

State: Arkansas **Filing Company:** UnitedHealthcare Plan of the River Valley, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO
Product Name: All Payer Appendices, etal. (PPR Payer Appendix v12)
Project Name/Number: All Payer Appendices, etal. (PPR Payer Appendix v12)/All Payer Appendices, etal. (PPR Payer Appendix v12)

Filing at a Glance

Company: UnitedHealthcare Plan of the River Valley, Inc.
 Product Name: All Payer Appendices, etal. (PPR Payer Appendix v12)
 State: Arkansas
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)
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 Filing Type: Form
 Date Submitted: 01/25/2013
 SERFF Tr Num: UHLC-128867987
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: FEES PAID
 Co Tr Num: ALL PAYER APPENDICES, ETAL. (PPR PAYER APPENDIX V12

 Implementation: On Approval
 Date Requested:
 Author(s): Kelly Smith
 Reviewer(s): Rosalind Minor (primary)
 Disposition Date: 01/30/2013
 Disposition Status: Approved-Closed
 Implementation Date:

State Filing Description:

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General Information

Project Name: All Payer Appendices, etal. (PPR Payer Appendix v12 Status of Filing in Domicile: Not Filed
Project Number: All Payer Appendices, etal. (PPR Payer Appendix v12 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 01/30/2013
State Status Changed: 01/28/2013 Deemer Date:
Created By: Kelly Smith Submitted By: Kelly Smith
Corresponding Filing Tracking Number: All Payer Appendices, etal. (PPR Payer Appendix v12

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
FPA and ANC pay apps in Arkansas.

These pay apps will be used with the following previously-approved templates, or any approved successor templates:

- UHC/FPA.ANC.AR.03.10
• UHC/FAC.MGA.ANCL-REGAPX.08.06.AR

Company and Contact

Filing Contact Information

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800 King Farm Blvd. 240-632-8061 [Phone]
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Rockville, MD 20850

Filing Company Information

UnitedHealthcare Plan of the River Valley, Inc. CoCode: 95378 State of Domicile: Illinois
1300 River Drive, Suite 200 Group Code: 707 Company Type: HMO
Moline, IL 61265 Group Name: State ID Number:
(309) 765-1485 ext. [Phone] FEIN Number: 36-3379945

Filing Fees

State: Arkansas Filing Company: UnitedHealthcare Plan of the River Valley, Inc.

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Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? No

Fee Explanation:

Per Company: No

Company	Amount	Date Processed	Transaction #
UnitedHealthcare Plan of the River Valley, Inc.	\$50.00	01/25/2013	66900905

SERFF Tracking #: UHLC-128867987 **State Tracking #:** **Company Tracking #:** ALL PAYER APPENDICES, ETAL. (PPR PAYER A...

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/30/2013	01/30/2013

SERFF Tracking #:

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Disposition

Disposition Date: 01/30/2013

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	PPR Payer Appendix v12, Per Diem Fixed OP Appendix v12, Per Diem APC Appendix v12, MS-DRG FixedOP Appendix v12, MS-DRG APC Appendix v12	Approved-Closed	Yes
Form	Mixed Fixed PPR Appendix v12, Home Health Services UB Appendix v12, ACS Free Standing 1500 UB Appendix v12	Approved-Closed	Yes
Form	ANC Hospice Appendix v12, ANC Dialysis Appendix v12	Approved-Closed	Yes

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All Payer Appendices, etal. (PPR Payer Appendix v12/All Payer Appendices, etal. (PPR Payer Appendix v12

Form Schedule

Lead Form Number: All Payer Appendices, etal. (PPR Payer Appendix v12

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/30/2013	PPR Payer Appendix v12, Per Diem Fixed OP Appendix v12, Per Diem APC Appendix v12, MS-DRG FixedOP Appendix v12, MS-DRG APC Appendix v12	PPR Payer Appendix v12, Per Diem Fixed OP Appendix v12, Per Diem APC Appendix v12, MS-DRG FixedOP Appendix v12, MS-DRG APC Appendix v12	FND	Initial		52.900	PPR Appendix v12.pdf Per Diem FixedOP Appendix v12.pdf Per Diem APC Appendix v12.pdf MS-DRG FixedOP Appendix v12.pdf MS-DRG APC Appendix v12.pdf

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Lead Form Number: All Payer Appendices, etal. (PPR Payer Appendix v12

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
2	Approved-Closed 01/30/2013	Mixed Fixed PPR Appendix v12, Home Health Services UB Appendix v12, ACS Free Standing 1500 UB Appendix v12	Mixed Fixed PPR Appendix v12, Home Health Services UB Appendix v12, ACS Free Standing 1500 UB Appendix v12	FND	Initial		52.900	Mixed Fixed PPR Appendix v12.pdf Home Health Services UB Appendix v12.pdf ASC Free Standing 1500 UB Appendix v12.pdf
3	Approved-Closed 01/30/2013	ANC Hospice Appendix v12, ANC Dialysis Appendix v12	ANC Hospice Appendix v12, ANC Dialysis Appendix v12	FND	Initial		52.900	ANC Hospice Appendix v12.pdf ANC Dialysis Appendix v12.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)

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MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

All Payer Appendix

Facility Name(s): _____

Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1

Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.5 of this Appendix.

MS-DRG (Medicare Severity Diagnosis-Related Groups): A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status.

Observation: Services furnished by Facility on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

PPR (Percentage Payment Rate): The percentage applied to Facility's Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine ("M.D.") or a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2

Contract Rate for Covered Services

- 2.1 Contract Rate.** For Covered Services rendered by Facility to a Customer, the applicable contract rates will be determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.
- 2.2 Inpatient Covered Services.** For the provision of Inpatient Covered Services to a Customer during an Admission, other than those addressed in Section 3.5, the contract rate will be _____% of Eligible Charges, less any applicable Customer Expenses. The contract rate for an Admission is the contract rate in effect on the date the Admission begins.

Notes to Inpatient Covered Services

Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

If Facility has a separate inpatient skilled nursing unit, hospice unit, or rehabilitation unit, the charges for the skilled nursing, hospice, or rehabilitation stay are to be submitted separately from the acute hospital stay.

- 2.3 Outpatient Covered Service Categories.** For the provision of Covered Services rendered by Facility to a Customer, other than those addressed in Section 2.2, Section 3.4, or Section 3.5, the contract rate will be _____% of Eligible Charges, less any applicable Customer Expenses. For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

Additional information regarding Emergency department visits under this Appendix

The following applies to Emergency department visits under this Appendix: Facility's Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OPPI/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change. In the event such change has a negative projected financial impact to United or its Payers, United and Facility, within 30 days of above notification, will evaluate and agree upon contract rates going forward that will assure that changes to Facility's Emergency department visits coding guidelines do not have the impact of increasing the amount paid by United or its Payers under this Appendix. Based on the agreed upon rate adjustment, both parties will execute an amendment to implement the adjusted contract rates going forward. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section, or due to Facility providing inaccurate information, United may recover those overpayments, as outlined in the Facility Participation Agreement.

In the event the parties are unable to agree on contract rates going forward, the matter may be resolved in accordance with the dispute resolution provisions of the Agreement. In addition to determining the impact of Facility's Emergency department visits coding guidelines changes, the Arbitrator may determine the new contract rates going forward necessary to ensure that United

and its Payers are not impacted by Facility's coding guideline changes from the effective date of the coding guideline change.

SECTION 3 **Miscellaneous Provisions**

- 3.1 Inclusive Rates.** The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.
- 3.2 Payment Code Updates.** United will update CPT codes, HCPCS codes, ICD-9-CM codes, or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.
- 3.3 Facility-based Physician and Other Provider Charges.** Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Appendix is in effect.

At any time after _____, the current contract rates for all Covered Services under this Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility's charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative _____ (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

[Current Contract Rate – (Current Contract Rate x Percentage Reduction) = New Contract Rate]

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%
Emergency Physicians	Emergency Room Services	10%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 1: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 2: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health – Medical Social Services
0116	Detox/Private	0570-0579	Home Health – Home Health Aide
0124	Psych/2bed	0580-0589	Home Health – Other Visits
0126	Detox/2bed	0590	Home Health – Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care

0154	Psych/Ward	0810-0819	Donor Bank/ Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab
0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees
0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521- 0522, 0524- 0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Center (FQHC)	3101-3109	Adult Care
0550-0559	Home Health - Skilled Nursing		
MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD9 37.52, 37.63- 37.66	Heart Transplant	010	Pancreas Transplant
005-006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

SECTION 4

Adjustment to Contract Rates Due to Changes in Facility’s Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility’s Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility’s Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

4.2 Duty to Give Notice. Facility will notify United at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

4.3 Content of Notice. Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

(a) Facility’s Chargemaster data before and after the increase in Facility’s Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:

- (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and
 - (ii) in a mutually acceptable format.
- (b) The effective date of the Facility's new Chargemaster;
- (c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:
- (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,
 - (ii) in a mutually acceptable format, and
 - (iii) separately for inpatient and outpatient services.
- (d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.; and
- (e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with United. Facility will cooperate with United in administration of this section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates and fixed contract rates (impacted by lesser of) using the estimates in the notice. United will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. United may implement the revised appendix without Facility's consent; provided that the revised appendix

contains no other changes. United will provide Facility with a copy of the revised Amendment, along with the effective date of the revised appendix.

4.6 United's right to audit. In addition to any other audit rights that United may have under this the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), United may recover those overpayments. United will give Facility notice of, and United intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates or fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement, modified as follows:

- (a) The parties will confer in good faith, and will resolve the matter through prospective and temporary contract rate adjustments to the contract rates for Covered Services set forth in this Appendix. Such prospective contract rate adjustment will be calculated to account for and neutralize the financial impact of the Customary Charge increase at issue to the contract rates set forth in this Appendix, so that Customary Charge increase will not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix. The temporary contract rate adjustment will be calculated to address, through an additional and temporary adjustment to the contract rates, the financial impact on all claims impacted by the Customary Charge increase (inpatient claims with the date the Admission started and outpatient claims with dates of service occurring on and following the date of the Customary Charge increase at issue) for dates of service prior to the effective date of the contract rate adjustment.
- (b) If the parties are unable to amicably resolve the matter and implement an updated appendix with prospective and temporary contract rate adjustments within 90 days of

receipt of the above-described notice, either party which remains dissatisfied may provide written notice to the other party of its decision to employ the services of a third party consultant with expertise in account relevant to the issues at hand rather than to an arbitrator selected as described in the Agreement to resolve the dispute. The consultant's scope will be limited to quantifying the financial impact of the Customary Charge increase and the prospective and temporary contract rate adjustments in dispute to the parties. The consultant will be jointly selected by the parties. The parties will work together in good faith to develop a list of eligible consultants by _____. The consultant fee will be shared equally between United and the Facility.

Each party will simultaneously and confidentially submit to the Consultant and to each other the following data elements:

- (i) a prospective contract rate adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), as described above, to account for the ongoing impact of the Customary Charge increase in dispute, for Covered Services with dates of service starting 30 days after the date of the Consultant's decision;
- (ii) a temporary adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), to the prospective contract rate adjustment, to account for the impact on claims that were impacted by the Customary Charge increase and that have dates of service prior to the effective date of the prospective contract rate adjustment described in the bullet immediately above this bullet (United may instead elect to address the claims with dates of service prior to effective date of the prospective contract rate adjustment by reprocessing those claims in accordance with the prospective contract rate adjustment, in which case the temporary adjustment will not be applied) (should United elect to reprocess the claims as set forth herein, the reprocessing process must be completed within ninety (90) days of the date of the Consultant's decision); and
- (iii) the length of time the temporary adjustment should remain in effect, and
- (iv) Utilization data that supports the party's prospective and temporary contract rate adjustment.

The data elements listed in (b)(i)-(iii) will collectively be referred to as each party's "Proposal."

- (c) Each party will have the same deadline for submitting their respective Proposals to the consultant; that deadline will be a date jointly selected by the parties or, if the parties cannot agree upon a date, the consultant will select a date. The consultant must select either the Proposal submitted by Facility in its entirety or the Proposal proposed by United in its entirety.
- (d) After the proposed findings are submitted to the consultant, the parties will meet with each other to review the submissions and explore the opportunity to resolve the dispute on a mutually satisfactory basis.
- (e) In the event the parties are unable to settle the matter, each party may submit to the consultant, with a copy to the other party, a response to the other party's Proposal; the deadline for submitting these responses will be jointly determined by the parties or, if the parties cannot agree upon a date, the consultant will select a date.

- (f) In the event the parties agree that a hearing should be held, or that a hearing is not necessary, the agreement of the parties will be followed. In the event that the parties cannot agree on whether a hearing is needed, the consultant will decide whether a hearing is necessary.
- (g) The decision of the consultant will be binding on the parties to the same extent as the decision of the arbitrator under the dispute resolution process set forth in the Agreement.

Chargemaster Notice Exhibit

All Payer Appendix

Facility Name(s): _____

Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1

Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.6 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

MS-DRG (Medicare Severity Diagnosis-Related Groups): A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status.

Observation: Services furnished by Facility on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated “Per Case” in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated “Per Diem” in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Unit via Facility Fee Schedule: The Payment Method designated “Per Unit via Facility Fee Schedule” in this Appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise specified in this Appendix, payment under the Per Unit via Facility Fee Schedule Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and Facility and ancillary services. The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule must always equal the number of times a procedure or service is performed.

Per Visit: The flat rate Payment Method designated “Per Visit” in this Appendix and applicable to Covered Services rendered to a Customer on one-calendar day period, for each Service Category within Section 2 for which a Per Visit Payment Method is indicated in this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia

supplies), medications, and Facility and ancillary services. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

PPR (Percentage Payment Rate): The percentage applied to Facility’s detail line item Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine (“M.D.”) or a Doctor of Osteopathy (“D.O.”) or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2 Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. The contract rate for an Admission is the contract rate in effect on the date the Admission begins.

Table 1A: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Medical/Surgical/ICU/CCU/PICU/ICU-Intermediate/CCU-Intermediate ^ (see note ^ below) Includes the following Revenue Codes Revenue Codes 0100-0101, 0110-0113, 0117, 0119-0123, 0127, 0129-0133, 0137, 0139-0143, 0147, 0149-0153, 0157, 0159-0160, 0164, 0169, 0170-0174, 0179, 0200-0203, 0206-0212, 0214, 0219	Per Diem	\$ _____
Hospice ~ ^ (see notes ~ and ^ below) Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656	Per Diem	\$ _____
Nursery* (see note * below) <ul style="list-style-type: none"> • Normal Newborn: MS-DRG 795 • Lower Level Neonate: MS-DRGs 789, 792, 794 • Higher Level Neonate: MS-DRGs 791, 793 • Severe Level Neonate: MS-DRG 790 	Per Diem Per Diem Per Diem Per Diem	\$ _____ \$ _____ \$ _____ \$ _____
Obstetrics (Mother only)* (see note * below) Vaginal delivery MS-DRGs: 767-768, 774-775 Cesarean Section MS-DRGs: 765-766	Per Case Per Case	\$ _____ \$ _____

False Labor MS-DRG: 780	Per Diem	\$ _____
Rehabilitation ~ ^ (see notes ~ and ^ below) Revenue Codes 0118, 0128, 0138, 0148, 0158	Per Diem	\$ _____
Hospital Sub-Acute Revenue Codes 0190-0194, 0199 However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.6 _____	Per Diem	\$ _____
Inpatient Skilled Nursing Services ~ (see note ~ below) Bill Types 211-219	Per Diem	\$ _____

Notes to Table 1A

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

^ However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by MS-DRGs or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.6 _____ .

Additional information regarding MS-DRGs under this Appendix

The following applies to MS-DRGs as used in this Appendix:

-United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement.

-The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

-All changes in the definition of MS-DRGs specified in the Final Rule will be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the definition are implemented under this Appendix, the previous definitions will apply. Claims with discharge dates 10/1 and later, that are processed during the period in between the CMS effective date and United's implementation date will continue to have the previous MS-DRG grouper applied. Claims with discharge dates 10/1 and later that are processed following United's implementation date for the MS-DRG grouper updates will have the new grouper applied.

Table 1B - Inpatient Cardiac Services for which the contract rate will not be determined according to Table 1A. For an Admission that includes any of the following Inpatient Covered Services provided to a Customer, the contract rates for the entire Admission are determined as follows.

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
001 w/ICD9 37.52, 37.63-37.66	Implant of Heart Assist System w MCC	\$ _____
002 w/ICD9 37.52, 37.63-37.66	Implant of Heart Assist System w/o MCC	\$ _____
215	Other Heart Assist System Implant	\$ _____
216	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization w MCC	\$ _____
217	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization w CC	\$ _____
219	Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization w MCC	\$ _____
220	Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization w CC	\$ _____
222	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure or Shock w MCC	\$ _____
223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure or Shock w/o MCC	\$ _____
224	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock w MCC	\$ _____
225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock w/o MCC	\$ _____
226	Cardiac Defibrillator Implant without Cardiac Catheterization w MCC	\$ _____
227	Cardiac Defibrillator Implant without Cardiac Catheterization w/o MCC	\$ _____
228	Other Cardiothoracic Procedures w MCC	\$ _____
229	Other Cardiothoracic Procedures w CC	\$ _____
231	Coronary Bypass with PTCA w MCC	\$ _____
232	Coronary Bypass with PTCA w/o MCC	\$ _____
233	Coronary Bypass with Cardiac Cath w MCC	\$ _____
234	Coronary Bypass with Cardiac Cath w/o MCC	\$ _____
235	Coronary Bypass without Cardiac Cath w MC	\$ _____
236	Coronary Bypass without Cardiac Cath w/o MCC	\$ _____
237	Major Cardiovascular Procedures w MCC	\$ _____
238	Major Cardiovascular Procedures w/o MCC	\$ _____
242	Permanent Cardiac Pacemaker Implant w MCC	\$ _____
243	Permanent Cardiac Pacemaker Implant w CC	\$ _____
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC .	\$ _____
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ vessels/stents	\$ _____
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC.	\$ _____

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
248	Percutaneous Cardiovascular Procedures with Non-drug Eluting Stent w MCC or 4+ vessels/stents	\$ _____
249	Percutaneous Cardiovascular Procedure with Non-Drug Eluting Stent w/o MCC	\$ _____
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent or AMI w MCC.	\$ _____
251	Percutaneous Cardiovascular Procedures without Coronary Artery Stent or AMI w/o MCC.	\$ _____
252	Other Vascular Procedures w MCC	\$ _____
253	Other Vascular Procedures w CC	\$ _____
258	Cardiac Pacemaker Device Replacement w MCC	\$ _____
259	Cardiac Pacemaker Device Replacement w/o MCC	\$ _____
260	Cardiac Pacemaker Revision except Device Replacement w MCC	\$ _____
261	Cardiac Pacemaker Revision except Device Replacement w CC	\$ _____
262	Cardiac Pacemaker Revision except Device Replacement w/o CC/MCC	\$ _____
286	Circulatory Disorders Except AMI with Cardiac Catheterization w MCC	\$ _____
287	Circulatory Disorders Except AMI with Cardiac Catheterization w/o MCC	\$ _____

Refer to “Additional information regarding MS-DRGs under this Appendix” under Table 1A for additional pertinent information.

Table 1C - Inpatient Orthopedic and Spine Services for which the contract rate will not be determined according to Table 1A. For an Admission that includes any of the following Inpatient Covered Services provided to a Customer, the contract rates for the entire Admission are determined as follows.

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
453	Combined Anterior/Posterior Spinal Fusion w MCC	\$ _____
454	Combined Anterior/Posterior Spinal Fusion w CC	\$ _____
455	Combined Anterior/Posterior Spinal Fusion w/o CC/MCC	\$ _____
456	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w MCC	\$ _____
457	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w CC	\$ _____
458	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection	\$ _____

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
	or 9+ Fusions w/o CC/MCC	
459	Spinal Fusion Except Cervical w MCC	\$ _____
460	Spinal Fusion Except Cervical w/o MCC	\$ _____
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity w MCC	\$ _____
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity w/o MCC	\$ _____
466	Revision of Hip or Knee Replacement w MCC	\$ _____
467	Revision of Hip or Knee Replacement w CC	\$ _____
468	Revision of Hip or Knee Replacement w/o CC/MCC	\$ _____
469	Major Joint Replacement or Reattachment of Lower Extremity w MCC	\$ _____
470	Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	\$ _____
471	Cervical Spinal Fusion w MCC	\$ _____
472	Cervical Spinal Fusion w CC	\$ _____
473	Cervical Spinal Fusion w/o CC/MCC	\$ _____
490	Back and Neck Procedures Except Spinal Fusion w CC/MCC or Disc Devices/Neurostimulator	\$ _____
491	Back and Neck Procedures Except Spinal Fusion w/o CC/MCC	\$ _____
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w MCC	\$ _____
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w CC	\$ _____
494	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w/o CC/MCC	\$ _____

Refer to “Additional information regarding MS-DRGs under this Appendix” under Table 1A for additional pertinent information.

2.2.1 Transfer of Customer. This Section applies only when a Per Case, Per Case plus Per Diem after Threshold or MS-DRG Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by the Centers for Medicare and Medicaid Services (CMS) except for MS-DRGs designated by CMS as “special pay” MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the “Imputed Per Diem Rate”) as described in the next sentence. The Imputed Per Diem Rate is

determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as “special pay” MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an imputed per diem rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is 50% of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

- (a) Based on CMS readmission guidelines; and
- (b) To readmissions with a related diagnosis (as determined by United); and
- (c) Prior to the determination of the contract rate for the subsequent Admission

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.3 Outpatient Covered Services. For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

2.3.1 Observation, Outpatient Therapeutic, Diagnostic, Emergency, Urgent Care Covered Services. For the provision of Observation, therapeutic, diagnostic, Emergency, and Urgent Care Covered Services rendered by Facility to a Customer on an outpatient basis (except for Outpatient Procedures addressed in Section 2.3.2 of this Appendix), the contract rate will be determined according to this Section 2.3.

If more than one type of Covered Service for which a Per Visit, Per Unit via Facility Fee Schedule, Payment Method applies are provided to a Customer during one calendar day, each of the applicable Payment Methods will be considered in calculating the aggregate contract rate for those Covered Services; provided, however, if the Customer receives any Covered Service for which a Per Case Payment Method applies, all Covered Services which would otherwise be paid

pursuant to a Per Visit, Per Unit via Facility Fee Schedule, Payment Method, will instead be included in the Per Case contract rate and will not be separately reimbursed _____.

The contract rate for outpatient Covered Services rendered by Facility to a Customer, as detailed on Table 2 below, will be determined according to the Payment Method listed in the table.

Table 2: Outpatient Diagnostic and Therapeutic Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery (Revenue Codes 0333 with CPT Code 61796-61800, 63620-63621, 77371, G0173, G0251)	Per Case	\$ _____
Observation (Revenue Code: 0762)	Per Case	\$ _____
Emergency (Revenue Codes: 0450-0452, 0459) (1)	Per Case	\$ _____
Urgent Care (Revenue Code: 0456)	Per Case	\$ _____
IV Therapy (Revenue Codes 0260, 0269)	Per Visit	\$ _____
Oncology Treatment (Revenue Codes: 0280, 0289)	Per Visit	\$ _____
Laboratory (Revenue Codes: 0300-0307, 0309, 0923, 0925) (See Facility Lab Fee Schedule Notes below and lab Fee Schedule Exhibit)	Per Unit via UHC Facility Lab Fee Schedule # _____	36 % of the “Source Fee” as described in the UHC Facility Lab Fee Schedule Exhibit
Pathology (Revenue Codes: 0310-0312, 0314, 0319) (See Facility Lab Fee Schedule Notes below and lab Fee Schedule Exhibit)	Per Unit Via UHC Facility Lab Fee Schedule # _____	36 %of the “Source Fee” as described in the UHC Facility Lab Fee Schedule Exhibit
Other Diagnostic Radiology (Revenue Codes 0320-0324, 0329) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Cyber Knife – Initial Visit (Revenue Code 0333 with CPT Code G0339)	Per Visit	\$ _____
Cyber Knife – Subsequent Visit (Revenue Code 0333 with CPT Code G0340)	Per Visit	\$ _____
Radiation Therapy (Revenue Codes 0330, 0333, 0339 without CPT Codes 61796-61800, 63620-63621, 77371, G0173, G0251, G0339-G0340)	Per Visit	\$ _____
Chemotherapy Administration (Revenue Codes: 0331-0332, 0335)	Per Visit	\$ _____
Nuclear Medicine (Revenue Codes 0340-0342, 0349) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit

Computerized Tomography (CT) Scan (Revenue Codes 0350-0352, 0359) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Blood and Blood Related Services (Revenue Code 0380-0389, 0390-0392, 0399)	Per Visit	\$ _____
Imaging Services (Revenue Codes: 0400, 0409)) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Diagnostic and Screening Mammography (Revenue Codes: 0401, 0403) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Ultrasound Imaging (Revenue Code: 0402) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Positron Emission Tomography (Revenue Code: 0404) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Respiratory Services (Revenue Codes: 0410, 0412, 0419)	Per Visit	\$ _____
Hyperbaric (Revenue Code: 0413)	Per Visit	\$ _____
Physical Therapy (Revenue Codes: 0420-0424, 0429)	Per Visit	\$ _____
Occupational Therapy (Revenue Codes: 0430-0434, 0439)	Per Visit	\$ _____
Speech Therapy (Revenue Codes: 0440-0444, 0449)	Per Visit	\$ _____
Pulmonary Function (Revenue Codes: 0460, 0469)	Per Visit	\$ _____
Audiology (Revenue Codes: 0470-0472, 0479)	Per Visit	\$ _____
Cardiology (Revenue Code 0480, 0489)	Per Visit	\$ _____
Cardiac Stress Test (Revenue Code: 0482)	Per Visit	\$ _____
Echocardiology (Revenue Code: 0483)	Per Visit	\$ _____
Ambulance - Land (Revenue Codes: 0540, 0542-0543, 0546-0549)	Per Visit	\$ _____
Ambulance - Air (Revenue Code: 0545)	Per Visit	\$ _____
Magnetic Resonance Imaging (Revenue Codes 0610-0612, 0614-0616, 0618, 0619) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Labor Room/Delivery Services (Revenue Codes 0720-0722, 0724, 0729)	Per Visit	\$ _____
EKG and ECG (Revenue Codes: 0730, 0739)	Per Visit	\$ _____

Holter Monitor/Telemetry (Revenue Codes: 0731-0732)	Per Visit	\$ _____
EEG (Revenue Codes 0740, without CPT Codes 95800-95801, 95805-95811, G0398-G0400)	Per Visit	\$ _____
Vaccine Administration (Revenue Code 0771)	Per Visit	\$ _____
Hemodialysis (Revenue Codes 0820-0825, 0829)	Per Visit	\$ _____
Peritoneal Dialysis, CAPD and CCPD (Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis) (Revenue Codes 0830-0835, 0839-0845, 0849-0855, 0859)	Per Visit	\$ _____
MEG (Revenue Codes 0860-0861)	Per Visit	\$ _____
Neuropsychological Testing and Biofeedback for NON-PSYCHIATRIC disorders only (Revenue Codes 0900, 0917-0918)	Per Visit	\$ _____
Other Diagnostic Services (Revenue Codes 0920, 0929 without CPT Codes 95800-95801, 95805-95811, G0398-G0400)	Per Visit	\$ _____
Sleep Studies - Unattended (Revenue Codes 0740, 0920, 0929 with CPT Codes 95800-95801, 95806, G0398-G0400)	Per Visit	\$ _____
Sleep Studies - Attended (Revenue Codes 0740, 0920, 0929 with CPT Codes 95805, 95807-95811)	Per Visit	\$ _____
Peripheral Vascular Lab (Revenue Code: 0921)	Per Visit	\$ _____
EMG (Revenue Code: 0922)	Per Visit	\$ _____
Allergy Testing (Revenue Code: 0924)	Per Visit	\$ _____
Other Therapeutic Services (Revenue Codes: 0940, 0949)	Per Visit	\$ _____
Education and Training (Revenue Code: 0942)	Per Visit	\$ _____
Cardiac Rehabilitation Therapy (Revenue Code: 0943)	Per Visit	\$ _____
Pulmonary Rehabilitation (Revenue Code:0948)	Per Visit	\$ _____

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission.

(1) Facility’s Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OPPTS/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change.

Facility Lab Fee Schedule Notes

Calculation of the contract rate for Laboratory and Pathology is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- The Per Unit via Facility Fee Schedule rates for existing codes are in effect until both parties mutually agree to rate changes.

- Unless otherwise indicated in the Facility Fee Schedule Specifications, Laboratory/Pathology Codes listed on the fee schedule that do not have a Primary or Gap Fill Source Fee will default to a contract rate of 50% PPR (“Fee Schedule Default PPR”) unless or until a Primary or Gap Fill Source Fee is published.
- There will be a quarterly update to the fee schedule to set fixed contract rates for new codes published throughout the previous quarter and codes previously priced according to the Fee Schedule Default PPR. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes in the UHC Facility Lab Fee Schedule by multiplying the “Primary Fee Source” rate or the applicable “Gap Fill Fee Source” rate by the same percentage as indicated in Table 2.
- Refer to the “Facility Fee Schedule Specifications” (included within the Facility Lab Fee Schedule Exhibit) for additional detail.
- _____ Payment Policies, as described in Article I of the Agreement, apply to this fee schedule reimbursement methodology.

Facility Radiology Fee Schedule Notes

Calculation of the contract rate for Radiology is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- The Per Unit via Facility Fee Schedule rates for existing codes are in effect until both parties mutually agree to rate changes.
- Unless otherwise indicated in the Facility Fee Schedule Specifications, Radiology Codes listed on the fee schedule that do not have a Primary or Gap Fill Source Fee will default to a contract rate of 50% PPR (“Fee Schedule Default PPR”) unless or until a Primary or Gap Fill Source Fee is published.
- There will be a quarterly update to the fee schedule to set fixed contract rates for new codes published throughout the previous quarter and codes previously priced according to the Fee Schedule Default PPR. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes in the UHC Facility Radiology Fee Schedule by multiplying the “Primary Fee Source” rate or the applicable “Gap Fill Fee Source” rate by the same percentage as indicated in Table 2.
- Refer to the “Facility Fee Schedule Specifications” (included within the Facility Radiology Fee Schedule Exhibit) for additional detail.
- _____ Payment Policies, as described in Article I of the Agreement, apply to this fee schedule reimbursement methodology.

2.3.2 Outpatient Procedures.

Outpatient Procedure: This Section applies to Covered Services rendered to a Customer that involves a Procedure, as listed in the UHC OPG (Outpatient Procedure Grouper) Exhibit to this Appendix, performed in an outpatient unit of Facility (“Outpatient Procedure”). For Outpatient Procedures, the contract rate will be based on a designated group number, as set forth in the table below and as further described in this Section 2.3.2. Unless otherwise specified in this Appendix, payment under this contract rate, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to Customer during an Outpatient Procedure. The group numbers below correspond with certain Outpatient Procedures identified in the UHC OPG Exhibit to this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. United may revise the information in the UHC OPG Exhibit based on newly published codes and updated Outpatient Procedure grouping information developed by CMS, which may be modified by United to include procedures that are not maintained by CMS, but are considered for payment under this Appendix. The codes indicated with a “Y” under the “OPG Eligible” column in the UHC OPG Exhibit that corresponds to the date of service, that are Covered Services, are considered eligible for payment under this Section 2.3.2. Any updates to the information in the UHC OPG Exhibit will be furnished to Facility upon request.

The UHC OPG Exhibit includes a comprehensive list of revenue codes and CPT/HCPCS codes for which the contract rate is determined according to the Outpatient Procedure Grouper table below. In the event a revenue code from the table below is billed with a CPT/HCPCS code indicated with an “N” under the “OPG Eligible” column in the UHC OPG Exhibit that corresponds to the date of service, the detail line item that includes that revenue code and CPT/HCPCS code is not eligible for consideration for reimbursement. However, if that detail line item is the only detail line item that has a revenue code from the table below, then the parties will consult as needed, at an operational level, to review the circumstances of the claim and assign appropriate CPT/HCPCS coding. Facility may resubmit the claim with the corrected coding information for consideration for reimbursement pursuant to this Appendix.

