Network Provider

Long Term Acute Care Facility

Contract

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Network Long-Term Acute Care Facility Contract

This Network Long-Term Acute Care Facility Contract, hereinafter "Contract," is between the Office of Management and Enterprise Services Employees Group Insurance Division (EGID, hereinafter "EGID," and the Network Long-Term Acute Care Facility, hereinafter "Facility," identified on the Signature Page.

I. RECITALS

1.1 EGID is a State of Oklahoma governmental agency that administers health, life, dental, and disability insurance benefits for State, education, local government, and other eligible employees and retirees, pursuant to the State and Education Employees Group Insurance Act, 74 O.S. (2001) § 1301 et seq.

1.2 The Facility is duly licensed by the state of residence and is certified to participate in the Medicare program under Title XVIII of the Social Security Act, and/or certified by The Joint Commission or Accreditation Association for Ambulatory Health Care, hereinafter "AAAHC", if applicable, and shall comply with all applicable federal, state, and local laws regulating such a Facility.

1.3 EGID administers self-funded health plans that are identified by the trade name "HealthChoice." HealthChoice Plans are intended to financially encourage the population of EGID Members, retirees and dependents to utilize Network Providers.

In consideration of the mutual covenants, promises and other good and valuable consideration, EGID and the Facility agree as follows:

II. DEFINITIONS

2.1 "Allowable Fee" means the maximum amount payable to a Facility by EGID and Member for Covered Services furnished pursuant to this Contract.

2.2 "ALOS" means the Geometric Average Length of Stay

2.3 "Base Rate" means a dollar amount established by EGID by which the MS- LTC-DRG Relative Weight is multiplied to obtain the MS-LTC-DRG Allowable Fee.

2.4 "Certification" means a function performed by EGID to review and certify services for medical necessity in identified areas of practice prior to services being rendered.

2.5 "CMS" means Centers for Medicare and Medicaid Services.

2.6 "Concurrent Review" means a function performed by EGID that determines and updates medical necessity for continued inpatient hospitalization.

2.7 "Cost to Charge Ratio" means the most recent statewide average total cost-to- charge ratio for

urban Oklahoma Facilities as published by CMS.

2.8 "Covered Services" means Medically Necessary services delivered by a Facility pursuant to this Contract and for which a Member is entitled to receive coverage by the terms and conditions of a HealthChoice Plan.

2.9 "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)).

2.10 "Facility Services" means those acute care inpatient and outpatient Facility Services that are covered by the HealthChoice Plan.

2.11 "Geometric Average Length of Stay" means the current version of the Geometric ALOS published by CMS for each MS-LTC-DRG.

2.12 "HealthChoice Plan" means the HealthChoice benefit plan designed to maximize Member's insurance benefit and financially encourage Members to use Network Providers.

2.13 "High Cost Outlier Allowable Fee" shall be determined as outlined in Article 6.4.

2.14 "Interrupted Stay" means a case in which a patient is discharged and then admitted directly to an inpatient acute care hospital, an Inpatient Rehabilitation Facility (IRF), a Skilled Nursing Facility (SNF) or a swing-bed and then returns to the same Facility within a fixed period of time. Currently, Medicare has determined the fixed period of time for each provider type is as follows:

a) Acute care hospital – 9 days or less
b) Inpatient Rehabilitation Facility (IRF) – 27 days or less
c) Skilled Nursing Facility (SNF) – 45 days or less
d) Swing-bed hospital – 45 days or less
e) Discharge to patient's home and readmission to Facility within three days, subject to update in accordance with CMS guidelines.

An Interrupted Stay is treated as one discharge for the purposes of payment and only one MS LTC-DRG payment is made.

2.15 "LTC" means a Long-Term Acute Care Hospital with an average length of stay of greater than 25 days. LTC facilities are identified by the last four digits of the Medicare provider number, which range between "2000" and "2299". Rehabilitation hospitals, Veterans Administration hospitals and psychiatric hospitals are not considered to be a LTC. LTCs can be a satellite and/or hospital- within-a-hospital or co-located within another facility.

2.16 "Medically Necessary" means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by EGID. Direct care and treatment are within standards of good medical practice within the community and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level

of service which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity of services the member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The services or supplies cannot be primarily for the convenience of the member, caregiver or provider. The fact that services or supplies are Medically Necessary does not, in itself, assure that the services or supplies are covered by the HealthChoice Plan.

2.17 "Medical Services" means the professional services provided by a Network Provider and covered by a HealthChoice Plan.

2.18 "Members" means all persons covered by EGID HealthChoice Plans, including eligible current and qualified former employees of participating entities and their eligible covered dependents. Qualified former employees include those who have retired or vested through an eligible State of Oklahoma retirement system, or who have completed the statutory required years of services, or who have other coverage rights through COBRA or the Oklahoma Personnel Act.

