AMENDMENT

This Amendment is made as of January 1, 2022 (Amendment Effective Date), between Aetna Health Inc., a Pennsylvania corporation, on behalf of itself and its Affiliates (hereinafter referred to as "Company") and Beth Israel Deaconess Medical Center, (hereinafter referred to as "Provider").

WHEREAS, the parties have entered into a Hospital Services Agreement ("Agreement") to provide health care services to Members;

WHEREAS, the parties wish to amend the Agreement as provided herein;

NOW, THEREFORE, in consideration of the mutual promises and undertakings contained herein, the parties agree to be legally bound as follows:

1. The Hospital Services Compensation Schedule of the Agreement is hereby deleted in its entirety and is hereby replaced with the Hospital Services Compensation Schedule attached hereto and made a part hereof.

2. The Urgent Care Center Service and Compensation Schedule of the Agreement is hereby deleted in its entirety and is hereby replaced with the Urgent Care Center Service and Rate Schedule attached hereto and made a part hereof.

3. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed below.

Accepted By:

PROVIDER

By: Deborah Devaux
Deborah Devaux (Dec 8, 2021 17:20 EST)

Printed Name: Deborah Devaux

Title: President, BILH Performance Network

Date: Dec 8, 2021

FEDERAL TAX I.D. NUMBER: 04-2103881

COMPANY

By: Colin E. McCarthy
Colin E. McCarthy (Jan 21, 2022 08:49 EST)

Printed Name: Colin E. McCarthy

Title: Network Market Head – Massachusetts

Date: Jan 21, 2022

HOSPITAL SERVICES
COMPENSATION SCHEDULE

INPATIENT RATES:

Service	Billing Codes	Rates
Intensive Care: MICU/SICU/PICU/CCU	**Revenue Codes:** 200, 201, 202, 203, 207, 208, 209, 210, 211, 212, 213, 219	$5949.00 Per Diem
Intermediate Care: (Step Down or Telemetry)	**Revenue Codes:** 206, 214	$4642.00 Per Diem
Medical Care	**Revenue Codes:** 100, 101, 110, 111, 112, 113, 117, 119, 120, 121, 122, 123, 127, 129, 130, 131, 132, 133, 137, 139, 140, 141, 142, 143, 147, 149, 150, 151, 152, 153, 157, 159, 160, 164, 167, 169	$4374.00 Per Diem (DAYS 0-1)
Surgical Care	**Revenue Codes:** 100, 101, 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 140, 141, 143, 147, 149, 150, 151, 153, 157, 159, 160, 164, 167, 169 **And** **Revenue Codes:** 360, 361, 362, 367, 369, 480, 481, 750, 790	$5802.00 Per Diem (DAYS 0-1)
Medical Care	**Revenue Codes:** 100, 101, 110, 111, 112, 113, 117, 119, 120, 121, 122, 123, 127, 129, 130, 131, 132, 133, 137, 139, 140, 141, 142, 143, 147, 149, 150, 151, 152, 153, 157, 159, 160, 164, 167, 169	$4374.00 Per Diem (DAYS 2-999)
Surgical Care	**Revenue Codes:** 100, 101, 110, 111, 113, 117, 119, 120, 121, 123, 127, 129, 130, 131, 133, 137, 139, 140, 141, 143, 147, 149, 150, 151, 153, 157, 159, 160, 164, 167, 169 **And** **Revenue Codes:** 360, 361, 362, 367, 369, 480, 481, 750, 790	$5199.00 Per Diem (DAYS 2-999)
Acute Rehab I	**Revenue Codes:** 118, 128, 138, 148, 158	Not Reimbursed

HOSPITAL SERVICES
COMPENSATION SCHEDULE

Nursery: Level I	**Revenue Codes:** 170, 171, 179	$1743.00 Per Diem
Nursery : Level II and III	**Revenue Codes:** 172, 173	$3487.00 Per Diem
Nursery: Level IV	**Revenue Codes:** 174	$5942.00 Per Diem
Skilled Care: Level I - Skilled Care Level II - Comprehensive Care	**Revenue Codes:** 190, 191, 192, 199	$1306.00 Per Diem
Sub-Acute Care: (Alternative Deliv) Level III-Complex Level IV-Intensive	**Revenue Codes:** 193, 194	$1746.00 Per Diem
Psychiatric Care	**Revenue Codes:** 114, 124, 134, 144, 154, 204	$1743.00 Per Diem
Inpatient Detoxification Services	**Revenue Codes:** 116, 126, 136, 146, 156 or 118, 128, 138, 148, 158, and Behavioral Health Rehab ICD-10 codes or HCPCS codes: H0008-H0011	Not Reimbursed
Maternity Care: Vaginal delivery incl newborn charges for Nursery Lev. 1 (Includes normal newborn)	**Revenue Codes:** 100, 101, 110, 111, 112, 120, 121, 122, 130, 131, 132, 140, 141, 142, 150, 151, 152, 160; ICD-10 Procedure codes: 10D07Z3 - 10D07Z8, 10E0XZZ	$3989.00 Per Diem
Maternity Care: C-Section delivery incl newborn charges for Nursery Lev. 1 (Includes normal newborn)	**Revenue Codes:** 100, 101, 110, 111, 112, 120, 121, 122, 130, 131, 132, 140, 141, 142, 150, 151, 152, 160: ICD-10 Procedure codes: 10D00Z0 - 10D00Z2	$4499.00 Per Diem

INPATIENT CARVE OUT RATES:

Service	Billing Codes	Rates
Med Record Copy Admin	**HCPC Codes:** S9981	$14.37 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Med Record Copy Per Page	**HCPC Codes:** S9982	$0.60 Per Unit Paid In Addition to Other Negotiated Rates

