HOSPITAL SERVICE
AND
RATE SCHEDULE
EFFECTIVE August 1, 2015
COLA August 1, 2016

INPATIENT START

Service	Billing Codes	Rates
DRG	All Active DRG Codes	~~$7800.00~~ $7917.00 Base Rate - Applied based upon Medicare Weights

INPATIENT CARVE OUT RATES:

Service	Billing Codes	Rates
Vaginal Delivery W Steriliz	**DRG Codes:** 767-768, 774-775	~~$4000.00~~ $4060.00 Case Rate (DAYS 0-2)
Vaginal Delivery W Steriliz	**DRG Codes:** 767-768, 774-775	~~$900.00~~ $914.00 Per Diem (DAYS 3-999)
Cesarean Section W Cc/mcc	**DRG Codes:** 765-766	~~$6000.00~~ $6090.00 Case Rate (DAYS 0-4)
Cesarean Section W Cc/mcc	**DRG Codes:** 765-766	~~$900.00~~ $914.00 Per Diem (DAYS 5-999)
Normal Newborn	**DRG Codes:** 795	~~$800.00~~ $812.00 Per Diem
Neonates, Died Or Transferred	**DRG Codes:** 789-794	65% of Billed Charges Rate Applies to Entire Bill

OUTPATIENT RATES:

Service	Billing Codes	Rates
Ambulatory Surgery: Default Rate	All surgical procedures not otherwise identified	65% of Billed Charges Rate Applies to Entire Bill
Emergency Care	**Revenue Codes:** 450, 451, 452, 459	65% of Billed Charges
Cardiac Catheterization Procedures	**HCPC Code:** G0448 **CPT4 Codes:** 0281T, 0291T, 0292T, 0293T, 0294T, 93451-93462, 93503-93505, 93530-93533	65% of Billed Charges Rate Applies to Entire Bill
Cardiac Catheterization Injections	CPT4 Codes: 93563-93568	65% of Billed Charges Rate Applies to Entire Bill

All Other Outpatient		65% of Billed Charges

{OUTPATIENT CARVE OUT RATES:

Service	Billing Codes	Rates
Observation Services	**Revenue Codes:** 760, 762, 769	65% of Billed Charges to Max of ~~$1600.00~~ $1624.00 Paid In Addition to Other Negotiated Rates
Laboratory Services	**CPT4 Codes:** 0085T, 80047-89356, 89398 **HCPC Codes:** S3800	~~330%~~ 335% of Aetna Market Fee Schedule Hospital Paid In Addition to Other Negotiated Rates - Technical Rate
Multiple Sleep Latency Or Maintenance Of Wakefulness Testing, Recording, Analysis And Interpretation	**CPT4 Codes:** 95805	~~$1271.00~~ $1290.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Sleep Study Unatt&resp Efft	**CPT4 Codes:** 95806	~~$250.00~~ $254.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Sleep Study, Attended	**CPT4 Codes:** 95807	~~$755.00~~ $766.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Polysomnography; Sleep Staging With 1-3 Additional Parameters Of Sleep, Attended By A Technologist	**CPT4 Codes:** 95808	~~$798.00~~ $810.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Polysomnography; Sleep Staging With 4 Or More Addl. Parameters Ofsleep Attended By A Technologist	**CPT4 Codes:** 95810	~~$1386.00~~ $1407.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Polysomnography; Sleep Staging With 4 Or More Addl. Parameters Ofsleep, With Cpap	**CPT4 Codes:** 95811	~~$1386.00~~ $1407.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date

Ct Scan	**Revenue Codes:** 350-359	~~$740.00~~ $751.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date
Mri	**Revenue Codes:** 610-619	~~$850.00~~ $863.00 Paid In Addition to Other Negotiated Rates Once Per Unique Code Per Service Date

PROFESSIONAL COMPONENTS:

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

TERMS AND CONDITIONS:

All payments are subject to the Policies promulgated by Company pursuant to this Agreement. Moreover, payments will be based on the level of care authorized by Company.

