payments have already been made, and may make adjustment to such claim payments, including but not limited to the following:

7.1.0 Medical Necessity or lowest cost setting determinations.

7.1.1 Bill/Claim validation determinations of coding accuracy.

7.1.2 Adjustments required for failure to comply with submission of claim instructions or requirements of The Plan.

ARTICLE VIII – APPEALS AND GRIEVANCE PROCEDURES

8.0 Both The Plan and Ancillary Provider agree to abide by and exhaust the Provider Appeals and Grievance Procedures set forth in Attachment E to this Agreement.

ARTICLE IX – OTHER PROVISIONS

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

9.1 Agreement Not Assignable: This Agreement or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party, which consent shall not be unreasonably withheld or delayed. However, The Plan may transfer, assign, delegate, or extend, all or part of its rights or obligations under this Agreement to any of its direct and indirect subsidiaries.

9.2 Applicability of Agreement:

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

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

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

9.2.3 Self-Funded Plans: The Plan has a division that performs services as a Third Party Administrator for employer groups which sponsor self-funded employee benefit programs. The terms of this Agreement and all addendums shall be applicable to services rendered to participants in such self-funded employee Benefit programs. From time to time with self-funded groups, The Plan may agree to process claims for dates of service prior to the employer group's effective date. In such cases, the terms of this Agreement and all addendums shall apply.

9.3 Basic Information: The Plan utilizes its website at www.bcbsok.com for communicating additional information to providers, including but not limited to billing information, quality improvement standards, and medical policies. The Plan agrees to maintain its website with current information, and reserves the right to make updates to its website without notice. The Plan shall use best efforts to provide advance notice to Ancillary Provider of substantive changes to information in the Provider section of its website. Ancillary Provider agrees to refer to the Provider section of The Plan's website for additional information regarding its relationship with The Plan.

9.4 Confidentiality of Member Records and/or Member Information: Both parties will protect the privacy of the Member's medical/clinical records from inappropriate or unauthorized use in accordance with state and federal law. All medical records and Member information shall be treated confidentially and no third party other than Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Oklahoma or another organization affiliated with or contracted with Health Care Service Corporation may obtain such records or Member information except as needed for purposes of quality improvement, utilization management, case management, compliance and claims processing, or unless otherwise required by law. Member information

includes, but is not limited to, any information that identifies an individual and/or relates to the physical or mental health or condition of a Member, or to the provision of health care to the Member (or the payment for such health care).

9.5 Coordination of Benefits: When the Member has another source of healthcare benefits, the following Coordination of Benefits rules shall apply in a manner consistent with Sections 2.0 and 2.0.0 of this Agreement:

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

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

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

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

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

9.5.2 If Medicare is primary and The Plan is secondary, reimbursement will be based upon the Medicare allowable. If Medicare is primary and there is no allowed reimbursement, then reimbursement will be based on The Plan's allowable.

9.6 Credentialing: If credentialing is required before Ancillary Provider can be a Participating Provider, then acceptance of this Agreement by The Plan is conditioned upon approval by The Plan's credentialing committee. Ancillary Provider's failure to meet credentialing criteria or receive approval from the credentialing committee is considered to be a breach and may result in termination of this Agreement.

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

9.7.0 Ancillary Provider authorizes The Plan to obtain Member PHI and other health care information through MyHealth Access Network.

9.7.1 Ancillary Provider acknowledges it is a Covered Entity as defined by HIPAA.

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

9.8.0 The Delegated Activity shall be set out in writing, and if such Delegated Activity includes credentialing and/or selection of Participating Providers, such written arrangement shall address

The Plan's right to review on an ongoing basis, approve and audit Ancillary Provider's credentialing process and/or right to review on an ongoing basis, approve, suspend and terminate such providers, as applicable;

9.8.1 The Plan shall conduct on-going monitoring and review of Ancillary Provider's performance of the Delegated Activity;

9.8.2 Ancillary Provider's performance of the Delegated Activity shall comply with all applicable laws and this Agreement.