2.19 "MS-LTC-DRG" means the Medicare Severity-Long Term Care-Diagnosis Related Groups and in an inpatient Facility classification, as published by CMS.

2.20 "MS-LTC-DRG Allowable Fee" means the MS-LTC-DRG relative weight as published by CMS multiplied by the Base Rate. For purposes of this contract, the MS-LTC-DRG Allowable Fee, as established by EGID shall serve as the payment rate, unless the reimbursement is to be a Short-Stay Outlier or a High Cost Outlier.

2.21 "MS-LTC-DRG Relative Weight" means the current version of the Relative Weight published by CMS for each MS-LTC-DRG.

2.22 "Network Provider" means a practitioner or Facility that is duly licensed under the laws of the state in which the Network Provider operates and/or is accredited by a nationally recognized accrediting organization approved by State or Federal guidelines, and have entered into an agreement with EGID to accept scheduled reimbursement for Covered Services and supplies provided to HealthChoice Members.

2.23 "Non-covered Services" are those services a) excluded from coverage by the HealthChoice Plan, in which case the Member is liable for the charges; or b) covered by the HealthChoice Plan but inappropriately billed and therefore excluded for reimbursement based on the clinical editing software.

2.20 "Outlier Threshold" means a dollar amount published by CMS by which the total billed charges on the claim must exceed the MS-LTC-DRG Allowable Fee in order to qualify for an outlier allowable fee.

2.25 "Per Diem" for Short-Stay Outliers means the MS-LTC-DRG Allowable Fee divided by the Geometric ALOS.

2.26 "Short-Stay Outlier" means a case that has a length of stay between one day up to and including 5/6 of the ALOS for the MS-LTC-DRG to which the case is grouped. Short-Stay outliers are also eligible for high cost outlier payments if their costs exceed the Outlier Threshold.

2.27 "Short-Stay Outlier Allowable Fee" means the lesser of the MS-LTC-DRG Allowable Fee or the Per Diem for Short-Stay Outlier multiplied by the actual length of stay multiplied by One Hundred Twenty percent (120%).

III. RELATIONSHIP BETWEEN EGID AND THE FACILITY

3.1 EGID negotiated and entered into this Contract with the Facility on behalf of the Members of an EGID HealthChoice Plan. The Facility is an independent contractor that has entered into this Contract to become a Network Facility and is not, nor is intended to be the agent or other legal representative of EGID in the performance of the provisions of this Contract. Nothing in this Contract shall be construed or be deemed to create a relationship contrary to that of independent contractor for the purposes of this Contract.

3.2 EGID and the Facility agree that all of the parties hereto shall respect and observe the facility/patient relationship which will be established and maintained by the Facility. The Facility may choose not to establish a facility/patient relationship if the Facility would have otherwise made the decision not to establish a facility/patient relationship had the patient not been a Member. The Facility reserves the right to refuse to furnish services to a Member in the same manner as they would any other patient.

3.3 Nothing in this Contract is intended to be construed, or be deemed to create any rights or remedies of any third party, including but not limited to, Network Facilities that are not identified by this Contract, except EGID Members defined in this Contract.

IV. FACILITY SERVICES AND RESPONSIBILITIES

4.1 The Facility shall provide quality, Medically Necessary Facility Services to Members, in a cost efficient manner, when such services are ordered by a licensed practitioner, who is a member of the Facility's medical staff and has been awarded the prerequisite clinical privileges to order and/or perform such services. Nothing in this Contract shall be construed to require the medical staff of the Facility to perform any procedure or course of treatment which the staff deems professionally unacceptable or is contrary to Facility policy.

4.2 The Facility shall provide Facility Services to Members in the same manner and quality as those services are provided to all other patients of the Facility.

4.3 The Facility has, and shall maintain, in good standing while this Contract is in effect, all licenses required by law, and if applicable, certification to participate in the Medicare program under Title XVIII of the Social Security Act and/or The Joint Commission.

4.4 The Facility agrees to make reasonable efforts to refer covered Members to other Network Facilities with which EGID contracts for Medically Necessary Services that the Facility cannot or chooses not to provide.

4.5 The Facility shall participate in the Certification and Concurrent Review procedures provided in Article VII and for purposes of reimbursement to abide by decisions resulting from that review subject to the Dispute Resolution rights provided in Article X.

4.6 The Facility shall furnish, at no cost to EGID, any medical and billing records covering any

Medical Services, for any Member, with the understanding that each Member, as a condition of enrollment in the HealthChoice Plan, has authorized such disclosure.

4.7 The Facility shall accurately complete the Network Facility Application which is attached to and made part of this Contract. The Facility shall notify EGID of any change in the information contained in the Application within fifteen (15) days of such change, including resolved litigation listed as "pending" on the original Network Facility Application.