Definition of Services:

The following service definitions are intended to help facilitate billing and payment between Hospital and Company.

1) **"Ambulatory Detoxification"** includes all services (including pre-admission services) and all related services such as physician, psychologist, nurse, counselor and all other treatment staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility.

2) **"Ambulatory Surgery"** includes all items, and services necessary to perform same day surgery or ambulatory surgery in an operating room or ambulatory surgery suite

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

4) **"Chemotherapy" (outpatient only)** includes the administration of chemotherapeutic agents.

5) **"Detoxification"** includes all services {pre-admission services}PATIP END$$$ and all related services for 24 hour inpatient level of care for members with substance-related disorders including semi-private accommodations, room and board and services such as physician, psychologist, nurse, counselor and all other treatment staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility. Rate applies when member is specifically in a Detoxification Unit.

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

7) **"Encounter Data"** – Information reported to Company for all laboratory services, as defined by the Centers for Medicare and Medicaid Services (CMS), provided to Company Members that are compensated through a capitation model.

8) **"Imaging Enhancing Substance"** – A substance that helps define areas of the body during X-rays, CT scans, MRI, or other imaging tests.

9) **"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.

11) **"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.

12) **"Intensive Outpatient"** includes all services (including pre-admission services) and all related services such as physician, psychologist, nurse, counselor and trained staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility. Services are provided at least 2 hours a day, at least 3 days per week.

13) **"Lab Results"** – The outcome of all laboratory services as defined by the Centers for Medicare and Medicaid Services (CMS) provided to Company Members.

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

15) **"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 Alternative Delivery Care. Rates are inclusive of all services; these include but are not limited to room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy; blood derivatives, blood product acquisition, processing and administration charges, ancillary services and all other services incidental to the hospital admission.

16) **"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, ancillary services and all other services incidental to the hospital admission. Distinct levels of nursery care are defined as follows:

Level I: "Newborn Nursing"

- Routine care of apparently normal full-term neonates, pre-term neonates or formerly sick neonates whose medical problems are resolved regardless of physical location in hospital.
- Infants who remain in the normal nursery for medical reasons beyond the discharge of their mothers are paid at a per diem rate at the Newborn Nursing level of care for those days beyond the discharge date of the mother.

Level II, III: "Continuing Care/Intermediate 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.
- 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.

All requirements set forth in this billing section will apply in determining the level of care provided, not the specific bed type occupied by the patient.

17) **"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.

18) **"Partial Hospitalization (Day Hospital Treatment)"** includes all services (including pre-admission services) and all related services such as physician, psychologist, nurse, counselor and trained staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility. Medically supervised, day, evening and/or night treatment programs; Services are provided at least 4 hours a day, at least 3 days per week.

19) **"Psychiatric Care"** includes all services and all related services for 24 hour inpatient level of care for members with mental disorders including semi-private accommodations, room and board and services such as physician, psychologist, nurse, counselor and trained staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility. Rate applies when member is specifically in a Psychiatric Unit.

20) **"Rehabilitation Care"** includes charges for rehabilitation care provided to patients in a rehabilitation bed; patients must receive at a minimum, three (3) hours of multidisciplinary therapy per day at least five days a week. Rates include room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy, ancillary services and all other services incidental to the hospital admission.

21) **"Rehabilitation Care (Alcohol and Drug)"** includes all services {pre-admission services} and all related services for 24 hour inpatient level of care for members with substance-related disorders including semi-private accommodations, room and board and services such as physician, psychologist, nurse, counselor and trained staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility. Rate applies when member is specifically in an Alcohol and Drug Rehabilitation Unit.

22) **"Residential Care"** includes all services (including pre-admission services) and all related services for 24 hour inpatient level of care for members with mental disorders as well as persons with substance-related disorders including semi-private accommodations, room and board and services such as physician, psychologist, nurse, counselor and trained staff services; individual, group, family and adjunctive therapies; psychiatric, psychological and medical lab tests; drugs, medicines, equipment use and supplies, history and physical examinations and all ancillary services performed at or arranged by Facility. Rate applies when member is specifically in a Residential Treatment Unit.