HOSPITAL SERVICES
COMPENSATION SCHEDULE

Cardiac Valve & Oth Maj Car	**DRG Codes:** 216, 217, 218	$100846.00 Case Rate (DAYS 0-22)
Cardiac Defib Implant	**DRG Codes:** 222, 223, 224, 225	$100846.00 Case Rate (DAYS 0-22)
Cardiac Valve & Oth Maj Card	**DRG Codes:** 219, 220, 221	$98271.00 Case Rate (DAYS 0-19)
Cardiac Defibrillator Implan	**DRG Codes:** 226, 227	$98271.00 Case Rate (DAYS 0-19)
Coronary Bypass W Ptca W Mcc	**DRG Codes:** 231, 232	$78790.00 Case Rate (DAYS 0-18)
Coronary Bypass W Cardiac	**DRG Codes:** 233, 234	$78790.00 Case Rate (DAYS 0-18)
Other Cardiothoracic Proc	**DRG Codes:** 228, 229	$98737.00 Case Rate (DAYS 0-18)
Coronary Bypass W/o Cardiac	**DRG Codes:** 235, 236	$68527.00 Case Rate (DAYS 0-12)
Perc Cardiovasc Proc	**DRG Codes:** 248, 249-251, 273, 274	$33395.00 Case Rate (DAYS 0-7)
Perc Cardiovasc Proc W Drug	**DRG Codes:** 246, 247	$33395.00 Case Rate (DAYS 0-7)
Permanent Cardiac Pacemaker	**DRG Codes:** 242, 243-245	$40656.00 Case Rate (DAYS 0-7)
Circulatory Disorders	**DRG Codes:** 286	$17709.00 Case Rate (DAYS 0-5)
Circulatory Disorders	**DRG Codes:** 287	$11029.00 Case Rate (DAYS 0-7)
Checkout For Orthotic/prosth	**CPT4 Codes:** 97763	$48.29 Per Unit
All Transplant Procedures And Services	**CPT4 Codes:** 32850-32854, 33930, 33933, 33935, 33940, 33944, 33945, 38230, 38240, 47133, 47143-47147, 48550, 48551, 48552, 48554, 48556, 50300, 50320, 50323, 50325, 50327-50329, 50340, 50360, 50365, 50370, 50380	Negotiated Case Rate

HOSPITAL SERVICES
COMPENSATION SCHEDULE

	DRG Codes: 001-002, 005-006, 007, 008, 652	
Electroconvulsive Therapy	**CPT4 Codes:** 90870 **Revenue Codes:** 901	$243.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Implants/Prosthetics > or = $500	**Revenue Codes:** 274, 275, 278	103% Billed Charges Paid In Addition to Other Negotiated Rates for a listed individual billing code only, when the sum of the listed individual billing code claim lines is greater than $499.99. Otherwise deny.

OUTPATIENT RATES:

Service	Billing Codes	Rates
Ambulatory Surgery - Aetna Enhanced Groupers: Category 1	**Aetna Enhanced Groupers**	$2039.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 2	**Aetna Enhanced Groupers**	$2825.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 3	**Aetna Enhanced Groupers**	$4271.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 4	**Aetna Enhanced Groupers**	$4944.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 5	**Aetna Enhanced Groupers**	$5997.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 6	**Aetna Enhanced Groupers**	$7062.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 7	**Aetna Enhanced Groupers**	$8163.00 Case Rate
Ambulatory Surgery - Aetna Enhanced Groupers: Category 8	**Aetna Enhanced Groupers**	$8315.00 Case Rate
Ambulatory Surgery: Default Rate	All surgical procedures not otherwise identified	$4944.00 Case Rate
Emergency Care - Level I	**CPT4 Codes:** 99281	$274.00 Case Rate

HOSPITAL SERVICES
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Emergency Care - Level II	**CPT4 Codes:** 99282	$538.00 Case Rate
Emergency Care - Level III	**CPT4 Codes:** 99283	$740.00 Case Rate
Emergency Care - Level IV	**CPT4 Codes:** 99284	$805.00 Case Rate
Emergency Care - Level V	**CPT4 Codes:** 99285	$881.00 Case Rate
Chemotherapy	**CPT4 Codes:** 51720, 96401-96542 **HCPC Codes:** Q0083, Q0084, Q0085	$279.00 Once Per Unique Code Per Service Date
Sleep Studies	**CPT4 Codes:** 95782, 95783, 95800, 95801, 95805, 95806, 95807, 95808, 95810, 95811 **HCPC Codes:** G0398, G0399, G0400	77% Billed Charges
Laboratory Services	**CDT Codes:** D0416, D0431, D0475, D0476, D0477, D0478, D0479, D0481, D0482, D0483 **CPT4 Codes:** 0002M-0018M, 0001U-0247U, 0248U-0259U, 0270U-0279U, 0058T, 0085T, 0111T, 0423T, 0443T, 0500T, 0564T, 58323, 80047-89356, 89398, 96902 **HCPC Codes:** C9803, G0027, G0103, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, G0306, G0307, G0327-G0328, G0416, G0432, G0433, G0435, G0452, G0472, G0475, G0476, G0480, G0481, G0482, G0483, G0499, G0659, G9143, H0003, H0049, P2028, P2029, P2031, P2033, P2038, P3000, P3001, P7001, Q0111, Q0112, Q0113, Q0114, Q0115, S3620, S3630, S3645, S3650, S3652, S3655, S3722, S3800, S3840, S3841, S3842, S3844, S3845, S3846, S3849,	77% Billed Charges

HOSPITAL SERVICES
COMPENSATION SCHEDULE

	S3850, S3852, S3853, S3854, S3861, S3865, S3866, S3870, U0001-U0005	
Radiology Services	**CPT4 Codes:** 0348T, 0349T, 0350T, 0351T, 0352T, 0353T, 0354T, 0469T, 0470T, 0471T, 0508T, 0546T, 0547T, 0554T, 0555T, 0556T, 0557T, 0558T, 0559T, 0560T, 0561T, 0562T, 0602T, 0603T, 0604T, 0605T, 0606T, 0607T, 0608T, 0609T, 0610T, 0611T, 0612T, 0615T, 0623T, 0624T, 0625T, 0626T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0640T, 0641T, 0642T, 0648T, 0649T, 0650T, 0651T, 0658T, 70010-79999	77% Billed Charges
Physical, Occupational and Speech Therapy	**CPT4 Codes:** 92507-92508, 92521, 92522, 92523, 92524, 97010-97546, 97763	77% Billed Charges
All Other Outpatient		77% Billed Charges

OUTPATIENT CARVE OUT RATES:

Service	Billing Codes	Rates
Med Record Copy Admin	**HCPC Codes:** S9981	$14.37 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Med Record Copy Per Page	**HCPC Codes:** S9982	$0.60 Per Unit Paid In Addition to Other Negotiated Rates
Global Electromyography	**CPT4 Codes:** 95860 **Including CPT4 Codes:** 95861, 95863, 95864, 95925	$354.00 Once Per Unique Code Per Service Date
Electrocardiogram, Complete	**CPT4 Codes:** 93000	$89.19 Per Unit

