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

IN WITNESS WHEREOF, the undersigned have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

HiLabs Health Management Inc.

Signature: _____

Name: ABC Person

Title: CEO, HiLabs Health Plan

Date: Feb 10, 2021

ABC Hospital

Signature: _____

Name: ABC Person

Title: Associate

Date: Feb 10, 2021

TIN: 999999999

ABC Care, Inc

Signature: _____

Name: _____

Title: CEO

Date: Feb 10, 2021

HiLabs Health Management, Inc. and Affiliates
219 ABC 2nd Street
ABXC MN 55401 Attn:
Legal Department

ABC Hospital

Address: ABC

City, State:XYZ

Attn:

EXHIBIT 2

BENEFIT PLANS

Facility will participate in Hilabs Health's network for the following types of Benefit Plans:

Commercial Benefit Plans: Benefit Plans issued or administered by Bright Health that are designed for purchase by individuals or groups and are not intended for government health programs such as Medicare, Medicaid, or the Children's Health Insurance Program. Commercial Benefit Plans include without limitation:

a. Individual and Family Plans (IFP). IFP Benefit Plans include:

i. Off-Exchange Benefit Plans: benefit plans that are eligible for sale in commercial individual and group markets; and

ii. Exchange Benefit Plans: subsidized and unsubsidized benefit plans sold on the state and federal health insurance marketplaces established under the Affordable Care Act ("ACA") or sold through other channels created by subsequent legislation at the state or federal level intended to replace the ACA marketplaces.

b. Limited Benefit Plans: Bright Secure and other indemnity coverage, short term limited duration, or other types of limited benefit plan.

c. Association Health Plans: coverage offered to members of an association with which Bright Health contracts to provide health care coverage pursuant to applicable Federal Department of Labor and State regulations.

Medicare Advantage Benefit Plans: Benefit Plans issued or administered by Bright Health pursuant to the Medicare Advantage program.

Bright Health may update the foregoing list of Benefit Plans types by providing Facility with ninety (90) days advance written notice prior to the to the effective date of such change via a mutually signed amendment agreed to by both parties.

EXHIBIT 4A

FACILITY PAYMENT APPENDIX FOR COMMERCIAL BENEFIT PLANS

Bright Health Facility Payment Appendix				
Effective Date: January 1, 2021 Line of Business: Commercial Benefit Plans Contract Rates: Bright agrees to pay Care Partner or Network Provider the lesser of Care Partner's or Network Provider's billed charges or the rates set forth within this Payment Appendix, less Member Expenses.				
Inpatient Rates				
Category	**Priority Ranking**	**Coding**	**Payment Methodology**	**Rate**
All Inpatient Services	N/A	All MS-DRG's	Percent of the Current Medicare Fee Schedule for Inpatient Prospective Payment System ("IPPS").	185%
Outpatient Rates				
Care Partner or Network Provider shall be reimbursed at 185% of the current Medicare Fee Schedule for Outpatient Prospective Payment System ("OPPS").				

Applicable Terms

Updates to MS-DRG Weights: Notwithstanding anything herein to the contrary, CMS MS DRG Weights will be updated annually.

Priority Ranking: Payment for services is based on the highest "Priority Ranking" set forth above. If a claim contains revenue/CPT codes from multiple outpatient service categories, reimbursement for such claims will be calculated using the highest Priority Ranking methodology with no additional payment for lower Priority Ranking service(s).

Medicare Fee Schedule: means the reimbursement that the provider would receive if the services were performed in the Medicare fee for service program in the same Medicare Locality, including both reimbursement rules and reimbursement rates in effect for the services except for the following:

a) the prevailing Medicare sequestration reduction imposed by the Budget Control Act of 2011 will not be applied when determining reimbursement rates under this Payment Appendix.
b) for Network Providers who participate in the Merit-based Incentive Payment System, in Alternative Payment Models, or in other CMS performance-based payment programs; bonuses, penalties, or other adjustments applied to Facility reimbursement by CMS in original Medicare will not be included by Bright Health in the Medicare Fee Schedule.
c) The prevailing CMS payment rules for original Medicare for HACs and Serious Reportable Events. Bright Health will reduce payment for those portions of the claims that are attribute to HACs and Serious Reportable Events in accordance with CMS' payment rules under the Deficit Reduction Act of 2005 and Section 3008 of the Affordable Care Act.

Medicare Fee Schedule Updates: The reimbursement will be at current Medicare Fee Schedule. The Medicare Fee Schedule will be updated within ninety (90) days of CMS publication of changes. In the event updates are made prior to the effective date of the updated Medicare fee schedule; the fee schedule effective date shall prevail. Claims incurred with dates of service prior to such fee schedule updates will not be reprocessed and will be reimbursed based on the rates in effect prior to such update.

Alternative Reimbursement: In the event a Covered Service is valued by Medicare but excluded from the specific Medicare Fee Schedule(s) listed in this fee appendix, the reimbursement amount for such Covered Service shall be equal to the lowest numeric percentage listed in this fee appendix of the applicable prevailing year's Medicare Fee Schedule, less Member Expenses.