4.8 The Facility shall reimburse EGID for any overpayments made to the Facility within sixty (60) days of the Facility's receipt of the written overpayment notification or shall respond with detail within said time if Facility disputes the request for additional payment. EGID shall provide the Facility individual letters of retraction for each patient sixty (60) days prior to the retraction being made.

As an exception EGID will immediately deduct overpayments due to resubmission of a corrected claim, or if information is received for a claim pending additional information that subsequently impacts a paid claim or a mutually agreed to audit adjustment.

EGID shall be entitled to additional payment if, within two years from the date of payment, EGID notifies Facility, in writing of the overpayment.

If Facility disputes the request for additional payment, the Parties shall work cooperatively and in good faith to resolve the payment issue on an informal basis within sixty (60) days of the first notification of the overpayment. If the Parties' attempt to resolve the issue is unsuccessful, then the dispute concerning the incorrect payment shall be resolved in accordance with the Dispute Resolution Process provided in Article X.

4.9 The Facility shall submit to a Member record audit upon fourteen (14) business days advance notice.

4.10 The Facility shall comply with the national standards for the electronic exchange of administrative and financial health care transactions required by the Health Insurance Portability and Accountability Act of 1996, hereinafter "HIPAA".

V. EGID SERVICES AND RESPONSIBILITIES

5.1 EGID agrees to pay the Facility compensation pursuant to the provisions of Article VI.

5.2 EGID agrees to grant the Facility the status of "Network Facility" and to identify the Facility as a Network Facility on informational materials disseminated to Members.

5.3 EGID agrees to continue listing the Facility as a Network Facility until this Contract terminates.

5.4 EGID agrees to provide the Facility with access to a listing of all Network Facilities via the Internet.

5.5 EGID agrees to provide appropriate identification for Members at the time of enrollment in a HealthChoice Plan and the effective date of coverage by EGID. The ID card shall provide an address and/or telephone number for verifying eligibility and benefits.

5.6 EGID agrees to acknowledge the confidentiality of patient's records and to only release pertinent clinical information in accordance with state and federal guidelines.

5.7 EGID shall give fourteen (14) business days' notice prior to an audit. Under no circumstances shall an audit of medical records by EGID delay payment to Facility under Article VI.

5.8 EGID shall maintain Certification and Concurrent Review programs in accordance with the Utilization Review Accreditation Commission's, hereinafter "URAC," standards in order to aid its Member in making decisions that will maximize medical benefits and reduce their financial risk.

5.9 EGID shall reimburse the Facility for any underpayments made to the Facility within thirty (30) days of EGID's receipt of the underpayment notification, or shall respond with detail within said time if EGID disputes the request for additional payment. Facility shall be entitled to additional payment if, within two (2) years from the date of payment, Facility notifies EGID in writing of the underpayment. If EGID disputes the request for additional payment, the Parties shall work cooperatively and in good faith to resolve the payment issue on an informal basis within sixty (60) days of the first notification of underpayment. If the Parties attempt to resolve the issue is unsuccessful, then the dispute concerning the payment shall be resolved in accordance with the Dispute Resolution Rights provided in Article X.

5.10 EGID shall comply with the national standards for the electronic exchange of administrative and financial health care transactions required by HIPAA.

5.11 EGID shall review the Base Rate Marginal Cost Factor, Outlier Threshold and Certification procedure list, notifying the Facility of changes by a general mailing sixty (60) days prior to implementation.

VI. COMPENSATION AND BILLING

6.1 The Facility shall only seek payment from EGID for the provision of Covered Services. The Facility agrees to accept the amount of the Allowable Fee for Covered Services as payment in full and agrees to only request payment from the Member for deductible, co-insurance and amounts for defined Non-Covered Services attributable to the Member's Health Choice Plan. The payment shall be calculated and limited to the methodologies defined by this Contract.

6.2 When the Allowable Fee exceeds billed charges, EGID shall pay the appropriate percentage of the Allowable Fee and Member shall pay the appropriate percentage of billed charges unless the Member has met the stop loss limitation and then EGID shall pay the Allowable Fee and the Member has no liability. A list of the CPT/HCPCS codes and the Allowable Fee for each can be found at the EGID website at www.ok.gov/sib/providers. It is EGID's intent to review and update the fee schedule annually. It is EGID's further intent to update the list as it deems necessary when new CPT/HCPCS codes are identified by the American Medical Association or CMS.