HOSPITAL SERVICES
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Cardiovascular Stress Test	**CPT4 Codes:** 93015	$366.00 Per Unit
Global Stress Thallium Testing	**CPT4 Codes:** 78451, 78452, 78453, 78454, 78466 **Including** **CPT4 Codes:** 78472, 78473, 93016, 93017, 93018 **CPT4 Codes:** 78451, 78452, 78453, 78454, 78466 **Including** **HCPC Codes:** A4641, A9500, A9505 **CPT4 Codes:** 78466 **Including** **CPT4 Codes:** 78478, 93015	$1389.00 Once Per Unique Code Per Service Date
Echo Exam Of Heart	**CPT4 Codes:** 93307	$413.00 Per Unit
Echo, Real-time(2d);limited	**CPT4 Codes:** 93308	$205.00 Per Unit
Echo Transesophageal6	**CPT4 Codes:** 93312	$541.00 Per Unit
Echo Transesophageal2	**CPT4 Codes:** 93313	$176.00 Per Unit
Echo Transesophageal4	**CPT4 Codes:** 93314	$366.00 Per Unit
Doppler Echo Exam, Heart	**CPT4 Codes:** 93320	$276.00 Per Unit
Doppler Color Flow Add-on	**CPT4 Codes:** 93325	$59.46 Per Unit
Echo Transthoracic	**CPT4 Codes:** 93350	$586.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93880	$461.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:**	$358.00 Per Unit

HOSPITAL SERVICES
COMPENSATION SCHEDULE

	93882	
Transcranial Doppler Study	**CPT4 Codes:** 93886	$531.00 Per Unit
Transcranial Doppler--f/u	**CPT4 Codes:** 93888	$437.00 Per Unit
Cardiac Catheterization	**HCPC Code:** C9758, C9760, G0448 **Includes:** CPT4 Codes: 93563-93568 **CPT4 Codes:** 0408T-0415T, 0543T-0545T, 0569T-0570T, 0613T, 0632T, 0643T-0646T, 33017-33019, 33289, 33340, 33477, 33745- 33746, 34717-34718, 93451-93462, 93503-93505, 93530-93533, 93590, 93591, 93592 **Includes:** CPT4 Codes: 93563-93568	$6451.00 Case Rate
High Complexity Cardiac Catheterization	**CPT4 Codes:** 92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944, 92986, 92990, 93799	$10553.00 Case Rate
Noninv Phys Studies-arteries	**CPT4 Codes:** 93922	$185.00 Per Unit
Noninvasive Physiologic Stud	**CPT4 Codes:** 93923	$349.00 Per Unit
Noninvasive Physiologic Stud	**CPT4 Codes:** 93924	$385.00 Per Unit
Non-invasive Vascular St/ic	**CPT4 Codes:** 93925	$364.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93926	$320.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93930	$353.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93931	$295.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93970	$383.00 Per Unit

HOSPITAL SERVICES
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Non-invasive Vascular Study	**CPT4 Codes:** 93971	$334.00 Per Unit
Vascular Study	**CPT4 Codes:** 93975	$424.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93976	$353.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93978	$378.00 Per Unit
Non-invasive Vascular Study	**CPT4 Codes:** 93979	$353.00 Per Unit
Penile Vascular Study	**CPT4 Codes:** 93980	$700.00 Per Unit
Penile Vascular Study	**CPT4 Codes:** 93981	$553.00 Per Unit
X-ray Exam Of Sinuses	**CPT4 Codes:** 70220	$122.00 Per Unit
X-ray Exam Chest Single View	**CPT4 Codes:** 71045	$78.37 Per Unit
Xray Exam Chest Two Views	**CPT4 Codes:** 71046	$100.00 Per Unit
X-ray Exam Of Lower Spine	**CPT4 Codes:** 72110	$144.00 Per Unit
X-ray Exam Of Shoulder	**CPT4 Codes:** 73030	$91.88 Per Unit
X-ray Exam Of Wrist	**CPT4 Codes:** 73100	$83.79 Per Unit
X-ray Exam Of Hand	**CPT4 Codes:** 73130	$83.78 Per Unit
X-ray Exam Of Knee	**CPT4 Codes:** 73562	$91.88 Per Unit
X-ray Exam Of Breast	**CPT4 Codes:** 77065-77067	$171.00 Per Unit
X-ray Exam Of Ankle	**CPT4 Codes:** 73610	$83.79 Per Unit

HOSPITAL SERVICES
COMPENSATION SCHEDULE

X-ray Exam Of Foot	**CPT4 Codes:** 73630	$83.79 Per Unit
Cat Scan Of Head Or Brain	**CPT4 Codes:** 70450	$636.00 Per Unit
Cat Scan Of Face, Jaw	**CPT4 Codes:** 70486	$685.00 Per Unit
Contrast X-ray Lower Spine	**CPT4 Codes:** 72265	$567.00 Per Unit
Basic Metabolic Panel	**CPT4 Codes:** 80048	$32.39 Per Unit
Comprehensive Metabolc Panel	**CPT4 Codes:** 80053	$35.16 Per Unit
Therapeutic Drug Assays	**CPT4 Codes:** 80178	$40.50 Per Unit
Urinalysis With Microscopy	**CPT4 Codes:** 81000	$13.49 Per Unit
Urinalysis	**CPT4 Codes:** 81005	$8.06 Per Unit
Bilirubin Total	**CPT4 Codes:** 82247-82248	$18.95 Per Unit
Assay Serum Iron	**CPT4 Codes:** 83540	$45.92 Per Unit
Hematocrit	**CPT4 Codes:** 85014	$24.33 Per Unit
Hemoglobin, Colorimetric	**CPT4 Codes:** 85018	$24.33 Per Unit
Blood Count	**CPT4 Codes:** 85032	$24.33 Per Unit
Basic Comprehensive Audiometry	**CPT4 Codes:** 92557 **Including** **CPT4 Codes:** 92553	$134.00 Once Per Unique Code Per Service Date
Breathing Capacity Test8	**CPT4 Codes:** 94010	$94.61 Per Unit

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Electroencephalogram (eeg)	**CPT4 Codes:** 95819	$312.00 Per Unit
Checkout For Orthotic/prosth	**CPT4 Codes:** 97763	$48.29 Per Unit
Us Exam, Pg Uterus, Compl	**CPT4 Codes:** 76805	$334.00 Per Unit
Each Additional Gestation (list Separately In Addition To 76805)	**CPT4 Codes:** 76810	$334.00 Per Unit
Us Exam, Pg Uterus Limit	**CPT4 Codes:** 76815-76816	$334.00 Per Unit
All Transplant Procedures And Services	**CPT4 Codes:** 32850-32854, 33930, 33933, 33935, 33940, 33944, 33945, 38230, 38240, 47133, 47143-47147, 48550, 48551, 48552, 48554, 48556, 50300, 50320, 50323, 50325, 50327-50329, 50340, 50360, 50365, 50370, 50380 **DRG Codes:** 001-002, 005-006, 007, 008, 652	Negotiated Case Rate
Chemotherapy (per Treatment)	**CPT4 Codes:** 36640, 96549	$279.00 Once Per Unique Code Per Service Date
All Other Drugs	**HCPC Codes:** A9520, A9575, A9586, C9081-C9082, C9084, C9462, C9482, C9488, J0120-J0593, J0595-J0885, J0887, J0888, J0895-J8999, J9030, J9032, J9036, J9039, J9144, J9210, J9223, J9271, J9281, J9299, J9308, J9316-J9317, J9356, Q0161, Q0243, Q0244-Q0245, Q0247, Q0249, Q2028, Q2041, Q2050, Q2054, Q3027, Q3028, Q4082, Q5101, Q5103-Q5106, Q5108, Q5109, Q5111, Q5120-Q5122, Q9950, Q9969, Q9991-Q9992	138% of Aetna Market Fee Schedule
Observation Services , for ER Services	**Revenue Codes:** 762	$2942.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Observation Services	**Revenue Codes:** 762	$2942.00 Once Per Unique Code Per Service

