

EXHIBIT 2

BENEFIT PLANS

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

Commercial Benefit Plans: Benefit Plans issued or administered by Starlight 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.

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

EXHIBIT 3

NETWORK PROVIDERS AND SERVICE LOCATIONS

See attached list of facilities and medical groups, including TIN and NPI numbers.

Facility Name	Address	TIN	NPI
Starlight Medical Center – Parnassus	505 Parnassus Ave San Fiero, CA 92343	94-3531657	1689745692
Starlight Medical Center – Mount Zion	1600 Divisadero St San Fiero, CA 91115	94-3531657	1689745692
Starlight Medical Center at Mission Bay	1825 4 th Street San Fiero, CA 91158	94-3531657	1689745692
Starlight Benioff Children's Hospital San Francisco	1845 4th Street San Fiero, CA 91158	94-3531657	1689745692
Starlight Orthopedics Institute	1500 Owens St San Fiero, CA 91158	94-3531657	1689745692

EXHIBIT 4A

FACILITY PAYMENT APPENDIX FOR COMMERCIAL BENEFIT PLANS

STARLIGHT MEDICAL CENTER/STARLIGHT BENIOFF CHILDREN'S HOSPITAL SAN FIERO

INPATIENT SERVICES - GENERAL		
SERVICE CATEGORY	METHOD	PAYMENT RATE
Medical/Surgical/ICU/CCU/PICU/ICU-Intermediate/CCU-Intermediate (unless otherwise specified in this Exhibit) Includes the following Revenue Codes: Revenue Codes 0100-0101, 0110-0113, 0117, 0118-0123, 0127-0133, 0137-0143, 0147-01 53, 0157-0160, 0164, 0169, 0200-0203, 0206-0212, 0214, 0219	Per Diem - for day 1 of any admission	\$ 12,535
	Per Diem - for day 2 of any admission	\$ 11,444
	Per Diem - for day 3 of any admission	\$ 10,470
Nursery (unless otherwise specified in Exhibit)	Normal Newborn Per Diem (Rev Codes 170, 171, 179)	\$ 3,099
	NICU Level II Per Diem (Rev Code 172)	\$ 9,504
	NICU Level III Per Diem (Rev Code 173)	\$ 12,130
	NICU Level IV Per Diem (Rev Code 174)	\$ 13,640
Obstetrics (unless otherwise specified in Exhibit). Mother only. Newborn(s) to be paid as a separate admission.		
Vaginal Delivery - MS-DRGs 767-768, 774-775, 796-798, 805-807	Per Case - Up to 4 days	\$ 24,524
	Per Diem for subsequent days	\$ 7,827
Cesarean Section - MS-DRGs 765-766, 783-788	Per Case - Up to 4 days	\$ 24,524
	Per Diem for subsequent days	\$ 7,827

Acute Rehabilitation (unless otherwise specified in this Exhibit) revenue codes 0118, 0128, 0138, 0148, 0158	Per Diem	\$ 10,470
Nitric Oxide- ICD-10 Codes 3EOF3SD, 3EOF7SD, 3EOF8SD	Per Diem paid in addition to all other services and per diems	\$ 7,375
ECMO/Tracheostomy MS-DRG 003	Per Diem	\$ 18,575

For an admission that includes any of the following inpatient covered services provided to a member, the contract rates for the entire admission (except for exclusionary items and inpatient outlier/stoploss) are determined as follows.

INPATIENT SERVICES - SPECIALTY/PER CASE RATES		
SERVICE CATEGORY	METHOD	PAYMENT RATE
Neurosurgery - MS-DRGs 020-027,031-033,614,615	Per Case - Up to 3 days	\$ 75,888
	Per Diem for subsequent days	\$ 10,470
Neurosurgery – Two Stage Epilepsy Procedure - ICD-10 Diagnoses Codes in the G40.xxx range AND ICD-10 Procedure Codes 00H002Z, OR 00H00MZ, 00H032Z, 00H03MZ, 00H042Z, 00H04MZ, AND 00P00MZ, OR 00P002Z, 00P03MZ, 00P032Z, 00P04MZ, 00P042Z, 00P0XMZ, 00P0X2Z	Per Case - Up to 4 days	\$ 92,575
	Per Diem for subsequent days	\$ 10,470
Bariatric Surgery - MS-DRGS 619-621 with ICD- 10 Diagnostic Code E66.01	Per Case - Up to 4 days	\$ 51,614
	Per Diem for subsequent days	\$ 10,470
Cardiac Catherization - MS-DRGs 286,287	Per Case - Up to 2 days	\$ 34,537
	Per Diem for subsequent days	\$ 10,470
Cardiac Surgery/Procedures - MS-DRGs 001, 002 (for VAD implant only), 215-236, 242-251,258-262,265-274	Per Case - Up to 5 days	\$ 78,896
	Per Diem for subsequent days	\$ 10,470
Adult Spine Surgery (patients 18 years of age or older) - MS-DRGs 028-030,453-460,471-473, 518-520 without Revenue Codes 113, 123, 173, 174, 203	Per Case - Up to 3 days	\$ 60,462