6.3 When processing inpatient claims, EGID agrees to pay the Facility the Allowable Fee based on appropriate billing according to the following:

a) EGID shall pay the appropriate percentage of the MS-LTC-DRG Allowable Fee and the Member shall pay the remainder of the MS-LTC- DRG Allowable Fee unless the

Member has met the stop loss limitation, and then EGID shall pay one hundred percent (100%) of the MS- LTC- DRG Allowable Fee and the Member has no liability.

b) The MS-LTC-DRG shall be controlling, subject to EGID's approval and article X of the Contract.

c) The MS-LTC-DRG Allowable Fee does not include any physician professional component fees, which are considered for payment according to separately billed Current Procedural Terminology code Allowable Fees.

d) EGID may reduce its payment by any deductibles, coinsurance and co- payments owed by the Member.

e) EGID shall include the day of admission but not the day of discharge when computing the number of facility days provided to a Member. Observation Facility confinements for which a room and board charge is incurred shall be paid based on inpatient benefits.

f) EGID shall use the current version of the MS-LTC-DRG grouper to categorize what shall constitute a procedure. EGID's and the Member's financial liability shall be limited to the Allowable Fee as determined by EGID.

g) The Facility agrees not to charge more for Medical Services to Members than the amount normally charged by the Facility to other patients for similar services.

6.4 EGID shall determine the Allowable Fee to a Facility for an unadjusted MS- LTC-DRG according to the following formula:

MS-LTC-DRG Allowable Fee = MS-LTC-DRG Relative Weight as published by CMS x Base Rate

6.5 Short-Stay Outlier mean a case that has a length of stay between one day and up to and including 5/6 of the ALOS for the MS-LTC-DRG to which the case is grouped. In the case of a Short-Stay Outlier, the Short-Stay Outlier Allowable Fee for the Facility shall be calculated as follows:

Per Diem for Short-Stay Outlier = MS-LTC-DRG Allowable Fee ÷ Geometric Average Length of Stay as published by CMS Short-Stay Outlier Allowable Fee = The lesser of the MS-LTC- DRG Allowable Fee or (Per Diem for Short-Stay Outlier x actual length of stay x 120%)

Short-Stay Outliers are also eligible for high cost outlier payments if the costs exceed the outlier threshold.

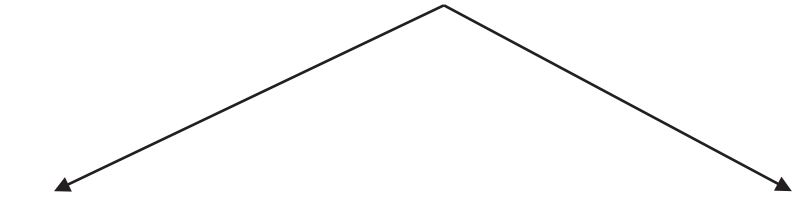
6.6 "High Cost Outlier Allowable Fee" means cases that have unusually high cost. In the case of a High Cost Outlier, the High Cost Outlier Allowable Fee for the Facility shall be calculated as follows:

High Cost Outlier Allowable Fee = ([Billed Charges – Disallowed Charges) x Cost to Charge Ratio] – MS-LTC-DRG Allowable Fee – Outlier Threshold) x 80% + MS-LTC-DRG Allowable Fee

6.7 In the case of Interrupted Stays, if the length of stay at the receiving Facility is equal to or less than applicable fixed period of time, it is considered to be an Interrupted Stay case and is therefore treated as a single (one) discharge for the purpose of payment. Only one MS-LTC-DRG payment will be made. Each interrupted period that occurs shall be evaluated individually regarding the number of days at the intervening Facility to determine if it meets the requirements of the Interrupted Stay policy. An Interrupted Stay is determined in accordance with the following flow chart prepared by CMS.

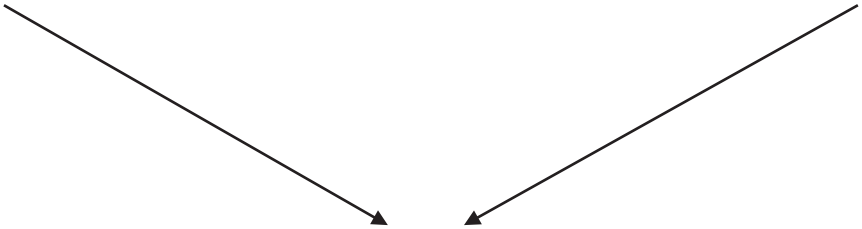
SHORT-STAY OUTLIERS AND INTERRUPTED STAYS

ADMISSION TO FACILITY



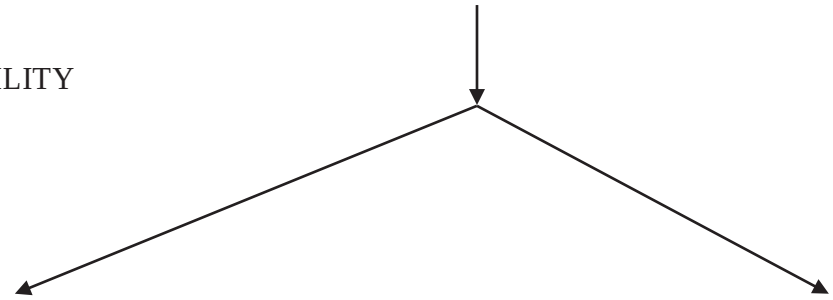
SHORT-STAY OUTLIER
LOS< or = 5/6 ALOS MS-LTC-DRG