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

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

9.9 Enforcement: The provisions of this Agreement may be enforced only by the Ancillary Provider or The Plan.

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

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

9.12 Governing Laws: This Agreement shall be governed by the laws of the State of Oklahoma from time-to-time in force without giving effect to its conflict of laws provision.

9.13 HCSC Divisions and Affiliates: The parties acknowledge that HCSC conducts its insurance business through its respective state operating divisions of Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas. For purposes of this Agreement, the term "HCSC" includes each such operating division, as well as any additional divisions, subsidiaries or affiliates through which it may at any time conduct all or a portion of its group or consumer health insurance business. The term 'affiliate' includes any entity in which HCSC has a material ownership interest or an entity that HCSC controls.

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

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

9.16 MyHealth Participation: If applicable, Ancillary Provider and The Plan agree to appropriately use the MyHealth Access Network related to the services provided to Members under this Agreement.

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

9.18 Notification of Operational Changes: Each party shall promptly notify the other of changes of its ownership, including but not limited to joint ventures, mergers, acquisitions, bankruptcy, reorganization, change of licensure or any other operational changes which may impact or affect this Agreement.

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

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

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

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

9.23 Waiver: The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof or modification of this Agreement.

ARTICLE X – TERM AND TERMINATION

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

10.1 Termination by Either Party: Either party may terminate this Agreement by providing the other party with at least ninety (90) days prior written notice. Termination pursuant to this Section 10.1 shall not entitle Ancillary Provider to the Appeals and Grievance Procedures set forth in Attachment E to this Agreement. If any addendum to this Agreement, including, but not limited to, the Blue Advantage PPO Addendum, has a termination provision that requires an extended notice period, the termination provision in the addendum will supersede the termination provisions set forth in this Agreement. This Agreement will remain in effect until that addendum is terminated.

10.2 Immediate Termination by The Plan: This Agreement can be terminated by The Plan at any time and such termination becomes effective at the time of service of written notice upon Ancillary Provider, or on such date stated by The Plan in the notice. Reasons for the termination under this Section 10.2 include, but are not limited to: failure to comply with quality improvement, peer review and utilization review procedures (except in Medical Emergencies), or failure to meet or maintain The Plan's credentialing criteria, or unprofessional conduct as determined by the appropriate state professional licensing agency, or filing false claims, or filing inappropriate claims after notification by The Plan, or conviction for any criminal offense, or conflict of interest between Ancillary Provider and The Plan as determined by federal and state laws and regulations, or any other change which has a substantial effect on Ancillary Provider's operations or management which are material considerations for The Plan's execution of this Agreement, unless otherwise agreed to in writing by The Plan. If Ancillary Provider should have its applicable Oklahoma license, or Drug Enforcement Agency (DEA) registration, forfeited or suspended, should be suspended from Medicare or Medicaid participation, or for any other reason, The Plan may, upon written notice to Ancillary Provider, immediately terminate this Agreement and/or Ancillary Provider's right to perform Covered Services for Members. If Ancillary Provider is taking any other action or behavior which The Plan, in good faith after consulting with Ancillary Provider, and after providing Ancillary Provider with a reasonable opportunity to correct the problem, believes to be an endangerment to Members' care or well-being, The Plan may immediately suspend or terminate Ancillary Provider's right to perform services for Members or terminate this Agreement on written notice to Ancillary Provider. Termination in accordance with this Section will supersede Section 10.1.