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		Date
Implants/Prosthetics > or = $500	**Revenue Codes:** 274, 275, 278	103% Billed Charges Paid In Addition to Other Negotiated Rates for a listed individual billing code only, when the sum of the listed individual billing code claim lines is greater than $499.99. Otherwise deny.
Global Fee Urgent Care Centers	**HCPC Codes:** S9083	Not Reimbursed
COVID-19 testing	**CPT4 Codes:** 0202U, 0223U, 0224U, 86318, 86328, 86769, 87426, 87635 **HCPC Codes:** C9803, G2023, G2024, U0001, U0002, U0003, U0004	101.1% of Medicare Physician Fee Schedule with GAP Codes Paid In Addition to Other Negotiated Rates
COVID-19 Vaccine Administration	**CPT4 Codes:** 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0021A, 0022A, 0031A, 0031A, 0041A, 0042A, 0064A	103% of Aetna Market Fee Schedule Paid In Addition to Other Negotiated Rates

PROFESSIONAL COMPONENTS:

Payment for professional services is not included in the rates specified in this Services and Compensation Schedule.

COMPENSATION TERMS AND CONDITIONS:

Definitions of Services:

The following service definitions are intended to help facilitate billing and payment between Hospital and Company. Payment will be based on the level of care authorized by Company following the Policies promulgated by Company pursuant to this Agreement.

1) **"Ambulatory Detoxification"** includes but not is limited to all services related to patient care, individual, family and/or group psychotherapy and consultative services for the treatment of substance abuse related disorders on an outpatient basis.

2) **"Ambulatory Surgery"** includes all items, services and pre-admission services and pre-procedure testing necessary to perform same day surgery or ambulatory surgery in an operating room or ambulatory surgery suite. Rates for Categories 6 and 8 are inclusive of intraocular lenses.

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3) **"Cardiac Testing, Cardiac Catheterization, and Other Cardiovascular Services (outpatient)"** includes technical component of diagnostic procedures and pre-procedure testing, all injections and all related lab services.

4) **"Chemotherapy" (outpatient only)** includes pre-procedure testing and the administration of chemotherapeutic agents.

5) **"Detoxification"** includes pre-admission services and all services related to patient care including semi-private accommodations.

6) **"Emergency Care"** includes all services and covered items related to patient care rendered as a result of an emergency room visit.

7) **"Intermediate Care (Step Down or Telemetry)"** includes charges for medical or surgical care provided to patients requiring telemetry services but no longer require intensive care nursing. Rates include all items included in Medical/Surgical Care and, in addition, such items and services as are normally and usually provided by the Hospital in conjunction with patients in its intermediate care (step down or telemetry) unit.

8) **"Intensive Care"** includes charges for medical or surgical care provided to patients who require a more intensive level of care, including coronary care, than is rendered in the general medical or surgical unit, or in the Intermediate Care (Step Down or Telemetry). Rates include all items included in Medical/Surgical Care and in addition, such items and services as are normally and usually provided by the Hospital in conjunction with patients in its intensive care and/or infant intensive care and/or coronary care units.

9) "**Intensive Outpatient"** Planned and structured program at least 2 hours per day or six hours per week; Services are designed to address a mental or a substance-related disorder and could include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

10) **"Maternity Care"** includes charges for services provided to patients for the purpose of delivering a baby. Rates include pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy and all other ancillary services incidental to the admission including all professional services billed by hospital.

11) **"Medical/Surgical Care"** includes charges for medical or surgical care provided in the general medical or surgical unit, when the level and complexity of clinical services required by Member exceed those for Sub-Acute (Alternative Delivery Care). Rates are inclusive of all services; these include but are not limited to pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy; blood derivatives, blood product acquisition, processing and administration charges; and all other ancillary services incidental to the admission including professional services billed by the hospital.

12) **"Nursery"** includes accommodation charges for nursing care to newborn and premature infants in nurseries. Rates include room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy and all other ancillary services incidental to the admission including professional services billed by the hospital. Distinct levels of nursery care are defined as follows:

Level I: "Newborn Nursing"
Routine care of apparently normal full-term or pre-term neonates.

Level II: "Continuing Care"
Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing per day than do normal neonates.

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Level III: "Intermediate Care"
Sick neonates who do not require intensive care, but require 6-12 hours of nursing each day.

Level IV: "Intensive Care"
Constant nursing and continuous cardiopulmonary and other support for severely ill neonates and infants.

13) **"Observation / Treatment Room"** includes use of a treatment room; or room charge associated with outpatient observation services, which are furnished by the hospital on the hospital's premises, including use of a bed, supplies, and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services must be ordered by a physician. The reason for observation must be stated in the orders for observation.

14) **"Partial Hospitalization (Day Hospital Treatment)"** includes all services and all related services such as physician, psychologist, counselor and trained staff services; individual, group and family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines. Medically supervised, day, evening and/or night treatment programs; Services are provided at least 4 hours a day, at least 3 days per week. Services are designed to address a mental health and/or substance related disorder through an individualized treatment plan provided by a coordinated multidisciplinary treatment team. Program must be licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority.

15) **"Psychiatric Care"** includes pre-admission services, room and board and related services; physician, psychologist, nurse, counselor and trained staff services; individual, group and family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use including electroconvulsive therapy and supplies; and all ancillary services performed at or arranged by Hospital.

16) **"Rehabilitation Care"** includes charges for rehabilitation care provided to patients in a rehabilitation bed; patients must receive more than four hours of therapy per day at least five days a week. Rates include pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy and all other ancillary services incidental to the admission including professional services billed by the hospital.

17) **"Rehabilitation Care (Alcohol and Drug)"** includes but is not limited to charges for Alcohol and Drug rehabilitation care provided to patients in a rehabilitation bed. Rates include but are not limited to pre-admission testing, room and board, nursing care, equipment and supplies, laboratory, pharmacy and all other ancillary services incidental to the admission including professional services billed by the Facility.