Table 3: Outpatient Procedure Grouper

Outpatient Procedures (Revenue Codes 0360, 0361, 0369, 0481, 0490, 0499, 0750 and 0790, and appropriate CPT or HCPCS Codes.) See the UHC OPG Exhibit for Revenue Code and CPT or HCPCS code criteria.	
Group Number	Per Case Contract Rate
0	\$ _____
1	\$ _____
2	\$ _____
3	\$ _____
4	\$ _____
5	\$ _____
6	\$ _____
7	\$ _____
8	\$ _____
9	\$ _____
10	\$ _____
Unlisted	\$ _____

2.3.3 Multiple Outpatient Procedures. When multiple Outpatient Procedures, including unlisted Outpatient Procedures, are performed on a Customer by Facility during one Outpatient Encounter, the contract rate is as follows: (1) the highest contract rate specified in Section 2.3.2 for which an Outpatient Procedure has been performed; plus (2) 50% of the contract rate specified in Section 2.3.2 for the Outpatient Procedure performed with the second highest contract rate. No additional payments for additional Outpatient Procedures performed during that Outpatient Encounter will be made; instead, such additional Outpatient Procedure(s) are included in the contract rate for the first two Outpatient Procedures.

2.3.4 Multiple Per Case Covered Services. If Outpatient Procedures, Observation, Emergency, and/or Urgent Care Covered Services are provided within a single Outpatient Encounter along with Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery (as specified in Section 2.3.1), a contract rate will apply only to the Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery; the Outpatient Procedures, Observation, Emergency, and/or Urgent Care service will be considered to have been included in the contract rate for the Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery.

If the Customer receives any Covered Services for which a Per Case Payment Method applies, all Covered Services during a single Outpatient Encounter that would otherwise have a contract rate pursuant to a Per Visit, Per Unit via Facility Fee Schedule, Payment Method will instead be included in the Per Case contract rate except for Covered Services eligible for reimbursement as a

pass through under Section 2.3.5.

If more than one Covered Service subject to a Per Case Payment Method applies during a single Outpatient Encounter (as specified in Section 2.3), the contract rate will be the rate applicable to the Covered Service with the highest ranking, as indicated in the Case Rate Service Ranking table below. No additional payments for additional Covered Services provided during that same single Outpatient Encounter, for which a Per Case Payment Method applies, will be made; instead, such additional Covered Services will be considered to have been included in the contract rate for the Covered Service with the highest ranking on the table below.

Services on the Case Rate Service Ranking table below are ranked from the highest ranking to the lowest ranking, with Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery, as identified in Section 2.3.1, having the highest ranking.

Case Rate Service Ranking
Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery
Outpatient Procedures, as identified in Section 2.3.2
Observation
Emergency
Urgent Care

SECTION 3 Miscellaneous Provisions

- 3.1 Inclusive Rates.** The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.
- 3.2 Payment Code Updates.** United will update CPT codes, HCPCS codes, ICD-9-CM codes, or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.
- 3.3 Facility-based Physician and Other Provider Charges.** Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after _____, the current contract rates for all Covered Services under this Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility’s charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative _____ (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

$$[\text{Current Contract Rate} - (\text{Current Contract Rate} \times \text{Percentage Reduction}) = \text{New Contract Rate}]$$

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%
Emergency Physicians	Emergency Room Services	10%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%
		%
		%
		%
		%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 4: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence

Revenue Code	Description	Revenue Code	Description
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes, when they are Covered Services billed with a Covered Service subject to a Per Case, Per Visit, Per Diem, MS-DRG, Per Unit via Facility Fee Schedule, PPR Per Case to a fixed cap, PPR Per Case or Per Unit Payment Method under this Appendix, are always considered included in other services. These Covered Services are therefore not subject to additional payment.

Services or items billed with listed codes in the table below, when they are Covered Services, but are not billed with a Covered Service subject to a Per Case, Per Visit, Per Diem, MS-DRG, Per Unit via Facility Fee Schedule, PPR Per Case to a fixed cap, PPR Per Case or Per Unit Payment Method under this Appendix, are subject to a PPR of _____ % of Eligible Charges for the Covered Service, less any applicable Customer Expenses. However, this PPR is subject to change under Section 4 as a result of changes to Facility’s Customary Charges. Additionally, adjustments to the PPR rate pursuant to Section 4 of this Appendix will carry forward into subsequent years.

Regardless of which of the above paragraphs apply, the Eligible Charges for the services or items listed in the table below are considered in other calculations for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, as permitted under the Agreement.

Table 5: Services that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0230-239	Nursing Increment	0541	Ambulance/Supply
0240-249	All Inclusive Ancillary	0544	Ambulance/Oxygen
0250	Pharmacy	0621	Med-Surg Sup/Incident Radiology
0251	Drugs/Generic	0622	Med-Surg Supplies Incident ODX
0252	Drugs/ Non Generic	0623	Surgical Dressing
0254	Drugs/Incidental Other DX	0631	Single Source Drug
0255	Drugs/Incidental Radiology	0632	Multiple Source Drug
0257	Drugs/Nonprescription	0633	Restrictive Prescription
0258	IV Solutions	0634	EPO < 10,000 Units
0259	Drugs/Other	0635	EPO 10,000 or More Units

Revenue Code	Description	Revenue Code	Description
0261	IV Therapy/Infusion Pump	0636 _____	Drugs Requiring Detailed Coding
0262	IV Therapy/RX Svs	0637	Self Administrable Drugs Not Requiring Detailed Coding
0263	IV Therapy/Drug/Supply Delv	0681	Trauma Level 1
0264	IV Therapy/Supplies	0682	Trauma Level 2
0270	Medical Surgical Supplies	0683-0689	Trauma Response
0271	Non Sterile Supply	0700	Cast Room
0272	Sterile Supply	0710	Recovery Room
0274	Prosthetic/Orthotic Device	0723	Circumcision
0275 _____	Pacemaker	0760-0761, 0769	Specialty Services/Treatment Room
0276 _____	Intraocular Lens	0770	Preventive Care Svr/General
0278 _____	Supply/Implants	0780	Telemedicine
0279	Supply/Other	0800-0809	IP Renal Dialysis
0343-0344 _____	Nuclear Medicine – Diagnostic/Therapeutic Radiopharmaceuticals	0880-0881, 0889	Dialysis Miscellaneous
0370-0379	Anesthesia	0946	Complex Med Equip
0500	OP Service	0947	Complex Med Equip/Ancillary
0509	OP/Other	0950-0952	Other Therapeutic Services
0510-0511, 0514-0520, 0523, 0526, 0529	Clinic	2101	Acupuncture
0530-0539	Osteopathic Services	2103	Massage

3.6 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 6: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health - Medical Social Services
0116	Detox/Private	0570-0579	Home Health -Home Health Aide
0124	Psych/2bed	0580-0589	Home Health -Other Visits
0126	Detox/2bed	0590	Home Health -Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen

Revenue Code	Description	Revenue Code	Description
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819	Donor Bank/Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab
0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees
0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Center(FQHC)	3101-3109	Adult Care
0550-0559	Home Health -Skilled Nursing		
MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD9 37.52, 37.63-37.66	Heart Transplant	010	Pancreas Transplant
005-006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

3.7 Open Heart Surgical Procedure Following Outpatient Cardiac Catheterization. If a Customer is admitted to Facility for an open heart surgical procedure within three calendar days of a cardiac catheterization Outpatient Procedure, the contract rate set forth in Section 2.3.2 will not apply, and the contract rate for an open heart procedure as set forth in Section 2.2 of this Appendix will be paid. No additional payments will be made for the cardiac catheterization services; instead, the cardiac catheterization services will be considered to have been reimbursed as part of the contract rate for the open-heart surgical procedure.

3.8 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Customer nor Payer will be

billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

SECTION 4

Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

- 4.1 Intent.** The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

- 4.2 Duty to Give Notice.** Facility will notify United at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

- 4.3 Content of Notice.** Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

(a) Facility's Chargemaster data before and after the increase in Facility's Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and

(ii) in a mutually acceptable format.

(b) The effective date of the Facility's new Chargemaster;

(c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services

Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,

- (ii) in a mutually acceptable format, and
- (iii) separately for inpatient and outpatient services.

(d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.; and

(e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with United. Facility will cooperate with United in administration of this section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates, excluding the 50% PPR default rate indicated in the Facility Lab and/or Radiology Fee Schedule Notes and applicable Specification Sheet and fixed contract rates (impacted by lesser of) using the estimates in the notice. United will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. United may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment, along with the effective date of the revised appendix.

4.6 United's right to audit. In addition to any other audit rights that United may have under the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), United may recover those overpayments. United will give Facility notice of, and United intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will

prospectively adjust the PPR contract rates and fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement, modified as follows:

- (a) The parties will confer in good faith, and will resolve the matter through prospective and temporary contract rate adjustments to the contract rates for Covered Services set forth in this Appendix. Such prospective contract rate adjustment will be calculated to account for and neutralize the financial impact of the Customary Charge increase at issue to the contract rates set forth in this Appendix, so that Customary Charge increase will not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix. The temporary contract rate adjustment will be calculated to address, through an additional and temporary adjustment to the contract rates, the financial impact on all claims impacted by the Customary Charge increase (inpatient claims with the date the Admission started and outpatient claims with dates of service occurring on and following the date of the Customary Charge increase at issue) for dates of service prior to the effective date of the contract rate adjustment.
- (b) If the parties are unable to amicably resolve the matter and implement an updated appendix with prospective and temporary contract rate adjustments within 90 days of receipt of the above-described notice, either party which remains dissatisfied may provide written notice to the other party of its decision to employ the services of a third party consultant with expertise in account relevant to the issues at hand rather than to an arbitrator selected as described in the Agreement to resolve the dispute. The consultant's scope will be limited to quantifying the financial impact of the Customary Charge increase and the prospective and temporary contract rate adjustments in dispute to the parties. The consultant will be jointly selected by the parties. The parties will work together in good faith to develop a list of eligible consultants by _____. The consultant fee will be shared equally between United and the Facility.

Each party will simultaneously and confidentially submit to the Consultant and to each other the following data elements:

- (i) a prospective contract rate adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), as described above, to account for the ongoing impact of the Customary Charge increase in dispute, for Covered Services with dates of service starting 30 days after the date of the Consultant's decision;

- (ii) a temporary adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), to the prospective contract rate adjustment, to account for the impact on claims that were impacted by the Customary Charge increase and that have dates of service prior to the effective date of the prospective contract rate adjustment described in the bullet immediately above this bullet (United may instead elect to address the claims with dates of service prior to effective date of the prospective contract rate adjustment by reprocessing those claims in accordance with the prospective contract rate adjustment, in which case the temporary adjustment will not be applied) (should United elect to reprocess the claims as set forth herein, the reprocessing process must be completed within ninety (90) days of the date of the Consultant's decision); and
- (iii) the length of time the temporary adjustment should remain in effect, and
- (iv) Utilization data that supports the party's prospective and temporary contract rate adjustment.

The data elements listed in (b)(i)-(iii) will collectively be referred to as each party's "Proposal."

- (c) Each party will have the same deadline for submitting their respective Proposals to the consultant; that deadline will be a date jointly selected by the parties or, if the parties cannot agree upon a date, the consultant will select a date. The consultant must select either the Proposal submitted by Facility in its entirety or the Proposal proposed by United in its entirety.
- (d) After the proposed findings are submitted to the consultant, the parties will meet with each other to review the submissions and explore the opportunity to resolve the dispute on a mutually satisfactory basis.
- (e) In the event the parties are unable to settle the matter, each party may submit to the consultant, with a copy to the other party, a response to the other party's Proposal; the deadline for submitting these responses will be jointly determined by the parties or, if the parties cannot agree upon a date, the consultant will select a date.
- (f) In the event the parties agree that a hearing should be held, or that a hearing is not necessary, the agreement of the parties will be followed. In the event that the parties cannot agree on whether a hearing is needed, the consultant will decide whether a hearing is necessary.
- (g) The decision of the consultant will be binding on the parties to the same extent as the decision of the arbitrator under the dispute resolution process set forth in the Agreement.

SECTION 5

Performance Based Compensation Program

To encourage Facility's efforts to improve both the quality and the efficiency of its patient care and to recognize successful performance with regard to these efforts, United will implement the PBC Program described by this Section 5, which provides to Facility the opportunity to qualify for adjustments to the Eligible Contract Rates, subject to meeting the program requirements described herein. Nothing herein is intended to compensate Facility for limiting or withholding clinically appropriate care from any Customer.

Facility understands and agrees that this Section 5 applies to, and only to, the Facility location(s) covered by this Appendix unless another Appendix to the Agreement expressly provides otherwise. If this Section 5 applies to more than one Facility location, Facility understands and agrees that the performance of all such locations will be measured in the aggregate to determine whether Facility has met the requirements hereunder. Implementation of the PBC Program in the event of changes in the locations covered by this Appendix is discussed in Section 5.7 below.

5.1 Definitions. Unless otherwise defined in this Section 5, capitalized terms used in this Section shall have the meanings assigned to them in this Appendix or in the Agreement.

Actual Performance Result: Facility's performance or experience with respect to a given Performance Measure based on the applicable Measurement Period or Data Capture Date, as determined using the applicable Performance Measure Criteria. Facility's Actual Performance Result is compared to the corresponding Performance Target to determine whether Facility successfully achieved the Performance Measure, as further discussed in Section 5.3. Actual Performance Results may be restated as described in Section 5.5.3.

Baseline: The value, as restated from time to time in accordance with Section 5.5.3, that represents Facility's level of performance or experience with respect to a given Performance Measure as measured with respect to the Baseline period set forth in the Baseline Exhibit.

Data Capture Date: The date during the Data Capture Period on which United obtains a third party data report.

Data Capture Period: With respect to those Performance Measures that are evaluated based on third party data, the date span during which United will obtain the applicable third party data reports. The Data Capture Period for a given Performance Measure is specified in the Timeline Exhibit.

Eligible Contract Rate: Each contract rate for a Covered Service that is reimbursed under this Appendix using any Payment Method other than a PPR or Per Unit via Facility Fee Schedule.

Measurement Period: The applicable date span used to determine Facility's Actual Performance Result with respect to each Performance Measure that is evaluated based on claims data, with or without United notification data. To determine Facility's Actual Performance Result for a given Performance Year on a Performance Measure that is evaluated based on claims data, with or without United notification data, as reflected in the final Performance Report, United will include not less than two months' claims run out for the Performance Measure.

Measurement Time: The applicable Measurement Period or Data Capture Period.

Payout Year or PY: Subject to earlier termination of the Agreement, each successive 12 month period, beginning with the first Payout Year, with respect to which Facility participates in the PBC Program. Subject to termination of the Agreement and Section 5.6.2, Eligible Contract Rates are adjusted during the Payout Year to reflect the Performance Escalator, if any, attributable to that Payout Year. The first Payout Year (or PY1) is the 12 month period that begins on the first anniversary of the Effective Date of the Agreement.

PBC Goal: The maximum adjustment to Eligible Contract Rates available under the PBC Program for a given Payout Year which, as further described in Section 5.3, is used to determine Facility's Performance Escalator.

PBC Program: United's Performance Based Compensation Program for hospitals, as described by this Section 5.

Performance Escalator: The increase to Eligible Contract Rates attributable to Facility's performance with respect to the Performance Measures for a given Payout Year, as determined and applied during that Payout Year in accordance with this Section 5.

Performance Measure: Each of the measures listed in the PBC Exhibit.

Performance Measure Criteria: United's description of and measurement logic for a particular Performance Measure.

Performance Points: The points associated with Facility's performance on a Performance Measure with respect to a given Payout Year, as set forth in the PBC Exhibit.

Performance Report: The interim quarterly or final report with respect to a given Payout Year that shows, on an interim or final basis, Facility's Actual Performance Results and the other information described in Section 5.5.2 of this Appendix.

Performance Target: The specified level of performance or experience that Facility must achieve on a particular Performance Measure with respect to a given Payout Year in order to meet the Performance Measure for purposes of this Section 5.

Rebased Contract Rate: The Eligible Contract Rate as adjusted to remove the impact of the Performance Escalator, as further described in Section 5.6 of this Appendix.

5.2 Eligibility to Participate in the PBC Program; Payout Year Terms.

5.2.1 Eligibility. To be eligible to participate in the PBC Program, Facility must be an acute inpatient hospital other than a long term acute care hospital, long term care hospital, or rehabilitation hospital.

5.2.2 Payout Year Terms. Subject to earlier termination of the Agreement, the Performance Measures, the corresponding Performance Targets, the allocation of Performance Points, and the applicable PBC Goal set forth in the PBC Exhibit and the Measurement Times set forth in the Timeline Exhibit will govern Facility's participation in the PBC Program with respect to each specified Payout Year.

Beginning with the first Payout Year for which terms are not specified in the PBC Exhibit, and with respect to each Payout Year thereafter, United and Facility agree to the following:

(a) At least 24 months prior to the first day of the next Payout Year for which the parties have not specified terms in writing, United and Facility will meet for the purpose of determining the applicable Performance Measures, the corresponding Performance Targets and Performance Points, and the applicable PBC Goal for that Payout Year. The parties will document the mutually agreed upon new terms in a written amendment signed by both parties within the timeframe specified in subparagraph 5.2.2(b).

(b) If the parties have not mutually agreed in writing on the Performance Measures, Performance Targets, Performance Points, and PBC Goal at least 18 months prior to the first day of the Payout Year to which such terms would apply, then the parties agree that they will keep the same Performance Measures, Performance Points, and PBC Goal used for the Payout Year immediately preceding that Payout Year and will use the applicable Section 5.2.2 default Performance Targets shown in the PBC Exhibit.

(c) For each subsequent Payout Year, the Measurement Time for a given Performance Measure will begin one year after the date on which the Measurement Time for that Performance Measure began for the prior Payout Year and continue for the same duration. If the parties agree on a new Performance Measure, it will have the standard Measurement Time assigned to that Performance Measure under the PBC Program based on the start date of Facility's next Payout Year.

5.3 Evaluation of Performance Measures; Performance Escalator. With respect to each Payout Year, United will assess Facility's Actual Performance Result for each Performance Measure. The Actual Performance Result will be determined in accordance with this Section 5 and the applicable Performance Measure Criteria. The Performance Measure Criteria for each of the Performance Measures in effect as of the effective date of this Appendix are provided in the Performance Measure Criteria Exhibits. United may modify the Performance Measure Criteria from time to time. United may implement the revised Performance Measure Criteria without Facility's consent if the same criteria are applicable to all or substantially all facilities in United's network that are subject to the corresponding Performance Measure. United will make the current Performance Measure Criteria for each Performance Measure available to Facility upon request.

If Facility's Actual Performance Result is equal to or better than the applicable Performance Target, Facility has met the Performance Measure. For each Performance Measure that Facility meets, United will credit Facility with the corresponding Performance Points shown in the PBC Exhibit. The maximum number of Performance Points available is 100. United will aggregate the Performance Points credited to Facility for all Performance Measures achieved with respect to a given Payout Year. The total Performance Points credited to Facility will range from 100 points to 0 points. United will use the following formula to determine the Performance Escalator attributable to that Payout Year:

$$[\text{total Performance Points} \div 100] * [\text{the PBC Goal}] = \text{Performance Escalator}$$

The Performance Escalator will be a percentage rounded up or down to the nearest one tenth of one percent (0.1%).

5.4 Data Sources. The PBC Exhibit indicates the data source United will use to assess Facility's performance on each Performance Measure. Such assessment is subject to the requirements and limitations set forth in this Section 5.4.

5.4.1 Claims. If the data source is claims:

(a) The applicable Performance Measure Criteria will describe the claims United will use to evaluate and report on Facility's performance with respect to each of the applicable Performance Measures.

(b) United is not currently able to include all claims submitted by Facility in the computation of Facility's performance on a Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of claims, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.4.2 Third Party Data. Except as expressly noted otherwise, if the data source is data made available by or through CMS or another third party:

(a) United will use the most current data available from the third party data source as of the Data Capture Date. If the third party has failed to timely update the available data, United will use the older data that is available as of the Data Capture Date. If more current data subsequently

becomes available during the Data Capture Period but after the Data Capture Date, United will have no obligation to use the more current data, but may do so in its sole discretion, provided that use of the newer data will not delay timely delivery of the Performance Report.

(b) If the third party changes the information available to United in such a way that United cannot reasonably or meaningfully determine Facility's Actual Performance Result in accordance with the applicable Performance Measure Criteria, United will update the applicable Performance Measure Criteria in accordance with Section 5.3 to describe the alternate method United will use to determine Facility's Actual Performance Result.

(c) If the third party (i) ceases to gather and/or publish such data, (ii) ceases to make the data available to United on reasonable terms, or (iii) materially changes the scope or type of data it makes available, then the parties will mutually agree on a replacement Performance Measure. Alternately, the parties may agree to eliminate the affected Performance Measure and reallocate the Performance Points to the remaining Performance Measures.

5.4.3 Notification Data. If the data source is claims and United notification data, Section 5.4.1 applies with regard to claims and, with regard to United notification data:

(a) The applicable Performance Measure Criteria will describe the data United will use to evaluate and report on Facility's performance with respect to the applicable Performance Measure.

(b) United is not currently able to include notification data associated with all claims submitted by Facility in computation of Facility's performance on this Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of data, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.5 Performance Reports, Restatements, and Reconsideration.

5.5.1 Performance Reports. With respect to each Payout Year, United will provide Facility with quarterly Performance Reports, or electronic access to such reports, regarding Facility's performance on the Performance Measures. These Performance Reports will be consistent with the Performance Reports that United provides to other facilities participating in United's PBC Program. Performance Reports based on United claims data will be prepared using a reasonable period for claims run out and report development. Interim Performance Reports will reflect a date range that is different from the applicable Measurement Period; only the final Performance Report for a given Payout Year will reflect the date range defined as the applicable Measurement Period. The final Performance Report for a given Payout Year determines the Performance Escalator, if any, to be applied in that Payout Year. The final Performance Report will be provided or made available on or before the Performance Report due date specified in the Timeline Exhibit.

5.5.2 Content of Performance Report. Each Performance Report will include, at a minimum, the following content:

- (a) the Performance Target and corresponding Performance Target value for each Performance Measure;
- (b) Facility's Actual Performance Result (in the final Performance Report) or an interim calculation of the Actual Performance Result (in the interim Performance Reports) for each Performance Measure;
- (c) the Performance Points earned based on final or interim performance;

- (d) the earned Performance Points as a percentage of the maximum Performance Points; and
- (e) the Performance Escalator (in the final Performance Report) or an interim calculation of the Performance Escalator (in the interim Performance Reports).

Subject to and as limited by contractual confidentiality obligations and all applicable state and federal laws (including but not limited to privacy laws), supporting data for Facility's Actual Performance Result on a given Performance Measure will be provided to Facility upon request.

5.5.3 Restatements. The Baseline and Actual Performance Result for a Performance Measure may be restated by United on a quarterly basis to take into account any one or more of the following:

- (a) adjustments made by CMS or another nationally recognized source, for example MS-DRG weights or NQF approved calculations, in order to accurately compare Facility's baseline measure to Facility's performance with respect to the applicable Payout Year;
- (b) the addition or deletion of a Facility location covered by this Appendix and participating in the PBC Program, in accordance with Section 5.7;
- (c) restated or additional claims information;
- (d) corrections to databases identified by United or by a third party vendor; and
- (e) the inclusion of additional Affiliate claims.

Restated Baseline and Actual Performance Results will be shown in the interim and final Performance Reports. Once the Performance Escalator for a given Payout Year has been implemented in accordance with Section 5.6, it will not thereafter be changed due to a subsequent restatement of a Baseline or Actual Performance Result.

5.5.4 Third Party Certification. United will engage a third party at least annually to certify the data, methodology, measurement logic and software code supporting each Performance Measure. Documentation of the certification will be provided to Facility upon request.

5.5.5 Facility Objections. After reviewing the Performance Report, if Facility disagrees with United's determination of one or more Actual Performance Result(s) for one or more Performance Measure(s) due to (1) how the applicable methodology was applied, (2) how the applicable logic was used, or (3) whether the applicable software code was used, Facility may request reconsideration of the disputed determination(s). Facility will follow this reconsideration process:

- (a) Facility will send to United the reconsideration request in writing, which may be sent electronically, within 10 business days after the date on which Facility received a copy of or electronic access to the final Performance Report. United will provide Facility with the appropriate mailing address or email address for reconsideration requests. If the reconsideration is not requested timely, Facility will be deemed to have waived its right to pursue reconsideration in any forum.
- (b) The reconsideration request must include all of the following:
 - i) identification of each Performance Measure to be reconsidered;
 - ii) identification of the Actual Performance Result calculated by United for each contested Performance Measure;
 - iii) a detailed explanation of why Facility believes that the methodology, logic or software code is improper; and
 - iv) any other relevant information to support Facility's reconsideration request.

5.5.6 Reconsideration Period. Following receipt of the reconsideration request, United will review and respond to Facility within 10 business days. Upon Facility's written request, United will provide

supporting data for each contested Performance Measure, subject to and as limited by contractual confidentiality obligations and applicable state and federal laws (including but not limited to privacy laws).

Within 10 business days after receiving United's response, Facility will inform United in writing whether the response has resolved Facility's concerns or not. If Facility still disagrees with United's Performance Report, the parties will promptly meet and confer about Facility's reconsideration request. If United and Facility have not reached a mutually satisfactory resolution regarding Facility's reconsideration request at least 45 days prior to the first day of the upcoming Payout Year, then the Performance Escalator will be effective on the first day of the first calendar month that begins at least 31 days after the date that the parties achieved such resolution. Contract rate adjustments described in Section 3 of this Appendix will not be delayed, and United will implement those adjustments effective as of the time specified in Section 3 in accordance with Section 5.6.

If the parties are unable to reach a mutually satisfactory resolution regarding Facility's reconsideration request, either party may initiate dispute resolution pursuant to Article VII of the Agreement.

5.6 Performance Escalator.

5.6.1 Application of Performance Escalator. The Performance Escalator, if any, determined in accordance with Section 5.3 will be applied to each Eligible Contract Rate, subject to the following adjustments:

- (a) The Performance Escalator is not intended to be cumulative in its effect from one year to the next. Accordingly, if a Performance Escalator is applied to the Eligible Contract Rates following successful performance by Facility with respect to a given Payout Year, the increase will always be removed from each rate effective as of the first day after the end of the Payout Year in which the Performance Escalator was applied. The removal of the Performance Escalator establishes the "Rebased Contract Rate." Any Performance Escalator applied hereunder will be applied to the Rebased Contract Rate. Likewise, and notwithstanding anything in this Appendix to the contrary, any annual adjustment made in accordance with Section 3 of this Appendix will be applied to the applicable Rebased Contract Rates (regardless of whether or not a Performance Escalator is also applicable in that contract year). This methodology is illustrated in the Example Section below.
- (b) The Performance Escalator is additive to any annual adjustment specified in Section 3 of this Appendix. Both the Section 3 adjustment and the Performance Escalator are applied to the applicable Rebased Contract Rate. This methodology is illustrated in the Example Section below.
- (c) Application of the Performance Escalator will take into account adjustments made under Section 4 of this Appendix. Notwithstanding anything in this Appendix to the contrary, a Section 4 Chargemaster adjustment will be made to the Eligible Contract Rate in effect at the time of such adjustment. In the event a Chargemaster adjustment occurred in the prior contract year the calculation to determine the Rebased Contract Rate will include the impact of that Chargemaster adjustment under Section 4. If a Chargemaster adjustment and a Performance Escalator become effective on the same date, the Chargemaster adjustment will occur after the calculation of the Rebased Contract Rates and the Performance Escalator will then be applied to the adjusted Rebased Contract Rate.
- (d) The adjusted Eligible Contract Rates will be rounded up or down to the nearest whole dollar.

Example Section:

Fixed Rate Example: Assume the contract rate for a given Covered Service is \$100 in the year preceding the first Payout Year of this example. This example shows achievement of a Performance Escalator of 1% applied during PY1; a Performance Escalator of 0% applied during PY2; and a Performance Escalator of 2% applied during PY3. Using the formula described below, Row H indicates the contract rate applicable during each of the following Payout Years:

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
A	prior year contract rate [1]	value from row H of prior year	n/a	\$100	\$103	\$104
B	Rebased Contract Rate	A – [value from row F of prior year]	n/a	\$100.00	\$102.00	\$104.00
C	Section 3 annual adjustment		n/a	2.0%	2.0%	2.0%
D	-- increase/decrease for Section 3 annual adjustment	B x C	n/a	\$2.00	\$2.04	\$2.08
E	Section 5 Performance Escalator		n/a	1.0%	0.0%	2.0%
F	-- increase for Section 5 Performance Escalator	B x E	n/a	\$1.00	\$0.00	\$2.08
G	total adjustment	D + F	n/a	\$3.00	\$2.04	\$4.16
H	adjusted contract rate (rounded)	B + G (except the rate applicable in the year prior to PY1)	\$100	\$103	\$104	\$108

[1] Section 5.6.1 discusses various adjustments that may be applicable to a given contract rate. Assume for purposes of this example that there are no other applicable contract rate adjustments beyond those shown in the table.

5.6.2 Adjustment to Eligible Contract Rates. United will adjust each Eligible Contract Rate to reflect the Performance Escalator, consistent with any other adjustments described in this Appendix. The Performance Escalator will be effective with respect to Covered Services furnished by Facility on or after the first day of the Payout Year for which the Performance Escalator was calculated or such later date as may be determined by the parties’ mutual written agreement or by an express term of this Appendix, and will continue in effect through the last day of the Payout Year, subject to the earlier termination of the Agreement or of this Payment Appendix. _____

5.7 Changes in Facility Locations Covered by this Appendix; Assignment. This Section 5.7 sets forth the parties’ expectations with respect to implementation of this Section 5 in the event of a change in the Facility locations subject to the Agreement. Any such change must occur in accordance with an applicable provision of the Agreement. Nothing in this Section 5.7 creates or will be construed to create any rights with regard to how or when changes in Facility locations, assignment or other transfer of the Agreement may occur.

- (a) If a location is added to the Agreement and covered by this Appendix after the end of the claims Measurement Periods, the new location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year. That location will be included in determining Facility's Actual Performance Results for the next Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.
- (b) If a location is added to the Agreement and covered by this Appendix before the end of the claims Measurement Periods, the new location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures for the corresponding Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.
- (c) If a location is deleted from this Appendix after the end of the claims Measurement Periods, that location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures with respect to the corresponding Payout Year. The deleted location will not be included in determining Facility's Actual Performance Results with respect to any additional Payout Years. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.
- (d) If a location is deleted from this Appendix before the end of the claims Measurement Periods, that location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year or any future Payout Year. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.
- (e) In the event of a partial assignment of the Agreement that includes this Appendix, or if this Appendix otherwise continues to apply to one or more (but not all) of the Facility locations previously contracted by or through Facility due to a merger or other transaction that results in Facility no longer owning and controlling such location(s), each such location will be treated as a "deleted location" for purposes of determining the period, if any, during which its performance or experience will continue to be aggregated with the remaining Facility locations. Once any continued period of aggregating ends, such location's performance or experience will be evaluated alone or with such other locations as are likewise subject to continued application of the Appendix following the assignment or transfer of such rights.
- (f) If the data used for evaluation of one of more of the applicable Performance Measures cannot be aggregated or segregated as contemplated by this Section 5.7 with respect to the performance of a particular location, the parties will use best efforts to implement the PBC Program with respect to such location(s) consistent with the intent of this Section 5.

UHC Facility Lab Fee Schedule Exhibit

Facility acknowledges receipt of an electronic version of the UHC Facility Lab Fee Schedule Exhibit. Attached is the “Facility Fee Schedule Specifications” and “Representative Facility Fee Schedule Sample”.

UHC Facility Radiology Fee Schedule Exhibit

Facility acknowledges receipt of an electronic version of the UHC Facility Radiology Fee Schedule Exhibit. Attached is the “Facility Fee Schedule Specifications” and “Representative Facility Fee Schedule Sample”.

UHC OPG (Outpatient Procedure Grouper) Exhibit

Facility acknowledges receipt of an electronic version of the UHC OPG (Outpatient Procedure Grouper) Exhibit.

REVENUE CODE:

0360, 0361, 0369

0481

0490, 0499

0750

0790

WITH CPT / HCPCS CODES THAT ARE CONSIDERED “OPG ELIGIBLE” AS NOTED WITH A “Y” IN THE MOST CURRENT UHC OPG (OUTPATIENT PROCEDURE GROUPE) EXHIBIT

Chargemaster Notice Exhibit

PBC Exhibit

Timeline Exhibit

Baseline Exhibit

Performance Measure Criteria Exhibits

All Payer Appendix

Facility or Facilities subject to this Appendix as of this Appendix Effective Date: _____
Tax ID: _____
Provider ID: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1 Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

APC (Ambulatory Payment Classifications): A system of classification, known as Ambulatory Payment Classifications, for outpatient hospital services based on, among other factors, CPT codes, HCPCS procedure codes, and payment status indicators.