ARTICLE XI – AMENDMENTS

11.0 Amendments: The Plan may amend this Agreement by providing Ancillary Provider written notice via mail or secure electronic format of such amendment at least ninety (90) days in advance of the effective date of the amendment. Notice will be sent to the attention of the contact person indicated on the cover page of this Agreement. If Ancillary Provider does not notify The Plan of nonacceptance, in writing by certified mail to The Plan's authorized representative as indicated on the cover page of this Agreement, at least forty-five (45) days prior to the effective date of the amendment, the amendment will be deemed to have been accepted by Ancillary Provider. Nonacceptance of proposed amendments will result in representatives of Ancillary Provider and The Plan meeting to resolve problems occurring as a result of the amendment(s). If an agreement has not been reached regarding the subject of the amendment prior to its effective date, this Agreement will terminate on the date designated by The Plan, or on the date agreed to by the parties. The period of time between the effective date of the amendment and the designated or agreed-to termination date shall be considered the "Transition Period". During the Transition Period the parties agree to cooperate to ensure the continuity of care of patients/Members, including but not limited to: providing notice to Members of Ancillary Provider's change in network status, the education of Members regarding other Participating Provider network options, and supporting the transition of care to providers in The Plan's networks, if requested by Members.

ARTICLE XII – CONFIDENTIALITY

12.0 Confidentiality: The terms and provisions of this Agreement, including but not limited to, the Maximum Reimbursement Allowances and credentialing application, are considered to be confidential, and as such shall not be made known to individuals or entities that are not parties to this Agreement without the written approval of The Plan. Ancillary Provider agrees to take appropriate and necessary precautions to prevent the unauthorized disclosure of confidential business or financial information and records relating to The Plan's operations under this Agreement, including the terms of this Agreement. This obligation of confidentiality, however, shall not preclude disclosure of information by Ancillary Provider or The Plan if disclosure is required to fulfill obligations imposed by federal or state law or ethical guidelines.

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

ATTACHMENT A
LOCATIONS OF ANCILLARY PROVIDER

The location(s) listed below are owned by Ancillary Provider and hereby made parties to this Agreement and all applicable addendums as of the effective date indicated on the cover page of this Agreement. Subsequent to the effective date of this Agreement, this Attachment A will be revised to add, remove or change locations in accordance with Section 2.14, and the effective date of each location will be as indicated below.

Location Name: Broken Arrow Fire Dept TIN: 73-6005109 NPI: 1336260918 License: EMS-023

Physical Address: 220 South 1st St. Broken Arrow, OK 74012 Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

Location Name: ________ TIN: ________ NPI: ________ License: ________

Physical Address: ________ Effective: ________ *(for internal use only)*

ATTACHMENT B
ANCILLARY SERVICES AND BILLING REQUIREMENTS

Ancillary Provider shall be a Participating Provider in the BlueTraditional, BlueChoice PPO, and BluePreferred Networks.

ARTICLE I – DEFINITIONS

1.0 Ambulance: A specially designed and equipped vehicle used only for transporting the sick and injured and staffed with personnel trained to provide first aid treatment, and operated under the license of a physician. At a minimum, it must contain a stretcher, oxygen, first aid supplies and other life-saving equipment.

1.1 Ambulance Transport Services: Ambulance Transport Services include Air Ambulance Transport Services and Ground Ambulance Transport Services.

1.1.0 Air Ambulance Transport Services: There are two types of Air Ambulance Transport Services:

(a) Fixed-Wing Air Ambulance: Fixed-Wing Air Ambulance Transport service is the transportation by a fixed-wing aircraft that is certified by the Federal Aviation Administration (FAA) as a Fixed-Wing Air Ambulance.

(b) Rotary-Wing Air Ambulance: Rotary-Wing Air Ambulance Transport Service is the transportation by a helicopter that is certified by the FAA as a Rotary-Wing Air Ambulance.

1.1.1 Ground Ambulance Transport Services: There are two levels of Ground Ambulance Transport Services:

(a) Basic Life Support ("BLS"): BLS provides basic emergency care, including control of bleeding, splinting of fractures, treatment of shock, delivery of babies, cardiopulmonary resuscitation (CPR) and other basic services.

(b) Advanced Life Support ("ALS"): ALS typically includes the use of complex life sustaining equipment and radio contact with a physician. Only Ambulance personnel who are trained in these services are allowed to provide them. Services must be consistent with training and include intravenous therapy, endotracheal intubation, administration of drugs by all routes, cardiac monitoring, and use of telemetry and defibrillation equipment. Specialized services performed during an ALS Ambulance trip are generally defined as those that can be performed only in an ALS certified vehicle.