18) **"Residential Care"** includes all services and related services to non-hospital 24 hour inpatient level of care that provides care for members with mental disorders as well as persons with substance-related disorders. Settings eligible for this level of care are licensed at the residential intermediate level or as an intermediate care facility. Requirements for this level of care include: On site, licensed behavioral Health professionals 24 hours per day; a comprehensive patient assessment preferably before admission, but at least upon admission, living arrangements that foster community living and peer interaction and are consistent with development needs; provision of group therapy sessions; ability to involve family/support systems in therapy; access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy; peer oriented activities; service which is managed by a licensed behavioral health professional who while not needing to be individually contracted, needs to meet the Aetna credentialing criteria as an individual practitioner, and who functions under the direction/supervision of a licensed psychiatrist (medical director); Individualized active treatment plan directed toward the alleviation of the impairment that caused the admission; level of skilled intervention consistent with patient risk; Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on-site or externally; 24 hour supervision with evidence of close and frequent observation; the availability of medical treatment, which must be actively supervised by an attending physician; on-site, licensed behavioral health, medical, or substance abuse professionals 24 hrs a day.

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19) **"Skilled Care"** includes charges for services provided to patients requiring inpatient skilled nursing care. Rates include pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy and all other ancillary services incidental to the admission including professional services billed by the hospital. Skilled Care includes all levels of care as defined below:

Level I – [Skilled Care]:
Minimal nursing intervention. Comorbidities do not complicate treatment plan. Assessment of vitals and body systems required 1-2 times per day.

Level II – [Comprehensive Care]:
Moderate nursing intervention. Active treatment of comorbidities. Assessment of vitals and body systems required 2-3 times per day.

20) **"Sub-Acute Eligible Care" / "Alternate Delivery Care"** ["Alternate Delivery Care"] includes charges for services provided to patients requiring inpatient sub acute care. Rates include pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy and all other ancillary services incidental to the admission including professional services billed by the hospital. Sub-Acute Eligible Care includes all levels of Skilled Care as defined below:

Level III – [Complex Care]:
Moderate to extensive nursing intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect treatment plan. Assessment of vitals and body systems required 3-4 times per day.

Level IV – [Intensive Care] :
Extensive nursing and technical intervention. Active medical care and treatment of comorbidities. Potential for comorbidities to affect the treatment plan. Assessment of vitals and body systems required 4-6 times per day.

21) **"Trauma Activation"** Notification of key hospital personnel in response to triage information from prehospital caregivers in advance of the patient's arrival. Prehospital notification must meet local, state, or American College of Surgeon's field triage criteria, or are delivered via interhospital transfer and are given appropriate team response. Patients who are "drive by" or arrive without notification do not qualify for trauma activation charges.

Additional Definitions:

"Aetna Enhanced Groupers" Specific CPT4 procedure codes fall into Aetna designated procedural payment groups; procedures within the same group are paid at a single rate. Includes all codes in Medicare Groupers plus additional medical and surgical codes as determined by Aetna. Payment is based upon the then current Aetna Enhanced Groupers and includes all items, services and pre-procedure testing necessary to perform an outpatient Ambulatory Surgery or procedure in an operating room or ambulatory surgery suite.

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where service is performed. This fee schedule is updated annually.
"Medicare Physician Fee Schedule with GAP codes" (MFS)- A fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule

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(CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Fee schedule contains rates published by local carrier for services where CMS does not provide a rate. Fee schedule contains rates published by Company for services where CMS or local carrier do not provide a rate. Rates published by Company for these services are AWP for drugs and AMFS for all other services. Company plans to update the schedule within 60 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Aetna payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

"Gatekeeper products" – For purposes of this Service and Rate Schedule, Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which encourage or promote the use of a Primary Care Physician, regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or (ii) an individual Member has selected a Primary Care Physician. Examples of Gated Commercial Health Products include, but are not limited to: HMO (Health Maintenance Organization), POS (Point of Service) (e.g., Managed Choice POS, Aetna Choice POS II), EPO (Exclusive Provider Organization). In some circumstances, certain Commercial Health Products (e.g., FEHB plans, student health plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Non-Gatekeeper products" – For purposes of this Service and Rate Schedule, Non-Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which do not allow for the designation and/or use of a Primary Care Physician in the administration of the product. Examples of Non-Gated Commercial Health Products include, but are not limited to: PPO (e.g., Open Choice PPO), Aetna Signature Administrators®, Passport to Healthcare® and the National Advantage program. In some circumstances, certain Commercial Health Products (e.g., FEHB plans, student health plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

<u>General</u>

a) Hospital Services shall include all programs, services, facilities, and equipment necessary for care. Rates are inclusive of any applicable member copayment, coinsurance or deductible, pre-admission services or pre-procedure testing , any professional services billed by the Hospital, and other services as may be expressly included in a given rate.

a1) Hospital shall be paid lesser of 100% of eligible billed charges or the applicable contracted rate herein for all services except:

Observation Services
Checkout For Orthotic/prosth
Med Record Copy Per Page
All Transplant Procedures And Services
Med Record Copy Admin
All Other Outpatient
Physical, Occupational and Speech Therapy
Radiology Services
Laboratory Services
Chemotherapy
Emergency Care - Level V
Emergency Care - Level IV
Emergency Care - Level III
Ambulatory Surgery: Default Rate
Emergency Care - Level II
Emergency Care - Level I