The Payment Method designated “APC” in this Appendix and applicable to Covered Services rendered to a Customer for each unit of service performed within the Outpatient Service Category for which the APC Payment Method is indicated in the Outpatient Service Categories Table of this Appendix. The contract rate is determined by applying the APC CMS relative weight to the contracted conversion factor, without separate consideration for wage index and outliers, modified in accordance with the applicable rate set forth in Table 2 in Section 2.3 of this Appendix. Unless otherwise specified in this Appendix, payment under the APC Payment Method, less any applicable Customer Expenses, is payment in full. In the event CMS makes any modification to the calculation of APC payments, the methodology and factors relating to such APC payments will be updated by United on or before the later of (a) thirty (30) days after the effective date of such modification; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will update the methodology and factors in accordance with such subsequent change within thirty (30) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) thirty (30) days after the date on which CMS initially places information regarding such modification in the public domain (e.g., CMS distributes program memoranda to hospitals). The contract rates for claims processed during the time period between CMS updates and United's updates are based on the date the claim is processed.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer’s Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer’s Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.6 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

MS-DRG (Medicare Severity Diagnosis-Related Groups): A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status.

Observation: Services furnished by Facility on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

OPPS (Outpatient Prospective Payment System): A prospective payment system implemented by CMS for hospital outpatient services. APCs are a component of the OPSS. Fee schedules are another component of this payment system.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated "Per Case" in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated "Per Diem" in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Unit via Facility Fee Schedule: The Payment Method designated "Per Unit via Facility Fee Schedule" in this Appendix, without separate consideration for geographic adjustment (unless otherwise specified in this Appendix), based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for services for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required

to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by the Centers for Medicare and Medicaid Services (CMS). In the event CMS makes any modification to the calculation of the CMS fee schedule(s) listed in Table 2, the fee schedule(s) will be updated by United on or before the later of (a) thirty (30) days after the effective date of such modification; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will update the fee schedule(s) in accordance with such subsequent change within thirty (30) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) thirty (30) days after the date on which CMS initially places information regarding such modification in the public domain (e.g., CMS distributes program memoranda to hospitals).

The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule, must always equal the number of times a procedure or service is performed.

PPR (Percentage Payment Rate): The percentage applied to Facility’s detail line item Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine (“M.D.”) or a Doctor of Osteopathy (“D.O.”) or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2 Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. The contract rate for an Admission is the contract rate in effect on the date the Admission begins.

Table 1A: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Medical/Surgical/ICU/CCU/PICU/ICU-Intermediate/CCU-Intermediate ^ (see note ^ below) Includes the following Revenue Codes Revenue Codes 0100-0101, 0110-0113, 0117, 0119-0123, 0127, 0129-0133, 0137, 0139-0143, 0147, 0149-0153, 0157, 0159-0160, 0164, 0169, 0170-0174, 0179, 0200-0203, 0206-0212, 0214, 0219	Per Diem	\$_____

Hospice ~ ^ (see notes ~ and ^ below) Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656	Per Diem	\$ _____
Nursery* (see note * below) • Normal Newborn: MS-DRG 795 • Lower Level Neonate: MS-DRGs 789, 792, 794 • Higher Level Neonate: MS-DRGs 791, 793 • Severe Level Neonate: MS-DRG 790	Per Diem Per Diem Per Diem Per Diem	\$ _____ \$ _____ \$ _____ \$ _____
Obstetrics (Mother only)* (see note * below) Vaginal delivery MS-DRGs: 767-768, 774-775	Per Case	\$ _____
Cesarean Section MS-DRGs: 765-766	Per Case	\$ _____
False Labor MS-DRG: 780	Per Diem	\$ _____
Rehabilitation ~ ^ (see notes ~ and ^ below) Revenue Codes 0118, 0128, 0138, 0148, 0158	Per Diem	\$ _____
Hospital Sub-Acute Revenue Codes 0190-0194, 0199 However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.5 _____	Per Diem	\$ _____
Inpatient Skilled Nursing Services~ (see note ~ below) Bill Types 211-219	Per Diem	\$ _____

Notes to Table 1A

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

^ However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by MS-DRGs or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.6 _____.

Additional information regarding MS-DRGs under this Appendix

The following applies to MS-DRGs as used in this Appendix:

-United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement.

-The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

-All changes in the definition of MS-DRGs specified in the Final Rule will be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the

definition are implemented under this Appendix, the previous definitions will apply. Claims with discharge dates 10/1 and later, that are processed during the period in between the CMS effective date and United's implementation date will continue to have the previous MS-DRG grouper applied. Claims with discharge dates 10/1 and later that are processed following United's implementation date for the MS-DRG grouper updates will have the new grouper applied.

Table 1B - Inpatient Cardiac Services for which the contract rate will not be determined according to Table 1A. For an Admission that includes any of the following Inpatient Covered Services provided to a Customer, the contract rates for the entire Admission are determined as follows.

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
001 w/ICD9 37.52, 37.63-37.66	Implant of Heart Assist System w MCC	\$ _____
002 w/ICD9 37.52, 37.63-37.66	Implant of Heart Assist System w/o MCC	\$ _____
215	Other Heart Assist System Implant	\$ _____
216	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization w MCC	\$ _____
217	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization w CC	\$ _____
219	Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization w MCC	\$ _____
220	Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization w CC	\$ _____
222	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure or Shock w MCC	\$ _____
223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure or Shock w/o MCC	\$ _____
224	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock w MCC	\$ _____
225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock w/o MCC	\$ _____
226	Cardiac Defibrillator Implant without Cardiac Catheterization w MCC	\$ _____
227	Cardiac Defibrillator Implant without Cardiac Catheterization w/o MCC	\$ _____
228	Other Cardiothoracic Procedures w MCC	\$ _____
229	Other Cardiothoracic Procedures w CC	\$ _____
231	Coronary Bypass with PTCA w MCC	\$ _____
232	Coronary Bypass with PTCA w/o MCC	\$ _____
233	Coronary Bypass with Cardiac Cath w MCC	\$ _____
234	Coronary Bypass with Cardiac Cath w/o MCC	\$ _____
235	Coronary Bypass without Cardiac Cath w MC	\$ _____
236	Coronary Bypass without Cardiac Cath w/o MCC	\$ _____
237	Major Cardiovascular Procedures w MCC	\$ _____

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
238	Major Cardiovascular Procedures w/o MCC	\$ _____
242	Permanent Cardiac Pacemaker Implant w MCC	\$ _____
243	Permanent Cardiac Pacemaker Implant w CC	\$ _____
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC .	\$ _____
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ vessels/stents	\$ _____
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC.	\$ _____
248	Percutaneous Cardiovascular Procedures with Non-drug Eluting Stent w MCC or 4+ vessels/stents	\$ _____
249	Percutaneous Cardiovascular Procedure with Non-Drug Eluting Stent w/o MCC	\$ _____
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent or AMI w MCC.	\$ _____
251	Percutaneous Cardiovascular Procedures without Coronary Artery Stent or AMI w/o MCC.	\$ _____
252	Other Vascular Procedures w MCC	\$ _____
253	Other Vascular Procedures w CC	\$ _____
258	Cardiac Pacemaker Device Replacement w MCC	\$ _____
259	Cardiac Pacemaker Device Replacement w/o MCC	\$ _____
260	Cardiac Pacemaker Revision except Device Replacement w MCC	\$ _____
261	Cardiac Pacemaker Revision except Device Replacement w CC	\$ _____
262	Cardiac Pacemaker Revision except Device Replacement w/o CC/MCC	\$ _____
286	Circulatory Disorders Except AMI with Cardiac Catheterization w MCC	\$ _____
287	Circulatory Disorders Except AMI with Cardiac Catheterization w/o MCC	\$ _____

Refer to “Additional information regarding MS-DRGs under this Appendix” under Table 1A for additional pertinent information.

Table 1C - Inpatient Orthopedic and Spine Services for which the contract rate will not be determined according to Table 1A. For an Admission that includes any of the following Inpatient Covered Services provided to a Customer, the contract rates for the entire Admission are determined as follows.

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
453	Combined Anterior/Posterior Spinal Fusion w MCC	\$ _____
454	Combined Anterior/Posterior Spinal Fusion w CC	\$ _____
455	Combined Anterior/Posterior Spinal Fusion w/o CC/MCC	\$ _____
456	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w MCC	\$ _____
457	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w CC	\$ _____
458	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w/o CC/MCC	\$ _____
459	Spinal Fusion Except Cervical w MCC	\$ _____
460	Spinal Fusion Except Cervical w/o MCC	\$ _____
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity w MCC	\$ _____
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity w/o MCC	\$ _____
466	Revision of Hip or Knee Replacement w MCC	\$ _____
467	Revision of Hip or Knee Replacement w CC	\$ _____
468	Revision of Hip or Knee Replacement w/o CC/MCC	\$ _____
469	Major Joint Replacement or Reattachment of Lower Extremity w MCC	\$ _____
470	Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	\$ _____
471	Cervical Spinal Fusion w MCC	\$ _____
472	Cervical Spinal Fusion w CC	\$ _____
473	Cervical Spinal Fusion w/o CC/MCC	\$ _____
490	Back and Neck Procedures Except Spinal Fusion w CC/MCC or Disc Devices/Neurostimulator	\$ _____
491	Back and Neck Procedures Except Spinal Fusion w/o CC/MCC	\$ _____
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w MCC	\$ _____
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w CC	\$ _____
494	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w/o CC/MCC	\$ _____

Refer to “Additional information regarding MS-DRGs under this Appendix” under Table 1A for additional pertinent information.

2.2.1 Transfer of Customer. This Section applies only when a MS-DRG or Per Case Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by the Centers for Medicare and Medicaid Services (CMS) except for MS-DRGs designated by CMS as “special pay” MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the “Imputed Per Diem Rate”) as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as “special pay” MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an imputed per diem rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is 50% of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

- (a) Based on CMS readmission guidelines; and
- (b) To readmissions with a related diagnosis (as determined by United); and
- (c) Prior to the determination of the contract rate for the subsequent Admission

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.3 Outpatient Covered Services. For the provision of Covered Services to a Customer, the contract rate is determined according to CMS rules governing the hospital Outpatient Prospective Payment System (except as otherwise set forth in this Appendix) and according to this Section 2.3. All coding and billing guidelines issued by CMS will be followed by Facility in submitting claims unless otherwise specified below in Table 2. Units reported must always equal the number of times a procedure or service is performed.

Table 2: Outpatient Service Category Table

SERVICES CATEGORY	PAYMENT METHOD	CONTRACT RATE
Ambulance (APC status indicator A) (See Facility Ambulance Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	100%
Laboratory/Pathology (APC status indicator A) (See Facility Laboratory/Pathology Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	36%
Non-implantable Prosthetics & Orthotics (APC status indicator A) (See Non-implantable Prosthetics & Orthotics Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	85%
Physical Therapy, Occupational Therapy, Speech Therapy, Mammography (APC status indicator A) (See PT, OT, ST, Mammography Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	90%
“Inpatient Procedures” (Certain procedures rendered on an outpatient basis, but designated by CMS as reimbursable only when rendered on an inpatient basis) (APC status indicator C) (See “Inpatient Procedures” Fee Schedule Notes below and “Inpatient Procedures” Fee Schedule Exhibit)	Per Unit via UHC Facility “Inpatient Procedures” Fee Schedule	90% as described in the UHC Facility "Inpatient Procedures" Fee Schedule Exhibit
Corneal Tissue Acquisition (APC status indicator F) (2)	PPR	_____ %
Hepatitis Vaccines (APC status indicator F) (See Facility Vaccine Fee Schedule Notes below and Vaccine Fee Schedule Exhibit)	Per Unit via UHC Facility Vaccine Fee Schedule	85% as described in the UHC Facility Vaccine Fee Schedule Exhibit
Device and Radiopharmaceuticals Pass-Throughs (APC status indicator H) (2)	PPR	_____ %
Influenza and Pneumococcal Pneumonia (PPV) Vaccines (APC status indicator L) (See Facility Vaccine Fee Schedule Notes below and Vaccine Fee Schedule Exhibit)	Per Unit via UHC Facility Vaccine Fee Schedule	85% as described in the UHC Facility Vaccine Fee Schedule Exhibit
All Other Facility Outpatient Covered Services (See All Other Facility Outpatient Covered Services Notes below) (1)	APC	Conversion Factor \$ _____

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission.

(1) Facility's Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OPPTS/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change. In the event such change has a negative projected financial impact to United or its Payers, United and Facility, within 30 days of above notification, will evaluate and agree upon contract rates going forward that will assure that changes to Facility's Emergency department visits coding guidelines do not have the impact of increasing the amount paid by United or its Payers under this Appendix. Based on the agreed upon rate adjustment, both parties will execute an amendment to implement the adjusted contract rates going forward. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section, or due to Facility providing inaccurate information, United may recover those overpayments, as outlined in the Facility Participation Agreement.

In the event the parties are unable to agree on contract rates going forward, the matter may be resolved in accordance with the dispute resolution provisions of the Agreement. In addition to determining the impact of Facility's Emergency department visits coding guidelines changes, the Arbitrator may determine the new contract rates going forward necessary to ensure that United and its Payers are not impacted by Facility's coding guideline changes from the effective date of the coding guideline change.

(2) When CMS changes the status indicator or Payment Method for CPT/HCPCS codes with a PPR Payment Method in Table 2 so that the CPT/HCPCS code(s) prices using an APC Payment Method, the contract rate under this Appendix for the code(s) will thereafter be determined using the "All Other Facility Outpatient Covered Services" Service Category listed in Table 2.

With regard to all services with a Payment Method of Per Unit via Facility Fee Schedule as determined by CMS, the process for implementing CMS updates is described in the definition set forth in this Appendix of Per Unit via Facility Fee Schedule.

Ambulance Fee Schedule Notes

The rates are derived from the CMS Ambulance Fee Schedule, as posted on the CMS website, based on the following:

- Carrier Code and Locality number,
- HCPCS code billed, and
- Base Rate & Urban Mileage fee

Facility Laboratory/Pathology Fee Schedule Notes

The rates are derived from the CMS Clinical Diagnostic Laboratory Fee Schedule, as posted on the CMS website, using, in order of priority, the National Limit, the Mid Point, or the highest of the listed state rates.

Non-implantable Prosthetics & Orthotics Fee Schedule Notes

The rates are derived from the CMS Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS) Fee Schedule, as posted on the CMS website, by using the Ceiling Rate as specified in the CMS DMEPOS file.

PT, OT, ST, Mammography Fee Schedule Notes

The rates are derived from the CMS National Physician Fee Schedule Relative Value File, as posted on the CMS website, using the Fully Implemented Facility Total RVU multiplied by the Conversion Factor as specified in the file.

“Inpatient Procedures” Fee Schedule Notes

As used in Table 2 and in these Fee Schedule Notes, “Inpatient Procedures” refers to procedures rendered as outpatient services that, as of the date of service, CMS reimburses only on an inpatient basis, but that may be reimbursable under this Appendix on an outpatient basis as described below.

Calculation of the contract rate under this Appendix for “Inpatient Procedures” is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- The “Per Unit via UHC Facility ‘Inpatient Procedures’ fee schedule” rates for existing codes are in effect until both parties mutually agree to rate changes, or until CMS assigns an APC payment to a given code.
- Only the Inpatient Procedure codes listed on the UHC Facility “Inpatient Procedures” fee schedule attached to this Appendix will be payable as “Inpatient Procedures” under Table 2. The contract rate for all other CMS “Inpatient Procedure” codes (including any codes added by CMS to its “Inpatient Procedures” list in the future) is zero.
- When CMS assigns an APC payment to a given “Inpatient Procedures” code, such code will no longer be payable under this Appendix through the UHC Facility “Inpatient Procedures” fee schedule. Instead, the contract rate under this Appendix for those codes will thereafter be determined using the APC payment method under Table 2.

Facility Vaccine Fee Schedule Notes

Calculation of the contract rate under this Appendix for Vaccines is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- Only the Vaccine codes listed on the current fee schedule will be payable under the UHC Facility Vaccine Fee Schedule. The contract rate for any vaccine code not on the fee schedule is determined based on the All Other Covered Facility Outpatient Services service category.
- There will be a quarterly update to the fee schedule to set fixed rates for all existing and newly published codes. The rates will be set based on AWP multiplied by the same percentage as indicated in Table 2.

“All Other Facility Outpatient Covered Services” Notes

Any CPT/HCPCS code for which CMS would not use a relative weight calculation will have a contract rate at the current CMS rate applicable for that CPT/HCPCS code.

SECTION 3 Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-9-CM codes, or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is

revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

3.3 Facility-based Physician and Other Provider Charges.

Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after _____, the current contract rates for all Covered Services under this Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility’s charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative _____ (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

[Current Contract Rate – (Current Contract Rate x Percentage Reduction) = New Contract Rate]

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%
Emergency Physicians	Emergency Room Services	10%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%
		%
		%
		%
		%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit

Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 3: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply-Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 This Section Intentionally Left Blank

3.6 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 4: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health - Medical Social Services
0116	Detox/Private	0570-0579	Home Health – Home Health Aide
0124	Psych/2bed	0580-0589	Home Health – Other Visits
0126	Detox/2bed	0590	Home Health – Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819	Donor Bank/ Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab
0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees
0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521-0522, 0524-0525, 0527-0528	Rural Health Clinics (RHC/Federally Qualified Health Centers (FQHC))	3101-3109	Adult Care

Revenue Code	Description	Revenue Code	Description
0550-0559	Home Health - Skilled Nursing		
MS-DRGs	Description	MS-DRGs	Description
001 - 002 w/o ICD9 37.52, 37.63-37.66	Heart Transplant	010	Pancreas Transplant
005 - 006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

3.7 Open Heart Surgical Procedure Following Outpatient Cardiac Catheterization. If a Customer is admitted to Facility for an open heart surgical procedure within three calendar days of a cardiac catheterization Outpatient Procedure, the contract rate set forth in Section 2.3 will not apply, and the contract rate for an open heart procedure as set forth in Section 2.2 of this Appendix will be paid. No additional payments will be made for the cardiac catheterization services; instead, the cardiac catheterization services will be considered to have been reimbursed as part of the contract rate for the open-heart surgical procedure.

3.8 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

3.9 CMS Outpatient Code Editor (OCE) edits. Payment under this Appendix is subject to certain of the CMS OCE edits. The OCE Exhibit to this Appendix lists the current CMS OCE edits, and indicates which ones will be applied to this Appendix as of the date this Appendix takes effect. United may apply an established CMS OCE edit to this Appendix, that was previously not applied to this Appendix, upon 90 days notice to Facility. New OCE edits implemented by CMS will apply to this Appendix unless United provides notice to Facility at least 15 days prior to the implementation date.

SECTION 4

Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have

the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

4.2 Duty to Give Notice. Facility will notify United at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

4.3 Content of Notice. Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

- (a) Facility's Chargemaster data before and after the increase in Facility's Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:
 - (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and
 - (ii) in a mutually acceptable format.
- (b) The effective date of the Facility's new Chargemaster;
- (c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:
 - (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,
 - (ii) in a mutually acceptable format, and
 - (iii) separately for inpatient and outpatient services.
- (d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate

will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.; and

(e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with United. Facility will cooperate with United in administration of this section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates and fixed contract rates (impacted by lesser of) using the estimates in the notice. United will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. United may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment, along with the effective date of the revised appendix.

4.6 United's right to audit. In addition to any other audit rights that United may have under the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), United may recover those overpayments. United will give Facility notice of, and United intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates and fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate

adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement, modified as follows:

(a) The parties will confer in good faith, and will resolve the matter through prospective and temporary contract rate adjustments to the contract rates for Covered Services set forth in this Appendix. Such prospective contract rate adjustment will be calculated to account for and neutralize the financial impact of the Customary Charge increase at issue to the contract rates set forth in this Appendix, so that Customary Charge increase will not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix. The temporary contract rate adjustment will be calculated to address, through an additional and temporary adjustment to the contract rates, the financial impact on all claims impacted by the Customary Charge increase (inpatient claims with the date the Admission started and outpatient claims with dates of service occurring on and following the date of the Customary Charge increase at issue) for dates of service prior to the effective date of the contract rate adjustment.

(b) If the parties are unable to amicably resolve the matter and implement an updated appendix with prospective and temporary contract rate adjustments within 90 days of receipt of the above-described notice, either party which remains dissatisfied may provide written notice to the other party of its decision to employ the services of a third party consultant with expertise in account relevant to the issues at hand rather than to an arbitrator selected as described in the Agreement to resolve the dispute. The consultant's scope will be limited to quantifying the financial impact of the Customary Charge increase and the prospective and temporary contract rate adjustments in dispute to the parties. The consultant will be jointly selected by the parties. The parties will work together in good faith to develop a list of eligible consultants by _____. The consultant fee will be shared equally between United and the Facility.

Each party will simultaneously and confidentially submit to the Consultant and to each other the following data elements:

(i) a prospective contract rate adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), as described above, to account for the ongoing impact of the Customary Charge increase in dispute, for Covered Services with dates of service starting 30 days after the date of the Consultant's decision;

(ii) a temporary adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), to the prospective contract rate adjustment, to account for the impact on claims that were impacted by the Customary Charge increase and that have dates of service prior to the effective date of the prospective contract rate adjustment described in the bullet immediately above this bullet (United may instead elect to address the claims with dates of service prior to effective date of the prospective contract rate adjustment by reprocessing those claims in accordance with the prospective contract rate adjustment, in which case the temporary adjustment will not be applied) (should United elect to reprocess the claims as set forth herein, the reprocessing process must be completed within ninety (90) days of the date of the Consultant's decision); and

(iii) the length of time the temporary adjustment should remain in effect, and

(iv) Utilization data that supports the party's prospective and temporary contract rate adjustment.

The data elements listed in (b)(i)-(iii) will collectively be referred to as each party's "Proposal."

(c) Each party will have the same deadline for submitting their respective Proposals to the consultant; that deadline will be a date jointly selected by the parties or, if the parties cannot agree upon a date, the consultant will select a date. The consultant must select either the Proposal submitted by Facility in its entirety or the Proposal proposed by United in its entirety.

(d) After the proposed findings are submitted to the consultant, the parties will meet with each other to review the submissions and explore the opportunity to resolve the dispute on a mutually satisfactory basis.

(e) In the event the parties are unable to settle the matter, each party may submit to the consultant, with a copy to the other party, a response to the other party's Proposal; the deadline for submitting these responses will be jointly determined by the parties or, if the parties cannot agree upon a date, the consultant will select a date.

(f) In the event the parties agree that a hearing should be held, or that a hearing is not necessary, the agreement of the parties will be followed. In the event that the parties cannot agree on whether a hearing is needed, the consultant will decide whether a hearing is necessary.

(g) The decision of the consultant will be binding on the parties to the same extent as the decision of the arbitrator under the dispute resolution process set forth in the Agreement.

SECTION 5

Performance Based Compensation Program

To encourage Facility's efforts to improve both the quality and the efficiency of its patient care and to recognize successful performance with regard to these efforts, United will implement the PBC Program described by this Section 5, which provides to Facility the opportunity to qualify for adjustments to the Eligible Contract Rates, subject to meeting the program requirements described herein. Nothing herein is intended to compensate Facility for limiting or withholding clinically appropriate care from any Customer.

Facility understands and agrees that this Section 5 applies to, and only to, the Facility location(s) covered by this Appendix unless another Appendix to the Agreement expressly provides otherwise. If this Section 5 applies to more than one Facility location, Facility understands and agrees that the performance of all such locations will be measured in the aggregate to determine whether Facility has met the requirements hereunder. Implementation of the PBC Program in the event of changes in the locations covered by this Appendix is discussed in Section 5.7 below.

5.1 Definitions. Unless otherwise defined in this Section 5, capitalized terms used in this Section shall have the meanings assigned to them in this Appendix or in the Agreement.

Actual Performance Result: Facility's performance or experience with respect to a given Performance Measure based on the applicable Measurement Period or Data Capture Date, as determined using the applicable Performance Measure Criteria. Facility's Actual Performance Result is compared to the corresponding Performance Target to determine whether Facility successfully achieved the Performance Measure, as further discussed in Section 5.3. Actual Performance Results may be restated as described in Section 5.5.3.

Baseline: The value, as restated from time to time in accordance with Section 5.5.3, that represents Facility's level of performance or experience with respect to a given Performance Measure as measured with respect to the Baseline period set forth in the Baseline Exhibit.

Data Capture Date: The date during the Data Capture Period on which United obtains a third party data report.

Data Capture Period: With respect to those Performance Measures that are evaluated based on third party data, the date span during which United will obtain the applicable third party data reports. The Data Capture Period for a given Performance Measure is specified in the Timeline Exhibit.

Eligible Contract Rate: Each contract rate for a Covered Service that is reimbursed under this Appendix using any Payment Method other than a PPR or Per Unit via Facility Fee Schedule.

Measurement Period: The applicable date span used to determine Facility's Actual Performance Result with respect to each Performance Measure that is evaluated based on claims data, with or without United notification data. To determine Facility's Actual Performance Result for a given Performance Year on a Performance Measure that is evaluated based on claims data, with or without United notification data, as reflected in the final Performance Report, United will include not less than two months' claims run out for the Performance Measure.

Measurement Time: The applicable Measurement Period or Data Capture Period.

Payout Year or PY: Subject to earlier termination of the Agreement, each successive 12 month period, beginning with the first Payout Year, with respect to which Facility participates in the PBC Program. Subject to termination of the Agreement and Section 5.6.2, Eligible Contract Rates are adjusted during the Payout Year to reflect the Performance Escalator, if any, attributable to that Payout Year. The first Payout Year (or PY1) is the 12 month period that begins on the first anniversary of the Effective Date of the Agreement.

PBC Goal: The maximum adjustment to Eligible Contract Rates available under the PBC Program for a given Payout Year which, as further described in Section 5.3, is used to determine Facility's Performance Escalator.

PBC Program: United's Performance Based Compensation Program for hospitals, as described by this Section 5.

Performance Escalator: The increase to Eligible Contract Rates attributable to Facility's performance with respect to the Performance Measures for a given Payout Year, as determined and applied during that Payout Year in accordance with this Section 5.

Performance Measure: Each of the measures listed in the PBC Exhibit.

Performance Measure Criteria: United's description of and measurement logic for a particular Performance Measure.

Performance Points: The points associated with Facility's performance on a Performance Measure with respect to a given Payout Year, as set forth in the PBC Exhibit.

Performance Report: The interim quarterly or final report with respect to a given Payout Year that shows, on an interim or final basis, Facility's Actual Performance Results and the other information described in Section 5.5.2 of this Appendix.

Performance Target: The specified level of performance or experience that Facility must achieve on a particular Performance Measure with respect to a given Payout Year in order to meet the Performance Measure for purposes of this Section 5.

Rebased Contract Rate: The Eligible Contract Rate as adjusted to remove the impact of the Performance Escalator, as further described in Section 5.6 of this Appendix.

5.2 Eligibility to Participate in the PBC Program; Payout Year Terms.

5.2.1 Eligibility. To be eligible to participate in the PBC Program, Facility must be an acute inpatient hospital other than a long term acute care hospital, long term care hospital, or rehabilitation hospital.

5.2.2 Payout Year Terms. Subject to earlier termination of the Agreement, the Performance Measures, the corresponding Performance Targets, the allocation of Performance Points, and the applicable PBC Goal set forth in the PBC Exhibit and the Measurement Times set forth in the Timeline Exhibit will govern Facility's participation in the PBC Program with respect to each specified Payout Year.

Beginning with the first Payout Year for which terms are not specified in the PBC Exhibit, and with respect to each Payout Year thereafter, United and Facility agree to the following:

(a) At least 24 months prior to the first day of the next Payout Year for which the parties have not specified terms in writing, United and Facility will meet for the purpose of determining the applicable Performance Measures, the corresponding Performance Targets and Performance Points, and the applicable PBC Goal for that Payout Year. The parties will document the mutually agreed upon new terms in a written amendment signed by both parties within the timeframe specified in subparagraph 5.2.2(b).

(b) If the parties have not mutually agreed in writing on the Performance Measures, Performance Targets, Performance Points, and PBC Goal at least 18 months prior to the first day of the Payout Year to which such terms would apply, then the parties agree that they will keep the same Performance Measures, Performance Points, and PBC Goal used for the Payout Year immediately preceding that Payout Year and will use the applicable Section 5.2.2 default Performance Targets shown in the PBC Exhibit.

(c) For each subsequent Payout Year, the Measurement Time for a given Performance Measure will begin one year after the date on which the Measurement Time for that Performance Measure began for the prior Payout Year and continue for the same duration. If the parties agree on a new Performance Measure, it will have the standard Measurement Time assigned to that Performance Measure under the PBC Program based on the start date of Facility's next Payout Year.

5.3 Evaluation of Performance Measures; Performance Escalator. With respect to each Payout Year, United will assess Facility's Actual Performance Result for each Performance Measure. The Actual Performance Result will be determined in accordance with this Section 5 and the applicable Performance Measure Criteria. The Performance Measure Criteria for each of the Performance Measures in effect as of the effective date of this Appendix are provided in the Performance Measure Criteria Exhibits. United may modify the Performance Measure Criteria from time to time. United may implement the revised Performance Measure Criteria without Facility's consent if the same criteria are applicable to all or substantially all facilities in United's network that are subject to the corresponding Performance Measure. United will make the current Performance Measure Criteria for each Performance Measure available to Facility upon request.

If Facility's Actual Performance Result is equal to or better than the applicable Performance Target, Facility has met the Performance Measure. For each Performance Measure that Facility meets, United will credit Facility with the corresponding Performance Points shown in the PBC Exhibit. The maximum number of Performance Points available is 100. United will aggregate the Performance Points credited to Facility for all Performance Measures achieved with respect to a given Payout Year. The total Performance Points credited to Facility will range from 100 points to 0 points. United will use the following formula to determine the Performance Escalator attributable to that Payout Year:

$$[\text{total Performance Points} \div 100] * [\text{the PBC Goal}] = \text{Performance Escalator}$$

The Performance Escalator will be a percentage rounded up or down to the nearest one tenth of one percent (0.1%).

5.4 Data Sources. The PBC Exhibit indicates the data source United will use to assess Facility's performance on each Performance Measure. Such assessment is subject to the requirements and limitations set forth in this Section 5.4.

5.4.1 Claims. If the data source is claims:

(a) The applicable Performance Measure Criteria will describe the claims United will use to evaluate and report on Facility's performance with respect to each of the applicable Performance Measures.

(b) United is not currently able to include all claims submitted by Facility in the computation of Facility's performance on a Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of claims, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.4.2 Third Party Data. Except as expressly noted otherwise, if the data source is data made available by or through CMS or another third party:

(a) United will use the most current data available from the third party data source as of the Data Capture Date. If the third party has failed to timely update the available data, United will use the older data that is available as of the Data Capture Date. If more current data subsequently becomes available during the Data Capture Period but after the Data Capture Date, United will have no obligation to use the more current data, but may do so in its sole discretion, provided that use of the newer data will not delay timely delivery of the Performance Report.

(b) If the third party changes the information available to United in such a way that United cannot reasonably or meaningfully determine Facility's Actual Performance Result in accordance with the applicable Performance Measure Criteria, United will update the applicable Performance Measure Criteria in accordance with Section 5.3 to describe the alternate method United will use to determine Facility's Actual Performance Result.

(c) If the third party (i) ceases to gather and/or publish such data, (ii) ceases to make the data available to United on reasonable terms, or (iii) materially changes the scope or type of data it makes available, then the parties will mutually agree on a replacement Performance Measure. Alternately, the parties may agree to eliminate the affected Performance Measure and reallocate the Performance Points to the remaining Performance Measures.

5.4.3 Notification Data. If the data source is claims and United notification data, Section 5.4.1 applies with regard to claims and, with regard to United notification data:

(a) The applicable Performance Measure Criteria will describe the data United will use to evaluate and report on Facility's performance with respect to the applicable Performance Measure.

(b) United is not currently able to include notification data associated with all claims submitted by Facility in computation of Facility's performance on this Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of data, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.5 Performance Reports, Restatements, and Reconsideration.