REGULAR STAY (RS)
LOS>5/6 ALOS MS-LTC-DRG



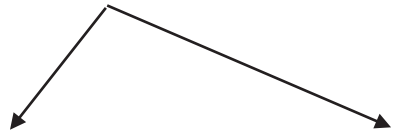
(Facility day count stops) DISCHARGED to
Inpatient Acute Care Hospital (INACH) Inpatient Rehabilitation Facility (IRF) Skilled Nursing Facility (SNF), or Swing-bed (SB)

RETURN to FACILITY



INTERRUPTED STAY
INACH LOS<OR=9 DAYS
27 DAYS; OR
SNF LOS<OR = 45 DAYS
Single MS-LTC-DRG Payment
(Facility day count resumed)

NEW ADMISSION
INACH LOS>9 DAYS; IRF<OR=
IRF LOS>27 DAYS; OR
SNF/SB LOS>45 DAYS
Separate MS-LTC-DRG Payments
(Facility day count stops)



SHORT STAY OUTLIER
Total LOS < or =5/6 ALOS MS-LTC-DRG

RS
Total LOS. 5/6 ALOS MS-LTC-DRG

6.8 When processing Outpatient claims, EGID agrees to pay the Facility the Allowable Fee based on appropriate billing according to the following:

a) If a procedure does not have an Allowable Fee, EGID will allow a percentage of the billed charges for Covered Services.
b) EGID shall pay the appropriate percentage of the Allowable Fee and the Member shall pay the remainder based on the Member's plan of benefits unless the Member has met the stop loss limitation, and then EGID shall pay 100% of the Allowable Fee and the Member has no liability.
c) EGID shall reduce its payment to the Facility by any deductibles, coinsurance and copayments owed by the Member.
d) The facility agrees not to charge more for Medical Services to Members than the amount normally charged by the Facility to other patients for similar services.
e) The Facility agrees that EGID utilizes a comprehensive claims editing system to assist in determining which charges for Covered Services to allow for payment and to assist in determining inappropriate billing and coding. Said system shall rely on Medicare and other industry standards in the development of its mutually exclusive, incidental, re-bundling, age conflict, gender conflict. Cosmetic, experimental and procedure editing, EGID shall provide the Facility, upon request from Facility, detailed information about the processes employed in the claims editing system adopted by EGID.

6.9 The Facility shall not charge the Member for Medical Services denied by the Certification or Concurrent Review procedures described in Article VII, unless the Facility has obtained a written waiver form that Member. Such a waiver shall be obtained only upon denial of Medical Services and prior to the provision of those Medical Services. The waiver shall clearly state that the Member shall be responsible for payment of Medical Services denied by EGID.

6.10 The Facility shall not collect amounts in excess of the HealthChoice Plan limits unless the Member has exceeded his/her annual or lifetime maximum.

6.11 The Facility shall refund to the Member within thirty (30) days of discovery any overpayment made by the member.

6.12 In a case in which EGID is primary under applicable coordination of benefit rules, EGID shall pay the amounts due under this Contract. In a case in which EGID is other than primary under the coordination of benefit rules, EGID shall pay the Member's liability for out of pocket expenses such as deductibles, copayments or coinsurance, under the primary policy, up to EGID's maximum liability under the terms of the Contract. No payment will be made for any charge that is not an allowed expense or an amount for which the Member is contractually held harmless under any coordinating policy.

6.13 The Facility shall bill EGID on standard and customary forms acceptable to EGID within 120 days of providing the Facility Services, or receipt of primary payors explanation of benefits, or from discovery that EGID is responsible for payment. The facility shall use the current CPT/HCPCS codes with appropriate modifiers and ICD diagnostic codes, when applicable. The facility shall furnish, upon request at no cost, all applicable medical and billing records, reasonably required by EGID to verify and substantiate the provision of Medical Services and

the charges for such services if the Member and the Facility are requesting reimbursement through EGID. This provision shall not apply in cases involving litigation, multiple payors, or where the patient has failed to notify the Facility that they were a Member.

6.14 In accordance with 74 O.S. (2007) § 1328, EGID shall reimburse the Facility within forty-five (45) days of receipt of billings that are accurate, complete and otherwise in accordance with Article VI of this contract. EGID will not be responsible for the delay or reimbursement due to circumstances beyond EGID's control.

6.15 The Facility agrees that EGID's subrogation rights or the existence of third party liability does not affect the Facility's agreement to accept the current Allowable Fee described in the Contract. Unrecorded alleged or recorded liens that are intended to secure charges for treatment rendered to or on behalf of a Member for amounts in excess of the Allowable Fee and/or which exceed the member's deductible and coinsurance liability as required by the Contract, are rendered invalid by the Facility's submission of a Member's claims to EGID.