		Per Diem for subsequent days	\$ 10,470
Pediatric Spine Surgery (patients 17 years of age or younger) - MS-DRGs 028-030,453-460,471-473, 518-520 with Revenue Codes 113, 123, 173, 174, 203		Per Case - Up to 3 days	\$ 89,590
		Per Diem for subsequent days	\$ 10,470
Major Joint Surgery - 461,462,466-470,483-489,492-494,507,508 MS-DRGs		Per Case - Up to 3 days	\$ 51,408
		Per Diem for subsequent days	\$ 10,470
Major Male Pelvic Surgery - 707,708 MS-DRGs		Per Case - Up to 3 days	\$ 39,815
		Per Diem for subsequent days	\$ 10,470
Gender Confirming Surgery - Male to Female Multiple Surgery Case Rate ICD-10 DX Codes F64.1, F64.2, F64.8 or F64.9 with ICD-10 Procedure Codes 0W4M070, 0W4M0J0, 0W4M0K0, 0W4M0Z0		Per Case - Up to 8 days	\$ 43,467
		Per Diem for subsequent days	\$ 10,470
Fetal Surgery - See separate listing of qualifying ICD-10 DX Codes and Procedure Codes		Per Case - Up to 3 days	\$ 53,166
		Per Diem for subsequent days	\$ 10,470
Melody Transcatheter Implantation - Procedure Codes 02RH37Z, 02RH38Z, 02RH3JZ, 02RH3KZ ICD-10		Per Case - Up to 2 days	\$ 72,500
		Per Diem for subsequent days	\$ 10,470
Transplant Admissions		Transplant services are specifically excluded from this Agreement, and shall be paid under the terms of the separate agreement between HughHealth Care Solutions, Inc. ("HughHealth") and Facility	N/A

INPATIENT EXCLUSIONARY ITEMS - INPATIENT OUTLIER

If eligible Facility's billed charges exceed three hundred seventy-three thousand, six hundred forty-eight dollars (\$373,648) for a hospital admission (the "Stoploss Threshold"), Starlight Health will pay fifty-nine and eighty-eight hundredths percent (59.88%) of Facility's billed charges in lieu of the Inpatient rates in this Exhibit for the entire admission. This inpatient outlier/stoploss provision shall only apply to inpatient admissions payable under this Exhibit. This inpatient outlier/stoploss provision does not apply to exclusionary items, and charges for such items will not be applied to the calculation of the Stoploss Threshold.

SERVICE CATEGORY	METHOD	PAYMENT RATE
Stop Loss Threshold	Billed Charges	\$ 373,648
Stop Loss Threshold Payment Rate	Percent of Billed Charges	59.88%

INPATIENT EXCLUSIONARY ITEMS - IMPLANTS

The additional and separately paid contract rate for implants (including internal fixation devices), devices, stents, pacemakers, prosthetics/orthotics, and laser accessories (revenue codes 0274, 0275, 0276, 0278, and 0624) that are Covered Services will be fifty-eight and thirty-nine hundredths percent (58.39%) of Facility's billed charges.

SERVICE CATEGORY	METHOD	PAYMENT RATE
Implants - Rev. Code 274, 275, 276, 278, and 624	Percent of Billed Charges	58.39%

INPATIENT EXCLUSIONARY ITEMS - HIGH COST DRUGS/BOTULISM IMMUNE GLOBULIN

The additional and separately paid contract rate for high cost drugs (revenue codes 0343, 0344, and 0636) for which Facility's billed charges are greater than one thousand two hundred and sixty-two dollars (\$1,262) ("Pass Through Threshold") per applicable revenue code, will be fifty-two and fifty-six hundredths percent (52.56%) of Facility's billed charges, paid for all billed charges (including those below the Pass Through Threshold).

The additional and separately paid rate for Botulism Immune Globulin-Pediatric (Revenue Codes 250, 258, or 636 with ICD-10 DX Codes A0.51 or A48.51 and CPT Codes 90288 or 90399) will be one hundred percent (100%) of Provider's billed charges.

Transplant admissions are excluded from this provision.