5.5.1 Performance Reports. With respect to each Payout Year, United will provide Facility with quarterly Performance Reports, or electronic access to such reports, regarding Facility's performance on the Performance Measures. These Performance Reports will be consistent with the Performance Reports that United provides to other facilities participating in United's PBC Program. Performance Reports based on United claims data will be prepared using a reasonable period for claims run out and report development. Interim Performance Reports will reflect a date range that is different from the applicable Measurement Period; only the final Performance Report for a given Payout Year will reflect the date range defined as the applicable Measurement Period. The final Performance Report for a given Payout Year determines the Performance Escalator, if any, to be applied in that Payout Year. The final Performance Report will be provided or made available on or before the Performance Report due date specified in the Timeline Exhibit.

5.5.2 Content of Performance Report. Each Performance Report will include, at a minimum, the following content:

- (a) the Performance Target and corresponding Performance Target value for each Performance Measure;
- (b) Facility's Actual Performance Result (in the final Performance Report) or an interim calculation of the Actual Performance Result (in the interim Performance Reports) for each Performance Measure;
- (c) the Performance Points earned based on final or interim performance;
- (d) the earned Performance Points as a percentage of the maximum Performance Points; and
- (e) the Performance Escalator (in the final Performance Report) or an interim calculation of the Performance Escalator (in the interim Performance Reports).

Subject to and as limited by contractual confidentiality obligations and all applicable state and federal laws (including but not limited to privacy laws), supporting data for Facility's Actual Performance Result on a given Performance Measure will be provided to Facility upon request.

5.5.3 Restatements. The Baseline and Actual Performance Result for a Performance Measure may be restated by United on a quarterly basis to take into account any one or more of the following:

- (a) adjustments made by CMS or another nationally recognized source, for example MS-DRG weights or NQF approved calculations, in order to accurately compare Facility's baseline measure to Facility's performance with respect to the applicable Payout Year;
- (b) the addition or deletion of a Facility location covered by this Appendix and participating in the PBC Program, in accordance with Section 5.7;
- (c) restated or additional claims information;
- (d) corrections to databases identified by United or by a third party vendor; and
- (e) the inclusion of additional Affiliate claims.

Restated Baseline and Actual Performance Results will be shown in the interim and final Performance Reports. Once the Performance Escalator for a given Payout Year has been implemented in accordance with Section 5.6, it will not thereafter be changed due to a subsequent restatement of a Baseline or Actual Performance Result.

5.5.4 Third Party Certification. United will engage a third party at least annually to certify the data, methodology, measurement logic and software code supporting each Performance Measure. Documentation of the certification will be provided to Facility upon request.

5.5.5 Facility Objections. After reviewing the Performance Report, if Facility disagrees with United's determination of one or more Actual Performance Result(s) for one or more Performance Measure(s) due to (1) how the applicable methodology was applied, (2) how the applicable logic was used, or (3) whether

the applicable software code was used, Facility may request reconsideration of the disputed determination(s). Facility will follow this reconsideration process:

(a) Facility will send to United the reconsideration request in writing, which may be sent electronically, within 10 business days after the date on which Facility received a copy of or electronic access to the final Performance Report. United will provide Facility with the appropriate mailing address or email address for reconsideration requests. If the reconsideration is not requested timely, Facility will be deemed to have waived its right to pursue reconsideration in any forum.

(b) The reconsideration request must include all of the following:

- i) identification of each Performance Measure to be reconsidered;
- ii) identification of the Actual Performance Result calculated by United for each contested Performance Measure;
- iii) a detailed explanation of why Facility believes that the methodology, logic or software code is improper; and
- iv) any other relevant information to support Facility's reconsideration request.

5.5.6 Reconsideration Period. Following receipt of the reconsideration request, United will review and respond to Facility within 10 business days. Upon Facility's written request, United will provide supporting data for each contested Performance Measure, subject to and as limited by contractual confidentiality obligations and applicable state and federal laws (including but not limited to privacy laws).

Within 10 business days after receiving United's response, Facility will inform United in writing whether the response has resolved Facility's concerns or not. If Facility still disagrees with United's Performance Report, the parties will promptly meet and confer about Facility's reconsideration request. If United and Facility have not reached a mutually satisfactory resolution regarding Facility's reconsideration request at least 45 days prior to the first day of the upcoming Payout Year, then the Performance Escalator will be effective on the first day of the first calendar month that begins at least 31 days after the date that the parties achieved such resolution. Contract rate adjustments described in Section 3 of this Appendix will not be delayed, and United will implement those adjustments effective as of the time specified in Section 3 in accordance with Section 5.6.

If the parties are unable to reach a mutually satisfactory resolution regarding Facility's reconsideration request, either party may initiate dispute resolution pursuant to Article VII of the Agreement.

5.6 Performance Escalator.

5.6.1 Application of Performance Escalator. The Performance Escalator, if any, determined in accordance with Section 5.3 will be applied to each Eligible Contract Rate, subject to the following adjustments:

(a) The Performance Escalator is not intended to be cumulative in its effect from one year to the next. Accordingly, if a Performance Escalator is applied to the Eligible Contract Rates following successful performance by Facility with respect to a given Payout Year, the increase will always be removed from each rate effective as of the first day after the end of the Payout Year in which the Performance Escalator was applied. The removal of the Performance Escalator establishes the "Rebased Contract Rate." Any Performance Escalator applied hereunder will be applied to the Rebased Contract Rate. Likewise, and notwithstanding anything in this Appendix to the contrary, any annual adjustment made in accordance with Section 3 of this Appendix will be applied to the applicable Rebased Contract Rates (regardless of whether or not a Performance Escalator is also applicable in that contract year). This methodology is illustrated in the Example Section below.

(b) The Performance Escalator is additive to any annual adjustment specified in Section 3 of this Appendix. Both the Section 3 adjustment and the Performance Escalator are applied to the applicable Rebased Contract Rate. This methodology is illustrated in the Example Section below.

(c) Application of the Performance Escalator will take into account adjustments made under Section 4 of this Appendix. Notwithstanding anything in this Appendix to the contrary, a Section 4 Chargemaster adjustment will be made to the Eligible Contract Rate in effect at the time of such adjustment. In the event a Chargemaster adjustment occurred in the prior contract year the calculation to determine the Rebased Contract Rate will include the impact of that Chargemaster adjustment under Section 4. If a Chargemaster adjustment and a Performance Escalator become effective on the same date, the Chargemaster adjustment will occur after the calculation of the Rebased Contract Rates and the Performance Escalator will then be applied to the adjusted Rebased Contract Rate.

(d) The adjusted Eligible Contract Rates will be rounded up or down to the nearest whole dollar.

Example Section:

Fixed Rate Example: Assume the contract rate for a given Covered Service is \$100 in the year preceding the first Payout Year of this example. This example shows achievement of a Performance Escalator of 1% applied during PY1; a Performance Escalator of 0% applied during PY2; and a Performance Escalator of 2% applied during PY3. Using the formula described below, Row H indicates the contract rate applicable during each of the following Payout Years:

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
A	prior year contract rate [1]	value from row H of prior year	n/a	\$100	\$103	\$104
B	Rebased Contract Rate	A – [value from row F of prior year]	n/a	\$100.00	\$102.00	\$104
C	Section 3 annual adjustment		n/a	2.0%	2.0%	2.0%
D	-- increase/decrease for Section 3 annual adjustment	B x C	n/a	\$2.00	\$2.04	\$2.0
E	Section 5 Performance Escalator		n/a	1.0%	0.0%	2.0%
F	-- increase for Section	B x E	n/a	\$1.00	\$0.00	\$2.0

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
	5 Performance Escalator					
G	total adjustment	D + F	n/a	\$3.00	\$2.04	\$4.1
H	adjusted contract rate (rounded)	B + G (except the rate applicable in the year prior to PY1)	\$100	\$103	\$104	\$108

[1] Section 5.6.1 discusses various adjustments that may be applicable to a given contract rate. Assume for purposes of this example that there are no other applicable contract rate adjustments beyond those shown in the table.

5.6.2 Adjustment to Eligible Contract Rates. United will adjust each Eligible Contract Rate to reflect the Performance Escalator, consistent with any other adjustments described in this Appendix. The Performance Escalator will be effective with respect to Covered Services furnished by Facility on or after the first day of the Payout Year for which the Performance Escalator was calculated or such later date as may be determined by the parties' mutual written agreement or by an express term of this Appendix, and will continue in effect through the last day of the Payout Year, subject to the earlier termination of the Agreement or of this Payment Appendix. _____

5.7 Changes in Facility Locations Covered by this Appendix; Assignment. This Section 5.7 sets forth the parties' expectations with respect to implementation of this Section 5 in the event of a change in the Facility locations subject to the Agreement. Any such change must occur in accordance with an applicable provision of the Agreement. Nothing in this Section 5.7 creates or will be construed to create any rights with regard to how or when changes in Facility locations, assignment or other transfer of the Agreement may occur.

(a) If a location is added to the Agreement and covered by this Appendix after the end of the claims Measurement Periods, the new location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year. That location will be included in determining Facility's Actual Performance Results for the next Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(b) If a location is added to the Agreement and covered by this Appendix before the end of the claims Measurement Periods, the new location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures for the corresponding Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(c) If a location is deleted from this Appendix after the end of the claims Measurement Periods, that location's performance will be included in determining Facility's Actual Performance Results on all

Performance Measures with respect to the corresponding Payout Year. The deleted location will not be included in determining Facility's Actual Performance Results with respect to any additional Payout Years. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(d) If a location is deleted from this Appendix before the end of the claims Measurement Periods, that location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year or any future Payout Year. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(e) In the event of a partial assignment of the Agreement that includes this Appendix, or if this Appendix otherwise continues to apply to one or more (but not all) of the Facility locations previously contracted by or through Facility due to a merger or other transaction that results in Facility no longer owning and controlling such location(s), each such location will be treated as a "deleted location" for purposes of determining the period, if any, during which its performance or experience will continue to be aggregated with the remaining Facility locations. Once any continued period of aggregating ends, such location's performance or experience will be evaluated alone or with such other locations as are likewise subject to continued application of the Appendix following the assignment or transfer of such rights.

(f) If the data used for evaluation of one of more of the applicable Performance Measures cannot be aggregated or segregated as contemplated by this Section 5.7 with respect to the performance of a particular location, the parties will use best efforts to implement the PBC Program with respect to such location(s) consistent with the intent of this Section 5.

UnitedHealthcare Outpatient Code Editor (OCE) Exhibit

ON – Edit applies per CMS

INACTIVE – CMS has turned the edit off and UHC is following CMS

OFF – UHC has turned the edit off

EDIT	Description	UHC Adoption Decision
1	Invalid diagnosis code	ON
2	Diagnosis and age conflict	ON
3	Diagnosis and sex conflict	ON
4	Medicare secondary payer alert	INACTIVE
5	E-code as reason for visit	ON
6	Invalid procedure code	ON
7	Procedure and age conflict	INACTIVE
8	Procedure and sex conflict	ON
9	Non-covered under Medicare outpatient benefit for reasons other than statute	OFF
10	Service submitted for verification of denial	OFF
11	Service submitted for review	OFF
12	Questionable covered service	OFF
13	Separate payment for services is not provided by Medicare	INACTIVE
14	Code indicates a site of service not included in OPPS	INACTIVE
15	Service unit out of range for procedure	ON
16	Multiple bilateral procedures without modifier 50	INACTIVE
17	Inappropriate specification of bilateral procedure	ON
18	Inpatient procedure	OFF
19	Mutually exclusive procedure that is not allowed by CCI even if appropriate modifier is present	ON
20	Component of a comprehensive procedure that is not allowed even if appropriate modifier is present	ON
21	Medical visit on same day as a type “T” or “S” procedure Without modifier -25	ON

22	Invalid modifier	ON
23	Invalid date	ON
24	Date out of OCE range	ON
25	Invalid age	ON
26	Invalid sex	ON
27	Only incidental services reported	ON
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	ON
29	Partial hospitalization service for non-mental health diagnosis	OFF
30	Insufficient services on day of partial hospitalization	OFF
31	Partial hospitalization on same day as electroconvulsive therapy or type T procedure	INACTIVE
32	Partial hospitalization claim spans 3 or less days with insufficient Services on at least one of the days	INACTIVE
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	INACTIVE
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	INACTIVE
35	Only activity therapy and/or occupational therapy services provided	OFF
36	Extensive mental health services provided on day of electroconvulsive therapy or significant procedure	INACTIVE
37	Terminated bilateral procedure or terminated procedure with units greater than one	ON
38	Inconsistency between implanted device and implantation procedure	ON
39	Mutually exclusive procedure that would be allowed if appropriate modifier were present	ON
40	Component of a comprehensive procedure that would be allowed if appropriate modifier were present	ON
41	Invalid revenue code	ON
42	Multiple medical visits on same day with same revenue code without condition code G0	ON
43	Transfusion or blood product exchange without specification of	ON

blood product

44	Observation revenue code on line item with non-observation HCPCS code	OFF
45	Service not appropriate for type of bill	ON
46	Partial hospitalization condition code 41 not approved for type of bill	ON
47	Service is not separately payable	ON
48	Revenue center requires HCPCS	ON
49	Service on same day as inpatient procedure	OFF
50	Non-covered based on statutory exclusion	ON
51	Multiple observations overlap in time	INACTIVE
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions	INACTIVE
53	Codes G0378 and G0379 only allowed with bill type 13x	OFF
54	Multiple codes for the same service	INACTIVE
55	Non-reportable for site of service	ON
56	E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1	INACTIVE
57	E/M condition not met for separately payable observation and line item date for code G0378 is 1/1	OFF
58	G0379 only allowed with G0378	OFF
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis	INACTIVE
60	Use of modifier CA with more than one procedure not allowed	ON
61	Service can only be billed to the DMERC	ON
62	Code not recognized; alternate code for same service may be available	ON
63	This OT code only billed on partial hospitalization claims	OFF
64	AT service not payable outside the partial hospitalization program	OFF
65	Revenue code not recognized by Medicare	ON

66	Code requires manual pricing	ON
67	Service provided prior to FDA approval	ON
68	Service provided prior to date of National Coverage Determination (NCD) approval	ON
69	Service provided outside approval period	ON
70	CA modifier requires patient status code 20	ON
71	Claim lacks required device code	OFF
72	Service not billable to the Fiscal Intermediary	ON
73	Incorrect billing of blood and blood products	ON
74	Units greater than one for bilateral procedure billed with modifier -50	ON
75	Incorrect billing of modifier - FB	ON
76	Trauma Response critical care code without revenue code 068x And CPT 99291	ON
77	Claim lacks required procedure code	ON
78	Claim lacks required radiolabeled product	ON
79	Incorrect billing of revenue code with HCPCS code	ON
80	Mental health code not approved for partial hospitalization	OFF
81	Mental health not payable outside the Partial Hospitalization Program	OFF
82	Charge exceeds token charge	ON
83	Service provided on or after end date of NCD Coverage	ON
84	Claim lacks required primary code	ON
85	Claim lacks required device or procedure code	ON

UHC Facility “Inpatient Procedures” Fee Schedule Exhibit

UHC Facility Vaccine Fee Schedule Exhibit

Chargemaster Notice Exhibit

PBC Exhibit

Timeline Exhibit

Baseline Exhibit

Performance Measure Criteria Exhibits

All Payer Appendix

Facility Name(s): _____

Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1

Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.6 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

MS-DRG or Medicare Severity Diagnosis-Related Groups: A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status. For purposes of determining the contract rate under this Appendix, the MS-DRG at discharge, as that term is defined in the Final Rule, as published by CMS and most recently made effective under this Appendix, will be controlling. All changes in the definition of MS-DRG's specified in the Final Rule will be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the definitions are implemented under this Appendix (as described in the previous sentence), the previous definitions will apply.

The Payment Method designated "MS-DRG" in this Appendix and applicable to Covered Services rendered to a Customer for an entire Admission. The contract rate is determined by applying the MS-DRG relative weight to the contracted base rate. Unless otherwise specified in this Appendix, payment under the MS-DRG Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are

characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occurs within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Observation: Services furnished by Facility on the Facility’s premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated “Per Case” in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated “Per Diem” in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Unit via Facility Fee Schedule: The Payment Method designated “Per Unit via Facility Fee Schedule” in this Appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise specified in this Appendix, payment under the Per Unit via Facility Fee Schedule Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees

billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and Facility and ancillary services. The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule must always equal the number of times a procedure or service is performed.

Per Visit: The flat rate Payment Method designated “Per Visit” in this Appendix and applicable to Covered Services rendered to a Customer on one-calendar day period, for each Service Category within Section 2 for which a Per Visit Payment Method is indicated in this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, and Facility and ancillary services. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

PPR (Percentage Payment Rate): The percentage applied to Facility’s detail line item Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine (“M.D.”) or a Doctor of Osteopathy (“D.O.”) or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. Unless otherwise specified in this Appendix, the contract rate for an Admission is the contract rate in effect on the date the Admission begins.

Table 1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
One Day Stay+ (see note + below) (All MS-DRG’s except those listed in Section 3.6 _____)	Per Case	\$ _____
All MS-DRG’s However, this service category does not apply where one of these services is billed in connection with Covered Services	MS-DRG	Base Rate \$ _____

included in any of the other service categories on this Inpatient Service Category Table or Section 3.6		
Obstetrics (Mother Only)* @ (see notes * and @ below) Vaginal Delivery MS-DRGs: 767-768, 774-775 Cesarean Section MS-DRGs: 765-766	Per Case	\$ _____
	Per Case	\$ _____
Nursery* @ (see notes * and @ below) • Normal Newborn: MS-DRG 795 • Lower Level Neonate: MS-DRGs 789, 792, 794 • Higher Level Neonate: MS -DRGs 791, 793 • Severe Level Neonate MS-DRG 790	Per Diem	\$ _____
	Per Diem	\$ _____
	Per Diem	\$ _____
	Per Diem	\$ _____
Hospice ~ (see note ~ below) Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656 However, this service category does not apply where one of these revenue codes is billed in connection with any service category defined by Bill Types on this Inpatient Service Category Table.	Per Diem	\$ _____
Rehabilitation~ @ (see notes ~ and @ below) Revenue Codes 0118, 0128, 0138, 0148, 0158 However, this service category does not apply where one of these services is billed in connection with any service category defined by Bill Types on this Inpatient Service Category Table.	Per Diem	\$ _____
Inpatient Skilled Nursing Services ~ (see note ~ below) Bill Types 211-219	Per Diem	\$ _____

United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement. The contract rate is determined by applying the Base Rate in effect for the date of Admission, the final MS-DRG (as determined by United from the coding information) and the relative weight _____ in effect under this Appendix as of the date of discharge (except for the time period between CMS' update and the United update, where the final MS-DRG and the relative weight will be based on the date the claim is processed).

+ A One Day Stay is an Admission during which Customer is admitted on a given day and is discharged at or prior to midnight at the end of the immediate next calendar day. One Day Stay service category does not apply to Rehabilitation, Hospice, Nursery and Inpatient Skilled Nursing Services. When a Customer is transferred as described in Section 2.2.1, the One Day Stay service category is not used in the calculation of the contract rate. Instead the applicable contract rate in Table1 is used in the transfer calculation.

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

@ The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

2.2.1 Transfer of Customer. This Section applies only when a MS-DRG or Per Case Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by the Centers for Medicare and Medicaid Services (CMS) except for MS-DRGs designated by CMS as “special pay” MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the “Imputed Per Diem Rate”) as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as “special pay” MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an imputed per diem rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is 50% of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

- (a) Based on CMS readmission guidelines; and
- (b) To readmissions with a related diagnosis (as determined by United); and
- (c) Prior to the determination of the contract rate for the subsequent Admission

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s)

where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.3 Outpatient Covered Services. For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

2.3.1 Observation, Outpatient Therapeutic, Diagnostic, Emergency, Urgent Care Covered Services. For the provision of Observation, therapeutic, diagnostic, Emergency, and Urgent Care Covered Services rendered by Facility to a Customer on an outpatient basis (except for Outpatient Procedures addressed in Section 2.3.2 of this Appendix), the contract rate will be determined according to this Section 2.3.

If more than one type of Covered Service for which a Per Visit, Per Unit via Facility Fee Schedule, Payment Method applies are provided to a Customer during one calendar day, each of the applicable Payment Methods will be considered in calculating the aggregate contract rate for those Covered Services; provided, however, if the Customer receives any Covered Service for which a Per Case Payment Method applies, all Covered Services which would otherwise be paid pursuant to a Per Visit, Per Unit via Facility Fee Schedule, Payment Method, will instead be included in the Per Case contract rate and will not be separately reimbursed _____.

The contract rate for outpatient Covered Services rendered by Facility to a Customer, as detailed on Table 2 below, will be determined according to the Payment Method listed in the table.

Table 2: Outpatient Diagnostic and Therapeutic Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery (Revenue Codes 0333 with CPT Code 61796-61800, 63620-63621, 77371, G0173, G0251)	Per Case	\$ _____
Observation (Revenue Code: 0762)	Per Case	\$ _____
Emergency (Revenue Codes: 0450-0452, 0459) (1)	Per Case	\$ _____
Urgent Care (Revenue Code: 0456)	Per Case	\$ _____
IV Therapy (Revenue Codes 0260, 0269)	Per Visit	\$ _____
Oncology Treatment (Revenue Codes: 0280, 0289)	Per Visit	\$ _____
Laboratory (Revenue Codes: 0300-0307, 0309, 0923, 0925) (See Facility Lab Fee Schedule Notes below and lab Fee Schedule Exhibit)	Per Unit via UHC Facility Lab Fee Schedule # _____	36 % of the “Source Fee” as described in the UHC Facility Lab Fee Schedule Exhibit
Pathology (Revenue Codes: 0310-0312, 0314, 0319) (See Facility Lab Fee Schedule Notes below and lab Fee Schedule Exhibit)	Per Unit Via UHC Facility Lab Fee Schedule # _____	36 % of the “Source Fee” as described in the UHC Facility Lab Fee Schedule Exhibit

Other Diagnostic Radiology (Revenue Codes 0320-0324, 0329) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Cyber Knife – Initial Visit (Revenue Code 0333 with CPT Code G0339)	Per Visit	\$ _____
Cyber Knife – Subsequent Visit (Revenue Code 0333 with CPT Code G0340)	Per Visit	\$ _____
Radiation Therapy (Revenue Codes 0330, 0333, 0339 without CPT Codes 61796-61800, 63620-63621, 77371, G0173, G0251, G0339-G0340)	Per Visit	\$ _____
Chemotherapy Administration (Revenue Codes: 0331-0332, 0335)	Per Visit	\$ _____
Nuclear Medicine (Revenue Codes 0340-0342, 0349) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Computerized Tomography (CT) Scan (Revenue Codes 0350-0352, 0359) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Blood and Blood Related Services (Revenue Code 0380-0389, 0390-0392, 0399)	Per Visit	\$ _____
Imaging Services (Revenue Codes: 0400, 0409)) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Diagnostic and Screening Mammography (Revenue Codes: 0401, 0403) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Ultrasound Imaging (Revenue Code: 0402) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Positron Emission Tomography (Revenue Code: 0404) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the “Source Fee” as described in the UHC Facility Radiology Fee Schedule Exhibit
Respiratory Services (Revenue Codes: 0410, 0412, 0419)	Per Visit	\$ _____

Hyperbaric (Revenue Code: 0413)	Per Visit	\$ _____
Physical Therapy-General and/or Physical Therapy-Evaluation and/or Reevaluation (Revenue Code 0420, 0424)	Per Unit	\$ _____
Occupational Therapy-General and/or Occupational Therapy-Evaluation and/or Reevaluation (Revenue Code 0430, 0434)	Per Unit	\$ _____
Speech Therapy (Revenue Codes: 0440-0444, 0449)	Per Visit	\$ _____
Pulmonary Function (Revenue Codes: 0460, 0469)	Per Visit	\$ _____
Audiology (Revenue Codes: 0470-0472, 0479)	Per Visit	\$ _____
Cardiology (Revenue Code 0480, 0489)	Per Visit	\$ _____
Cardiac Stress Test (Revenue Code: 0482)	Per Visit	\$ _____
Echocardiology (Revenue Code: 0483)	Per Visit	\$ _____
Ambulance - Land (Revenue Codes: 0540, 0542-0543, 0546-0549)	Per Visit	\$ _____
Ambulance - Air (Revenue Code: 0545)	Per Visit	\$ _____
Magnetic Resonance Imaging (Revenue Codes 0610-0612, 0614-0616, 0618, 0619) (See Facility Radiology Fee Schedule Notes below and Radiology Fee Schedule Exhibit)	Per Unit via UHC Facility Radiology Fee Schedule # _____	_____ % of the "Source Fee" as described in the UHC Facility Radiology Fee Schedule Exhibit
Labor Room/Delivery Services (Revenue Codes 0720-0722, 0724, 0729)	Per Visit	\$ _____
EKG and ECG (Revenue Codes: 0730, 0739)	Per Visit	\$ _____
Holter Monitor/Telemetry (Revenue Codes: 0731-0732)	Per Visit	\$ _____
EEG (Revenue Codes 0740, without CPT Codes 95800-95801, 95805-95811, G0398-G0400)	Per Visit	\$ _____
Vaccine Administration (Revenue Code 0771)	Per Visit	\$ _____
Hemodialysis (Revenue Codes 0820-0825, 0829)	Per Visit	\$ _____
Peritoneal Dialysis, CAPD and CCPD (Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis) (Revenue Codes 0830-0835, 0839-0845, 0849-0855, 0859)	Per Visit	\$ _____
MEG (Revenue Codes 0860-0861)	Per Visit	\$ _____
Neuropsychological Testing and Biofeedback for NON-PSYCHIATRIC disorders only (Revenue Codes 0900, 0917-0918)	Per Visit	\$ _____
Other Diagnostic Services (Revenue Codes 0920, 0929 without CPT Codes 95800-95801, 95805-95811, G0398-G0400)	Per Visit	\$ _____
Sleep Studies - Unattended (Revenue Codes 0740, 0920, 0929 with CPT Codes 95800-95801, 95806, G0398-G0400)	Per Visit	\$ _____
Sleep Studies - Attended (Revenue Codes 0740, 0920, 0929 with CPT Codes 95805, 95807-95811)	Per Visit	\$ _____
Peripheral Vascular Lab (Revenue Code: 0921)	Per Visit	\$ _____
EMG (Revenue Code: 0922)	Per Visit	\$ _____
Allergy Testing (Revenue Code: 0924)	Per Visit	\$ _____
Other Therapeutic Services (Revenue Codes: 0940, 0949)	Per Visit	\$ _____

Education and Training (Revenue Code: 0942)	Per Visit	\$ _____
Cardiac Rehabilitation Therapy (Revenue Code: 0943)	Per Visit	\$ _____
Pulmonary Rehabilitation (Revenue Code:0948)	Per Visit	\$ _____

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission.

(1) Facility’s Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OPPTS/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change.

Facility Lab Fee Schedule Notes

Calculation of the contract rate for Laboratory and Pathology is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- The Per Unit via Facility Fee Schedule rates for existing codes are in effect until both parties mutually agree to rate changes.
- Unless otherwise indicated in the Facility Fee Schedule Specifications, Laboratory/Pathology Codes listed on the fee schedule that do not have a Primary or Gap Fill Source Fee will default to a contract rate of 50% PPR (“Fee Schedule Default PPR”) unless or until a Primary or Gap Fill Source Fee is published.
- There will be a quarterly update to the fee schedule to set fixed contract rates for new codes published throughout the previous quarter and codes previously priced according to the Fee Schedule Default PPR. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes in the UHC Facility Lab Fee Schedule by multiplying the “Primary Fee Source” rate or the applicable “Gap Fill Fee Source” rate by the same percentage as indicated in Table 2.
- Refer to the “Facility Fee Schedule Specifications” (included within the Facility Lab Fee Schedule Exhibit) for additional detail.
- _____ Payment Policies, as described in Article I of the Agreement, apply to this fee schedule reimbursement methodology.

Facility Radiology Fee Schedule Notes

Calculation of the contract rate for Radiology is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- The Per Unit via Facility Fee Schedule rates for existing codes are in effect until both parties mutually agree to rate changes.
- Unless otherwise indicated in the Facility Fee Schedule Specifications, Radiology Codes listed on the fee schedule that do not have a Primary or Gap Fill Source Fee will default to a contract rate of 50% PPR (“Fee Schedule Default PPR”) unless or until a Primary or Gap Fill Source Fee is published.

- There will be a quarterly update to the fee schedule to set fixed contract rates for new codes published throughout the previous quarter and codes previously priced according to the Fee Schedule Default PPR. The contract rates will be set based on the same methodology used to establish the contract rates for the existing codes in the UHC Facility Radiology Fee Schedule by multiplying the “Primary Fee Source” rate or the applicable “Gap Fill Fee Source” rate by the same percentage as indicated in Table 2.
- Refer to the “Facility Fee Schedule Specifications” (included within the Facility Radiology Fee Schedule Exhibit) for additional detail.
- _____ Payment Policies, as described in Article I of the Agreement, apply to this fee schedule reimbursement methodology.

2.3.2 Outpatient Procedures.

Outpatient Procedure: This Section applies to Covered Services rendered to a Customer that involves a Procedure, as listed in the UHC OPG (Outpatient Procedure Grouper) Exhibit to this Appendix, performed in an outpatient unit of Facility (“Outpatient Procedure”). For Outpatient Procedures, the contract rate will be based on a designated group number, as set forth in the table below and as further described in this Section 2.3.2. Unless otherwise specified in this Appendix, payment under this contract rate, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to Customer during an Outpatient Procedure. The group numbers below correspond with certain Outpatient Procedures identified in the UHC OPG Exhibit to this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. United may revise the information in the UHC OPG Exhibit based on newly published codes and updated Outpatient Procedure grouping information developed by CMS, which may be modified by United to include procedures that are not maintained by CMS, but are considered for payment under this Appendix. The codes indicated with a “Y” under the “OPG Eligible” column in the UHC OPG Exhibit that corresponds to the date of service, that are Covered Services, are considered eligible for payment under this Section 2.3.2. Any updates to the information in the UHC OPG Exhibit will be furnished to Facility upon request.

The UHC OPG Exhibit includes a comprehensive list of revenue codes and CPT/HCPCS codes for which the contract rate is determined according to the Outpatient Procedure Grouper table below. In the event a revenue code from the table below is billed with a CPT/HCPCS code indicated with an “N” under the “OPG Eligible” column in the UHC OPG Exhibit that corresponds to the date of service, the detail line item that includes that revenue code and CPT/HCPCS code is not eligible for consideration for reimbursement. However, if that detail line item is the only detail line item that has a revenue code from the table below, then the parties will consult as needed, at an operational level, to review the circumstances of the claim and assign appropriate CPT/HCPCS coding. Facility may resubmit the claim with the corrected coding information for consideration for reimbursement pursuant to this Appendix.

Table 3: Outpatient Procedure Grouper

Outpatient Procedures (Revenue Codes 0360, 0361, 0369, 0481, 0490, 0499, 0750 and 0790, and appropriate CPT or HCPCS Codes.) See the UHC OPG Exhibit for Revenue Code and CPT or HCPCS code criteria.	
Group Number	Per Case Contract Rate
0	\$ _____
1	\$ _____
2	\$ _____
3	\$ _____
4	\$ _____
5	\$ _____

6	\$ _____
7	\$ _____
8	\$ _____
9	\$ _____
10	\$ _____
Unlisted	\$ _____

2.3.3 Multiple Outpatient Procedures. When multiple Outpatient Procedures, including unlisted Outpatient Procedures, are performed on a Customer by Facility during one Outpatient Encounter, the contract rate is as follows: (1) the highest contract rate specified in Section 2.3.2 for which an Outpatient Procedure has been performed; plus (2) 50% of the contract rate specified in Section 2.3.2 for the Outpatient Procedure performed with the second highest contract rate. No additional payments for additional Outpatient Procedures performed during that Outpatient Encounter will be made; instead, such additional Outpatient Procedure(s) are included in the contract rate for the first two Outpatient Procedures.

2.3.4 Multiple Per Case Covered Services. If Outpatient Procedures, Observation, Emergency, and/or Urgent Care Covered Services are provided within a single Outpatient Encounter along with Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery (as specified in Section 2.3.1), a contract rate will apply only to the Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery; the Outpatient Procedures, Observation, Emergency, and/or Urgent Care service will be considered to have been included in the contract rate for the Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery.