23) **"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, ancillary services and all services incidental to the hospital admission. 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.

24) **"Sub-Acute Eligible Care" / "Alternate Delivery Care"** ["Alternate Delivery Care"] includes charges for services provided to patients requiring inpatient subacute care. Rates include {pre-admission services} room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy, ancillary services and all other services incidental to the hospital admission. 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.

Additional 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.

Aetna Market Fee Schedule Hospital" (AMFSH) - A fee schedule that is based upon the contracted location where service is performed. Company may periodically update this fee schedule. For services that include a professional and technical component, rates will be set based upon the technical rate only. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the period prior to the completion of the updates. In the event that Hospital reasonably believes that future updates to the Aetna Market Fee Schedule Hospital may have a material adverse financial impact upon Hospital, Hospital agrees to notify Company within thirty (30) days of receipt of Notice of change to the Aetna Market Fee Schedule Hospital, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement.

"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 Service and Rate Schedule.

General

a) Hospital Services shall include all programs, services, facilities, and equipment necessary for care. Rates are inclusive of any applicable member Copayment, Coinsurance, Deductible and any applicable tax, including but not limited to sales tax, and $$$PATIP START{pre-admission services}PATIP END$$$ or $$$PATOP START{}PATOP END$$$ any professional services billed by the Hospital, and other services as may be expressly included in a given rate.

a1) $$$LESSEROF START{ Hospital shall be paid at the lesser of eligible billed charges or the applicable contracted rate herein.
}LESSEROF END$$$

$$$LESSEROF GRID START{ }LESSEROF GRID END$$$ $$$RESPDIFF START{}RESPDIFF END$$$
a2) $$$ADMPAY START{The rate applied will be the applicable Agreement rate in effect on the date of discharge.}ADMPAY END$$$

b) Case rates apply on the first day of admission if a case rate procedure is performed at any time during the inpatient stay.

c) The rate for maternity services includes the mother only. Newborn services will be paid at the applicable nursery rate. Multiple births will be paid at the applicable nursery rate.

d) Multiple Procedure Processing:

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 100.00% of the contracted rate. Subsequent procedures will be reimbursed at 100.00% of the contracted rate.

Cardiac Cath OP - Hospital: 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 100.00% of the contracted rate. Subsequent procedures will be reimbursed at 100.00% of the contracted rate.

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 surgery services will be paid at the applicable Ambulatory Surgery payment rate. Emergency services will be paid in addition to the Ambulatory Surgery Service at the applicable emergency room visit rate. If an emergency room visit results in observation services, the services associated with the emergency room visit will be paid at the applicable emergency room payment rate. The observation services will be paid in addition to the emergency room services, according to the observation services payment rate 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 meet or exceed 24 hours, the applicable observation services payment rate will be paid. Observation services will be paid in addition to ambulatory surgery services at the applicable observation services rate. If an emergency room visit results in observation services, the services associate with the emergency room visit will be paid at the applicable emergency room payment rate, The observation services will be paid in addition to the emergency room services and according to the observation services payment rate, when such services are in conjunction with emergency room visits.

g) 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 and outpatient services will be paid at the applicable rate herein.

h) Personal comfort and convenience items are not eligible for payment.under the terms of this contract. In accordance with Section 3.2.2 Billing of Members, services that are not Covered Services may be billed to the Members by Hospital only if: (a) the Member's Plan provides and/or Company confirms that the services are not covered; (b) the Member was advised in writing prior to the services being rendered that the specific services are not Covered Services; and (c) the Member agreed in writing to pay for such services.

i) 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 Rate 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 Rate Schedule.

j) Any equipment and/or services provided by an alternate facility or vendor during the course of an admission or procedure shall be the financial responsibility of the Hospital, and will be considered included in the rate noted in this rate schedule.