VII. UTILIZATION REVIEW

7.1 The Facility shall adhere to and cooperate with EGID's Certification and Concurrent Review procedures. These procedures do not guarantee a Member's eligibility or that benefits are payable, but assure the Facility that the Medical Services to be provided are covered by the HealthChoice Plan.

7.2 The Facility shall notify EGID, of any inpatient hospital admission, transplant procedure, specific outpatient Facility procedures or surgeries identified on EGID website at http://www.sib.ok.gov/precert. EGID shall notify Facilities of changes to the Certification list by a general mailing sixty (60) days prior to implementing the change. A Facility shall request Certification at least three days prior to the scheduled admission, surgery and/or procedure. A request for Certification shall be made within one working day after an Emergency admission, Outpatient Services, or observation stay with duration greater than 24 hours. Such notification shall be at no charge to EGID or the Member. Failure to comply with the Certification or Concurrent Review requirements shall result in the Facility's Allowable Fee being reduced by ten percent (10%) if the procedure is confirmed as Medically Necessary retrospectively and, if not confirmed, there shall be no reimbursement.

7.3 The Certification and Concurrent Review requirements are intended to maximize insurance benefits assuring that Facility and Medical Services are provided to the Member at the appropriate level of care. In no event is it intended that the procedures interfere with the provider's decision to order admission to or discharge the patient from the Facility.

7.4 EGID shall maintain review procedures in accordance with standards established by the Utilization Review Accreditation Commission and screening criteria that take into account professionally acceptable standards for quality medical care in the community. EGID shall consider all relevant information concerning the Member before a determination is made regarding whether the service is Medically Necessary.

7.5 EGID shall respond to requests for all Certifications by immediately assigning a code number to each request.

7.6 At the time of the Certification request the Facility should be prepared to give the following information:

a) Member's name and identification number,
b) age and sex,
c) diagnosis,
d) reason for admission,
e) scheduled date of admission,
f) planned procedure or surgery,
g) scheduled date of surgery or procedure,
h) name of Facility,
i) name of physician, and
j) Member status (i.e., employee or dependent).

7.7 EGID shall not retrospectively deny any previously approved care. The Facility shall update EGID as the Member's condition or diagnosis changes. Updated information may result in a change of the originally approved length of stay.

7.8 Upon the Member's request, EGID shall reconsider any non-approved Medical Services. The Facility may submit a formal written appeal to EGID.

7.9 The Facility shall request Certification before the admission or referral of Members to non-network hospitals. EGID shall review Emergency referrals to non-network hospitals to determine whether the admission was Medically Necessary and an Emergency as defined in this Contract.

VIII. LIABILITY AND INSURANCE

8.1 Neither party to this Contract, EGID nor the Facility, or 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 Contract and the terms and provisions herein.

8.2 The Facility shall be required to obtain general and medical liability coverage for claims of acts and omissions of the Facility and its employees and agents. Such coverage shall be maintained at a level of not less than that which is mandated by the state in which the facility is located or not less than One Million Dollars ($1,000,000) per incident, when the Facility is not regulated by statute. EGID shall be notified thirty (30) days prior to cancellation. If coverage is lost or reduced below specified limits, this Contract may be canceled by EGID.

IX. MARKETING, ADVERTISING AND PUBLICITY

9.1 EGID shall encourage its Members to use the services of the Network Facility.

9.2 EGID shall have the right to use the name, address, phone number and specialty of the Facility in a provider listing for purposes of informing Members and prospective Members of the identity of the Facility, and otherwise carrying out the terms of this Contract.

9.3 The Facility shall have the right to publicize its status as a Network Facility.

X. DISPUTE RESOLUTION

10.1 The Facility may participate in the Dispute Resolution Process as established by EGID and detailed in the provider manual. Permitted Facility disputes include: clean claims; untimely claim submission; disagreements in regard to the amount paid on a claim; clinical editing; medical necessity; Certification; and other disagreements relating to contractual provisions and issues. Issues not subject to the Dispute Resolution Process include, but are not limited to: Rights beyond the HealthChoice Plan's obligation to Members; EGID's Allowable Fee; coordination of benefits; application of Member co-payments, coinsurance, and deductibles; plan coverage and exclusions; and issues and disputes initiated by Members as a result of the Member's grievance hearing rights, established by 74 O.S. (2001) § 1306(6), which is the Member's exclusive remedy by law. In order to initiate the Dispute Resolution Process, Facilities shall contact EGID. Nothing in this Article shall interfere with either party's rights under Article XI.