New and Non-Medicare Valued Codes: Reimbursement for new codes shall be determined using the current RVUs at the time the new codes are added with the current locality and conversion factors until the next Medicare Fee Schedule Update. For codes that are not valued by applicable Medicare Fee Schedules, reimbursement for Covered Services shall be the lesser of Care Partner's or Network Provider's billed charges or the Bright Health Plan Fee Schedule. Bright Health may update the Bright Health Plan Fee Schedule rates from time to time. In the event a code is not valued by Medicare Fee Schedules or the Bright Health Plan Fee Schedule, reimbursement shall be 25% of Care Partner's or Network Provider's billed charges.

Readmissions: In the event a member requires hospitalization by Care Partner or Network Provider, or another facility that is a provider affiliate, within thirty (30) days of discharge from a prior hospitalization or within thirty (30) days of the date of service for an outpatient procedure, and Bright Health determines that the hospitalization was for treatment of complications or avoidable detrimental consequences of the prior hospitalization or outpatient procedure, Bright Health will not reimburse Network Provider

EXHIBIT 4B

FACILITY PAYMENT APPENDIX FOR MEDICARE ADVANTAGE BENEFIT PLANS

Bright Health Facility Payment Appendix
Effective Date: January 1, 2021 **Line of Business:** Medicare Advantage Plans **Contract Rates:** Bright agrees to pay Care Partner or Network Provider in the lesser of Care Partner's or Network Provider's billed charges or the rates set forth within this Payment Appendix, less Member Expenses.
Inpatient Rates
Care Partner or Network Provider shall be reimbursed at 102% of the Prevailing Medicare Fee Schedule for Acute Inpatient Prospective Payment System. All inpatient Hospital Services with a non- codable Medicare DRG will be reimbursed at fifty percent (50%) of Hospital's billed charges, not to exceed $3,500 per day.
Outpatient Rates
Care Partner or Network Provider shall be reimbursed at 102% of the Prevailing Medicare Fee Schedule for Outpatient Prospective Payment System
Additional Terms

Updates to MS-DRG Weights: Notwithstanding anything herein to the contrary, CMS MS-DRG Weights will be updated annually.

Prevailing Medicare Fee Schedule: means the reimbursement that the provider would receive if the services were performed in the Medicare fee for service program in the same locality, including both reimbursement rules and reimbursement rates in effect for the services. For the purposes of the Prevailing Medicare Fee Schedule, among the other applicable Medicare reimbursement rules, Bright Health will apply the following:

(a) The prevailing Medicare sequestration reduction imposed by the Budget Control Act of 2011, as amended, for services provided by ACO to Members under Medicare Advantage Benefit Plans. Such sequestration reduction will be applied at the same level and methodology as if the reimbursement were made in original Medicare.

(b) For Network Providers who participate in the Merit-based Incentive Payment System, in Alternative Payment Models, or in other CMS performance-based payment programs; bonuses, penalties, or other adjustments applied to Facility or individual Network Provider reimbursements by CMS in original Medicare will not be included by Bright Health in the Prevailing Medicare Fee Schedule.

(c) The prevailing CMS payment rules for original Medicare for HACs and Serious Reportable Events. Bright Health will reduce payment for those portions of the claims that are attribute to HACs and Serious Reportable Events in accordance with CMS' payment rules under the Deficit Reduction Act of 2005 and Section 3008 of the Affordable Care Act.

Prevailing Medicare Fee-Schedule Updates: The Prevailing Medicare Fee Schedule will be updated within ninety (90) days of the CMS publication of changes. Claims incurred with dates of service prior to such updates will not be reprocessed and will be reimbursed based on the rates in effect prior to such update.

Alternative Reimbursement: In the event a Covered Service is valued by Medicare but excluded from the specific Medicare Fee Schedule(s) listed in this fee appendix, the reimbursement amount for such Covered Service shall be equal to the lowest numeric percentage listed in this fee appendix of the applicable prevailing year's Medicare Fee Schedule, less Member Expenses.

New and Non-Medicare Valued Codes: Reimbursement for new codes shall be determined using the current RVUs at the time the new codes are added with the current locality and conversion factors until the next Medicare Fee Schedule Update. For codes that are not valued by applicable Medicare Fee Schedules, reimbursement for Covered Services shall be the lesser of Care Partner's or Network Provider's billed charges or the Bright HealthPlan Fee Schedule. Bright Health may update the Bright Health Plan Fee Schedule rates from time to time. In the event a code is not valued by Medicare or the Bright Health Plan Fee Schedule, reimbursement shall be 30% of Care Partner or Network Provider's billed charges.

Readmissions: In the event a member requires hospitalization by Care Partner or Network Provider, or another facility that is a provider affiliate, within thirty (30) days of discharge from a prior hospitalization or within thirty (30) days of the date of service for an outpatient procedure, claims will be reimbursed in accordance with CMS guidelines and methodologies in effect on the date of service. Network Provider, or another facility that is a provider affiliate, further agrees not to reject any patient transfers from a non-participating facility or provider, if the Network Provider is the originating admitting care provider/facility.

Charge Master Increase: Care Partner is limited to annual charge master increases for those Covered Services provided to Members and paid by Bright at the percent of Care Partner's billed charges not to exceed seven percent (7%) during any twelve (12) month period occurring after the contract effective date. Care Partner will provide Bright written notice of any increase in Care Partner'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 Care Partner. Bright may also request from Care Partner up to twice each year, and Care Partner will furnish to Bright in an electronic format acceptable to Bright, Care Partner '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. If Charge Master Increase exceeds seven percent (7%), applicable rates will be adjusted to neutralize impact above seven percent (7%).