ARTICLE II – AGREEMENTS OF ANCILLARY PROVIDER

2.0 Ambulance Transport Services: Ancillary Provider has an established, equipped, and staffed Ambulance vehicle, and is designated as an Ambulance Transport Service provider licensed by the Oklahoma State Department of Health.

ARTICLE III – BILLING REQUIREMENTS

3.0 Claim Filing: Ancillary Provider is required to submit Properly Filed Claims to The Plan at Ancillary Provider's Usual Charge using either the CMS 1500 claim form and subsequent revisions or The Plan's paperless claims entry system (electronically). Ancillary Provider must submit claims within one hundred eighty (180) days of the date of the service or within one hundred eighty (180) days after the primary payor's dated Explanation of Claims Submission, and look to The Plan for payment except for coinsurance,

deductible, and noncovered amounts. Claims will be accepted beyond the one hundred eighty (180) day period if the Member's Benefit Agreement allows a longer timely filing period. Claims which are not submitted within the later of either the above one hundred eighty (180) day period or within the timely filing requirements of the Member's Benefit Agreement will not be honored and Ancillary Provider agrees not to bill The Plan or Member for services associated with such claims. The form must include the following:

(a) Current HCPCS code for appropriate Ambulance Transport Service

(b) Mileage (if not using the HCPCS code that includes mileage)

(c) Pick-up and destination points (this can often be provided with the Ambulance Transport Service modifiers; if not, information can be supplied in the "comments" section of the claim form)

(d) Appropriate information regarding accident/injury in occurrence code fields

(e) Not Otherwise Classified ("NOC") Code should follow NOC Code guidelines (description of services is required).

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

(g) The appropriate place of service.

(h) Ancillary Provider's organizational National Provider Identifier (NPI) for Ambulance Transport Services

(i) All other relevant information required by The Plan to adjudicate claims

ATTACHMENT C
MAXIMUM REIMBURSEMENT ALLOWANCES

1.0 Applicability of Reimbursement: The table below represents the Maximum Reimbursement Allowance for the provision of Ambulance Transport Services to Members for the networks identified on Attachment B. The lesser of Ancillary Provider's charges for Covered Services or The Plan's Maximum Reimbursement Allowance herein shall be paid for Covered Services provided to all persons included in the definition of "Member" and as described in Section 8.2 of the Agreement unless the terms of a separate network participation agreement apply. Ancillary Provider agrees to hold such individuals harmless from any sums in excess of the Maximum Reimbursement Allowance.

1.1 The Plan will not reimburse, nor may Ancillary Provider collect from the Member, any amounts for professional services unless such services have been rendered to an identifiable individual patient, and are supported by a written report.

MAXIMUM REIMBURSEMENT ALLOWANCE

Emergency Transport Services	$642.27
Non-emergency Transport Services	$367.50
Ground mileage, per statute mile	$12.00 per mile
Air Ambulance Transport Services (fixed or rotary wing)	Will be consistent with The Plan's current reimbursement methodology

All supplies and services are included in the base rate for each category of service described above.

ATTACHMENT D
UTILIZATION MANAGEMENT

There are no utilization management requirements for Ambulance Transport Services.

ATTACHMENT E
APPEALS AND GRIEVANCE PROCEDURES

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

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

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

1.0.2 Contract Termination Requests for Consideration are related to the termination of this Agreement by The Plan, which does not involve a decision or action taken by The Plan's Credentialing Committee. Termination pursuant to Section 10.1 of this Agreement shall not entitle Ancillary Provider to the Appeals and Grievance Procedures set forth in this Attachment E to this Agreement.

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

1.1 Types of Utilization Management Appeals: There are two types of Utilization Management (UM) appeals available to Ancillary Provider: expedited/urgent care or standard. An appeal is a formal request for review or reconsideration of a determination to reduce or deny a service. Any appeal regarding a Medical Necessity, experimental or investigational Preauthorization determination, submitted by Ancillary Provider, will be considered an appeal on behalf of the Member.