k) If an inpatient admission results in a transfer to another acute care facility, claims will be paid at the lesser of the Derived DRG rate or the per diem rate of ~~$3,500~~ $3,552, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

l) Submission of Lab Results and Encounters. Hospital agrees to use best efforts submit Lab Results to Company, in the form and manner specified by Company and within industry standards. Hospital agrees to submit Lab Results using Secured File Transfer Protocol process. Hospital agrees to send Lab Results to Company on a monthly basis. Subject to applicable laws and regulations, Hospital will transmit data to Company, if requested by Company, using Company's selected vendor. Company agrees that all necessary confidentiality requirements of Hospital will be adhered to by Company's selected vendor. Use of this selected vendor will not delay electronic payment remittance or electronic response to claim data currently in process.

m) $$$DRG AUDIT {Company may conduct DRG validation audits. Company or its designee will notify Hospital of its intent to audit. Company or the authorized Company representative will provide Hospital with a listing of the medical records they wish to review. This list is to contain the Member´s name, date of birth, DRG, dates of service, and if available Hospital patient control number and/or medical record number as listed on the UB-04. Information requested for DRG validation audits shall be limited to the Member´s medical record. Hospital will provide requested medical records within thirty (30) days of
request.
If an audit indicates that a DRG or a payment requires adjustment, Company or the authorized representative of Company shall provide written notice to the Hospital stating the reason for the adjustment. If Hospital disagrees with a proposed modification, it shall appeal in writing the basis of its dispute and include supporting documentation it deems helpful to clarify its position. Company shall likewise respond to such appeals within thirty (30) days of receipt. If Hospital does not dispute Company´s or Company´s authorized representative findings, then Company or Company´s representative can request the claim be refunded via the overpayment recovery process in this Agreement.}DRG AUDIT$$$ If such audits exceed five (5%) of total inpatient claims, then the parties will convene to discuss alternatives to this provision.

n) 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.

o) Not all hospitals participate in the Institutes of Excellence transplant program (IOE) program; unless hospital has executed a separate transplant services agreement or a transplant services amendment/addendum with company and/or its affiliates for participation in the IOE program ("transplant agreement"), and continues to meet company's IOE criteria, hospital is not a participating provider for members in the IOE program.

Except as specifically outlined in a current transplant agreement, nothing in this schedule applies to transplant services provided under the IOE program. Any references herein to transplant services apply only to non-IOE transplant services, unless specifically noted otherwise in the transplant services agreement.

Except with respect to Medicare members as described below, in the event of a conflict between this schedule and a transplant agreement, the terms of the transplant agreement shall prevail.

Medicare Members Receiving Transplants under the Institutes of Excellence Program: The Parties specifically agree that if Provider participates in the Company's and/or its Affiliates' Institutes of Excellence Transplant Program (IOE), and the Transplant Agreement/Amendment/Addendum applicable to the IOE Program is silent on reimbursement for Medicare Program members, then any Medicare Compensation Schedule in this Hospital Agreement shall also apply to IOE Transplant services rendered to Medicare members.

Billing

p) Unless the code is no longer a valid code, Hospital must utilize the codes set forth in the Rate Schedule when billing. Rate is based on the level of care provided, not the bed type occupied by the patient. When billing for Ambulatory Surgery, Hospital must utilize both the indicated CPT4 code and the appropriate surgical Revenue Code.

q) All professional services billed under the Hospital's federal tax identification number on a UB-04 (or its equivalent in the event UB-04s are no longer the standard billing form) billing form are not eligible for payment. All professional services billed under the Hospital's tax identification number on a CMS 1500 or equivalent form shall be paid at the Aetna Market Fee Schedule or applicable contracted rate.

Coding

r) 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).

Charge Master Increases

s) Charge Master Limit. Company acknowledges that Hospital may increase the billed charge amounts within its charge master ("Charge Master Increase"). However, Hospital shall provide Company written notice at least thirty (30) days prior to the effective date of a Charge Master Increase in accordance with the Notice section of the Agreement. Such notice will include the amount of the Charge Master Increase and its effective date. Company is entitled to rely upon the information contained in Hospital's notice of Charge Master Increases for the purpose of adjusting payment rates as set forth below. Company will communicate to Hospital in writing, via certified letter, the revised percentage of charge rate(s) [**and stop loss threshold(s)]**, if any.