If the Customer receives any Covered Services for which a Per Case Payment Method applies, all Covered Services during a single Outpatient Encounter that would otherwise have a contract rate pursuant to a Per Visit, Per Unit via Facility Fee Schedule, Payment Method will instead be included in the Per Case contract rate except for Covered Services eligible for reimbursement as a pass through under Section 2.3.5.

If more than one Covered Service subject to a Per Case Payment Method applies during a single Outpatient Encounter (as specified in Section 2.3), the contract rate will be the rate applicable to the Covered Service with the highest ranking, as indicated in the Case Rate Service Ranking table below. No additional payments for additional Covered Services provided during that same single Outpatient Encounter, for which a Per Case Payment Method applies, will be made; instead, such additional Covered Services will be considered to have been included in the contract rate for the Covered Service with the highest ranking on the table below.

Services on the Case Rate Service Ranking table below are ranked from the highest ranking to the lowest ranking, with Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery, as identified in Section 2.3.1, having the highest ranking.

Case Rate Service Ranking
Particle Beam, Gamma Ray, or Linear Accelerator Stereotactic Radiosurgery
Outpatient Procedures, as identified in Section 2.3.2
Observation
Emergency
Urgent Care

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-9-CM codes, or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

3.3 Facility-based Physician and Other Provider Charges. Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after _____, the current contract rates for all Covered Services under this Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility’s charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative _____ (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

$$[\text{Current Contract Rate} - (\text{Current Contract Rate} \times \text{Percentage Reduction}) = \text{New Contract Rate}]$$

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%

Emergency Physicians	Emergency Room Services	10%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%
		%
		%
		%
		%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 4: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes, when they are Covered Services billed with a Covered Service subject to a Per Case, Per Visit, Per Diem, MS-DRG, Per Unit via Facility Fee Schedule, PPR Per Case to a fixed cap, PPR Per Case or Per Unit Payment Method under this Appendix, are always considered included in other services. These Covered Services are therefore not subject to additional payment.

Services or items billed with listed codes in the table below, when they are Covered Services, but are not billed with a Covered Service subject to a Per Case, Per Visit, Per Diem, MS-DRG, Per Unit via Facility Fee Schedule, PPR Per Case to a fixed cap, PPR Per Case or Per Unit Payment Method under this Appendix, are subject to a PPR of _____ % of Eligible Charges for the Covered Service, less any applicable Customer Expenses. However, this PPR is subject to change under Section 4 as a result of changes to Facility’s Customary Charges. Additionally, adjustments to the PPR rate pursuant to Section 4 of this Appendix will carry forward into subsequent years.

Regardless of which of the above paragraphs apply, the Eligible Charges for the services or items listed in the table below are considered in other calculations for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, as permitted under the Agreement.

Table 5: Services that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0230-239	Nursing Increment	0541	Ambulance/Supply
0240-249	All Inclusive Ancillary	0544	Ambulance/Oxygen
0250	Pharmacy	0621	Med-Surg Sup/Incident Radiology
0251	Drugs/Generic	0622	Med-Surg Supplies Incident ODX
0252	Drugs/ Non Generic	0623	Surgical Dressing
0254	Drugs/Incidental Other DX	0631	Single Source Drug
0255	Drugs/Incidental Radiology	0632	Multiple Source Drug
0257	Drugs/Nonprescription	0633	Restrictive Prescription
0258	IV Solutions	0634	EPO < 10,000 Units
0259	Drugs/Other	0635	EPO 10,000 or More Units
0261	IV Therapy/Infusion Pump	0636 _____	Drugs Requiring Detailed Coding
0262	IV Therapy/RX Svs	0637	Self Administrable Drugs Not Requiring Detailed Coding
0263	IV Therapy/Drug/Supply Delv	0681	Trauma Level 1
0264	IV Therapy/Supplies	0682	Trauma Level 2
0270	Medical Surgical Supplies	0683-0689	Trauma Response
0271	Non Sterile Supply	0700	Cast Room
0272	Sterile Supply	0710	Recovery Room
0274 _____	Prosthetic/Orthotic Device	0723	Circumcision
0275 _____	Pacemaker	0760-0761, 0769	Specialty Services/Treatment Room
0276 _____	Intraocular Lens	0770	Preventive Care Svr/General
0278 _____	Supply/Implants	0780	Telemedicine
0279	Supply/Other	0800-0809	IP Renal Dialysis
0343-0344 _____	Nuclear Medicine – Diagnostic/Therapeutic Radiopharmaceuticals	0880-0881, 0889	Dialysis Miscellaneous
0370-0379	Anesthesia	0946	Complex Med Equip
0500	OP Service	0947	Complex Med Equip/Ancillary
0509	OP/Other	0950-0952	Other Therapeutic Services

Revenue Code	Description	Revenue Code	Description
0510-0511, 0514-0520, 0523, 0526, 0529	Clinic	2101	Acupuncture
0530-0539	Osteopathic Services	2103	Massage

3.6 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 6: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health - Medical Social Services
0116	Detox/Private	0570-0579	Home Health -Home Health Aide
0124	Psych/2bed	0580-0589	Home Health -Other Visits
0126	Detox/2bed	0590	Home Health -Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819	Donor Bank/Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab
0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees
0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Center(FQHC)	3101-3109	Adult Care
0550-0559	Home Health -Skilled Nursing		
MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD9 37.52,	Heart Transplant	010	Pancreas Transplant

Revenue Code	Description	Revenue Code	Description
37.63-37.66			
005-006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

3.7 Open Heart Surgical Procedure Following Outpatient Cardiac Catheterization. If a Customer is admitted to Facility for an open heart surgical procedure within three calendar days of a cardiac catheterization Outpatient Procedure, the contract rate set forth in Section 2.3.2 will not apply, and the contract rate for an open heart procedure as set forth in Section 2.2 of this Appendix will be paid. No additional payments will be made for the cardiac catheterization services; instead, the cardiac catheterization services will be considered to have been reimbursed as part of the contract rate for the open-heart surgical procedure.

3.8 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

SECTION 4

Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

4.2 Duty to Give Notice. Facility will notify United at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

4.3 Content of Notice. Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

(a) Facility's Chargemaster data before and after the increase in Facility's Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and

(ii) in a mutually acceptable format.

(b) The effective date of the Facility's new Chargemaster;

(c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,

(ii) in a mutually acceptable format, and

(iii) separately for inpatient and outpatient services.

(d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.; and

(e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with United. Facility will cooperate with United in administration of this section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

- 4.5 Adjustment to Contract Rates.** Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates, excluding the 50% PPR default rate indicated in the Facility Lab and/or Radiology Fee Schedule Notes and applicable Specification Sheet and fixed contract rates (impacted by lesser of) using the estimates in the notice. United will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. United may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment, along with the effective date of the revised appendix.
- 4.6 United's right to audit.** In addition to any other audit rights that United may have under the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.
- 4.7 Recovery of overpayments.** In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), United may recover those overpayments. United will give Facility notice of, and United intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates and fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

- 4.8 Dispute resolution.** In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement, modified as follows:
- (a) The parties will confer in good faith, and will resolve the matter through prospective and temporary contract rate adjustments to the contract rates for Covered Services set forth in this Appendix. Such prospective contract rate adjustment will be calculated to account for and neutralize the financial impact of the Customary Charge increase at issue to the contract rates set forth in this Appendix, so that Customary Charge increase will not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix. The temporary contract rate adjustment will be

calculated to address, through an additional and temporary adjustment to the contract rates, the financial impact on all claims impacted by the Customary Charge increase (inpatient claims with the date the Admission started and outpatient claims with dates of service occurring on and following the date of the Customary Charge increase at issue) for dates of service prior to the effective date of the contract rate adjustment.

- (b) If the parties are unable to amicably resolve the matter and implement an updated appendix with prospective and temporary contract rate adjustments within 90 days of receipt of the above-described notice, either party which remains dissatisfied may provide written notice to the other party of its decision to employ the services of a third party consultant with expertise in account relevant to the issues at hand rather than to an arbitrator selected as described in the Agreement to resolve the dispute. The consultant's scope will be limited to quantifying the financial impact of the Customary Charge increase and the prospective and temporary contract rate adjustments in dispute to the parties. The consultant will be jointly selected by the parties. The parties will work together in good faith to develop a list of eligible consultants by _____. The consultant fee will be shared equally between United and the Facility.

Each party will simultaneously and confidentially submit to the Consultant and to each other the following data elements:

- (i) a prospective contract rate adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), as described above, to account for the ongoing impact of the Customary Charge increase in dispute, for Covered Services with dates of service starting 30 days after the date of the Consultant's decision;
- (ii) a temporary adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), to the prospective contract rate adjustment, to account for the impact on claims that were impacted by the Customary Charge increase and that have dates of service prior to the effective date of the prospective contract rate adjustment described in the bullet immediately above this bullet (United may instead elect to address the claims with dates of service prior to effective date of the prospective contract rate adjustment by reprocessing those claims in accordance with the prospective contract rate adjustment, in which case the temporary adjustment will not be applied) (should United elect to reprocess the claims as set forth herein, the reprocessing process must be completed within ninety (90) days of the date of the Consultant's decision); and
- (iii) the length of time the temporary adjustment should remain in effect, and
- (iv) Utilization data that supports the party's prospective and temporary contract rate adjustment.

The data elements listed in (b)(i)-(iii) will collectively be referred to as each party's "Proposal."

- (c) Each party will have the same deadline for submitting their respective Proposals to the consultant; that deadline will be a date jointly selected by the parties or, if the parties cannot agree upon a date, the consultant will select a date. The consultant must select either the Proposal submitted by Facility in its entirety or the Proposal proposed by United in its entirety.

- (d) After the proposed findings are submitted to the consultant, the parties will meet with each other to review the submissions and explore the opportunity to resolve the dispute on a mutually satisfactory basis.
- (e) In the event the parties are unable to settle the matter, each party may submit to the consultant, with a copy to the other party, a response to the other party's Proposal; the deadline for submitting these responses will be jointly determined by the parties or, if the parties cannot agree upon a date, the consultant will select a date.
- (f) In the event the parties agree that a hearing should be held, or that a hearing is not necessary, the agreement of the parties will be followed. In the event that the parties cannot agree on whether a hearing is needed, the consultant will decide whether a hearing is necessary.
- (g) The decision of the consultant will be binding on the parties to the same extent as the decision of the arbitrator under the dispute resolution process set forth in the Agreement.

SECTION 5

Performance Based Compensation Program

To encourage Facility's efforts to improve both the quality and the efficiency of its patient care and to recognize successful performance with regard to these efforts, United will implement the PBC Program described by this Section 5, which provides to Facility the opportunity to qualify for adjustments to the Eligible Contract Rates, subject to meeting the program requirements described herein. Nothing herein is intended to compensate Facility for limiting or withholding clinically appropriate care from any Customer.

Facility understands and agrees that this Section 5 applies to, and only to, the Facility location(s) covered by this Appendix unless another Appendix to the Agreement expressly provides otherwise. If this Section 5 applies to more than one Facility location, Facility understands and agrees that the performance of all such locations will be measured in the aggregate to determine whether Facility has met the requirements hereunder. Implementation of the PBC Program in the event of changes in the locations covered by this Appendix is discussed in Section 5.7 below.

5.1 Definitions. Unless otherwise defined in this Section 5, capitalized terms used in this Section shall have the meanings assigned to them in this Appendix or in the Agreement.

Actual Performance Result: Facility's performance or experience with respect to a given Performance Measure based on the applicable Measurement Period or Data Capture Date, as determined using the applicable Performance Measure Criteria. Facility's Actual Performance Result is compared to the corresponding Performance Target to determine whether Facility successfully achieved the Performance Measure, as further discussed in Section 5.3. Actual Performance Results may be restated as described in Section 5.5.3.

Baseline: The value, as restated from time to time in accordance with Section 5.5.3, that represents Facility's level of performance or experience with respect to a given Performance Measure as measured with respect to the Baseline period set forth in the Baseline Exhibit.

Data Capture Date: The date during the Data Capture Period on which United obtains a third party data report.

Data Capture Period: With respect to those Performance Measures that are evaluated based on third party data, the date span during which United will obtain the applicable third party data reports. The Data Capture Period for a given Performance Measure is specified in the Timeline Exhibit.

Eligible Contract Rate: Each contract rate for a Covered Service that is reimbursed under this Appendix using any Payment Method other than a PPR or Per Unit via Facility Fee Schedule.

Measurement Period: The applicable date span used to determine Facility's Actual Performance Result with respect to each Performance Measure that is evaluated based on claims data, with or without United notification data. To determine Facility's Actual Performance Result for a given Performance Year on a Performance Measure that is evaluated based on claims data, with or without United notification data, as reflected in the final Performance Report, United will include not less than two months' claims run out for the Performance Measure.

Measurement Time: The applicable Measurement Period or Data Capture Period.

Payout Year or PY: Subject to earlier termination of the Agreement, each successive 12 month period, beginning with the first Payout Year, with respect to which Facility participates in the PBC Program. Subject to termination of the Agreement and Section 5.6.2, Eligible Contract Rates are adjusted during the Payout Year to reflect the Performance Escalator, if any, attributable to that Payout Year. The first Payout Year (or PY1) is the 12 month period that begins on the first anniversary of the Effective Date of the Agreement.

PBC Goal: The maximum adjustment to Eligible Contract Rates available under the PBC Program for a given Payout Year which, as further described in Section 5.3, is used to determine Facility's Performance Escalator.

PBC Program: United's Performance Based Compensation Program for hospitals, as described by this Section 5.

Performance Escalator: The increase to Eligible Contract Rates attributable to Facility's performance with respect to the Performance Measures for a given Payout Year, as determined and applied during that Payout Year in accordance with this Section 5.

Performance Measure: Each of the measures listed in the PBC Exhibit.

Performance Measure Criteria: United's description of and measurement logic for a particular Performance Measure.

Performance Points: The points associated with Facility's performance on a Performance Measure with respect to a given Payout Year, as set forth in the PBC Exhibit.

Performance Report: The interim quarterly or final report with respect to a given Payout Year that shows, on an interim or final basis, Facility's Actual Performance Results and the other information described in Section 5.5.2 of this Appendix.

Performance Target: The specified level of performance or experience that Facility must achieve on a particular Performance Measure with respect to a given Payout Year in order to meet the Performance Measure for purposes of this Section 5.

Rebased Contract Rate: The Eligible Contract Rate as adjusted to remove the impact of the Performance Escalator, as further described in Section 5.6 of this Appendix.

5.2 Eligibility to Participate in the PBC Program; Payout Year Terms.

5.2.1 Eligibility. To be eligible to participate in the PBC Program, Facility must be an acute inpatient hospital other than a long term acute care hospital, long term care hospital, or rehabilitation hospital.

5.2.2 Payout Year Terms. Subject to earlier termination of the Agreement, the Performance Measures, the corresponding Performance Targets, the allocation of Performance Points, and the applicable PBC Goal set forth in the PBC Exhibit and the Measurement Times set forth in the Timeline Exhibit will govern Facility's participation in the PBC Program with respect to each specified Payout Year.

Beginning with the first Payout Year for which terms are not specified in the PBC Exhibit, and with respect to each Payout Year thereafter, United and Facility agree to the following:

(a) At least 24 months prior to the first day of the next Payout Year for which the parties have not specified terms in writing, United and Facility will meet for the purpose of determining the applicable Performance Measures, the corresponding Performance Targets and Performance Points, and the applicable PBC Goal for that Payout Year. The parties will document the mutually agreed upon new terms in a written amendment signed by both parties within the timeframe specified in subparagraph 5.2.2(b).

(b) If the parties have not mutually agreed in writing on the Performance Measures, Performance Targets, Performance Points, and PBC Goal at least 18 months prior to the first day of the Payout Year to which such terms would apply, then the parties agree that they will keep the same Performance Measures, Performance Points, and PBC Goal used for the Payout Year immediately preceding that Payout Year and will use the applicable Section 5.2.2 default Performance Targets shown in the PBC Exhibit.

(c) For each subsequent Payout Year, the Measurement Time for a given Performance Measure will begin one year after the date on which the Measurement Time for that Performance Measure began for the prior Payout Year and continue for the same duration. If the parties agree on a new Performance Measure, it will have the standard Measurement Time assigned to that Performance Measure under the PBC Program based on the start date of Facility's next Payout Year.

5.3 Evaluation of Performance Measures; Performance Escalator. With respect to each Payout Year, United will assess Facility's Actual Performance Result for each Performance Measure. The Actual Performance Result will be determined in accordance with this Section 5 and the applicable Performance Measure Criteria. The Performance Measure Criteria for each of the Performance Measures in effect as of the effective date of this Appendix are provided in the Performance Measure Criteria Exhibits. United may modify the Performance Measure Criteria from time to time. United may implement the revised Performance Measure Criteria without Facility's consent if the same criteria are applicable to all or substantially all facilities in United's network that are subject to the corresponding Performance Measure. United will make the current Performance Measure Criteria for each Performance Measure available to Facility upon request.

If Facility's Actual Performance Result is equal to or better than the applicable Performance Target, Facility has met the Performance Measure. For each Performance Measure that Facility meets, United will credit Facility with the corresponding Performance Points shown in the PBC Exhibit. The maximum number of Performance Points available is 100. United will aggregate the Performance Points credited to Facility for all Performance Measures achieved with respect to a given Payout Year. The total Performance Points credited to Facility will range from 100 points to 0 points. United will use the following formula to determine the Performance Escalator attributable to that Payout Year:

$$[\text{total Performance Points} \div 100] * [\text{the PBC Goal}] = \text{Performance Escalator}$$

The Performance Escalator will be a percentage rounded up or down to the nearest one tenth of one percent (0.1%).

5.4 Data Sources. The PBC Exhibit indicates the data source United will use to assess Facility's performance on each Performance Measure. Such assessment is subject to the requirements and limitations set forth in this Section 5.4.

5.4.1 Claims. If the data source is claims:

(a) The applicable Performance Measure Criteria will describe the claims United will use to evaluate and report on Facility's performance with respect to each of the applicable Performance Measures.

(b) United is not currently able to include all claims submitted by Facility in the computation of Facility's performance on a Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of claims, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.4.2 Third Party Data. Except as expressly noted otherwise, if the data source is data made available by or through CMS or another third party:

(a) United will use the most current data available from the third party data source as of the Data Capture Date. If the third party has failed to timely update the available data, United will use the older data that is available as of the Data Capture Date. If more current data subsequently becomes available during the Data Capture Period but after the Data Capture Date, United will have no obligation to use the more current data, but may do so in its sole discretion, provided that use of the newer data will not delay timely delivery of the Performance Report.

(b) If the third party changes the information available to United in such a way that United cannot reasonably or meaningfully determine Facility's Actual Performance Result in accordance with the applicable Performance Measure Criteria, United will update the applicable Performance Measure Criteria in accordance with Section 5.3 to describe the alternate method United will use to determine Facility's Actual Performance Result.

(c) If the third party (i) ceases to gather and/or publish such data, (ii) ceases to make the data available to United on reasonable terms, or (iii) materially changes the scope or type of data it makes available, then the parties will mutually agree on a replacement Performance Measure. Alternately, the parties may agree to eliminate the affected Performance Measure and reallocate the Performance Points to the remaining Performance Measures.

5.4.3 Notification Data. If the data source is claims and United notification data, Section 5.4.1 applies with regard to claims and, with regard to United notification data:

(a) The applicable Performance Measure Criteria will describe the data United will use to evaluate and report on Facility's performance with respect to the applicable Performance Measure.

(b) United is not currently able to include notification data associated with all claims submitted by Facility in computation of Facility's performance on this Performance Measure (for example,

certain Affiliate claims). If United is later able to include a broader set of data, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.5 Performance Reports, Restatements, and Reconsideration.

5.5.1 Performance Reports. With respect to each Payout Year, United will provide Facility with quarterly Performance Reports, or electronic access to such reports, regarding Facility's performance on the Performance Measures. These Performance Reports will be consistent with the Performance Reports that United provides to other facilities participating in United's PBC Program. Performance Reports based on United claims data will be prepared using a reasonable period for claims run out and report development. Interim Performance Reports will reflect a date range that is different from the applicable Measurement Period; only the final Performance Report for a given Payout Year will reflect the date range defined as the applicable Measurement Period. The final Performance Report for a given Payout Year determines the Performance Escalator, if any, to be applied in that Payout Year. The final Performance Report will be provided or made available on or before the Performance Report due date specified in the Timeline Exhibit.

5.5.2 Content of Performance Report. Each Performance Report will include, at a minimum, the following content:

- (a) the Performance Target and corresponding Performance Target value for each Performance Measure;
- (b) Facility's Actual Performance Result (in the final Performance Report) or an interim calculation of the Actual Performance Result (in the interim Performance Reports) for each Performance Measure;
- (c) the Performance Points earned based on final or interim performance;
- (d) the earned Performance Points as a percentage of the maximum Performance Points; and
- (e) the Performance Escalator (in the final Performance Report) or an interim calculation of the Performance Escalator (in the interim Performance Reports).

Subject to and as limited by contractual confidentiality obligations and all applicable state and federal laws (including but not limited to privacy laws), supporting data for Facility's Actual Performance Result on a given Performance Measure will be provided to Facility upon request.

5.5.3 Restatements. The Baseline and Actual Performance Result for a Performance Measure may be restated by United on a quarterly basis to take into account any one or more of the following:

- (a) adjustments made by CMS or another nationally recognized source, for example MS-DRG weights or NQF approved calculations, in order to accurately compare Facility's baseline measure to Facility's performance with respect to the applicable Payout Year;
- (b) the addition or deletion of a Facility location covered by this Appendix and participating in the PBC Program, in accordance with Section 5.7;
- (c) restated or additional claims information;
- (d) corrections to databases identified by United or by a third party vendor; and
- (e) the inclusion of additional Affiliate claims.

Restated Baseline and Actual Performance Results will be shown in the interim and final Performance Reports. Once the Performance Escalator for a given Payout Year has been implemented in accordance with Section 5.6, it will not thereafter be changed due to a subsequent restatement of a Baseline or Actual Performance Result.

5.5.4 Third Party Certification. United will engage a third party at least annually to certify the data, methodology, measurement logic and software code supporting each Performance Measure. Documentation of the certification will be provided to Facility upon request.

5.5.5 Facility Objections. After reviewing the Performance Report, if Facility disagrees with United's determination of one or more Actual Performance Result(s) for one or more Performance Measure(s) due to (1) how the applicable methodology was applied, (2) how the applicable logic was used, or (3) whether the applicable software code was used, Facility may request reconsideration of the disputed determination(s). Facility will follow this reconsideration process:

- (a) Facility will send to United the reconsideration request in writing, which may be sent electronically, within 10 business days after the date on which Facility received a copy of or electronic access to the final Performance Report. United will provide Facility with the appropriate mailing address or email address for reconsideration requests. If the reconsideration is not requested timely, Facility will be deemed to have waived its right to pursue reconsideration in any forum.
- (b) The reconsideration request must include all of the following:
 - i) identification of each Performance Measure to be reconsidered;
 - ii) identification of the Actual Performance Result calculated by United for each contested Performance Measure;
 - iii) a detailed explanation of why Facility believes that the methodology, logic or software code is improper; and
 - iv) any other relevant information to support Facility's reconsideration request.

5.5.6 Reconsideration Period. Following receipt of the reconsideration request, United will review and respond to Facility within 10 business days. Upon Facility's written request, United will provide supporting data for each contested Performance Measure, subject to and as limited by contractual confidentiality obligations and applicable state and federal laws (including but not limited to privacy laws).

Within 10 business days after receiving United's response, Facility will inform United in writing whether the response has resolved Facility's concerns or not. If Facility still disagrees with United's Performance Report, the parties will promptly meet and confer about Facility's reconsideration request. If United and Facility have not reached a mutually satisfactory resolution regarding Facility's reconsideration request at least 45 days prior to the first day of the upcoming Payout Year, then the Performance Escalator will be effective on the first day of the first calendar month that begins at least 31 days after the date that the parties achieved such resolution. Contract rate adjustments described in Section 3 of this Appendix will not be delayed, and United will implement those adjustments effective as of the time specified in Section 3 in accordance with Section 5.6.

If the parties are unable to reach a mutually satisfactory resolution regarding Facility's reconsideration request, either party may initiate dispute resolution pursuant to Article VII of the Agreement.

5.6 Performance Escalator.

5.6.1 Application of Performance Escalator. The Performance Escalator, if any, determined in accordance with Section 5.3 will be applied to each Eligible Contract Rate, subject to the following adjustments:

- (a) The Performance Escalator is not intended to be cumulative in its effect from one year to the next. Accordingly, if a Performance Escalator is applied to the Eligible Contract Rates following successful performance by Facility with respect to a given Payout Year, the increase will always

be removed from each rate effective as of the first day after the end of the Payout Year in which the Performance Escalator was applied. The removal of the Performance Escalator establishes the “Rebased Contract Rate.” Any Performance Escalator applied hereunder will be applied to the Rebased Contract Rate. Likewise, and notwithstanding anything in this Appendix to the contrary, any annual adjustment made in accordance with Section 3 of this Appendix will be applied to the applicable Rebased Contract Rates (regardless of whether or not a Performance Escalator is also applicable in that contract year). This methodology is illustrated in the Example Section below.

(b) The Performance Escalator is additive to any annual adjustment specified in Section 3 of this Appendix. Both the Section 3 adjustment and the Performance Escalator are applied to the applicable Rebased Contract Rate. This methodology is illustrated in the Example Section below.

(c) Application of the Performance Escalator will take into account adjustments made under Section 4 of this Appendix. Notwithstanding anything in this Appendix to the contrary, a Section 4 Chargemaster adjustment will be made to the Eligible Contract Rate in effect at the time of such adjustment. In the event a Chargemaster adjustment occurred in the prior contract year the calculation to determine the Rebased Contract Rate will include the impact of that Chargemaster adjustment under Section 4. If a Chargemaster adjustment and a Performance Escalator become effective on the same date, the Chargemaster adjustment will occur after the calculation of the Rebased Contract Rates and the Performance Escalator will then be applied to the adjusted Rebased Contract Rate.

(d) The adjusted Eligible Contract Rates will be rounded up or down to the nearest whole dollar.

Example Section:

Fixed Rate Example: Assume the contract rate for a given Covered Service is \$100 in the year preceding the first Payout Year of this example. This example shows achievement of a Performance Escalator of 1% applied during PY1; a Performance Escalator of 0% applied during PY2; and a Performance Escalator of 2% applied during PY3. Using the formula described below, Row H indicates the contract rate applicable during each of the following Payout Years:

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
A	prior year contract rate [1]	value from row H of prior year	n/a	\$100	\$103	\$104
B	Rebased Contract Rate	A – [value from row F of prior year]	n/a	\$100.00	\$102.00	\$104.00
C	Section 3 annual adjustment		n/a	2.0%	2.0%	2.0%
D	-- increase/decrease for Section 3 annual adjustment	B x C	n/a	\$2.00	\$2.04	\$2.08
E	Section 5 Performance Escalator		n/a	1.0%	0.0%	2.0%
F	-- increase for Section 5 Performance Escalator	B x E	n/a	\$1.00	\$0.00	\$2.08
G	total adjustment	D + F	n/a	\$3.00	\$2.04	\$4.16

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
H	adjusted contract rate (rounded)	B + G (except the rate applicable in the year prior to PY1)	\$100	\$103	\$104	\$108

[1] Section 5.6.1 discusses various adjustments that may be applicable to a given contract rate. Assume for purposes of this example that there are no other applicable contract rate adjustments beyond those shown in the table.

5.6.2 Adjustment to Eligible Contract Rates. United will adjust each Eligible Contract Rate to reflect the Performance Escalator, consistent with any other adjustments described in this Appendix. The Performance Escalator will be effective with respect to Covered Services furnished by Facility on or after the first day of the Payout Year for which the Performance Escalator was calculated or such later date as may be determined by the parties' mutual written agreement or by an express term of this Appendix, and will continue in effect through the last day of the Payout Year, subject to the earlier termination of the Agreement or of this Payment Appendix. _____

5.7 Changes in Facility Locations Covered by this Appendix; Assignment. This Section 5.7 sets forth the parties' expectations with respect to implementation of this Section 5 in the event of a change in the Facility locations subject to the Agreement. Any such change must occur in accordance with an applicable provision of the Agreement. Nothing in this Section 5.7 creates or will be construed to create any rights with regard to how or when changes in Facility locations, assignment or other transfer of the Agreement may occur.

(a) If a location is added to the Agreement and covered by this Appendix after the end of the claims Measurement Periods, the new location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year. That location will be included in determining Facility's Actual Performance Results for the next Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(b) If a location is added to the Agreement and covered by this Appendix before the end of the claims Measurement Periods, the new location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures for the corresponding Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(c) If a location is deleted from this Appendix after the end of the claims Measurement Periods, that location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures with respect to the corresponding Payout Year. The deleted location will not be included in determining Facility's Actual Performance Results with respect to any additional Payout Years. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(d) If a location is deleted from this Appendix before the end of the claims Measurement Periods, that location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year or any future Payout Year. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(e) In the event of a partial assignment of the Agreement that includes this Appendix, or if this Appendix otherwise continues to apply to one or more (but not all) of the Facility locations previously contracted by or through Facility due to a merger or other transaction that results in Facility no longer owning and controlling such location(s), each such location will be treated as a "deleted location" for purposes of determining the period, if any, during which its performance or experience will continue to be aggregated with the remaining Facility locations. Once any continued period of aggregating ends, such location's performance or experience will be evaluated alone or with such other locations as are likewise subject to continued application of the Appendix following the assignment or transfer of such rights.

(f) If the data used for evaluation of one of more of the applicable Performance Measures cannot be aggregated or segregated as contemplated by this Section 5.7 with respect to the performance of a particular location, the parties will use best efforts to implement the PBC Program with respect to such location(s) consistent with the intent of this Section 5.

UHC Facility Lab Fee Schedule Exhibit

Facility acknowledges receipt of an electronic version of the UHC Facility Lab Fee Schedule Exhibit. Attached is the “Facility Fee Schedule Specifications” and “Representative Facility Fee Schedule Sample”.

UHC Facility Radiology Fee Schedule Exhibit

Facility acknowledges receipt of an electronic version of the UHC Facility Radiology Fee Schedule Exhibit. Attached is the “Facility Fee Schedule Specifications” and “Representative Facility Fee Schedule Sample”.

UHC OPG (Outpatient Procedure Grouper) Exhibit

Facility acknowledges receipt of an electronic version of the UHC OPG (Outpatient Procedure Grouper) Exhibit.

REVENUE CODE:

0360, 0361, 0369

0481

0490, 0499

0750

0790

WITH CPT / HCPCS CODES THAT ARE CONSIDERED “OPG ELIGIBLE” AS NOTED WITH A “Y” IN THE MOST CURRENT UHC OPG (OUTPATIENT PROCEDURE GROUPE) EXHIBIT

Chargemaster Notice Exhibit

PBC Exhibit

Timeline Exhibit

Baseline Exhibit

Performance Measure Criteria Exhibits

All Payer Appendix

Facility Name(s): _____

Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1

Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

APC (Ambulatory Payment Classifications): A system of classification, known as Ambulatory Payment Classifications, for outpatient hospital services based on, among other factors, CPT codes, HCPCS procedure codes, and payment status indicators.

The Payment Method designated “APC” in this Appendix and applicable to Covered Services rendered to a Customer for each unit of service performed within the Outpatient Service Category for which the APC Payment Method is indicated in the Outpatient Service Categories Table of this Appendix. The contract rate is determined by applying the APC CMS relative weight to the contracted conversion factor, without separate consideration for wage index and outliers, modified in accordance with the applicable rate set forth in Table 2 in Section 2.3 of this Appendix. Unless otherwise specified in this Appendix, payment under the APC Payment Method, less any applicable Customer Expenses, is payment in full. In the event CMS makes any modification to the calculation of APC payments, the methodology and factors relating to such APC payments will be updated by United on or before the later of (a) thirty (30) days after the effective date of such modification; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will update the methodology and factors in accordance with such subsequent change within thirty (30) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) thirty (30) days after the date on which CMS initially places information regarding such modification in the public domain (e.g., CMS distributes program memoranda to hospitals). The contract rates for claims processed during the time period between CMS updates and United's updates are based on the date the claim is processed.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer’s Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer’s Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.6 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

MS-DRG or Medicare Severity Diagnosis-Related Groups: A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status. For purposes of determining the contract rate under this Appendix, the MS-DRG at discharge, as that term is defined in the Final Rule, as published by CMS and most recently made effective under this Appendix, will be controlling. All changes in the definition of MS-DRG's specified in the Final Rule will be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the definitions are implemented under this Appendix (as described in the previous sentence), the previous definitions will apply.