XI. TERM AND TERMINATION

11.1 The termination notice required by the terms of this Contract, shall be provided in writing and (1) mailed by the United States Postal Service (USPS), postage prepaid, certified mail, return receipt requested; or, (2) delivered by an overnight delivery company with written delivery confirmation; or, (3) hand delivered with written delivery confirmation. Notice to EGID shall be to the attention of Network Management, 3545 N.W. 58th, Suite 600, Oklahoma City, Oklahoma 73112. Notice to the Facility shall be to the address listed on the HealthChoice Network Facility Contract Signature Page or the mailing address on record. The notice shall be effective on the date indicated on the return receipt or written delivery confirmation

11.2 Either party may terminate this Contract with or without cause, upon giving thirty (30) days written notice pursuant to 12.2 at any time during the term of this Contract.

11.3 Nothing in this Contract shall be construed to limit either party's remedies at law or in equity in the event of a material breach of this Contract.

11.4 Following termination of this Contract, EGID shall continue to have access, at no cost, to the Facility's records of care and services provided to Members for five (5) years from the date of provision of the Medical Services to which the records refer.

11.5 This Contract shall terminate with respect to a Facility upon:

a) the loss or suspension of the Facility's license to operate in the state of residence, The Joint Commission's or Medicare certification; or
b) failure to maintain Facility's professional and general liability coverage in accordance with this Contract;
c) insolvency of either party.

XII. GENERAL PROVISIONS

12.1 This Contract 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.

12.2 At any place within this Contract that notice is required, it is the intention of the parties that only

those with regard to termination by either party of participation in the Contract must be sent by certified mail, a return receipt requested, at no other time when notice is required by this Contract is there an obligation by either party to use certified mail. The Network Newsletter serves as the primary method by which providers receive all other notifications mandated by the terms of the provider contracts. These notices from EGID may be sent via electronic newsletters distributed electronically to each Network Provider's correspondence email address. Printed newsletters are sent via the postal service to the mailing address on record for providers without internet access or those who have undeliverable email addresses.

12.3 Notwithstanding the provisions in Section 12.1, EGID may designate an administrator to administer any of the terms of this Contract.

12.4 This Contract is the agreement between EGID and the Facility relating to the rights granted and the obligations assumed by the parties concerning the provision of Facility Services to Members. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Contract, not expressly set forth in this Contract, are of no force or effect.

12.5 This Contract, or any part or section of it, may be amended at any time during the term of the Contract by mutual written consent of duly authorized representatives of EGID and the Facility in accordance with 12.2.

12.6 This Contract is subject to all applicable Oklahoma State Statutes and Rules codified at the Oklahoma Administrative Code. Any provision of this Contract, which is not in conformity with existing or future legislation, shall be considered amended to comply with such legislation. Any interpretations or disputes with respect to contract provisions shall be resolved in accordance with the laws of the State of Oklahoma.

12.7 The terms and provisions of this Contract 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 Contract, or any one provision, in accordance with the intent and purpose of the parties hereto.

12.8 EGID and the Facility agree that this Contract may be formed according to the Oklahoma Uniform Electronic Transactions Act, 12A O.S. § 15-101 et seq. (Act). The Facility acknowledges that the Contract terms are located in HCLTACFCv2.2 at https://omes.ok.gov/services/healthchoice/providers/contracts-and-applications and after downloading the Contract, and submitting the completed Application, signed and returned the Signature Page to EGID, EGID will note its approval on the Signature Page and return to the Facility. The Contract terms, Application, Signature page and any required information submitted by the Facility are records that may be stored as EGID electronic records under the Act.

12.9 All Providers certify that neither they nor their principals are presently debarred or suspended or otherwise ineligible according to the Excluded Parties List System (EPLS)/Office of Inspector General (OIG) excluded provider lists.

HealthChoice

Network Provider Facility Credentialing Information
Contract/Application

HealthChoice requires all three addresses on the respective pages of the application.

1. **Service Address** – This address is used for the location where health care services are performed and/or the physical location of the provider. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all HealthChoice Network Providers.

2. **Mailing Address** – Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

3. **Billing Address** – This address is used for submitting all claims to HealthChoice for processing and appears in box 33 of the CMS-1500 claim form or box 2 on the UB-04. If box 2 is not used by the facility, the billing address appears in Box 1 of the UB-04. Claims will be paid exclusively to the billing address.

Each address must have a corresponding phone number, email address, fax number and contact person.

Insurance Certificate/Face Sheet must have name of the applicant listed as the insured. The insurance limits must be at the levels required in the contract and must indicate clearly the coverage type(s) stated in the contract. Product liability coverage in lieu of professional/medical liability is acceptable for DME only.

W-9 forms must be signed and list only the Tax ID number for each location listed on the application which will be used on claim forms

Please return entire application packet with the new information.

Claim information is available through the Medical and Dental Claims Administrator Web Site HealthChoice Connect at http://www.healthchoiceconnect.com/. Go to Provider Login, then New Provider Registration to register for a user ID and password.

HealthChoice

Network Facility
Application Requirements

Thank you for your interest in the HealthChoice Provider Network.

Please complete the attached Application and submit with the required attachments listed below.

