



Plan Code: 2540

**AirMedCare Network Group Full Census Membership
For Wise County**

Organization: Wise County
Mailing Address: PO Box 899
 Decatur, TX 76234
Contact: JD Clark
Phone: 940-627-3341
Email: hr@co.wise.tx.us
County: Wise

Membership Sales Manager/Base: Brittani Countryman / Base #068

Participants:

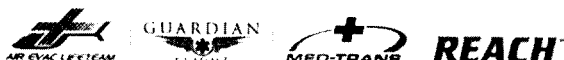
1. The Organization is paying AirMedCare Network the fees shown below so the individuals (Participants) listed on the attached Participant List can be members of AirMedCare Network, an alliance of affiliated air ambulance providers *(each a "Company") as provided in this Agreement.
 - o A Participant must be actively affiliated with the Organization (as a member, director, officer, employee or similar relationship) as indicated on the Participant List when the fee for such Participant is paid.
2. For annual payment plans, the Organization may later add a Participant by providing AirMedCare Network with an updated census list

Fees and Payment:

No. of Participants in Initial Group	<u>Annual Rate</u>	<u>Total</u>
Census Slots	\$ 60.00	\$ -
	Total	<u>\$ -</u>

General Provisions:

1. Participant memberships will be effective upon AirMedCare Network' receipt of (a) this Agreement signed by the Organization, (b) payment as provided above and (c) monthly employee census list completed by the Participants/Company. Memberships will automatically expire for an employee at the time they are no longer employed with the company. No refunds.
2. AirMedCare Network agrees that Participant Lists (a) will be used by AirMedCare Network only for the purpose of delivering AirMedCare Network services, (b) will be treated like any other AirMedCare Network confidential information and (c) will not be used, sold or shared with any third party inconsistent with this provision.
3. This membership plan will be effective for 12 months, effective as of 10-1-2020, and will be evaluated by both parties annually at least 30 days prior to anniversary date, if (a) no termination notice has been sent by either party and (b) payment for the renewal period is received by AirMedCare Network before expiration of the grace period. Either party may terminate this Agreement at any time and for any reason with 30 days prior written notice to the other party, but termination will not affect issued memberships.





Terms and Conditions

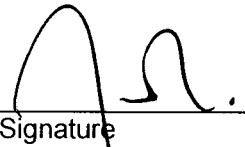
AirMedCare Network is an alliance of affiliated air ambulance providers* (each a "**Company**"). An AirMedCare Network membership automatically enrolls you as a member in each Company's membership program. Membership ensures the patient will have no out-of-pocket flight expenses if flown by a Company by providing prepaid protection against a Company's air ambulance costs that are not covered by a member's insurance or other benefits or third party responsibility, subject to the following terms and conditions:

1. Patient transport will be to the closest appropriate medical facility for medical conditions that are deemed by AMCN Provider attending medical professionals to be life- or limb-threatening, or that could lead to permanent disability, and which require emergency air ambulance transport. A patient's medical condition, not membership status, will dictate whether or not air transportation is appropriate and required. Under all circumstances, an AMCN Provider retains the sole right and responsibility to determine whether or not a patient is flown.
2. AMCN Provider air ambulance services may not be available when requested due to factors beyond its control, such as use of the appropriate aircraft by another patient or other circumstances governed by operational requirements or restrictions including, but not limited to, equipment manufacturer limitations, governmental regulations, maintenance requirements, patient condition, age or size, or weather conditions. FAA restrictions prohibit most AMCN Provider aircraft from flying in inclement weather conditions. The primary determinant of whether to accept a flight is always the safety of the patient and medical flight crews. Emergent ground ambulance transport of a member by an AMCN Provider will be covered under the same terms and conditions.
3. Members who have insurance or other benefits, or third party responsibility claims, that cover the cost of ambulance services are financially liable for the cost of AMCN Provider services up to the limit of any such available coverage. In return for payment of the membership fee, the AMCN Provider will consider its air ambulance costs that are not covered by any insurance, benefits or third party responsibility available to the member to have been fully prepaid. The AMCN Provider reserves the right to bill directly any appropriate insurance, benefits provider or third party for services rendered, and members authorize their insurers, benefits providers and responsible third parties to pay any covered amounts directly to the AMCN Provider. Members agree to remit to the AMCN Provider any payment received from insurance or benefit providers or any third party for air medical services provided by the AMCN Provider, not to exceed regular charges. Neither the Company nor AirMedCare Network is an insurance company. Membership is not an insurance policy and cannot be considered as a secondary insurance coverage or a supplement to any insurance coverage. **Neither the Company nor AirMedCare Network will be responsible for payment for services provided by another ambulance service.**
4. Membership starts 15 days after the Company receives a complete application with full payment; however, the waiting period will be waived for unforeseen events occurring during such time. Members must be natural persons. Memberships are non-refundable and non-transferable.
5. Some state laws prohibit Medicaid beneficiaries from being offered membership or being accepted into membership programs. By applying, members certify to the Company that they are not Medicaid beneficiaries.
6. These terms and conditions supersede all previous terms and conditions between a member and the Company or AirMedCare Network, including any other writings, or verbal representations, relating to the terms and conditions of membership.

*Air Evac EMS, Inc. / Guardian Flight, LLC / Med-Trans Corporation / REACH Air Medical Services, LLC -- These terms and conditions apply to all AirMedCare Network participating provider membership programs, regardless of which participating provider transports you.



Agreed to by:



Signature

JD Clark

Printed Name

County Judge

Title

Wise County

Organization Name

11-2-2020

Date

Keith Hovey

Signature

Keith Hovey

Printed Name

Vice President

Title

Membership

Division

10/27/2020

Date

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

1 of 1

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

OFFICE USE ONLY CERTIFICATION OF FILING

Certificate Number:
2020-681346

Date Filed:
10/21/2020

Date Acknowledged:
11-2-2020

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.
Air Evac Lifeteam
OFallon, MO United States

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.
Wise County

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.
2540
Offering membership coverage for air ambulance transports provided by an AirMedCare Network provider. Local provider is Air Evac Lifeteam.

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary
	Preissler, Michael	Lewisville, TX United States	X	
	Van Horne, Ted	Greenwood Village, CO United	X	
	Owen, Randy	Greenwood Village, CO United	X	
	Myers, Seth	OFallon, MO United States	X	

5 Check only if there is NO Interested Party.

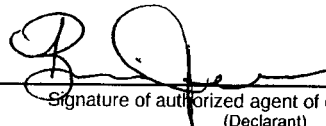
6 UNSWORN DECLARATION

My name is Brandi Jordan, and my date of birth is 3/7/85.

My address is 4408 CR 7100 West Plains MO 65775 USA
(street) (city) (state) (zip code) (country)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Howell County, State of Missouri, on the 22 day of Oct, 2020.
(month) (year)


Signature of authorized agent of contracting business entity (Declarant)