The Payment Method designated "MS-DRG" in this Appendix and applicable to Covered Services rendered to a Customer for an entire Admission. The contract rate is determined by applying the MS-DRG relative weight to the contracted base rate. Unless otherwise specified in this Appendix, payment under the MS-DRG Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Observation: Services furnished by Facility on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

OPPS (Outpatient Prospective Payment System): A prospective payment system implemented by CMS for hospital outpatient services. APCs are a component of the OPPS. Fee schedules are another component of this payment system.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated "Per Case" in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services

(including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated “Per Diem” in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Unit via Facility Fee Schedule: The Payment Method designated “Per Unit via Facility Fee Schedule” in this Appendix, without separate consideration for geographic adjustment (unless otherwise specified in this Appendix), based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for services for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by the Centers for Medicare and Medicaid Services (CMS). In the event CMS makes any modification to the calculation of the CMS fee schedule(s) listed in Table 2, the fee schedule(s) will be updated by United on or before the later of (a) thirty (30) days after the effective date of such modification; provided, however, in the event CMS makes a change to such modification after the effective date of such modification, United will update the fee schedule(s) in accordance with such subsequent change within thirty (30) days after the date on which CMS places information regarding such subsequent change in the public domain, or (b) thirty (30) days after the date on which CMS initially places information regarding such modification in the public domain (e.g., CMS distributes program memoranda to hospitals).

The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule, must always equal the number of times a procedure or service is performed.

PPR (Percentage Payment Rate): The percentage applied to Facility’s detail line item Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine (“M.D.”) or a Doctor of Osteopathy (“D.O.”) or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2

Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by

Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. Unless otherwise specified in this Appendix, the contract rate for an Admission is the contract rate in effect on the date the Admission begins.

Table 1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
One Day Stay+ (see note + below) (All MS-DRG's except those listed in Section 3.6_____)	Per Case	\$_____
All MS-DRG's However, this service category does not apply where one of these services is billed in connection with Covered Services included in any of the other service categories on this Inpatient Service Category Table or Section 3.6_____)	MS-DRG	Base Rate \$_____
Obstetrics (Mother Only) * @ (see notes * and @ below)		
Vaginal delivery MS-DRGs: 767-768, 774-775	Per Case	\$_____
Cesarean Section MS-DRGs 765-766	Per Case	\$_____
Nursery* @ (see notes * and @ below)		
• Normal Newborn: MS-DRG 795	Per Diem	\$_____
• Lower Level Neonate: MS-DRGs 789, 792, 794	Per Diem	\$_____
• Higher Level Neonate: MS -DRGs 791, 793	Per Diem	\$_____
• Severe Level Neonate MS-DRG 790	Per Diem	\$_____
Hospice ~ (see note ~ below) Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656	Per Diem	\$_____
However, this service category does not apply where one of these revenue codes is billed in connection with any service category defined by Bill Types on this Inpatient Service Category Table.		
Rehabilitation~ @ (see notes ~ and @ below) Revenue Codes 0118, 0128, 0138, 0148, 0158	Per Diem	\$_____
However, this service category does not apply where one of these services is billed in connection with any service category defined by Bill Types on this Inpatient Service Category Table.		
Inpatient Skilled Nursing Services ~ (see note ~ below) Bill Types 211-219	Per Diem	\$_____

United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement. The contract rate is determined by applying the Base Rate in effect for the date of

Admission, the final MS-DRG (as determined by United from the coding information) and the relative weight _____ in effect under this Appendix as of the date of discharge (except for the time period between CMS' update and the United update, where the final MS-DRG and the relative weight will be based on the date the claim is processed).

+ A One Day Stay is an Admission during which Customer is admitted on a given day and is discharged at or prior to midnight at the end of the immediate next calendar day. One Day Stay service category does not apply to Rehabilitation, Hospice, Nursery and Inpatient Skilled Nursing Services. When a Customer is transferred as described in Section 2.2.1, the One Day Stay service category is not used in the calculation of the contract rate. Instead the applicable contract rate in Table1 is used in the transfer calculation.

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

@ The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

2.2.1 Transfer of Customer. This Section applies only when a MS-DRG or Per Case Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by the Centers for Medicare and Medicaid Services (CMS) except for MS-DRGs designated by CMS as "special pay" MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the "Imputed Per Diem Rate") as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as "special pay" MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an imputed per diem rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is 50% of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

- (a) Based on CMS readmission guidelines; and
- (b) To readmissions with a related diagnosis (as determined by United); and
- (c) Prior to the determination of the contract rate for the subsequent Admission

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.3 Outpatient Covered Services. For the provision of Covered Services to a Customer, the contract rate is determined according to CMS rules governing the hospital Outpatient Prospective Payment System (except as otherwise set forth in this Appendix) and according to this Section 2.3. All coding and billing guidelines issued by CMS will be followed by Facility in submitting claims unless otherwise specified below in Table 2. Units reported must always equal the number of times a procedure or service is performed.

Table 2: Outpatient Service Category Table

SERVICES CATEGORY	PAYMENT METHOD	CONTRACT RATE
Ambulance (APC status indicator A) (See Facility Ambulance Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	100%
Laboratory/Pathology (APC status indicator A) (See Facility Laboratory/Pathology Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	36%
Non-implantable Prosthetics & Orthotics (APC status indicator A) (See Non-implantable Prosthetics & Orthotics Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	85%
Physical Therapy, Occupational Therapy, Speech Therapy, Mammography (APC status indicator A) (See PT, OT, ST, Mammography Fee Schedule Notes below)	Per Unit via Facility Fee Schedule as determined by CMS	90%

“Inpatient Procedures” (Certain procedures rendered on an outpatient basis, but designated by CMS as reimbursable only when rendered on an inpatient basis) (APC status indicator C) (See “Inpatient Procedures” Fee Schedule Notes below and “Inpatient Procedures” Fee Schedule Exhibit)	Per Unit via UHC Facility “Inpatient Procedures” Fee Schedule _____	90% as described in the UHC Facility “Inpatient Procedures” Fee Schedule Exhibit
Corneal Tissue Acquisition (APC status indicator F) (2)	PPR	_____ %
Hepatitis Vaccines (APC status indicator F) (See Facility Vaccine Fee Schedule Notes below and Vaccine Fee Schedule Exhibit)	Per Unit via UHC Facility Vaccine Fee Schedule	85% as described in the UHC Facility Vaccine Fee Schedule Exhibit
Device and Radiopharmaceuticals Pass-Throughs (APC status indicator H) (2)	PPR	_____ %
Influenza and Pneumococcal Pneumonia (PPV) Vaccines (APC status indicator L) (See Facility Vaccine Fee Schedule Notes below and Vaccine Fee Schedule Exhibit)	Per Unit via UHC Facility Vaccine Fee Schedule	85% as described in the UHC Facility Vaccine Fee Schedule Exhibit
All Other Facility Outpatient Covered Services (See All Other Facility Outpatient Covered Services Notes below) (1)	APC	Conversion Factor \$_____

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission.

(1) Facility’s Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OP/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change. In the event such change has a negative projected financial impact to United or its Payers, United and Facility, within 30 days of above notification, will evaluate and agree upon contract rates going forward that will assure that changes to Facility’s Emergency department visits coding guidelines do not have the impact of increasing the amount paid by United or its Payers under this Appendix. Based on the agreed upon rate adjustment, both parties will execute an amendment to implement the adjusted contract rates going forward. In the event that United determines that an overpayment to Facility has resulted due to Facility’s failure to give timely notice as required under this Section, or due to Facility providing inaccurate information, United may recover those overpayments, as outlined in the Facility Participation Agreement.

In the event the parties are unable to agree on contract rates going forward, the matter may be resolved in accordance with the dispute resolution provisions of the Agreement. In addition to determining the impact of Facility’s Emergency department visits coding guidelines changes, the Arbitrator may

determine the new contract rates going forward necessary to ensure that United and its Payers are not impacted by Facility's coding guideline changes from the effective date of the coding guideline change.

(2) When CMS changes the status indicator or Payment Method for CPT/HCPCS codes with a PPR Payment Method in Table 2 so that the CPT/HCPCS code(s) prices using an APC Payment Method, the contract rate under this Appendix for the code(s) will thereafter be determined using the "All Other Facility Outpatient Covered Services" Service Category listed in Table 2.

With regard to all services with a Payment Method of Per Unit via Facility Fee Schedule as determined by CMS, the process for implementing CMS updates is described in the definition set forth in this Appendix of Per Unit via Facility Fee Schedule.

Ambulance Fee Schedule Notes

The rates are derived from the CMS Ambulance Fee Schedule, as posted on the CMS website, based on the following:

- Carrier Code and Locality number,
- HCPCS code billed, and
- Base Rate & Urban Mileage fee

Facility Laboratory/Pathology Fee Schedule Notes

The rates are derived from the CMS Clinical Diagnostic Laboratory Fee Schedule, as posted on the CMS website, using, in order of priority, the National Limit, the Mid Point, or the highest of the listed state rates.

Non-implantable Prosthetics & Orthotics Fee Schedule Notes

The rates are derived from the CMS Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS) Fee Schedule, as posted on the CMS website, by using the Ceiling Rate as specified in the CMS DMEPOS file.

PT, OT, ST, Mammography Fee Schedule Notes

The rates are derived from the CMS National Physician Fee Schedule Relative Value File, as posted on the CMS website, using the Fully Implemented Facility Total RVU multiplied by the Conversion Factor as specified in the file.

"Inpatient Procedures" Fee Schedule Notes

As used in Table 2 and in these Fee Schedule Notes, "Inpatient Procedures" refers to procedures rendered as outpatient services that, as of the date of service, CMS reimburses only on an inpatient basis, but that may be reimbursable under this Appendix on an outpatient basis as described below.

Calculation of the contract rate under this Appendix for "Inpatient Procedures" is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- The "Per Unit via UHC Facility 'Inpatient Procedures' fee schedule" rates for existing codes are in effect until both parties mutually agree to rate changes, or until CMS assigns an APC payment to a given code.
- Only the Inpatient Procedure codes listed on the UHC Facility "Inpatient Procedures" fee schedule attached to this Appendix will be payable as "Inpatient Procedures" under Table 2. The contract rate for all other CMS "Inpatient Procedure" codes (including any codes added by CMS to its "Inpatient Procedures" list in the future) is zero.
- When CMS assigns an APC payment to a given "Inpatient Procedures" code, such code will no longer be payable under this Appendix through the UHC Facility "Inpatient Produces" fee schedule. Instead, the contract rate under this Appendix for those codes will thereafter be determined using the APC payment method under Table 2.

Facility Vaccine Fee Schedule Notes

Calculation of the contract rate under this Appendix for Vaccines is based on the following:

- Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment.
- Only the Vaccine codes listed on the current fee schedule will be payable under the UHC Facility Vaccine Fee Schedule. The contract rate for any vaccine code not on the fee schedule is determined based on the All Other Covered Facility Outpatient Services service category.
- There will be a quarterly update to the fee schedule to set fixed rates for all existing and newly published codes. The rates will be set based on AWP multiplied by the same percentage as indicated in Table 2.

“All Other Facility Outpatient Covered Services” Notes

Any CPT/HCPCS code for which CMS would not use a relative weight calculation will have a contract rate at the current CMS rate applicable for that CPT/HCPCS code.

SECTION 3 Miscellaneous Provisions

- 3.1 Inclusive Rates.** The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.
- 3.2 Payment Code Updates.** United will update CPT codes, HCPCS codes, ICD-9-CM codes, or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.
- 3.3 Facility-based Physician and Other Provider Charges.** Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after _____, the current contract rates for all Covered Services under this Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility’s charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative _____ (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for

services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

$$[\text{Current Contract Rate} - (\text{Current Contract Rate} \times \text{Percentage Reduction}) = \text{New Contract Rate}]$$

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%
Emergency Physicians	Emergency Room Services	10%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%
		%
		%
		%
		%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 3: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply-Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 This Section Intentionally Left Blank

3.6 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services

rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 4: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health - Medical Social Services
0116	Detox/Private	0570-0579	Home Health – Home Health Aide
0124	Psych/2bed	0580-0589	Home Health – Other Visits
0126	Detox/2bed	0590	Home Health – Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819	Donor Bank/ Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab
0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees
0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521-0522, 0524-0525, 0527-0528	Rural Health Clinics (RHC/Federally Qualified Health Centers (FQHC))	3101-3109	Adult Care
0550-0559	Home Health - Skilled Nursing		
MS-DRGs	Description	MS-DRGs	Description
001 - 002 w/o ICD9 37.52, 37.63-37.66	Heart Transplant	010	Pancreas Transplant
005 - 006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

3.7 Open Heart Surgical Procedure Following Outpatient Cardiac Catheterization. If a Customer is admitted to Facility for an open heart surgical procedure within three calendar days of a cardiac catheterization Outpatient Procedure, the contract rate set forth in Section 2.3 will not apply, and the contract rate for an open heart procedure as set forth in Section 2.2 of this Appendix will be paid. No additional payments will be made for the cardiac catheterization services; instead, the cardiac catheterization services will be considered to have been reimbursed as part of the contract rate for the open-heart surgical procedure.

3.8 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by

Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

- 3.9 CMS Outpatient Code Editor (OCE) edits.** Payment under this Appendix is subject to certain of the CMS OCE edits. The OCE Exhibit to this Appendix lists the current CMS OCE edits, and indicates which ones will be applied to this Appendix as of the date this Appendix takes effect. United may apply an established CMS OCE edit to this Appendix, that was previously not applied to this Appendix, upon 90 days notice to Facility. New OCE edits implemented by CMS will apply to this Appendix unless United provides notice to Facility at least 15 days prior to the implementation date.

SECTION 4

Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

- 4.1 Intent.** The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

- 4.2 Duty to Give Notice.** Facility will notify United at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

- 4.3 Content of Notice.** Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

(a) Facility's Chargemaster data before and after the increase in Facility's Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:

(i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services

Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and

- (ii) in a mutually acceptable format.
- (b) The effective date of the Facility's new Chargemaster;
- (c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:
- (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,
 - (ii) in a mutually acceptable format, and
 - (iii) separately for inpatient and outpatient services.
- (d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.; and
- (e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with United. Facility will cooperate with United in administration of this section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates and fixed contract rates (impacted by lesser of) using the estimates in the notice. United will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. United may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment, along with the effective date of the revised appendix.

4.6 United's right to audit. In addition to any other audit rights that United may have under the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or

provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), United may recover those overpayments. United will give Facility notice of, and United intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates and fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement, modified as follows:

- (a) The parties will confer in good faith, and will resolve the matter through prospective and temporary contract rate adjustments to the contract rates for Covered Services set forth in this Appendix. Such prospective contract rate adjustment will be calculated to account for and neutralize the financial impact of the Customary Charge increase at issue to the contract rates set forth in this Appendix, so that Customary Charge increase will not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix. The temporary contract rate adjustment will be calculated to address, through an additional and temporary adjustment to the contract rates, the financial impact on all claims impacted by the Customary Charge increase (inpatient claims with the date the Admission started and outpatient claims with dates of service occurring on and following the date of the Customary Charge increase at issue) for dates of service prior to the effective date of the contract rate adjustment.
- (b) If the parties are unable to amicably resolve the matter and implement an updated appendix with prospective and temporary contract rate adjustments within 90 days of receipt of the above-described notice, either party which remains dissatisfied may provide written notice to the other party of its decision to employ the services of a third party consultant with expertise in account relevant to the issues at hand rather than to an arbitrator selected as described in the Agreement to resolve the dispute. The consultant's scope will be limited to quantifying the financial impact of the Customary Charge increase and the prospective and temporary contract rate adjustments in dispute to the

parties. The consultant will be jointly selected by the parties. The parties will work together in good faith to develop a list of eligible consultants by _____. The consultant fee will be shared equally between United and the Facility.

Each party will simultaneously and confidentially submit to the Consultant and to each other the following data elements:

- (i) a prospective contract rate adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), as described above, to account for the ongoing impact of the Customary Charge increase in dispute, for Covered Services with dates of service starting 30 days after the date of the Consultant's decision;
- (ii) a temporary adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), to the prospective contract rate adjustment, to account for the impact on claims that were impacted by the Customary Charge increase and that have dates of service prior to the effective date of the prospective contract rate adjustment described in the bullet immediately above this bullet (United may instead elect to address the claims with dates of service prior to effective date of the prospective contract rate adjustment by reprocessing those claims in accordance with the prospective contract rate adjustment, in which case the temporary adjustment will not be applied) (should United elect to reprocess the claims as set forth herein, the reprocessing process must be completed within ninety (90) days of the date of the Consultant's decision); and
- (iii) the length of time the temporary adjustment should remain in effect, and
- (iv) Utilization data that supports the party's prospective and temporary contract rate adjustment.

The data elements listed in (b)(i)-(iii) will collectively be referred to as each party's "Proposal."

- (c) Each party will have the same deadline for submitting their respective Proposals to the consultant; that deadline will be a date jointly selected by the parties or, if the parties cannot agree upon a date, the consultant will select a date. The consultant must select either the Proposal submitted by Facility in its entirety or the Proposal proposed by United in its entirety.
- (d) After the proposed findings are submitted to the consultant, the parties will meet with each other to review the submissions and explore the opportunity to resolve the dispute on a mutually satisfactory basis.
- (e) In the event the parties are unable to settle the matter, each party may submit to the consultant, with a copy to the other party, a response to the other party's Proposal; the deadline for submitting these responses will be jointly determined by the parties or, if the parties cannot agree upon a date, the consultant will select a date.
- (f) In the event the parties agree that a hearing should be held, or that a hearing is not necessary, the agreement of the parties will be followed. In the event that the parties cannot agree on whether a hearing is needed, the consultant will decide whether a hearing is necessary.

- (g) The decision of the consultant will be binding on the parties to the same extent as the decision of the arbitrator under the dispute resolution process set forth in the Agreement.

SECTION 5

Performance Based Compensation Program

To encourage Facility's efforts to improve both the quality and the efficiency of its patient care and to recognize successful performance with regard to these efforts, United will implement the PBC Program described by this Section 5, which provides to Facility the opportunity to qualify for adjustments to the Eligible Contract Rates, subject to meeting the program requirements described herein. Nothing herein is intended to compensate Facility for limiting or withholding clinically appropriate care from any Customer.

Facility understands and agrees that this Section 5 applies to, and only to, the Facility location(s) covered by this Appendix unless another Appendix to the Agreement expressly provides otherwise. If this Section 5 applies to more than one Facility location, Facility understands and agrees that the performance of all such locations will be measured in the aggregate to determine whether Facility has met the requirements hereunder. Implementation of the PBC Program in the event of changes in the locations covered by this Appendix is discussed in Section 5.7 below.

5.1 Definitions.. Unless otherwise defined in this Section 5, capitalized terms used in this Section shall have the meanings assigned to them in this Appendix or in the Agreement.

Actual Performance Result: Facility's performance or experience with respect to a given Performance Measure based on the applicable Measurement Period or Data Capture Date, as determined using the applicable Performance Measure Criteria. Facility's Actual Performance Result is compared to the corresponding Performance Target to determine whether Facility successfully achieved the Performance Measure, as further discussed in Section 5.3. Actual Performance Results may be restated as described in Section 5.5.3.

Baseline: The value, as restated from time to time in accordance with Section 5.5.3, that represents Facility's level of performance or experience with respect to a given Performance Measure as measured with respect to the Baseline period set forth in the Baseline Exhibit.

Data Capture Date: The date during the Data Capture Period on which United obtains a third party data report.

Data Capture Period: With respect to those Performance Measures that are evaluated based on third party data, the date span during which United will obtain the applicable third party data reports. The Data Capture Period for a given Performance Measure is specified in the Timeline Exhibit.

Eligible Contract Rate: Each contract rate for a Covered Service that is reimbursed under this Appendix using any Payment Method other than a PPR or Per Unit via Facility Fee Schedule.

Measurement Period: The applicable date span used to determine Facility's Actual Performance Result with respect to each Performance Measure that is evaluated based on claims data, with or without United notification data. To determine Facility's Actual Performance Result for a given Performance Year on a Performance Measure that is evaluated based on claims data, with or without United notification data, as reflected in the final Performance Report, United will include not less than two months' claims run out for the Performance Measure.

Measurement Time: The applicable Measurement Period or Data Capture Period.

Payout Year or PY: Subject to earlier termination of the Agreement, each successive 12 month period, beginning with the first Payout Year, with respect to which Facility participates in the PBC Program. Subject to termination of the Agreement and Section 5.6.2, Eligible Contract Rates are adjusted during the Payout Year to reflect the Performance Escalator, if any, attributable to that Payout Year. The first Payout Year (or PY1) is the 12 month period that begins on the first anniversary of the Effective Date of the Agreement.

PBC Goal: The maximum adjustment to Eligible Contract Rates available under the PBC Program for a given Payout Year which, as further described in Section 5.3, is used to determine Facility's Performance Escalator.

PBC Program: United's Performance Based Compensation Program for hospitals, as described by this Section 5.

Performance Escalator: The increase to Eligible Contract Rates attributable to Facility's performance with respect to the Performance Measures for a given Payout Year, as determined and applied during that Payout Year in accordance with this Section 5.

Performance Measure: Each of the measures listed in the PBC Exhibit.

Performance Measure Criteria: United's description of and measurement logic for a particular Performance Measure.

Performance Points: The points associated with Facility's performance on a Performance Measure with respect to a given Payout Year, as set forth in the PBC Exhibit.

Performance Report: The interim quarterly or final report with respect to a given Payout Year that shows, on an interim or final basis, Facility's Actual Performance Results and the other information described in Section 5.5.2 of this Appendix.

Performance Target: The specified level of performance or experience that Facility must achieve on a particular Performance Measure with respect to a given Payout Year in order to meet the Performance Measure for purposes of this Section 5.

Rebased Contract Rate: The Eligible Contract Rate as adjusted to remove the impact of the Performance Escalator, as further described in Section 5.6 of this Appendix.

5.2 Eligibility to Participate in the PBC Program; Payout Year Terms.

5.2.1 Eligibility. To be eligible to participate in the PBC Program, Facility must be an acute inpatient hospital other than a long term acute care hospital, long term care hospital, or rehabilitation hospital.

5.2.2 Payout Year Terms. Subject to earlier termination of the Agreement, the Performance Measures, the corresponding Performance Targets, the allocation of Performance Points, and the applicable PBC Goal set forth in the PBC Exhibit and the Measurement Times set forth in the Timeline Exhibit will govern Facility's participation in the PBC Program with respect to each specified Payout Year.

Beginning with the first Payout Year for which terms are not specified in the PBC Exhibit, and with respect to each Payout Year thereafter, United and Facility agree to the following:

(a) At least 24 months prior to the first day of the next Payout Year for which the parties have not specified terms in writing, United and Facility will meet for the purpose of determining the applicable Performance Measures, the corresponding Performance Targets and Performance Points, and the applicable PBC Goal for that Payout Year. The parties will document the mutually agreed upon new terms in a written amendment signed by both parties within the timeframe specified in subparagraph 5.2.2(b).

(b) If the parties have not mutually agreed in writing on the Performance Measures, Performance Targets, Performance Points, and PBC Goal at least 18 months prior to the first day of the Payout Year to which such terms would apply, then the parties agree that they will keep the same Performance Measures, Performance Points, and PBC Goal used for the Payout Year immediately preceding that Payout Year and will use the applicable Section 5.2.2 default Performance Targets shown in the PBC Exhibit.

(c) For each subsequent Payout Year, the Measurement Time for a given Performance Measure will begin one year after the date on which the Measurement Time for that Performance Measure began for the prior Payout Year and continue for the same duration. If the parties agree on a new Performance Measure, it will have the standard Measurement Time assigned to that Performance Measure under the PBC Program based on the start date of Facility's next Payout Year.

5.3 Evaluation of Performance Measures; Performance Escalator. With respect to each Payout Year, United will assess Facility's Actual Performance Result for each Performance Measure. The Actual Performance Result will be determined in accordance with this Section 5 and the applicable Performance Measure Criteria. The Performance Measure Criteria for each of the Performance Measures in effect as of the effective date of this Appendix are provided in the Performance Measure Criteria Exhibits. United may modify the Performance Measure Criteria from time to time. United may implement the revised Performance Measure Criteria without Facility's consent if the same criteria are applicable to all or substantially all facilities in United's network that are subject to the corresponding Performance Measure. United will make the current Performance Measure Criteria for each Performance Measure available to Facility upon request.

If Facility's Actual Performance Result is equal to or better than the applicable Performance Target, Facility has met the Performance Measure. For each Performance Measure that Facility meets, United will credit Facility with the corresponding Performance Points shown in the PBC Exhibit. The maximum number of Performance Points available is 100. United will aggregate the Performance Points credited to Facility for all Performance Measures achieved with respect to a given Payout Year. The total Performance Points credited to Facility will range from 100 points to 0 points. United will use the following formula to determine the Performance Escalator attributable to that Payout Year:

$$[\text{total Performance Points} \div 100] * [\text{the PBC Goal}] = \text{Performance Escalator}$$

The Performance Escalator will be a percentage rounded up or down to the nearest one tenth of one percent (0.1%).

5.4 Data Sources. The PBC Exhibit indicates the data source United will use to assess Facility's performance on each Performance Measure. Such assessment is subject to the requirements and limitations set forth in this Section 5.4.

5.4.1 Claims. If the data source is claims:

(a) The applicable Performance Measure Criteria will describe the claims United will use to evaluate and report on Facility's performance with respect to each of the applicable Performance Measures.

(b) United is not currently able to include all claims submitted by Facility in the computation of Facility's performance on a Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of claims, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.4.2 Third Party Data. Except as expressly noted otherwise, if the data source is data made available by or through CMS or another third party:

(a) United will use the most current data available from the third party data source as of the Data Capture Date. If the third party has failed to timely update the available data, United will use the older data that is available as of the Data Capture Date. If more current data subsequently becomes available during the Data Capture Period but after the Data Capture Date, United will have no obligation to use the more current data, but may do so in its sole discretion, provided that use of the newer data will not delay timely delivery of the Performance Report.

(b) If the third party changes the information available to United in such a way that United cannot reasonably or meaningfully determine Facility's Actual Performance Result in accordance with the applicable Performance Measure Criteria, United will update the applicable Performance Measure Criteria in accordance with Section 5.3 to describe the alternate method United will use to determine Facility's Actual Performance Result.

(c) If the third party (i) ceases to gather and/or publish such data, (ii) ceases to make the data available to United on reasonable terms, or (iii) materially changes the scope or type of data it makes available, then the parties will mutually agree on a replacement Performance Measure. Alternately, the parties may agree to eliminate the affected Performance Measure and reallocate the Performance Points to the remaining Performance Measures.

5.4.3 Notification Data. If the data source is claims and United notification data, Section 5.4.1 applies with regard to claims and, with regard to United notification data:

(a) The applicable Performance Measure Criteria will describe the data United will use to evaluate and report on Facility's performance with respect to the applicable Performance Measure.

(b) United is not currently able to include notification data associated with all claims submitted by Facility in computation of Facility's performance on this Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of data, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.5 Performance Reports, Restatements, and Reconsideration.

5.5.1 Performance Reports. With respect to each Payout Year, United will provide Facility with quarterly Performance Reports, or electronic access to such reports, regarding Facility's performance on the Performance Measures. These Performance Reports will be consistent with the Performance Reports

that United provides to other facilities participating in United's PBC Program. Performance Reports based on United claims data will be prepared using a reasonable period for claims run out and report development. Interim Performance Reports will reflect a date range that is different from the applicable Measurement Period; only the final Performance Report for a given Payout Year will reflect the date range defined as the applicable Measurement Period. The final Performance Report for a given Payout Year determines the Performance Escalator, if any, to be applied in that Payout Year. The final Performance Report will be provided or made available on or before the Performance Report due date specified in the Timeline Exhibit.

5.5.2 Content of Performance Report. Each Performance Report will include, at a minimum, the following content:

- (a) the Performance Target and corresponding Performance Target value for each Performance Measure;
- (b) Facility's Actual Performance Result (in the final Performance Report) or an interim calculation of the Actual Performance Result (in the interim Performance Reports) for each Performance Measure;
- (c) the Performance Points earned based on final or interim performance;
- (d) the earned Performance Points as a percentage of the maximum Performance Points; and
- (e) the Performance Escalator (in the final Performance Report) or an interim calculation of the Performance Escalator (in the interim Performance Reports).

Subject to and as limited by contractual confidentiality obligations and all applicable state and federal laws (including but not limited to privacy laws), supporting data for Facility's Actual Performance Result on a given Performance Measure will be provided to Facility upon request.

5.5.3 Restatements. The Baseline and Actual Performance Result for a Performance Measure may be restated by United on a quarterly basis to take into account any one or more of the following:

- (a) adjustments made by CMS or another nationally recognized source, for example MS-DRG weights or NQF approved calculations, in order to accurately compare Facility's baseline measure to Facility's performance with respect to the applicable Payout Year;
- (b) the addition or deletion of a Facility location covered by this Appendix and participating in the PBC Program, in accordance with Section 5.7;
- (c) restated or additional claims information;
- (d) corrections to databases identified by United or by a third party vendor; and
- (e) the inclusion of additional Affiliate claims.

Restated Baseline and Actual Performance Results will be shown in the interim and final Performance Reports. Once the Performance Escalator for a given Payout Year has been implemented in accordance with Section 5.6, it will not thereafter be changed due to a subsequent restatement of a Baseline or Actual Performance Result.

5.5.4 Third Party Certification. United will engage a third party at least annually to certify the data, methodology, measurement logic and software code supporting each Performance Measure. Documentation of the certification will be provided to Facility upon request.

5.5.5 Facility Objections. After reviewing the Performance Report, if Facility disagrees with United's determination of one or more Actual Performance Result(s) for one or more Performance Measure(s) due to (1) how the applicable methodology was applied, (2) how the applicable logic was used, or (3) whether the applicable software code was used, Facility may request reconsideration of the disputed determination(s). Facility will follow this reconsideration process:

(a) Facility will send to United the reconsideration request in writing, which may be sent electronically, within 10 business days after the date on which Facility received a copy of or electronic access to the final Performance Report. United will provide Facility with the appropriate mailing address or email address for reconsideration requests. If the reconsideration is not requested timely, Facility will be deemed to have waived its right to pursue reconsideration in any forum.

(b) The reconsideration request must include all of the following:

- i) identification of each Performance Measure to be reconsidered;
- ii) identification of the Actual Performance Result calculated by United for each contested Performance Measure;
- iii) a detailed explanation of why Facility believes that the methodology, logic or software code is improper; and
- iv) any other relevant information to support Facility's reconsideration request.

5.5.6 Reconsideration Period. Following receipt of the reconsideration request, United will review and respond to Facility within 10 business days. Upon Facility's written request, United will provide supporting data for each contested Performance Measure, subject to and as limited by contractual confidentiality obligations and applicable state and federal laws (including but not limited to privacy laws).

Within 10 business days after receiving United's response, Facility will inform United in writing whether the response has resolved Facility's concerns or not. If Facility still disagrees with United's Performance Report, the parties will promptly meet and confer about Facility's reconsideration request. If United and Facility have not reached a mutually satisfactory resolution regarding Facility's reconsideration request at least 45 days prior to the first day of the upcoming Payout Year, then the Performance Escalator will be effective on the first day of the first calendar month that begins at least 31 days after the date that the parties achieved such resolution. Contract rate adjustments described in Section 3 of this Appendix will not be delayed, and United will implement those adjustments effective as of the time specified in Section 3 in accordance with Section 5.6.

If the parties are unable to reach a mutually satisfactory resolution regarding Facility's reconsideration request, either party may initiate dispute resolution pursuant to Article VII of the Agreement.

5.6 Performance Escalator.

5.6.1 Application of Performance Escalator. The Performance Escalator, if any, determined in accordance with Section 5.3 will be applied to each Eligible Contract Rate, subject to the following adjustments:

(a) The Performance Escalator is not intended to be cumulative in its effect from one year to the next. Accordingly, if a Performance Escalator is applied to the Eligible Contract Rates following successful performance by Facility with respect to a given Payout Year, the increase will always be removed from each rate effective as of the first day after the end of the Payout Year in which the Performance Escalator was applied. The removal of the Performance Escalator establishes the "Rebased Contract Rate." Any Performance Escalator applied hereunder will be applied to the Rebased Contract Rate. Likewise, and notwithstanding anything in this Appendix to the contrary, any annual adjustment made in accordance with Section 3 of this Appendix will be applied to the applicable Rebased Contract Rates (regardless of whether or not a Performance Escalator is also applicable in that contract year). This methodology is illustrated in the Example Section below.