Complete all sections of the application. If an area of inquiry is not applicable to the facility, please indicate. If you need additional space to provide complete answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

Retain the Contract for your records.

REQUIRED ATTACHMENTS

Please attach a copy of each of the following documents to your completed Application:

- ☐ **Current state(s) license(s)**
- ☐ **Face Sheet of current general and medical liability insurance policy**
  Insurance Certificate/Face Sheet must have the name or the Facility listed as the insured. The insurance limits must be at the levels in the Contract and must indicate clearly that it is general and medical liability coverage.
- ☐ **W-9 form for each Federal Tax Identification Number**
  W-9 forms must be signed and list only the Federal Tax Identification Number listed on the Application which will be used on claim forms submitted to HealthChoice.
- ☐ **Contract Signature Page**
- ☐ **Copy of Medicare Certification Letter**
- ☐ **Copy of TJC, AAAHC, or CARF Accreditation (if applicable)**

Incomplete applications will be returned.

HealthChoice

Network Facility Application

The completed Network Facility Application should be returned to the Office of Management and Enterprise Services Employees Group Insurance Division in its entirety, accompanied by the applicable attachments. You may mail, fax or email the completed application to:

Office of Management and Enterprise Services
Employees Group Insurance Division
ATTN: Network Management
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112
Phone: 1-405-717-8790 or 1-844-804-2642
Fax: 1-405-717-8977
EGID.NetworkManagement@omes.ok.gov

General Information

Legal Name of Owner: _____

Trade Name/DBA: _____

Medicare Facility Classification: _____ Medicare Number: _____

License Information

State: _____

License Number: _____

Expiration Date: _____

A copy of facility license is required for each state of practice.

Accreditation

Is this Facility accredited by The Joint Commission: ☐Yes ☐No

The Joint Commission Program ID Number: _____

Date of most current accreditation: _____ Expiration Date: _____

Is this Facility accredited by the AAAHC? ☐Yes ☐No

Date of most current accreditation: _____ Expiration Date: _____

Is this Facility accredited by CARF? ☐Yes ☐No

Date of most current accreditation: _____ Expiration Date: _____

Insurance Information

Copy of Insurance Certificate/face sheet is required.

Please provide the following information about the Facility's current general and medical liability insurance coverage.

Name of Carrier: _____

Limits of General and Medical Liability Per Occurrence: _____ Expiration Date: _____

Important Facility Contacts

CEO/Administrator: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

CFO: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Credentialing Contact: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Address Information

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 form for each Federal Tax ID number.

Physical Address – physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: _____

_____

City State ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing Address

Mailing Address: _____

_____

City State ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing contact information, if listed, will be utilized for all legal, contractual notices as defined in section 11.2 or 12.2 of the facility contracts. An email address must be included for this contact in order to access the online fee schedules. All notices will be sent electronically.

Billing/Remit Address – for claims payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

_____

City State ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Additional Location

Federal Tax ID Number: _____ National Provider Identification: _____

Attach a completed W9 form for each Federal Tax ID number.

Physical Address – physical location of the Facility

THIS ADDRESS AND PHONE NUMBER WILL APPEAR ON THE WEBSITE PROVIDER DIRECTORY.

Physical Address: _____

_____

City State ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Mailing Address- for correspondence/credentialing

Mailing Address: _____

_____

City State ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Billing/Remit Address – for claims payments and remittance statements

ALL BILLING INFORMATION BELOW MUST MATCH THE INFORMATION REFLECTED ON THE CLAIMS SUBMITTED.

Name Submitted on Claims: _____

Billing Office Name (if applicable): _____

Billing Address: _____

_____

City State ZIP

Phone: _____ Fax: _____

Contact Person: _____

Email Address: _____

Please use copies of these pages to report any additional locations.

HealthChoice

Network Long-Term Acute Care Facility
Contract Signature Page

The Office of Management and Enterprise Services Employees Group Insurance Division (EGID), and the facility incorporate by reference the terms and conditions of the Network Facility Contract into this Signature Page. EGID and the facility further agree that the effective date of the contract is the effective date denoted on the copy of the executed signature page returned to the facility. The original of the signed document will remain on file in the office of EGID.

FOR THE FACILITY:

_____
Legal Name of Owner (Typed or Printed)

_____
Trade Name/DBA (Typed or Printed)

_____
Federal Tax ID Number

Address of the Facility:

_____

_____

_____
Authorized Officer or Representative (Typed or Printed)

_____
Title

_____
Signature

_____
Signature Date

FOR EGID:

_____
Paul S. King
Deputy Administrator
Employees Group Insurance Division

Please return the completed Application, Signature Page, and required attachments to:
Office of Management Enterprise Services
Employees Group Insurance Division
ATTN: Network Management
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112
Phone: 405-717-8790 or 844-804-2642
Fax: 405-717-8977
EGID.NetworkManagement@omes.ok.gov