Prior to an appeal, Ancillary Provider may request a peer-to-peer conversation with the Medical Director, Utilization Management, who made the Preauthorization decision. Ancillary Provider may call the Utilization Management Department as instructed on The Plan's website at www.bcbsok.com. The Medical Director, Utilization Management, making the determination or another medical director within the Blue Cross and Blue Shield of Oklahoma family of companies, will be available within one business day to discuss the Preauthorization decision. If the decision not to Preauthorize the requested service is upheld after the conversation, Ancillary Provider has the option to proceed with an appeal.

1.1.0 Expedited Appeals: An expedited or urgent care appeal is a request, usually by telephone or fax, for an additional review of a determination not to Preauthorize a service. The review is conducted by a clinical peer who was not involved in the original decision not to Preauthorize and is not the subordinate of the person making the original determination. An expedited appeal applies to urgent care requests. Urgent care requests are defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. It does not apply to non-urgent or post-service/retrospective requests. Local specialty providers, Managing Care Managing Claims (MCMC), Advanced Medical Review (AMR), Medical Evaluation Services (MES) and

Medical Review Institute of America, Inc. (MRI) are external consultants who may be utilized in the appeal process. A determination will be made within 72 hours of receipt of the request. To initiate an expedited appeal:

(a) Call the Utilization Management Department the number listed on the back of the Member's card or on The Plan's website at www.bcbsok.com.

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

- Member name
- Member ID number
- Member reference number if known
- Date of service
- Name of facility where services are being rendered, if applicable
- Name of ordering/attending physician

1.1.1 Standard Appeals: A standard appeal is a request to review a determination not to Preauthorize an admission, extension or stay, or other health care service conducted by a peer reviewer who was not involved in any previous Preauthorization decision nor the subordinate of the peer making the original determination. A standard appeal applies to non-urgent or post-service/retrospective requests. It must be made in writing accompanied by all or applicable parts of the Member's medical record required to perform the review. A statement from the Member, attending/ordering physician, or facility is needed to perform the review. Local specialty providers, Managing Care Managing Claims (MCMC), Advanced Medical Review (AMR), Medical Evaluation Services (MES) and Medical Review Institute of America, Inc. (MRI) are review consultants who may be utilized in the appeal process. Standard appeals may be requested within one hundred eighty (180) days from the date of notice of the Preauthorization determination. A standard appeal request should be submitted to the appropriate address provided on The Plan's website at www.bcbsok.com.

The written request should include:

- Name of the requestor
- Member name
- Member ID number
- Member reference number if known
- Date of service
- Name of facility where services are being rendered, if applicable
- Name of ordering/attending physician
- Any documentation, including medical records that Ancillary Provider wants to become a part of the review file
- A letter/statement indicating the issue and resolution being sought

1.2 Credentialing Committee Appeals: The Plan has developed an appeals process for all Participating Providers whose network contract(s) are cancelled for either a medical or non-medical reason by the Credentialing Committee. (Providers who are denied acceptance in a network by the Credentialing Committee also have access to this appeals process.) All Credentialing appeals are to be sent to the appropriate address provided on The Plan's website at www.bcbsok.com.

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

(a) Level One (1) Written Appeals: All appeals should be made in writing and submitted to the Credentialing Committee Chair within thirty (30) days of receipt of the denial/cancellation notice. The Credentialing Committee Chair will forward the appeal to the Peer Review Committee (East or West) for review. This Committee will review the written appeal, all additional submitted information and credentialing file documentation pertaining to the deficiencies. At least three qualified individuals of which at least one is a Participating Provider who is not involved with The Plan's management and who is a clinical peer of Ancillary Provider who is filing the appeal (if the appeal is clinical in nature) and not previously involved with the Credentialing Committee decision or action, will participate in the Level One process.

Ancillary Provider will be notified by Certified Mail Return Receipt Requested, within ten (10) business days of the Committee's decision.

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

1. The Chairperson of the committee will select the date for Ancillary Provider's appearance before the committee and will notify the provider of the time, date and place for its appearance. Ancillary Provider will be notified of this meeting by Certified Mail Return Receipt Requested.