(b) The Performance Escalator is additive to any annual adjustment specified in Section 3 of this Appendix. Both the Section 3 adjustment and the Performance Escalator are applied to the applicable Rebased Contract Rate. This methodology is illustrated in the Example Section below.

(c) Application of the Performance Escalator will take into account adjustments made under Section 4 of this Appendix. Notwithstanding anything in this Appendix to the contrary, a Section 4 Chargemaster adjustment will be made to the Eligible Contract Rate in effect at the time of such adjustment. In the event a Chargemaster adjustment occurred in the prior contract year the calculation to determine the Rebased Contract Rate will include the impact of that Chargemaster adjustment under Section 4. If a Chargemaster adjustment and a Performance Escalator become effective on the same date, the Chargemaster adjustment will occur after the calculation of the Rebased Contract Rates and the Performance Escalator will then be applied to the adjusted Rebased Contract Rate.

(d) The adjusted Eligible Contract Rates will be rounded up or down to the nearest whole dollar.

Example Section:

Fixed Rate Example: Assume the contract rate for a given Covered Service is \$100 in the year preceding the first Payout Year of this example. This example shows achievement of a Performance Escalator of 1% applied during PY1; a Performance Escalator of 0% applied during PY2; and a Performance Escalator of 2% applied during PY3. Using the formula described below, Row H indicates the contract rate applicable during each of the following Payout Years:

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
A	prior year contract rate [1]	value from row H of prior year	n/a	\$100	\$103	\$104
B	Rebased Contract Rate	A – [value from row F of prior year]	n/a	\$100.00	\$102.00	\$104.00
C	Section 3 annual adjustment		n/a	2.0%	2.0%	2.0%
D	-- increase/decrease for Section 3 annual adjustment	B x C	n/a	\$2.00	\$2.04	\$2.08
E	Section 5 Performance Escalator		n/a	1.0%	0.0%	2.0%
F	-- increase for Section 5 Performance Escalator	B x E	n/a	\$1.00	\$0.00	\$2.08
G	total adjustment	D + F	n/a	\$3.00	\$2.04	\$4.16
H	adjusted contract rate (rounded)	B + G (except the rate applicable in the year prior to PY1)	\$100	\$103	\$104	\$108

[1] Section 5.6.1 discusses various adjustments that may be applicable to a given contract rate. Assume for purposes of this example that there are no other applicable contract rate adjustments beyond those shown in the table.

5.6.2 Adjustment to Eligible Contract Rates. United will adjust each Eligible Contract Rate to reflect the Performance Escalator, consistent with any other adjustments described in this Appendix. The Performance Escalator will be effective with respect to Covered Services furnished by Facility on or after the first day of the Payout Year for which the Performance Escalator was calculated or such later date as may be determined by the parties' mutual written agreement or by an express term of this Appendix, and will continue in effect through the last day of the Payout Year, subject to the earlier termination of the Agreement or of this Payment Appendix. _____

5.7 Changes in Facility Locations Covered by this Appendix; Assignment. This Section 5.7 sets forth the parties' expectations with respect to implementation of this Section 5 in the event of a change in the Facility locations subject to the Agreement. Any such change must occur in accordance with an applicable provision of the Agreement. Nothing in this Section 5.7 creates or will be construed to create any rights with regard to how or when changes in Facility locations, assignment or other transfer of the Agreement may occur.

(a) If a location is added to the Agreement and covered by this Appendix after the end of the claims Measurement Periods, the new location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year. That location will be included in determining Facility's Actual Performance Results for the next Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(b) If a location is added to the Agreement and covered by this Appendix before the end of the claims Measurement Periods, the new location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures for the corresponding Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(c) If a location is deleted from this Appendix after the end of the claims Measurement Periods, that location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures with respect to the corresponding Payout Year. The deleted location will not be included in determining Facility's Actual Performance Results with respect to any additional Payout Years. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(d) If a location is deleted from this Appendix before the end of the claims Measurement Periods, that location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year or any future Payout Year. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(e) In the event of a partial assignment of the Agreement that includes this Appendix, or if this Appendix otherwise continues to apply to one or more (but not all) of the Facility locations previously contracted by or through Facility due to a merger or other transaction that results in Facility no longer owning and controlling such location(s), each such location will be treated as a

“deleted location” for purposes of determining the period, if any, during which its performance or experience will continue to be aggregated with the remaining Facility locations. Once any continued period of aggregating ends, such location’s performance or experience will be evaluated alone or with such other locations as are likewise subject to continued application of the Appendix following the assignment or transfer of such rights.

(f) If the data used for evaluation of one of more of the applicable Performance Measures cannot be aggregated or segregated as contemplated by this Section 5.7 with respect to the performance of a particular location, the parties will use best efforts to implement the PBC Program with respect to such location(s) consistent with the intent of this Section 5.

UnitedHealthcare Outpatient Code Editor (OCE) Exhibit

ON – Edit applies per CMS

INACTIVE – CMS has turned the edit off and UHC is following CMS

OFF – UHC has turned the edit off

EDIT	Description	UHC Adoption Decision
1	Invalid diagnosis code	ON
2	Diagnosis and age conflict	ON
3	Diagnosis and sex conflict	ON
4	Medicare secondary payer alert	INACTIVE
5	E-code as reason for visit	ON
6	Invalid procedure code	ON
7	Procedure and age conflict	INACTIVE
8	Procedure and sex conflict	ON
9	Non-covered under Medicare outpatient benefit for reasons other than statute	OFF
10	Service submitted for verification of denial	OFF
11	Service submitted for review	OFF
12	Questionable covered service	OFF
13	Separate payment for services is not provided by Medicare	INACTIVE
14	Code indicates a site of service not included in OPPS	INACTIVE
15	Service unit out of range for procedure	ON
16	Multiple bilateral procedures without modifier 50	INACTIVE
17	Inappropriate specification of bilateral procedure	ON
18	Inpatient procedure	OFF
19	Mutually exclusive procedure that is not allowed by CCI even if appropriate modifier is present	ON
20	Component of a comprehensive procedure that is not	ON

allowed even if appropriate modifier is present

21	Medical visit on same day as a type “T” or “S” procedure Without modifier -25	ON
22	Invalid modifier	ON
23	Invalid date	ON
24	Date out of OCE range	ON
25	Invalid age	ON
26	Invalid sex	ON
27	Only incidental services reported	ON
28	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	ON
29	Partial hospitalization service for non-mental health diagnosis	OFF
30	Insufficient services on day of partial hospitalization	OFF
31	Partial hospitalization on same day as electroconvulsive therapy or type T procedure	INACTIVE
32	Partial hospitalization claim spans 3 or less days with insufficient Services on at least one of the days	INACTIVE
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	INACTIVE
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	INACTIVE
35	Only activity therapy and/or occupational therapy services provided	OFF
36	Extensive mental health services provided on day of electroconvulsive therapy or significant procedure	INACTIVE
37	Terminated bilateral procedure or terminated procedure with units greater than one	ON
38	Inconsistency between implanted device and implantation procedure	ON
39	Mutually exclusive procedure that would be allowed if appropriate modifier were present	ON
40	Component of a comprehensive procedure that would be allowed if appropriate modifier were present	ON
41	Invalid revenue code	ON

42	Multiple medical visits on same day with same revenue code without condition code G0	ON
43	Transfusion or blood product exchange without specification of blood product	ON
44	Observation revenue code on line item with non-observation HCPCS code	OFF
45	Service not appropriate for type of bill	ON
46	Partial hospitalization condition code 41 not approved for type of bill	ON
47	Service is not separately payable	ON
48	Revenue center requires HCPCS	ON
49	Service on same day as inpatient procedure	OFF
50	Non-covered based on statutory exclusion	ON
51	Multiple observations overlap in time	INACTIVE
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions	INACTIVE
53	Codes G0378 and G0379 only allowed with bill type 13x	OFF
54	Multiple codes for the same service	INACTIVE
55	Non-reportable for site of service	ON
56	E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1	INACTIVE
57	E/M condition not met for separately payable observation and line item date for code G0378 is 1/1	OFF
58	G0379 only allowed with G0378	OFF
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis	INACTIVE
60	Use of modifier CA with more than one procedure not allowed	ON
61	Service can only be billed to the DMERC	ON
62	Code not recognized; alternate code for same service may be available	ON

63	This OT code only billed on partial hospitalization claims	OFF
64	AT service not payable outside the partial hospitalization program	OFF
65	Revenue code not recognized by Medicare	ON
66	Code requires manual pricing	ON
67	Service provided prior to FDA approval	ON
68	Service provided prior to date of National Coverage Determination (NCD) approval	ON
69	Service provided outside approval period	ON
70	CA modifier requires patient status code 20	ON
71	Claim lacks required device code	OFF
72	Service not billable to the Fiscal Intermediary	ON
73	Incorrect billing of blood and blood products	ON
74	Units greater than one for bilateral procedure billed with modifier -50	ON
75	Incorrect billing of modifier - FB	ON
76	Trauma Response critical care code without revenue code 068x And CPT 99291	ON
77	Claim lacks required procedure code	ON
78	Claim lacks required radiolabeled product	ON
79	Incorrect billing of revenue code with HCPCS code	ON
80	Mental health code not approved for partial hospitalization	OFF
81	Mental health not payable outside the Partial Hospitalization Program	OFF
82	Charge exceeds token charge	ON
83	Service provided on or after end date of NCD Coverage	ON
84	Claim lacks required primary code	ON
85	Claim lacks required device or procedure code	ON

UHC Facility “Inpatient Procedures” Fee Schedule Exhibit

UHC Facility Vaccine Fee Schedule Exhibit

Chargemaster Notice Exhibit

PBC Exhibit

Timeline Exhibit

Baseline Exhibit

Performance Measure Criteria Exhibits

Mixed Fixed/PPR All Payer Appendix

Facility Name(s): _____
Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1 Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Covered Service: a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.5 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form

MS-DRG (Medicare Severity Diagnosis-Related Groups): A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status.

Observation: Services furnished by Facility on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated "Per Case" in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but

not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated “Per Diem” in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

PPR (Percentage Payment Rate): The percentage applied to Facility’s Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine (“M.D.”) or a Doctor of Osteopathy (“D.O.”) or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2 Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. The contract rate for an Admission is the contract rate in effect on the date the Admission begins.

Table _____: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Medical/Surgical/ICU/CCU/PICU/ICU-Intermediate/CCU-Intermediate ^ (see note ^ below) Includes the following Revenue Codes	Per Diem	\$ _____

Revenue Codes 0100-0101, 0110-0113, 0117, 0119-0123, 0127, 0129-0133, 0137, 0139-0143, 0147, 0149-0153, 0157, 0159-0160, 0164, 0169, 0170-0174, 0179, 0200-0203, 0206-0212, 0214, 0219		
Hospice ~ ^ (see notes ~ and ^ below) Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656	Per Diem	\$ _____
Nursery* (see note * below) • Normal Newborn: MS-DRG 795 • Lower Level Neonate: MS-DRGs 789, 792, 794 • Higher Level Neonate: MS-DRGs 791, 793 • Severe Level Neonate: MS-DRG 790	Per Diem Per Diem Per Diem Per Diem	\$ _____ \$ _____ \$ _____ \$ _____
Obstetrics (Mother only)* (see note * below) Vaginal delivery MS-DRGs: 767-768, 774-775	Per Case	\$ _____
Cesarean Section MS-DRGs: 765-766	Per Case	\$ _____
False Labor MS-DRG: 780	Per Diem	\$ _____
Rehabilitation ~ ^ (see notes ~ and ^ below) Revenue Codes 0118, 0128, 0138, 0148, 0158	Per Diem	\$ _____
Hospital Sub-Acute Revenue Codes 0190-0194, 0199 However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.5 _____	Per Diem	\$ _____
Inpatient Skilled Nursing Services~ (see note ~ below) Bill Types 211-219	Per Diem	\$ _____

Notes to Table

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

^ However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by MS-DRGs or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.5 _____.

Additional information regarding MS-DRGs under this Appendix

The following applies to MS-DRGs as used in this Appendix:

-United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement.

The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

-All changes in the definition of MS-DRGs specified in the Final Rule will be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the definition are implemented under this Appendix, the previous definitions will apply. Claims with discharge dates 10/1 and later, that are processed during the period in between the CMS effective date and United's implementation date will continue to have the previous MS-DRG grouper applied. Claims with discharge dates 10/1 and later that are processed following United's implementation date for the MS-DRG grouper updates will have the new grouper applied.

Table 1B - Inpatient Cardiac Services for which the contract rate will not be determined according to Table 1A. For an Admission that includes any of the following Inpatient Covered Services provided to a Customer, the contract rates for the entire Admission are determined as follows.

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
001 w/ICD9 37.52, 37.63-37.66	Implant of Heart Assist System w MCC	\$ _____
002 w/ICD9 37.52, 37.63-37.66	Implant of Heart Assist System w/o MCC	\$ _____
215	Other Heart Assist System Implant	\$ _____
216	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization w MCC	\$ _____
217	Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization w CC	\$ _____
219	Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization w MCC	\$ _____
220	Cardiac Valve & Other Major Cardiothoracic Procedures without Cardiac Catheterization w CC	\$ _____
222	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure or Shock w MCC	\$ _____
223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction, Heart Failure or Shock w/o MCC	\$ _____
224	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock w MCC	\$ _____
225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction, Heart Failure or Shock w/o MCC	\$ _____
226	Cardiac Defibrillator Implant without Cardiac Catheterization w MCC	\$ _____
227	Cardiac Defibrillator Implant without Cardiac Catheterization w/o MCC	\$ _____
228	Other Cardiothoracic Procedures w MCC	\$ _____
229	Other Cardiothoracic Procedures w CC	\$ _____
231	Coronary Bypass with PTCA w MCC	\$ _____
232	Coronary Bypass with PTCA w/o MCC	\$ _____
233	Coronary Bypass with Cardiac Cath w MCC	\$ _____
234	Coronary Bypass with Cardiac Cath w/o MCC	\$ _____
235	Coronary Bypass without Cardiac Cath w MC	\$ _____

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
236	Coronary Bypass without Cardiac Cath w/o MCC	\$ _____
237	Major Cardiovascular Procedures w MCC	\$ _____
238	Major Cardiovascular Procedures w/o MCC	\$ _____
242	Permanent Cardiac Pacemaker Implant w MCC	\$ _____
243	Permanent Cardiac Pacemaker Implant w CC	\$ _____
244	Permanent Cardiac Pacemaker Implant w/o CC/MCC .	\$ _____
246	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with MCC or 4+ vessels/stents	\$ _____
247	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent w/o MCC.	\$ _____
248	Percutaneous Cardiovascular Procedures with Non-drug Eluting Stent w MCC or 4+ vessels/stents	\$ _____
249	Percutaneous Cardiovascular Procedure with Non-Drug Eluting Stent w/o MCC	\$ _____
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent or AMI w MCC.	\$ _____
251	Percutaneous Cardiovascular Procedures without Coronary Artery Stent or AMI w/o MCC.	\$ _____
252	Other Vascular Procedures w MCC	\$ _____
253	Other Vascular Procedures w CC	\$ _____
258	Cardiac Pacemaker Device Replacement w MCC	\$ _____
259	Cardiac Pacemaker Device Replacement w/o MCC	\$ _____
260	Cardiac Pacemaker Revision except Device Replacement w MCC	\$ _____
261	Cardiac Pacemaker Revision except Device Replacement w CC	\$ _____
262	Cardiac Pacemaker Revision except Device Replacement w/o CC/MCC	\$ _____
286	Circulatory Disorders Except AMI with Cardiac Catheterization w MCC	\$ _____
287	Circulatory Disorders Except AMI with Cardiac Catheterization w/o MCC	\$ _____

Refer to “Additional information regarding MS-DRGs under this Appendix” under Table 1A for additional pertinent information.

Table 1C - Inpatient Orthopedic and Spine Services for which the contract rate will not be determined according to Table 1A. For an Admission that includes any of the following Inpatient Covered Services provided to a Customer, the contract rates for the entire Admission are determined as follows.

MS-DRG	DESCRIPTION	PER CASE CONTRACT RATE
453	Combined Anterior/Posterior Spinal Fusion w MCC	\$ _____
454	Combined Anterior/Posterior Spinal Fusion w CC	\$ _____
455	Combined Anterior/Posterior Spinal Fusion w/o CC/MCC	\$ _____
456	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w MCC	\$ _____
457	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w CC	\$ _____
458	Spinal Fusion Except Cervical with Spinal Curve, Malignancy, Infection or 9+ Fusions w/o CC/MCC	\$ _____
459	Spinal Fusion Except Cervical w MCC	\$ _____
460	Spinal Fusion Except Cervical w/o MCC	\$ _____
461	Bilateral or Multiple Major Joint Procedures of Lower Extremity w MCC	\$ _____
462	Bilateral or Multiple Major Joint Procedures of Lower Extremity w/o MCC	\$ _____
466	Revision of Hip or Knee Replacement w MCC	\$ _____
467	Revision of Hip or Knee Replacement w CC	\$ _____
468	Revision of Hip or Knee Replacement w/o CC/MCC	\$ _____
469	Major Joint Replacement or Reattachment of Lower Extremity w MCC	\$ _____
470	Major Joint Replacement or Reattachment of Lower Extremity w/o MCC	\$ _____
471	Cervical Spinal Fusion w MCC	\$ _____
472	Cervical Spinal Fusion w CC	\$ _____
473	Cervical Spinal Fusion w/o CC/MCC	\$ _____
490	Back and Neck Procedures Except Spinal Fusion w CC/MCC or Disc Devices/Neurostimulator	\$ _____
491	Back and Neck Procedures Except Spinal Fusion w/o CC/MCC	\$ _____
492	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w MCC	\$ _____
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w CC	\$ _____
494	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur w/o CC/MCC	\$ _____

Refer to “Additional information regarding MS-DRGs under this Appendix” under Table 1A for additional pertinent information.

2.2.1 Transfer of Customer. This Section applies only when a Per Case, Per Case plus Per Diem after Threshold or MS-DRG Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate

that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by the Centers for Medicare and Medicaid Services (CMS) except for MS-DRGs designated by CMS as “special pay” MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the “Imputed Per Diem Rate”) as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as “special pay” MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an imputed per diem rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is 50% of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

- (a) Based on CMS readmission guidelines; and
- (b) To readmissions with a related diagnosis (as determined by United); and
- (c) Prior to the determination of the contract rate for the subsequent Admission

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.3 Outpatient Covered Services. For the provision of Covered Services rendered by Facility to a Customer, other than those addressed in Section 2.2, Section 3.4, or Section 3.5, the contract rate will be _____ % of Eligible Charges, less any applicable Customer Expenses. However, this Percentage Payment Rate is subject to change under Section 4 as a result changes to Facility’s Customary Charges. Additionally, adjustments to the PPR rate pursuant to Section 4 of this

Appendix will carry forward into subsequent years. For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission

Additional information regarding Emergency department visits under this Appendix

The following applies to Emergency department visits under this Appendix:

Facility's Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the CY 2008 OPSS/ASC final rule with comment period (72 FR 66805). Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change. In the event such change has a negative projected financial impact to United or its Payers, United and Facility, within 30 days of above notification, will evaluate and agree upon contract rates going forward that will assure that changes to Facility's Emergency department visits coding guidelines do not have the impact of increasing the amount paid by United or its Payers under this Appendix. Based on the agreed upon rate adjustment, both parties will execute an amendment to implement the adjusted contract rates going forward. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section, or due to Facility providing inaccurate information, United may recover those overpayments, as outlined in the Facility Participation Agreement.

In the event the parties are unable to agree on contract rates going forward, the matter may be resolved in accordance with the dispute resolution provisions of the Agreement. In addition to determining the impact of Facility's Emergency department visits coding guidelines changes, the Arbitrator may determine the new contract rates going forward necessary to ensure that United and its Payers are not impacted by Facility's coding guideline changes from the effective date of the coding guideline change.

SECTION 3 Miscellaneous Provisions

- 3.1 Inclusive Rates.** The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-9-CM codes, or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

3.3 Facility-based Physician and Other Provider Charges. Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after _____, the current contract rates for all Covered Services under this Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility’s charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative _____ (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

$$[\text{Current Contract Rate} - (\text{Current Contract Rate} \times \text{Percentage Reduction}) = \text{New Contract Rate}]$$

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%
Emergency Physicians	Emergency Room Services	10%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%
		%
		%
		%
		%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not

considered in any calculation for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 2: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 3: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health – Medical Social Services
0116	Detox/Private	0570-0579	Home Health – Home Health Aide
0124	Psych/2bed	0580-0589	Home Health – Other Visits
0126	Detox/2bed	0590	Home Health – Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819	Donor Bank/ Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911- 0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab

0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees
0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Center (FQHC)	3101-3109	Adult Care
0550-0559	Home Health - Skilled Nursing		
MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD9 37.52, 37.63-37.66	Heart Transplant	010	Pancreas Transplant
005-006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

3.6 Open Heart Surgical Procedure Following Outpatient Cardiac Catheterization. If a Customer is admitted to Facility for an open heart surgical procedure within three calendar days of a cardiac catheterization Outpatient Procedure, the contract rate set forth in Section 2.3 will not apply, and the contract rate for an open heart procedure as set forth in Section 2.2 of this Appendix will be paid. No additional payments will be made for the cardiac catheterization services; instead, the cardiac catheterization services will be considered to have been reimbursed as part of the contract rate for the open-heart surgical procedure.

3.7 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility’s contract rate as determined in this Appendix and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

SECTION 4

Adjustment to Contract Rates Due to Changes in Facility’s Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility’s Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered

Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

4.2 Duty to Give Notice. Facility will notify United at least 60 days prior to the implementation date of any increase by Facility to its Customary Charges or a change in an algorithm or formula used to determine the mark up to be applied to the acquisition price for any items or services which is likely to result in an increase in Customary Charges for either inpatient or outpatient Covered Services.

4.3 Content of Notice. Any notice required by Section 4.2 will include, separately for inpatient and outpatient Covered Services, the following:

- (a) Facility's Chargemaster data before and after the increase in Facility's Customary Charges with the following criteria and in the format described in the attached Chargemaster Notice Exhibit:
 - (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix, and
 - (ii) in a mutually acceptable format.
- (b) The effective date of the Facility's new Chargemaster;
- (c) Utilization for Payers to which this Appendix is applicable for the most recent twelve months of data available prior to the increase in Facility's increase to its Customary Charges. Utilization is to be reported with the following criteria:
 - (i) by service item with revenue code mapping, excluding revenue codes listed in the Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment Table and the Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement Table of this Appendix,
 - (ii) in a mutually acceptable format, and
 - (iii) separately for inpatient and outpatient services.
- (d) Facility's estimate of the new inpatient and outpatient PPR contract rates rounded to the nearest digit to the right of the decimal point going forward at which the cost to Payers of PPR Covered Services will be no greater than the cost during the previous contract year. Facility's estimates will be in the format described in the attached Chargemaster Notice Exhibit. Facility will use the formula(s) in the attached Chargemaster Notice Exhibit to calculate its estimate of the new PPR contract rates. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.; and

(e) Facility's estimate of the fixed contract rates going forward, at which the cost to Payers of fixed rate Covered Services will be the same as it was prior to the Customary Charge increase triggering the lesser of logic calculation. Facility's estimate will assume that utilization reported in (c) above will be the same before and after the Customary Charge increase.

4.4 Cooperation with United. Facility will cooperate with United in administration of this section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates and fixed contract rates (impacted by lesser of).

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates and fixed contract rates (impacted by lesser of) using the estimates in the notice. United will create and implement a new version of this Appendix. The revised appendix will be identical to this Appendix, other than the revised PPR contract rates and fixed contract rates (impacted by lesser of) set forth in the notice. United may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment, along with the effective date of the revised appendix.

4.6 United's right to audit. In addition to any other audit rights that United may have under this the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information, or due to Facility providing incorrect estimates of the adjustments needed to the PPR contract rates or fixed contract rates (impacted by lesser of), United may recover those overpayments. United will give Facility notice of, and United intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates or fixed contract rates (impacted by lesser of) to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement, modified as follows:

- (a) The parties will confer in good faith, and will resolve the matter through prospective and temporary contract rate adjustments to the contract rates for Covered Services set forth in this Appendix. Such prospective contract rate adjustment will be calculated to account for and neutralize the financial impact of the Customary Charge increase at issue to the contract rates set forth in this Appendix, so that Customary Charge increase will not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix. The temporary contract rate adjustment will be calculated to address, through an additional and temporary adjustment to the contract rates, the financial impact on all claims impacted by the Customary Charge increase (inpatient claims with the date the Admission started and outpatient claims with dates of service occurring on and following the date of the Customary Charge increase at issue) for dates of service prior to the effective date of the contract rate adjustment.
- (b) If the parties are unable to amicably resolve the matter and implement an updated appendix with prospective and temporary contract rate adjustments within 90 days of receipt of the above-described notice, either party which remains dissatisfied may provide written notice to the other party of its decision to employ the services of a third party consultant with expertise in account relevant to the issues at hand rather than to an arbitrator selected as described in the Agreement to resolve the dispute. The consultant's scope will be limited to quantifying the financial impact of the Customary Charge increase and the prospective and temporary contract rate adjustments in dispute to the parties. The consultant will be jointly selected by the parties. The parties will work together in good faith to develop a list of eligible consultants by _____. The consultant fee will be shared equally between United and the Facility.

Each party will simultaneously and confidentially submit to the Consultant and to each other the following data elements:

- (i) a prospective contract rate adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), as described above, to account for the ongoing impact of the Customary Charge increase in dispute, for Covered Services with dates of service starting 30 days after the date of the Consultant's decision;
- (ii) a temporary adjustment (the PPR contract rates or fixed contract rates (impacted by lesser of)), to the prospective contract rate adjustment, to account for the impact on claims that were impacted by the Customary Charge increase and that have dates of service prior to the effective date of the prospective contract rate adjustment described in the bullet immediately above this bullet (United may instead elect to address the claims with dates of service prior to effective date of the prospective contract rate adjustment by reprocessing those claims in accordance with the prospective contract rate adjustment, in which case the temporary adjustment will not be applied) (should United elect to reprocess the claims as set forth herein, the reprocessing process must be completed within ninety (90) days of the date of the Consultant's decision); and
- (iii) the length of time the temporary adjustment should remain in effect, and
- (iv) Utilization data that supports the party's prospective and temporary contract rate adjustment.

The data elements listed in (b)(i)-(iii) will collectively be referred to as each party's "Proposal."

- (c) Each party will have the same deadline for submitting their respective Proposals to the consultant; that deadline will be a date jointly selected by the parties or, if the parties cannot agree upon a date, the consultant will select a date. The consultant must select either the Proposal submitted by Facility in its entirety or the Proposal proposed by United in its entirety.
- (d) After the proposed findings are submitted to the consultant, the parties will meet with each other to review the submissions and explore the opportunity to resolve the dispute on a mutually satisfactory basis.
- (e) In the event the parties are unable to settle the matter, each party may submit to the consultant, with a copy to the other party, a response to the other party's Proposal; the deadline for submitting these responses will be jointly determined by the parties or, if the parties cannot agree upon a date, the consultant will select a date.
- (f) In the event the parties agree that a hearing should be held, or that a hearing is not necessary, the agreement of the parties will be followed. In the event that the parties cannot agree on whether a hearing is needed, the consultant will decide whether a hearing is necessary.
- (g) The decision of the consultant will be binding on the parties to the same extent as the decision of the arbitrator under the dispute resolution process set forth in the Agreement.

SECTION 5

Performance Based Compensation Program

To encourage Facility's efforts to improve both the quality and the efficiency of its patient care and to recognize successful performance with regard to these efforts, United will implement the PBC Program described by this Section 5, which provides to Facility the opportunity to qualify for adjustments to the Eligible Contract Rates, subject to meeting the program requirements described herein. Nothing herein is intended to compensate Facility for limiting or withholding clinically appropriate care from any Customer.

Facility understands and agrees that this Section 5 applies to, and only to, the Facility location(s) covered by this Appendix unless another Appendix to the Agreement expressly provides otherwise. If this Section 5 applies to more than one Facility location, Facility understands and agrees that the performance of all such locations will be measured in the aggregate to determine whether Facility has met the requirements hereunder. Implementation of the PBC Program in the event of changes in the locations covered by this Appendix is discussed in Section 5.7 below.

5.1 Definitions.. Unless otherwise defined in this Section 5, capitalized terms used in this Section shall have the meanings assigned to them in this Appendix or in the Agreement.

Actual Performance Result: Facility's performance or experience with respect to a given Performance Measure based on the applicable Measurement Period or Data Capture Date, as determined using the applicable Performance Measure Criteria. Facility's Actual Performance Result is compared to the corresponding Performance Target to determine whether Facility successfully achieved the Performance Measure, as further discussed in Section 5.3. Actual Performance Results may be restated as described in Section 5.5.3.

Baseline: The value, as restated from time to time in accordance with Section 5.5.3, that represents Facility's level of performance or experience with respect to a given Performance Measure as measured with respect to the Baseline period set forth in the Baseline Exhibit.

Data Capture Date: The date during the Data Capture Period on which United obtains a third party data report.

Data Capture Period: With respect to those Performance Measures that are evaluated based on third party data, the date span during which United will obtain the applicable third party data reports. The Data Capture Period for a given Performance Measure is specified in the Timeline Exhibit.

Eligible Contract Rate: Each contract rate for a Covered Service that is reimbursed under this Appendix using any Payment Method other than a PPR or Per Unit via Facility Fee Schedule.

Measurement Period: The applicable date span used to determine Facility's Actual Performance Result with respect to each Performance Measure that is evaluated based on claims data, with or without United notification data. To determine Facility's Actual Performance Result for a given Performance Year on a Performance Measure that is evaluated based on claims data, with or without United notification data, as reflected in the final Performance Report, United will include not less than two months' claims run out for the Performance Measure.

Measurement Time: The applicable Measurement Period or Data Capture Period.

Payout Year or PY: Subject to earlier termination of the Agreement, each successive 12 month period, beginning with the first Payout Year, with respect to which Facility participates in the PBC Program. Subject to termination of the Agreement and Section 5.6.2, Eligible Contract Rates are adjusted during the Payout Year to reflect the Performance Escalator, if any, attributable to that Payout Year. The first Payout Year (or PY1) is the 12 month period that begins on the first anniversary of the Effective Date of the Agreement.

PBC Goal: The maximum adjustment to Eligible Contract Rates available under the PBC Program for a given Payout Year which, as further described in Section 5.3, is used to determine Facility's Performance Escalator.

PBC Program: United's Performance Based Compensation Program for hospitals, as described by this Section 5.

Performance Escalator: The increase to Eligible Contract Rates attributable to Facility's performance with respect to the Performance Measures for a given Payout Year, as determined and applied during that Payout Year in accordance with this Section 5.

Performance Measure: Each of the measures listed in the PBC Exhibit.

Performance Measure Criteria: United's description of and measurement logic for a particular Performance Measure.

Performance Points: The points associated with Facility's performance on a Performance Measure with respect to a given Payout Year, as set forth in the PBC Exhibit.

Performance Report: The interim quarterly or final report with respect to a given Payout Year that shows, on an interim or final basis, Facility's Actual Performance Results and the other information described in Section 5.5.2 of this Appendix.

Performance Target: The specified level of performance or experience that Facility must achieve on a particular Performance Measure with respect to a given Payout Year in order to meet the Performance Measure for purposes of this Section 5.

Rebased Contract Rate: The Eligible Contract Rate as adjusted to remove the impact of the Performance Escalator, as further described in Section 5.6 of this Appendix.

5.2 Eligibility to Participate in the PBC Program; Payout Year Terms.

5.2.1 Eligibility. To be eligible to participate in the PBC Program, Facility must be an acute inpatient hospital other than a long term acute care hospital, long term care hospital, or rehabilitation hospital.

5.2.2 Payout Year Terms. Subject to earlier termination of the Agreement, the Performance Measures, the corresponding Performance Targets, the allocation of Performance Points, and the applicable PBC Goal set forth in the PBC Exhibit and the Measurement Times set forth in the Timeline Exhibit will govern Facility's participation in the PBC Program with respect to each specified Payout Year.