In the event, Hospital implements an aggregate Charge Master Increase for those services rendered to Members and paid by Company as a percentage of Hospital's eligible billed charges that exceeds five percent (5%) during the immediately preceding twelve month period occurring on or after the effective date of the Agreement ("Charge Master Limit"), Company shall adjust all percentage of charge rates [**and stop loss thresholds]** in the manner described below. Adjusted percentage of charge rates [**and stop loss thresholds]** shall be effective on the effective date of the Charge Master Increase. Charges for Implants, prosthetics, pace makers and high cost drugs are excluded from this provision.

Company will review Hospital eligible billed charges received by Company within three months after the full year proceeding the increase. Eligible billed charges paid by Company as a percentage of Hospital's billed charges will be used in Company's review. Eligible billed charges received after the effective date of the Charge Master Increase will be compared to the eligible billed charges received prior to the effective date of the Charge Master Increase. Charge Master Increases will then be multiplied by the units reimbursed by Company during the immediately preceding twelve (12) month contract period and aggregated to determine the total Charge Master Increase. If Company determines (a) a Charge Master Increase that is higher than a Charge Master Increase reported by Hospital or (b) a Charge Master Increase not reported by Hospital that exceeds the Charge Master Limit, Company shall report such Charge Master Increase to Hospital and supporting data and calculations.

Rate Adjustments. The adjustment to percentage of charge rates will be equal to the current payment rate multiplied by one plus the Charge Master Limit divided by one plus the Charge Master Increase as calculated in the section "Payment Rate Example" below. Adjusted percentage of charge rates will be rounded to the nearest one tenth of one percent (0.1%).

[All stop loss threshold(s) will be adjusted by the full amount of the Charge Master Increase, regardless if the Charge Master Limit has been exceeded, to ensure the number of cases exceeding the stop loss threshold does not change as a result of the Charge Master Increase. Adjusted stop loss thresholds will be rounded to the nearest whole dollar amount.]

Charge Master Limit = 5%
Example Charge Master Increase = 6%

Payment Rate Example: Payment Rate Example:
Payment Rate = 48%
Adjusted Payment Rate = 47.55%
(48% X 1.05 / 1.06) = 47.5472%
rounded to the nearest one tenth of one percent (0.1%)

Stop Loss Threshold Example:
Stop Loss Threshold = $100,000.00
Adjusted Stop Loss Threshold = $106,000.00
($100,000.00 X 1.06 = $106,000.00)]

Adjustments to percentage of charge rates [**and stop loss thresholds]** will be applicable to the current and future Hospital Service and Rate Schedule(s) under this Agreement.

Overpayment Calculations. When Company is not notified or is not sufficiently notified of a Charge Master Increase prior to the increase effective date, appropriate rate adjustments can not be implemented upon the effective date of the Charge Master Increase, resulting in overpayments by Company. Company will calculate amounts paid to Hospital due to Charge Master Increases that exceed the Charge Master Limit to determine overpaid amounts ("Overpayments"). **[In addition, claims that exceed the Stop Loss Threshold due to a Charge Master Increase will be included in the Overpayment calculation.]** Company shall notify Hospital in writing of the Overpayments and provide claim detail for the overpaid claims.

Hospital agrees to remit the Overpayments to Company in accordance with the overpayment language provisions contained within this Agreement.

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.

Stop Loss:

In the event Hospital´s eligible billed charges for inpatient Covered Services for an individual Member´s admission exceed ~~$87000.00~~ $91,350.00 ("Threshold"), then the following shall apply: Company shall compensate Hospital according to the negotiated rate for those inpatient days through the Member´s discharge day, plus 60.00 % of the Hospital´s eligible billed charges that exceed the Threshold.

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.
COLA END

Start Date	End Date	Adjustment Based On:
08.01.2016	07/31/2017	Fixed Rate of 1.50%

Cola Excluded Services:
Neonates, Died Or Transferrd - Rate
Stop Loss - Threshold