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Ambulatory Surgery - Aetna Enhanced Groupers: Category 8
Ambulatory Surgery - Aetna Enhanced Groupers: Category 7
Ambulatory Surgery - Aetna Enhanced Groupers: Category 6
Ambulatory Surgery - Aetna Enhanced Groupers: Category 5
Ambulatory Surgery - Aetna Enhanced Groupers: Category 4
Ambulatory Surgery - Aetna Enhanced Groupers: Category 3
Ambulatory Surgery - Aetna Enhanced Groupers: Category 2
Ambulatory Surgery - Aetna Enhanced Groupers: Category 1
Global Fee Urgent Care Centers
Nursery: Level IV
Nursery :Level II and III
Nursery: Level I
Surgical Care
Sub-Acute Care:(Alternative Deliv):Level III-Complex:Level IV-Intensive
Skilled Care: Level I - Skilled Care: Level II - Comprehensive Care
Intermediate Care: (Step Down or Telemetry)
Intensive Care: MICU/SICU/PICU/CCU
Maternity Care:C-Section delivery incl newborn charges for Nursery Lev. 1 (Includes normal newborn)
Medical Care
Medical Care
Surgical Care
Maternity Care:Vaginal delivery incl newborn charges for Nursery Lev. 1 (Includes normal newborn)
Psychiatric Care
Cardiac Valve & Oth Maj Car
Cardiac Defib Implant
Circulatory Disorders
Electroconvulsive Therapy
Circulatory Disorders
Permanent Cardiac Pacemaker
Perc Cardiovasc Proc W Drug
Perc Cardiovasc Proc
Coronary Bypass W/o Cardiac
Other Cardiothoracic Proc
Coronary Bypass W Cardiac
Coronary Bypass W Ptca W Mcc
Cardiac Defibrillator Implan
Cardiac Valve & Oth Maj Card
Inpatient Detoxification Services
Acute Rehab I
Implants/Prosthetics > or = $500
Sleep Studies
Us Exam, Pg Uterus, Compl
Hemoglobin, Colorimetric
Hematocrit
High Complexity Cardiac Catheterization
Non-invasive Vascular Study
Non-invasive Vascular Study
Doppler Color Flow Add-on
Doppler Echo Exam, Heart
Echo Transesophageal4
Echo Transesophageal2
Echo Transesophageal6
Echo, Real-time(2d);limited

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Echo Exam Of Heart
Cardiovascular Stress Test
Electrocardiogram, Complete
Global Electromyography
Assay Serum Iron
X-ray Exam Of Wrist
Non-invasive Vascular Study
Therapeutic Drug Assays
Comprehensive Metabolc Panel
Basic Metabolic Panel
X-ray Exam Of Breast
X-ray Exam Of Knee
X-ray Exam Of Foot
X-ray Exam Of Ankle
X-ray Exam Of Hand
X-ray Exam Of Shoulder
X-ray Exam Of Lower Spine
Xray Exam Chest Two Views
Penile Vascular Study
Vascular Study
Non-invasive Vascular Study
Non-invasive Vascular Study
Chemotherapy (per Treatment)
Us Exam, Pg Uterus Limit
Each Additional Gestation (list Separately In Addition To 76805)
Electroencephalogram (eeg)
Breathing Capacity Test8
Blood Count
Contrast X-ray Lower Spine
Cat Scan Of Face, Jaw
Cat Scan Of Head Or Brain
Non-invasive Vascular Study
Non-invasive Vascular Study
Non-invasive Vascular St/ic
Noninvasive Physiologic Stud
Noninvasive Physiologic Stud
Noninv Phys Studies-arteries
Transcranial Doppler--f/u
Transcranial Doppler Study
Echo Transthoracic
Global Stress Thallium Testing
X-ray Exam Chest Single View
X-ray Exam Of Sinuses
Penile Vascular Study
Basic Comprehensive Audiometry
Non-invasive Vascular Study
Non-invasive Vascular Study
Non-invasive Vascular Study
Bilirubin Total
Urinalysis
Urinalysis With Microscopy
All Other Drugs
Cardiac Catheterization

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Observation Services

Those items marked as "Paid In Addition to" will not be included in the rate calculation for services contracted with a "Rate Applies to Entire Bill" methodology and will be reviewed and priced individually according to their contracted rate.

a2) The rate applied will be the applicable Agreement rate in effect on the date of discharge.

b) Case rates apply on the first day of admission if a case rate procedure is performed at any time during the inpatient stay. Unless otherwise specified trim/outlier days will be compensated at the applicable inpatient payment rate.

c) The rate for maternity services includes both the mother and healthy newborn(s). Based on the applicable Company product and claim processing platform, the total case rate payment may be allocated at 100% to the mother's claim and 0% to the newborn's claim or 80% to mother's claim and 20% to the newborn's claim. Multiple births will be paid at the applicable nursery rate.

d) Multiple Procedure Processing:

High Complexity Cardiac Catheterization: The primary procedure will be reimbursed at 100.00% of the contracted rate. The secondary procedure will be reimbursed at 50.00% of the contracted rate. Subsequent procedures will be reimbursed at 25.00% of the contracted rate.

Ambulatory Surgery - Groupers: The primary surgical procedure will be identified as the highest applicable category. The primary procedure will be reimbursed at 100.00% of the contracted rate. The secondary procedure will be reimbursed at 50.00% of the contracted rate. Subsequent procedures will be reimbursed at 25.00% of the contracted rate.

Ambulatory Surgery - Default: The primary surgical procedure will be identified as the highest applicable category. The primary procedure will be reimbursed at 100.00% of the contracted rate. The secondary procedure will be reimbursed at 50.00% of the contracted rate. Subsequent procedures will be reimbursed at 25.00% of the contracted rate.

Cardiac Cath: The primary surgical procedure will be identified as the highest applicable category. The primary procedure will be reimbursed at 100.00% of the contracted rate. The secondary procedure will be reimbursed at 50.00% of the contracted rate. Subsequent procedures will be reimbursed at 25.00% of the contracted rate.

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e) If an emergency room visit results in an admission, the claims for the entire admission, including the services rendered in the emergency room will be paid at the applicable inpatient payment rate, and will not include the emergency room visit rate. If an Ambulatory Surgery is performed as a result of an emergency room visit, the claims for the entire episode of care, including the services rendered in the emergency room will be paid at the applicable Ambulatory Surgery payment rate, and will not include the emergency room visit rate. If an emergency room visit results in observation services, the claims will be paid at the applicable emergency room payment rate, and payment will not include the Observation/Treatment Room rates. Observation services will be paid when such services are in conjunction with emergency room visits.

f) If an observation service results in an inpatient admission, the claim for the entire admission, including the observation charges will be paid at the applicable inpatient payment rate, and will not include the observation service rates. If observation services do not result in an inpatient admission and meet or exceed 24 hours the applicable inpatient rate for one inpatient day will be paid. If outpatient observation services do not result in an inpatient admission and meet or exceed 24 hours the applicable inpatient rate for one inpatient day will be paid.Observation services will not be paid in conjunction with ambulatory surgery services. Recovery room services will not be paid in conjunction with ambulatory surgery. If an emergency room visit results in observation services, the claims will be paid at the applicable emergency room payment rate, and payment will not include the Observation/Treatment Room rates. Observation services will be paid when such services are in conjunction with emergency room visits.

g) If trauma activation results in an admission, the claims for the entire admission, including trauma activation and the services rendered in the emergency room will be paid at the applicable inpatient payment rate, and will not include the trauma activation rate. If an Ambulatory Surgery is performed as a result of trauma activation, the claims for the entire admission, including the trauma activation and services rendered in emergency room will be paid at the applicable Ambulatory Surgery payment rate, and will not include the emergency room visit rate or the trauma activation rate. If trauma activation and the emergency room visit results in observation services, the claims will be paid at the applicable emergency room rate, and will not include the Observation/Treatment Room rate or the trauma activation rate.