SERVICE CATEGORY	METHOD	PAYMENT RATE
High Cost Drugs Threshold - Rev. Code 343,344, 636	Billed Charges	\$ 1,262
High Cost Drugs Pass Through Threshold Payment Rate	Percent of Billed Charges	52.56%
Botulism Immune Globulin-Pediatric Carveout - Rev Codes 250, 258, or 636 with ICD-10 DX Codes A0.51 or A48.51 and CPT codes 90288 or 90399	Percent of Billed Charges	100%

Exclusionary Items - Patient Transport Charges (Pre and Post-Discharge)		
The additional and separately paid contract rate for patient transport charges (revenue code 0542 for pre and post-discharge transport) will be fifty-seven and seventy-six hundredths percent (57.76%) of Facility's billed charges		
Patient Transport Charges (Pre and Post-Discharge) Revenue Code 0542	Percent of Billed Charges	57.76%

OUTPATIENT SERVICES - GENERAL		
SERVICE CATEGORY	METHOD	PAYMENT RATE
All Outpatient Services (except Exclusionary Items)	Percent of Billed Charges	53.36%

OUTPATIENT EXCLUSIONARY ITEMS - BOTULISM IMMUNE GLOBULIN		
The additional and separately paid rate for Botulism Immune Globulin-Pediatric (Revenue Codes 250, 258, or 636 with ICD-10 DX Codes A0.51 or A48.51 and CPT Codes 90288 or 90399) will be one hundred percent (100%) of Provider's billed charges.		
SERVICE CATEGORY	METHOD	PAYMENT RATE
Botulism Immune Globulin-Pediatric Carveout - Rev Codes 250, 258, or 636 with ICD-10 DX Codes A0.51 or A48.51 and CPT codes 90288 or 90399	Percent of Billed Charges	100%

OUTPATIENT EXCLUSIONARY ITEMS - REFERENCE LABORATORY TESTS		
The additional and separately paid rate for Reference Laboratory Tests (CPT Code Series 8xxxx with modifier -90) will be one hundred percent (100%) of Provider's billed charges.		
SERVICE CATEGORY	METHOD	PAYMENT RATE
Reference Lab Tests Carveout - CPT Code Series 8xxxx with modifier - 90	Percent of Billed Charges	100%

OUTPATIENT EXCLUSIONARY ITEMS – DRUGS/BIOLOGICALS

Outpatient High Cost Drugs (unless payable under the “Drug/Biologics with a Provider cost of greater than \$100,000 per single treatment for any Inpatient/Outpatient admission” below).

SERVICE CATEGORY	METHOD	PAYMENT RATE
All Other Outpatient High Cost Drugs – Rev. Code 343, 344, 636	Percent of Billed Charges	45%

INPATIENT AND OUTPATIENT EXCLUSIONARY ITEMS - DRUGS/BIOLOGICS WITH HOSPITAL COST OF GREATER THAN \$100,000 PER TREATMENT

The additional and separately paid rate for qualifying Drugs/Biologics (those with a cost to Provider of greater than \$100,000 per single treatment) will be Provider's cost for such items.

SERVICE CATEGORY	METHOD	PAYMENT RATE
Drugs and Biologics - Rev Code 636, 343, 344	Provider Cost	Provider Cost

CODING CHANGES

The MS DRGS, Revenue Codes, CPT4 codes, HCPCS Codes, ICD-10 Codes and any other codes listed herein represent those currently in use for the procedures referenced in this Exhibit. Except as provided below, any change, published in the Federal Register or other recognized source within the healthcare community, that assigns any of the procedures listed herein to a new or additional MS DRG, Revenue Code, CPT4 Code, HCPCS Code, or ICD-10 Code, shall be considered incorporated into this Exhibit effective as of the effective date indicated for such change(s) in the Federal Register or such other recognized source within the healthcare community.

FETAL SURGERY DIAGNOSTIC AND PROCEDURE CODES

<u>ICD10 Diagnosis Code:</u>	<u>ICD10 Procedure Codes:</u>	<u>ICD10 Procedure Codes:</u>
O35.0XX0	10Q00ZE	10Q03YY
O35.0XX1	10Q00ZF	10Q03ZE
O35.0XX2	10Q00ZG	10Q03ZF
O35.0XX3	10Q00ZH	10Q03ZG
O35.0XX4	10Q00ZJ	10Q03ZH
O35.0XX5	10Q00ZK	10Q03ZJ
O35.0XX9	10Q00ZL	10Q03ZK
O35.8XX0	10Q00ZM	10Q03ZL
O35.8XX1	10Q00ZN	10Q03ZM
O35.8XX2	10Q00ZP	10Q03ZN
O35.8XX3	10Q00ZQ	10Q03ZP
O35.8XX4	10Q00ZR	10Q03ZQ
O35.8XX5	10Q00ZS	10Q03ZR
O35.8XX9	10Q00ZT	10Q03ZS
<u>O43.022</u>	10Q00ZV	10Q03ZT
	10Q00ZY	10Q03ZV