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

3. Ancillary Provider is given ten (10) minutes to present its appeal.

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

5. After the questioning period is completed, the provider will be dismissed, the Committee will discuss the issue and a decision/determination will be made. The decision will be final.

6. The provider will be notified by Certified Mail Return Receipt Requested within ten (10) business days of the committee's decision.

1.3 Contract Termination Requests for Consideration: If this Agreement is terminated by The Plan, and does not involve a decision or action taken by The Plan's Credentialing Committee, Ancillary Provider may submit a written request to The Plan to reconsider its decision to terminate this Agreement. Such written request must be received by The Plan within thirty (30) days of the date of the letter notifying Ancillary Provider of the termination. The request will be considered by an authorized representative or representatives of The Plan not involved in the original termination decision. Ancillary Provider will be provided a written response to the request for reconsideration within thirty (30) days of receipt of the request by The Plan. All requests for reconsideration are to be sent to:

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

1.4 Contractual Inquiries/Appeals: If Ancillary Provider has an inquiry or complaint, which does not fall under one of the other categories and relates to this Agreement, an initial attempt should be made to resolve it by communication with The Plan's Network Management Department. If a resolution cannot be reached, a written appeal process is available.

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

1.4.1 Contractual Appeal: Contractual appeals can be requested for reconsideration regarding Benefits, pricing, claims adjudication, and/or claims processing guidelines. All contractual appeals must be submitted in writing using the Claim Appeal/Reconsideration Review Request form located on The Plan's website at www.bcbsok.com. Contractual appeals must be received by The Plan within one hundred eighty (180) days of the initial claims adjudication date to be considered.

The written request should include the following information:

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

Appeals should be mailed to the applicable address provided on the form.

Ancillary Provider will be notified of a decision for contractual appeals in a timely manner. If the appeal results in additional payment, Ancillary Provider will be notified on the detail of remittance. All other appeal responses will be mailed directly to Ancillary Provider.

1.4.2 Executive Mediation: If the dispute has not been resolved to Ancillary Provider's satisfaction, the parties shall attempt in good faith to resolve the dispute by negotiation between executives who have authority to settle the controversy and who are at a higher level of management than the persons with direct responsibility for administration of this Agreement who have not already reviewed the matter.

Any party may give the other party written notice of the unresolved dispute. Within fifteen (15) days after delivery of the notice, the receiving party shall submit to the other a written response. The notice and the response shall include (a) a statement of each party's position, and (b) the name and title of the executive who will represent that party and of any other person who will accompany the executive. Within thirty (30) days after delivery of the disputing party's notice, the executives of both parties shall meet at the mutually acceptable time and place, and thereafter as often as they reasonably deem necessary, to attempt to resolve the dispute. All reasonable requests for information made by one party to the other will be honored. All negotiations pursuant to this paragraph are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

1.4.3 Binding Arbitration: After exhaustion of Ancillary Provider's contractual complaint inquiries and appeals process and the executive mediation process as outlined above, if the issue has not been resolved to both parties' satisfaction, either party may request that the issue be submitted to binding arbitration. Notice of a demand for arbitration shall be sent in writing to the other party no later than six (6) months after conclusion of the executive mediation process above. Failure to send notice within the aforementioned time shall result in the other party being entitled to object to submission of the matter to arbitration. Such binding arbitration shall be conducted in Tulsa, Oklahoma, by a single arbitrator in accordance with the American Health Lawyers' Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The arbitrator shall be selected by agreement of the parties from a list of arbitrators provided by the American Health Lawyers' Association Alternative Dispute Resolution Service. Unless otherwise determined by the arbitrator, the arbitration fees shall be shared equally by the parties, and each party shall pay its own attorney's fees and other costs associated with the arbitration.

To the extent of the subject matter of the arbitration, the determination of the arbitrator shall be binding not only on the parties to this Agreement, but also on any other entity controlled by or in control of or under common control with the party, to the extent that such affiliate joins in the arbitration. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.