h) Hospital will provide Company ninety (90) days advance notice of any services to be offered not previously offered and not specifically contracted above. Until rates are agreed upon, new inpatient services will be paid at the medical/surgical inpatient per diem.

i) Blood and blood product charges are not eligible for payment, except where State-mandated. These charges cannot be billed to member. Blood derivatives and blood product acquisition, processing, and administration charges are eligible for payment.

j) Personal comfort and convenience items are not eligible for payment.

k) In the event Hospital has entered into a contract with a behavioral health contractor which, at the time of the provision of Covered Services to a Member by Hospital, is party to a behavioral health contract with Company or an Affiliate ("Aetna Behavioral Health Contractor"), Hospital will be compensated in accordance with the Aetna Behavioral Health Contractor's established rates for Mental Health, Detoxification and Substance Abuse Rehabilitation services, which will supersede the rates in this Compensation Schedule. If the Aetna Behavioral Health Contractor does not have an established rate for the Covered Services provided to a Member by Hospital in its agreement with Hospital, or if Hospital does not have an agreement with Aetna Behavioral Health Contractor, Hospital will be compensated in accordance with this Compensation Schedule.

<u>Encounter Data</u>

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l) In the event Hospital is capitated for any Hospital Services, Hospital agrees to provide Company with encounter data by type of Covered Service rendered to Members in the form and manner as specified by Company. Hospital represents that such encounter data is truthful and complete.

Billing

m) Hospital must utilize the codes set forth in the compensation schedule when billing. Compensation is based on levels of care provided, not the specific bed type occupied by the patient.

n) All professional services billed, including services billed by Participating Providers, under the Hospital's federal tax identification number on a UB-92 (or its equivalent in the event UB-92s are no longer the standard billing form) billing form are not eligible for payment. All professional services billed, including services billed by Participating Providers, under the Hospital's tax identification number on an HCFA 1500 or equivalent form shall be paid at the Aetna Market Fee Schedule.

Coding

o) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

p) Limit on Certain Charge Master Increases. Hospital is limited to annual charge master increases for those covered services provided to Members and paid by Company at the percent of Hospital's billed charges not to exceed zero percent 0%) during any twelve (12) month period occurring after the contract effective date. Hospital will provide Company written notice of any increase in Hospital's charge master thirty (30) days prior to the effective date of such increase via a certified letter signed by the Chief Financial Officer or other authorized officer of the Hospital. Company may also request from Hospital up to twice each year, and Hospital will furnish to Company in an electronic format acceptable to Company, Hospital's prior year charge master with effective date(s) and current year charge master with effective date(s). Charge master files will contain industry standard and legally mandated compliant coding as well as rates.

1) Calculation. Company will compute charge master increases on a per service (per code) basis by comparing Hospital's billed charge received by Company prior to the increase against Hospital's billed charge received by Company after the increase. Company's measurement of charge master increases will be derived using the average unit cost based on the most recent 12 months of claim data for all service codes subject to a percent-of-charges compensation method and may be adjusted to reflect a weighted average increase based on this calculation.

2) Adjustment to Compensation Rates. Increases in excess of the zero percent 0%) limitation will result in an immediate additional discount to Company for all services paid for hereunder on a percent of eligible billed charges basis. The increased discount, expressed as a percentage, will be equal to the charge master increase for such charges in excess of zero percent 0%), and will become effective on the date of the charge master increase. Company reserves the right to audit the Hospital charge master. Any failure by Company to request the information and to conduct the charge master audit in the timeframe referenced above shall not operate as a

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waiver of Company's right to such information or to conduct such audit hereunder or as a waiver of the discount referenced in this subsection (2).

q) Implant Device Payment Terms and Conditions. Except as otherwise described below, the rates set forth in this Compensation Schedule include compensation for all charges for patient care as defined in the **COMPENSATION TERMS AND CONDITIONS**. However, recognizing the high cost associated with some specific implant devices, Company agrees to pay for certain specified devices in addition to the rates set forth in this Compensation Schedule according to the following terms:

Implant Device(s)

Revenue code	274	Prosthetics
Revenue code	275	Pacemaker
Revenue code	278	Other Implants

For implant devices billed under revenue code(s) 274, 275 and/or 278, only those items considered an implant device are eligible for additional payment. These include, but are not limited to:

☐ Anchors	☐ Grafts	☐ Plates	☐ Shunts
☐ Artificial joints	☐ Pins	☐ Screws	☐ Stents
☐ Pacemakers	☐ Defibrillators	☐ Valves	☐ Heart Pumps

The following items are not eligible for additional payment under the above mentioned revenue code(s). These include, but are not limited to:

- Materials and supplies (such as sutures, customized surgical kits, medical surgical supplies, clips, (other than radiological site markers), etc.) provided during the procedure.
- Guide wires, endoscopes and catheters associated with implant procedures (Note: Angioplasties without the use of stents are not considered implant procedures).
- Implant device(s) ordered, but not implanted in the patient during the procedure.

For any individual case (i.e., single inpatient admission or single outpatient visit) that includes a covered implant device eligible for additional payment as set forth in the above revenue codes and the Hospital's eligible billed charges for the implant device meets or exceeds five hundred dollars ($500.00), Company shall pay Hospital one hundred and three percent (103%) of Hospital's eligible billed charges for the implant device. For any individual case that includes a covered implant device which does not meet or exceed the charge threshold stated above, charges for the implant device(s) are not eligible for additional payment. Any other services or supplies billed under these revenue codes that do not meet the criteria indicated above will not be eligible for additional payment.
The Threshold applies to the sum of each unique revenue code. The Threshold cannot be met by the addition of charges for multiple revenue codes. Eligible billed charges for the revenue codes that are less than or equal to the Threshold amount stated above are not eligible for Implant Carve-Out payment.

Hospital will provide Company written notice of any increase in Hospital's mark-up policy for implantable items within thirty (30) days of such increase via a certified letter signed by the Chief Financial Officer or other executive officer of the Hospital. Increases in the mark-up percentage will be directly offset by a corresponding reduction to the percentage of eligible billed charges.

Claim Example #1

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Hospital bills revenue code 275 at $300 (one line item billed)
Threshold met? NO
Additional Payment = $0

Claim Example #2
Hospital bills revenue code 278 (three separate billed lines) totaling $5,001
Threshold met? YES
Additional Payment = $5,001 X 103% = $5,151.30

Company and/or its agents or designees shall have the right to audit Hospital's billed charges against Hospital invoices, detailed billing statements and/or associated documentation for each eligible implant device upon request to verify that the costs of the item relates to Hospital's billed charges for the item as outlined above. Should Company and/or its agents or designees determine it has overpaid Hospital based upon an audit, Hospital agrees to refund to Company the difference between what Company paid and the Hospital's acquisition cost of the implant device(s) within forty-five (45) days of such refund request by Company. Company reserves the right to offset such payment against any other monies due to Hospital in accordance with the provisions of the Agreement dealing with overpayments.

DRG:

All services identified by MS-DRGs are subject to verification by Company using the MEDICARE PROSPECTIVE PAYMENT GROUPER version of grouping software in use by Company on the date of discharge. MS-DRGs submitted by the Hospital that do not coincide with the MS-DRG assigned by Company's grouping software will be paid at the applicable rate for the assigned MS-DRG. Company will update the Medicare IPPS Grouper software within 30 days of the later to occur of (i) the CMS effective date; or (ii) CMS release date. Until updated in Company's systems, Company will pay based upon the prior versions of the Medicare IPPS grouper software.

COLA:
The payment rates identified in this compensation schedule will be, unless otherwise herein expressly provided, automatically adjusted by Company per the terms below. The adjusted rates will be rounded to the nearest dollar for specific fixed rates greater than or equal to $100.00.

Start Date	End Date	Adjustment Based On:

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01/01/2023	12/31/2023	Fixed Rate of 3.00%

Cola Excluded Services:

Implants/Prosthetics > or = $500 - Rate and Threshold
COVID-19 testing - Rate

Reference laboratory services are not eligible for payment. These services are generally indicated with a bill type of 141, hospital laboratory services provided to non-patients.

URGENT CARE CENTER
SERVICE AND RATE SCHEDULE

SERVICES:

Facility agrees to provide urgent office-based medical services, stat laboratory and plain x-ray film services, minor surgical procedures, closed treatment of fractures as is clinically prudent, and injectables as clinically indicated.

Urgent Care Services shall not include routine/preventive care, follow-up care from a recent visit to the Facility, physical therapy, elective surgical procedures, routine immunizations or flu shots, and laboratory and radiological exams which are not associated with the treatment of an acute illness.

Follow-up care shall be directed to the member's Primary Care Physician.

OUTPATIENT RATES:

Service	Billing Codes	Rates
Global Fee Urgent Care Centers	**HCPC Codes:** S9083	$190.55 Once Per Unique Code Per Service Date
All Services not otherwise identified		Not Reimbursed

OUTPATIENT CARVE OUT RATES:

Service	Billing Codes	Rates
COVID-19 Vaccine Administration	**CPT4 Codes:** 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0021A, 0022A, 0031A, 0041A, 0042A, 0064A	103% of Aetna Market Fee Schedule
COVID-19 Testing	**CPT4 Codes:** 87635, 99211 **HCPC Codes:** U0001, U0002, U0003, U0004	101.1% of Medicare Physician Fee Schedule with GAP Codes

Definitions:

"**Aetna Market Fee Schedule**" (AMFS) – A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

"Medicare Physician Fee Schedule with GAP codes" (MFS)- A fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Fee schedule contains rates published by local carrier for services where CMS does not provide a rate. Fee schedule contains rates published by Company for services where CMS or local carrier do not provide a rate. Rates published by Company for these services are AWP for drugs and AMFS for all other services. Company plans to update the schedule within 60 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Aetna payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

"Gatekeeper products" – For purposes of this Service and Rate Schedule, Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which encourage or promote the use of a Primary Care Physician, regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or (ii) an individual Member has selected a Primary Care Physician. Examples of Gated Commercial Health Products include, but are not limited to: HMO (Health Maintenance Organization), POS (Point of Service) (e.g., *Managed Choice POS*, *Aetna Choice POS II*), EPO (Exclusive Provider Organization). In some circumstances, certain Commercial Health Products (e.g., FEHB plans, student health plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Non-Gatekeeper products" – For purposes of this Service and Rate Schedule, Non-Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which do not allow for the designation and/or use of a Primary Care Physician in the administration of the product. Examples of Non-Gated Commercial Health Products include, but are not limited to: PPO (e.g., *Open Choice PPO*), Aetna Signature Administrators®, Passport to Healthcare® and the National Advantage program. In some circumstances, certain Commercial Health Products (e.g., FEHB plans, student health plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

Service Groupings – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Rate Schedule.

RATE TERM AND CONDITIONS:

a) Facility agrees to accept an "All-Inclusive Visit Rate" as payment in full for all Covered Services including but not limited to diagnostic laboratory and radiology, procedures, injectables, and durable medical equipment provided to Members during the urgent care visit. Facility must utilize the codes set forth in the rate section above.

b) All Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. Provider shall be paid at the lesser of eligible billed charges or the applicable contracted rate herein.

c) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new and/or changes to existing codes. Such updates may include assignment and/or reassignment to Service Groupings for new and/or existing codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period. Unless otherwise specified, the reimbursement for new, replacement, reassigned, or modified code(s) will be paid on the same basis or at a comparable rate as set forth within this Schedule.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

d) Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment. Medicare Payment Adjustments do not include performance based incentive payments made under traditional Medicare as the result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its implementing regulations, as may be amended from time to time.

e) Those items marked as "Paid In Addition to" will not be included in the rate calculation for services contracted with a "Rate Applies to Entire Bill" methodology and will be reviewed and priced individually according to their contracted rate.

f) For any items paid based upon Average Wholesale Price ("AWP") or a percentage of AWP, the AWP will be adjusted to take into account any discounts and/or rebates made available to Provider from a manufacturer or otherwise for such drug.

g) The parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (e.g., MIPS, APM).

h) Facility subcontracts with providers ("Subcontracted Providers") to provide Covered Services. Subcontracted Providers are defined as individuals, entities, professionals or vendors with whom Facility has entered into an agreement to provide services that may include, but are not limited to Covered Services such as pathology services, laboratory services, anesthesia and radiology services.

Subcontracted Providers may bill Company for such Covered Services when payment is not contractually included as part of Facility's reimbursement under this Agreement.

Facility agrees that the reimbursement terms of this Agreement are based on the expectation that Facility shall use Participating Providers to provide one hundred percent (100%) of Covered Services. Company shall monitor Facility's use of Participating Providers.

COLA:
The payment rates identified in this compensation schedule will be, unless otherwise herein expressly provided, automatically adjusted by Company per the terms below. The adjusted rates will be rounded to the nearest dollar for rates greater than or equal to $100.

Start Date	End Date	Adjustment Based On:
01/01/2023	12/31/2023	Fixed Rate of 3.00%

Cola Excluded Services:
COVID-19 Testing - Rate