Beginning with the first Payout Year for which terms are not specified in the PBC Exhibit, and with respect to each Payout Year thereafter, United and Facility agree to the following:

(a) At least 24 months prior to the first day of the next Payout Year for which the parties have not specified terms in writing, United and Facility will meet for the purpose of determining the applicable Performance Measures, the corresponding Performance Targets and Performance Points, and the applicable PBC Goal for that Payout Year. The parties will document the mutually agreed upon new terms in a written amendment signed by both parties within the timeframe specified in subparagraph 5.2.2(b).

(b) If the parties have not mutually agreed in writing on the Performance Measures, Performance Targets, Performance Points, and PBC Goal at least 18 months prior to the first day of the Payout Year to which such terms would apply, then the parties agree that they will keep the same Performance Measures, Performance Points, and PBC Goal used for the Payout Year immediately preceding that Payout Year and will use the applicable Section 5.2.2 default Performance Targets shown in the PBC Exhibit.

(c) For each subsequent Payout Year, the Measurement Time for a given Performance Measure will begin one year after the date on which the Measurement Time for that Performance Measure began for the prior Payout Year and continue for the same duration. If the parties agree on a new Performance Measure, it will have the standard Measurement Time assigned to that Performance Measure under the PBC Program based on the start date of Facility's next Payout Year.

5.3 Evaluation of Performance Measures; Performance Escalator. With respect to each Payout Year, United will assess Facility's Actual Performance Result for each Performance Measure. The Actual Performance Result will be determined in accordance with this Section 5 and the applicable Performance Measure Criteria. The Performance Measure Criteria for each of the Performance Measures in effect as of the effective date of this Appendix are provided in the Performance Measure Criteria Exhibits. United may modify the Performance Measure Criteria from time to time. United may implement the revised Performance Measure Criteria without Facility's consent if the same criteria are applicable to all or substantially all facilities in United's network that are subject to the corresponding Performance Measure. United will make the current Performance Measure Criteria for each Performance Measure available to Facility upon request.

If Facility's Actual Performance Result is equal to or better than the applicable Performance Target, Facility has met the Performance Measure. For each Performance Measure that Facility meets, United will credit Facility with the corresponding Performance Points shown in the PBC Exhibit. The maximum number of Performance Points available is 100. United will aggregate the Performance Points credited to Facility for all Performance Measures achieved with respect to a given Payout Year. The total Performance Points credited to Facility will range from 100 points to 0 points. United will use the following formula to determine the Performance Escalator attributable to that Payout Year:

$$[\text{total Performance Points} \div 100] * [\text{the PBC Goal}] = \text{Performance Escalator}$$

The Performance Escalator will be a percentage rounded up or down to the nearest one tenth of one percent (0.1%).

5.4 Data Sources. The PBC Exhibit indicates the data source United will use to assess Facility's performance on each Performance Measure. Such assessment is subject to the requirements and limitations set forth in this Section 5.4.

5.4.1 Claims. If the data source is claims:

(a) The applicable Performance Measure Criteria will describe the claims United will use to evaluate and report on Facility's performance with respect to each of the applicable Performance Measures.

(b) United is not currently able to include all claims submitted by Facility in the computation of Facility's performance on a Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of claims, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.4.2 Third Party Data. Except as expressly noted otherwise, if the data source is data made available by or through CMS or another third party:

(a) United will use the most current data available from the third party data source as of the Data Capture Date. If the third party has failed to timely update the available data, United will use the older data that is available as of the Data Capture Date. If more current data subsequently becomes available during the Data Capture Period but after the Data Capture Date, United will have no obligation to use the more current data, but may do so in its sole discretion, provided that use of the newer data will not delay timely delivery of the Performance Report.

(b) If the third party changes the information available to United in such a way that United cannot reasonably or meaningfully determine Facility's Actual Performance Result in accordance with the applicable Performance Measure Criteria, United will update the applicable Performance Measure Criteria in accordance with Section 5.3 to describe the alternate method United will use to determine Facility's Actual Performance Result.

(c) If the third party (i) ceases to gather and/or publish such data, (ii) ceases to make the data available to United on reasonable terms, or (iii) materially changes the scope or type of data it makes available, then the parties will mutually agree on a replacement Performance Measure. Alternately, the parties may agree to eliminate the affected Performance Measure and reallocate the Performance Points to the remaining Performance Measures.

5.4.3 Notification Data. If the data source is claims and United notification data, Section 5.4.1 applies with regard to claims and, with regard to United notification data:

(a) The applicable Performance Measure Criteria will describe the data United will use to evaluate and report on Facility's performance with respect to the applicable Performance Measure.

(b) United is not currently able to include notification data associated with all claims submitted by Facility in computation of Facility's performance on this Performance Measure (for example, certain Affiliate claims). If United is later able to include a broader set of data, United may update the applicable Performance Measure Criteria in accordance with Section 5.3. United will use the new criteria for preparation of the next Performance Report (interim or final).

5.5 Performance Reports, Restatements, and Reconsideration.

5.5.1 Performance Reports. With respect to each Payout Year, United will provide Facility with quarterly Performance Reports, or electronic access to such reports, regarding Facility's performance on the Performance Measures. These Performance Reports will be consistent with the Performance Reports that United provides to other facilities participating in United's PBC Program. Performance Reports based on United claims data will be prepared using a reasonable period for claims run out and report development. Interim Performance Reports will reflect a date range that is different from the applicable Measurement Period; only the final Performance Report for a given Payout Year will reflect the date range defined as the applicable Measurement Period. The final Performance Report for a given Payout Year determines the Performance Escalator, if any, to be applied in that Payout Year. The final Performance Report will be provided or made available on or before the Performance Report due date specified in the Timeline Exhibit.

5.5.2 Content of Performance Report. Each Performance Report will include, at a minimum, the following content:

- (a) the Performance Target and corresponding Performance Target value for each Performance Measure;
- (b) Facility's Actual Performance Result (in the final Performance Report) or an interim calculation of the Actual Performance Result (in the interim Performance Reports) for each Performance Measure;
- (c) the Performance Points earned based on final or interim performance;
- (d) the earned Performance Points as a percentage of the maximum Performance Points; and
- (e) the Performance Escalator (in the final Performance Report) or an interim calculation of the Performance Escalator (in the interim Performance Reports).

Subject to and as limited by contractual confidentiality obligations and all applicable state and federal laws (including but not limited to privacy laws), supporting data for Facility's Actual Performance Result on a given Performance Measure will be provided to Facility upon request.

5.5.3 Restatements. The Baseline and Actual Performance Result for a Performance Measure may be restated by United on a quarterly basis to take into account any one or more of the following:

- (a) adjustments made by CMS or another nationally recognized source, for example MS-DRG weights or NQF approved calculations, in order to accurately compare Facility's baseline measure to Facility's performance with respect to the applicable Payout Year;
- (b) the addition or deletion of a Facility location covered by this Appendix and participating in the PBC Program, in accordance with Section 5.7;
- (c) restated or additional claims information;
- (d) corrections to databases identified by United or by a third party vendor; and
- (e) the inclusion of additional Affiliate claims.

Restated Baseline and Actual Performance Results will be shown in the interim and final Performance Reports. Once the Performance Escalator for a given Payout Year has been implemented in accordance with Section 5.6, it will not thereafter be changed due to a subsequent restatement of a Baseline or Actual Performance Result.

5.5.4 Third Party Certification. United will engage a third party at least annually to certify the data, methodology, measurement logic and software code supporting each Performance Measure. Documentation of the certification will be provided to Facility upon request.

5.5.5 Facility Objections. After reviewing the Performance Report, if Facility disagrees with United's determination of one or more Actual Performance Result(s) for one or more Performance Measure(s) due to (1) how the applicable methodology was applied, (2) how the applicable logic was used, or (3) whether the applicable software code was used, Facility may request reconsideration of the disputed determination(s). Facility will follow this reconsideration process:

- (a) Facility will send to United the reconsideration request in writing, which may be sent electronically, within 10 business days after the date on which Facility received a copy of or electronic access to the final Performance Report. United will provide Facility with the appropriate mailing address or email address for reconsideration requests. If the reconsideration is not requested timely, Facility will be deemed to have waived its right to pursue reconsideration in any forum.
- (b) The reconsideration request must include all of the following:
 - i) identification of each Performance Measure to be reconsidered;
 - ii) identification of the Actual Performance Result calculated by United for each contested Performance Measure;
 - iii) a detailed explanation of why Facility believes that the methodology, logic or software code is improper; and
 - iv) any other relevant information to support Facility's reconsideration request.

5.5.6 Reconsideration Period. Following receipt of the reconsideration request, United will review and respond to Facility within 10 business days. Upon Facility's written request, United will provide supporting data for each contested Performance Measure, subject to and as limited by contractual confidentiality obligations and applicable state and federal laws (including but not limited to privacy laws).

Within 10 business days after receiving United's response, Facility will inform United in writing whether the response has resolved Facility's concerns or not. If Facility still disagrees with United's Performance Report, the parties will promptly meet and confer about Facility's reconsideration request. If United and Facility have not reached a mutually satisfactory resolution regarding Facility's reconsideration request at least 45 days prior to the first day of the upcoming Payout Year, then the Performance Escalator will be effective on the first day of the first calendar month that begins at least 31 days after the date that the parties achieved such resolution. Contract rate adjustments described in Section 3 of this Appendix will

not be delayed, and United will implement those adjustments effective as of the time specified in Section 3 in accordance with Section 5.6.

If the parties are unable to reach a mutually satisfactory resolution regarding Facility's reconsideration request, either party may initiate dispute resolution pursuant to Article VII of the Agreement.

5.6 Performance Escalator.

5.6.1 Application of Performance Escalator. The Performance Escalator, if any, determined in accordance with Section 5.3 will be applied to each Eligible Contract Rate, subject to the following adjustments:

- (a) The Performance Escalator is not intended to be cumulative in its effect from one year to the next. Accordingly, if a Performance Escalator is applied to the Eligible Contract Rates following successful performance by Facility with respect to a given Payout Year, the increase will always be removed from each rate effective as of the first day after the end of the Payout Year in which the Performance Escalator was applied. The removal of the Performance Escalator establishes the "Rebased Contract Rate." Any Performance Escalator applied hereunder will be applied to the Rebased Contract Rate. Likewise, and notwithstanding anything in this Appendix to the contrary, any annual adjustment made in accordance with Section 3 of this Appendix will be applied to the applicable Rebased Contract Rates (regardless of whether or not a Performance Escalator is also applicable in that contract year). This methodology is illustrated in the Example Section below.
- (b) The Performance Escalator is additive to any annual adjustment specified in Section 3 of this Appendix. Both the Section 3 adjustment and the Performance Escalator are applied to the applicable Rebased Contract Rate. This methodology is illustrated in the Example Section below.
- (c) Application of the Performance Escalator will take into account adjustments made under Section 4 of this Appendix. Notwithstanding anything in this Appendix to the contrary, a Section 4 Chargemaster adjustment will be made to the Eligible Contract Rate in effect at the time of such adjustment. In the event a Chargemaster adjustment occurred in the prior contract year the calculation to determine the Rebased Contract Rate will include the impact of that Chargemaster adjustment under Section 4. If a Chargemaster adjustment and a Performance Escalator become effective on the same date, the Chargemaster adjustment will occur after the calculation of the Rebased Contract Rates and the Performance Escalator will then be applied to the adjusted Rebased Contract Rate.
- (d) The adjusted Eligible Contract Rates will be rounded up or down to the nearest whole dollar.

Example Section:

Fixed Rate Example: Assume the contract rate for a given Covered Service is \$100 in the year preceding the first Payout Year of this example. This example shows achievement of a Performance Escalator of 1% applied during PY1; a Performance Escalator of 0% applied during PY2; and a Performance Escalator of 2% applied during PY3. Using the formula described below, Row H indicates the contract rate applicable during each of the following Payout Years:

Row	Description	Formula	Year prior to PY1	PY1	PY2	PY3
A	prior year contract rate [1]	value from row H of prior year	n/a	\$100	\$103	\$104
B	Rebased Contract Rate	A – [value from row F of prior year]	n/a	\$100.00	\$102.00	\$104.00
C	Section 3 annual adjustment		n/a	2.0%	2.0%	2.0%
D	-- increase/decrease for Section 3 annual adjustment	B x C	n/a	\$2.00	\$2.04	\$2.08
E	Section 5 Performance Escalator		n/a	1.0%	0.0%	2.0%
F	-- increase for Section 5 Performance Escalator	B x E	n/a	\$1.00	\$0.00	\$2.08
G	total adjustment	D + F	n/a	\$3.00	\$2.04	\$4.16
H	adjusted contract rate (rounded)	B + G (except the rate applicable in the year prior to PY1)	\$100	\$103	\$104	\$108

[1] Section 5.6.1 discusses various adjustments that may be applicable to a given contract rate. Assume for purposes of this example that there are no other applicable contract rate adjustments beyond those shown in the table.

5.6.2 Adjustment to Eligible Contract Rates. United will adjust each Eligible Contract Rate to reflect the Performance Escalator, consistent with any other adjustments described in this Appendix. The Performance Escalator will be effective with respect to Covered Services furnished by Facility on or after the first day of the Payout Year for which the Performance Escalator was calculated or such later date as may be determined by the parties' mutual written agreement or by an express term of this Appendix, and will continue in effect through the last day of the Payout Year, subject to the earlier termination of the Agreement or of this Payment Appendix. _____

5.7 Changes in Facility Locations Covered by this Appendix; Assignment. This Section 5.7 sets forth the parties' expectations with respect to implementation of this Section 5 in the event of a change in the Facility locations subject to the Agreement. Any such change must occur in accordance with an applicable provision of the Agreement. Nothing in this Section 5.7 creates or will be construed to create any rights with regard to how or when changes in Facility locations, assignment or other transfer of the Agreement may occur.

(a) If a location is added to the Agreement and covered by this Appendix after the end of the claims Measurement Periods, the new location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year. That location will be included in determining Facility's Actual Performance Results for the next Payout Year and the Baseline or Actual Performance Result for

each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(b) If a location is added to the Agreement and covered by this Appendix before the end of the claims Measurement Periods, the new location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures for the corresponding Payout Year and the Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 to take into account the new location.

(c) If a location is deleted from this Appendix after the end of the claims Measurement Periods, that location's performance will be included in determining Facility's Actual Performance Results on all Performance Measures with respect to the corresponding Payout Year. The deleted location will not be included in determining Facility's Actual Performance Results with respect to any additional Payout Years. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(d) If a location is deleted from this Appendix before the end of the claims Measurement Periods, that location's performance will not be included in determining Facility's Actual Performance Results on any Performance Measures with respect to the corresponding Payout Year or any future Payout Year. The Baseline or Actual Performance Result for each Performance Measure, if applicable, will be restated in accordance with Section 5.5.3 with respect to the first Payout Year that excludes the deleted location.

(e) In the event of a partial assignment of the Agreement that includes this Appendix, or if this Appendix otherwise continues to apply to one or more (but not all) of the Facility locations previously contracted by or through Facility due to a merger or other transaction that results in Facility no longer owning and controlling such location(s), each such location will be treated as a "deleted location" for purposes of determining the period, if any, during which its performance or experience will continue to be aggregated with the remaining Facility locations. Once any continued period of aggregating ends, such location's performance or experience will be evaluated alone or with such other locations as are likewise subject to continued application of the Appendix following the assignment or transfer of such rights.

(f) If the data used for evaluation of one of more of the applicable Performance Measures cannot be aggregated or segregated as contemplated by this Section 5.7 with respect to the performance of a particular location, the parties will use best efforts to implement the PBC Program with respect to such location(s) consistent with the intent of this Section 5.

Chargemaster Notice Exhibit

Home Health Services All Payer Appendix

Facility Name(s): _____
Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by Facility when it is acting as a Home Health Service provider to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1 Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Ancillary Medical Supplies: Routine supplies used in conjunction with the professional services are included in the Per Unit or Per Visit Payment Methods. Routine supplies include, but are not limited to, the following: gauze pads, tape, band-aids, gloves, face masks, alcohol, alcohol pad/wipes, cotton balls/swabs, lubricant jelly, thermometers, lab draw supplies, needles, syringes, gowns, and aprons.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Institutional Claim: Any UB-04 or electronic version or successor form.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Unit: The flat rate Payment Method designated "Per Unit" in this Appendix and applicable to Covered Services rendered to a Customer for each unit of service performed within a Home Health Services Category for which a Per Unit Payment Method is indicated in the Home Health Services Category Table of this Appendix. Unless otherwise specified in this Appendix, payment under the Per Unit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, all Ancillary Medical Supplies, professional and non-professional services billed by Facility on an Institutional Claim, educational materials, Customer education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered. The units reported for Covered Services for which the contract rate is a Per Unit must always equal the number of times a procedure or service is performed.

Per Visit: The flat rate Payment Method designated “Per Visit” in this Appendix and applicable to Covered Services rendered to a Customer during one continuous encounter for each Home Health Services Category for which a Per Visit Payment Method is indicated in the Home Health Services Category Table of this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, all Ancillary Medical Supplies, professional and non-professional services billed by Facility on an Institutional Claim, educational materials, Customer education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered.

Physician: A Doctor of Medicine ("M.D."), a Doctor of Osteopathy ("D.O.") who is duly licensed under the laws of the jurisdiction in which Covered Services are provided.

SECTION 2 Contract Rate for Covered Services

2.1 Contract Rate for Home Health Services. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Section 2.2 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Home Health Covered Services. For the provision of Covered Services to a Customer, the contract rate is determined as follows:

Table 1: Home Health Services Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Physical Therapy (Revenue Code 0421)	Per Visit	\$ _____
Occupational Therapy (Revenue Code 0431)	Per Visit	\$ _____
Speech Therapy (Revenue Code 0441)	Per Visit	\$ _____
Enterostomal Therapy (Revenue Code 0551 with CPT Code 99505)	Per Visit	\$ _____
Nursing Services – Skilled Nursing	Per Visit (up to 2 hours)	\$ _____
Revenue Code 0551		
Revenue Code 0552	Per Unit (for each additional hour)	\$ _____
Medical Social Services (Revenue Code 0561)	Per Visit	\$ _____

Home Health Aide (Revenue Code 0572)	Per Unit (for each hour)	\$ _____
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Nursing Services – Licensed Practical Nurse Revenue Code 0581	Per Visit (up to 2 hours)	\$ _____
Revenue Code 0582	Per Unit (for each additional hour)	\$ _____

2.3 Additional Protocols and Service Standards. During the term of the Agreement, Facility will comply with the following additional Protocols and Service Standards:

1. Facility will provide prior notification to United or to designee identified by United for all home health services provided. If additional nursing hours are required beyond the notification for the initial visit which may be on a Per Visit or Per Unit, notification will need to be made prior to rendering the additional home health services. No separate billing is allowed except if nursing services require additional time beyond the initial 2-hour visit.
2. Facility will meet and be bound by the service expectations set forth in the Home Health Service Standards Exhibit to the extent applicable.
3. Facility will have all laboratory work done by one of United’s participating nationally or locally contracted reference laboratories and billed by the laboratory.
4. Facility will provide services pursuant to a medical treatment plan reviewed at least every sixty (60) days and ordered by a Physician who has given proper notification of such medical treatment plan to United or to designee identified by United. In addition, such medical treatment plan will be pursuant to the Customer's Benefit Plan.

**SECTION 3
Miscellaneous Provisions**

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Table 1 are all-inclusive, including without limitation applicable taxes, and represent the entire payment for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.

Services in the service categories listed in Table 1 that are not rendered in accordance with the treatment plan requested or recommended by the Customer’s Physician are not subject to reimbursement under this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as

prohibited under the Agreement. However, when these services are not Covered Services, per the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

- 3.2 Payment Code Updates.** United will update CPT codes, HCPCS codes, ICD-9-CM codes or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

Home Health Service Standards Exhibit

Service Area	Service Expectations
Service/Staffing	
Access	Facility will accept all case referrals for services within its licensure, scope of practice and geographic service area. Facility will not discriminate against United's customers in favor of another payor.
24 hour/7 day availability	Professional staff is available 24/7 and Customers are given documentation on after hours numbers.
Staffing Credentials	All Professional staff are certified or licensed in their applicable specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws.
Staff Orientation and Ongoing Training	There is a written orientation plan with documented skill demonstrations. Minimum skill demonstration requirements identified/met before staff go "solo". There is dedicated training staff. There is documentation of initial and ongoing training programs including policies and procedures.
New Technology	Educational programs related to new technology are presented to Facility staff when appropriate.
Service Response Time	Facility will contact customer within 24 hours of referral.
Quality	
Professional Accreditation	Facility must be accredited by JCAHO, CHAP or ACHC or comply with United's credentialing requirements in all provider sites serving Customers. Facility will have Medicare and Medicaid provider numbers in all geographic areas in which Covered Services are administered.
Consistency	There is documentation of consistent training programs including policies and procedures in all Facility sites.
Continuous Quality Improvement (CQI)	There is a documented CQI program identifying (through data) opportunities for real time, measured improvement in areas of core competencies in all Covered Service categories. There are demonstrated ties between CQI findings and staff orientation, training, policies and procedures.
Customer Complaints	Complaints are logged by category and type, with specific corrective action plans for any patterns There are complaints registered on < 2 % of Customer cases.
Referring Physician Complaints	Complaints are logged by category and type, with specific corrective action plans for any patterns There are complaints registered on < 2 % of Physician's referred Customer cases.
Data Reporting and Measurement	
Customer Satisfaction	There is a quarterly report submitted to United for each Service category. A United approved satisfaction survey is sent to all Customers on discharge and for long term cases every 6

	<p>months.</p> <p>There is a statistically significant response rate.</p> <p>There is a > 95% satisfaction rate as being “Satisfactory” or better. “Satisfactory” will be defined as a rating of 3.0 or greater, based on a 5.0 point scale.</p> <p>There is a documented plan to address specific areas with < 80% satisfaction rate.</p>
Referring Physician Satisfaction	<p>There is a quarterly report submitted to United for each Service category.</p> <p>A United approved satisfaction survey is sent to all Customers on discharge and for long term cases every 6 months.</p> <p>There is a statistically significant response rate.</p> <p>There is a \geq 95% satisfaction rate as being “Satisfactory” or better. “Satisfactory” will be defined as a rating of 3.0 or greater, based on a 5.0 point scale.</p> <p>There is a documented plan to address specific areas with \leq 80% satisfaction rate.</p>
Regulatory Audit Results	<p>Facility will have available and permit access upon United’s request regulatory audit results. E.g. JCAHO accreditation status, Medicare and Medicaid surveys.</p>
Utilization	<p>Facility will submit to United upon request quarterly utilizations reports.</p> <p>Reports will include but not be limited to the following: trend by disease, average number of nursing visits/hours per case, number of readmits to the hospital, average time Facility took to respond to requests for services, and types of cases Facility was not able to fill.</p>
Billing	
Electronic Billing	<p>100% of all claims are submitted electronically for those claims that can be received electronically by United.</p>
Complete/Clean Claim Submission	<p>95% of all claims submitted contain accurate and all required information necessary to process the claim as defined in the Administrative Guide.</p>
Coding Methodology	<p>Standard coding methodology is used in billing United.</p>
Training and Communication	
Case Communication	<p>There are standard forms and processes to communicate Customer status information to referring Physician and United at no extra charge to Customer, referring Physician or United.</p>
Joint Operating Committee	<p>There are standard, quarterly meetings upon request with United staff to review data reports, quality issues, and address any administration issues.</p>

Ambulatory Surgical Center All Payer Appendix

Facility Name(s): _____

Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by or at Facility when it is acting as a Free Standing Ambulatory Surgical Center provider to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1

Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.5 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A Methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated "Per Case" in this Appendix applicable to Covered Services rendered to a Customer during a single Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, observation, post-surgical care, extended recovery, recovery care, 23-hour care, surgical services diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications.

Physician: A Doctor of Medicine (“M.D.”) or a Doctor of Osteopathy (“D.O.”) or another health care professional as authorized under state law and facility bylaws to refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3 and/or 3 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Outpatient Procedures: This Section applies to Covered Services rendered to a Customer that involves a Procedure, as listed in the UHC OPG (Outpatient Procedure Grouper) Exhibit to this Appendix, performed in an ambulatory surgical center (“Outpatient Procedure”). For Outpatient Procedures, the contract rate will be based on a designated group number, as set forth in the table below and as further described in this Section 2.2. Unless otherwise specified in this Appendix, payment under this contract rate, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to Customer during an Outpatient Procedure. The group numbers below correspond with certain Outpatient Procedures identified in the UHC OPG Exhibit to this Appendix. Facility is required to identify procedures by revenue code (if billing on an Institutional Claim) and CPT/HCPCS code (and to append the SG modifier to the procedure code(s) if billing on a CMS 1500 claim form) to receive payment. United may revise the information in the UHC OPG Exhibit based on newly published codes and updated Outpatient Procedure grouping information developed by CMS, which may be modified by United to include procedures that are not maintained by CMS, but are considered for payment under this Appendix. The codes indicated with a “Y” under the “OPG Eligible” column in the UHC OPG Exhibit that corresponds to the date of service, that are Covered Services, are considered eligible for payment under this Section 2.2. Any updates to the information in the UHC OPG Exhibit will be furnished to Facility upon request.

The UHC OPG Exhibit includes a comprehensive list of revenue codes and CPT/HCPCS codes for which the contract rate is determined according to the Outpatient Procedure Grouper table below. In the event a revenue code from the table below is billed with a CPT/HCPCS code indicated with an “N” under the “OPG Eligible” column in the UHC OPG Exhibit that corresponds to the date of service, the detail line item that includes that revenue code and CPT/HCPCS code is not eligible for consideration for reimbursement. However, if that detail line item is the only detail line item that has a revenue code from the table below, then the parties will consult as needed, at an operational level, to review the circumstances of the claim and assign appropriate CPT/HCPCS coding. Facility may resubmit the claim with the corrected coding information for consideration for reimbursement pursuant to this Appendix.

Table _____ : Outpatient Procedure Grouper

Outpatient Procedures (Revenue Codes* 0360, 0361, 0369, 0481, 0490, 0499, 0750 and 0790 and appropriate CPT and/or HCPCS Codes) See the UHC OPG Exhibit for Revenue Code and CPT or HCPCS code criteria. *If billing on an Institutional Claim	
Group Number	Per Case Contract Rate
0	\$ _____
1	\$ _____

2	\$ _____
3	\$ _____
4	\$ _____
5	\$ _____
6	\$ _____
7	\$ _____
8	\$ _____
9	\$ _____
10	\$ _____
Unlisted	\$ _____

2.3 Multiple Outpatient Procedures. When multiple Outpatient Procedures, which includes unlisted Outpatient Procedures _____ are performed on a Customer by Facility during one Outpatient Encounter, the contract rate is as follows: (1) the highest contract rate specified in Section 2.2 for which an Outpatient Procedure has been performed; plus (2) 50% of the contract rate specified in Section 2.2 for the Outpatient Procedure performed with the second highest contract rate. No additional payments for additional Outpatient Procedures performed during that Outpatient Encounter will be made; instead, such additional Outpatient Procedure(s) are included in the contract rate for the first two Outpatient Procedures.

SECTION 3 Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-9-CM codes or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

3.3 Facility-based Physician and Other Provider Charges. Facility will make its best efforts to assure that all Facility-based Physicians and other provider groups are participating providers as long as the Agreement is in effect.

At any time after _____, the current contract rates for all Covered Services under this

Appendix will be reduced by United by 2% for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility’s charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by 10%. The reductions will be cumulative (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be 4%), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:

$$[\text{Current Contract Rate} - (\text{Current Contract Rate} \times \text{Percentage Reduction}) = \text{New Contract Rate}]$$

Rate Reduction Table.

Facility-Based Physician Group	Contract Rates Reduced	Percentage Reduction
Anesthesiologists	All contract rates for Covered Services of any kind	2%
Pathologists	All contract rates for Covered Services of any kind	2%
Radiologists	All contract rates for Covered Services of any kind	2%

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment, including the calculation of “lesser of” determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 2: Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement. Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 3: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0290-0299	Durable Medical Equipment	0650-0654, 0657-0659	Hospice Services
0362	OR/Organ Transplant	0660-0669	Respite Care
0367	OR/Kidney Transplant	0810-0819	Donor Bank/ Bone, Organ, Skin, Bank
0512	Clinic - Dental Clinic	0882	Dialysis/Home Aid Visit
0513	Clinic - Psychiatric Clinic	0901-0907	Psychiatric/Psychological Treatments
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Center (FQHC)	0911-0916, 0919	Psychiatric/Psychological Services
0550-0559	Home Health - Skilled Nursing	0941	Recreation/RX
0560-0569	Home Health - Medical Social Services	0944	Drug Rehab
0570-0579	Home Health - Home Health Aide	0945	Alcohol Rehab
0580-0589	Home Health - Other Visits	0960-0989	Professional Fees
0590	Home Health - Units of Service	1000-1005	Behavioral Health Accommodations
0600-0609	Home Health Oxygen	3101-3109	Adult Care
0640-0649	Home IV Therapy Services		
MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD9 37.52, 37.63 – 37.66	Heart Transplant	010	Pancreas Transplant
005-006	Liver Transplant	014	Allogeneic Bone Marrow Transplant
007	Lung Transplant	016-017	Autologous Bone Marrow Transplant
008	Pancreas/Kidney Transplant	652	Kidney Transplant

UHC OPG (Outpatient Procedure Grouper) Exhibit

Facility acknowledges receipt of an electronic version of the UHC OPG (Outpatient Procedure Grouper) Exhibit.

REVENUE CODE:

0360, 0361, 0369

0481

0490, 0499

0750

0790

WITH CPT / HCPCS CODES THAT ARE CONSIDERED “OPG ELIGIBLE” AS NOTED WITH A “Y” IN THE MOST CURRENT UHC OPG (OUTPATIENT PROCEDURE GROUPE) EXHIBIT

Hospice All Payer Appendix

Facility Name(s): _____
Effective Date of this Appendix: _____

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by Facility when it is acting as a Hospice provider to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1 Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospice bed. Admission applies only to those services provided by order of a Physician.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Institutional Claim: Any UB-04 or electronic version or successor form.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Diem: The Payment Method designated "Per Diem" in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, palliative chemotherapy, palliative radiation, IV hydration, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Unit: The flat rate Payment Method designated "Per Unit" in this Appendix and applicable to Covered Services rendered to a Customer for each unit of service performed within a Home Hospice Care

Service Category for which a Per Unit Payment Method is indicated in Table 2 of this Appendix. Unless otherwise specified in this Appendix, payment under the Per Unit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, palliative chemotherapy, palliative radiation, IV hydration, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, and facility and ancillary services.

Per Visit: The flat rate Payment Method designated “Per Visit” in this Appendix and applicable to Covered Services rendered to a Customer on one-calendar day period, for each Home Hospice Care Service Category for which a Per Visit Payment Method is indicated in Table 2 of this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, palliative chemotherapy, palliative radiation, IV hydration, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, and facility and ancillary services. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

SECTION 2 Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3 and/or 3 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. Unless otherwise specified in this Appendix, the contract rate for an Admission is the contract rate in effect on the date the Admission begins:

Table 1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
General Inpatient Hospice (nonrespite) Revenue Code 0656 with Bill Type 82x (Hospital-Based) or Revenue Code 0656 with Bill Type 81x (Nonhospital-Based)	Per Diem	\$_____
Inpatient Respite Care Revenue Code 0655 with Bill Type 82x (Hospital-Based) or Revenue Code 0655 with Bill Type 81x (Nonhospital-Based)	Per Diem	\$_____

2.3 Home Hospice Care Covered Services. For the provision of home hospice care Covered Services rendered by Facility to a Customer on an outpatient basis the contract rate will be determined according to this Section 2.3.

The contract rate for home hospice care Covered Services rendered by Facility to a Customer, for which a Per Visit or Per Unit Payment Method is detailed on Table 2 below, will be determined according to the table.

Table 2: Home Hospice Care Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Routine Home Care – Hospice (Revenue Code 0651) ¹	Per Visit	\$ _____
Continuous Home Care – Hospice (Revenue Code 0652) ^{2,3}	Per Unit	\$ _____

¹ Routine home care rate is reimbursable for each day the patient is under the care of the hospice and receiving Hospice Covered Services, but not receiving one of the other service categories in this Appendix.

² Continuous home care is defined as a minimum of 8 hours of home care, not necessarily consecutive, during a 24-hour day, which begins and ends at midnight. Nursing care must be provided for at least half of the period of care and must be provided by either a registered nurse (RN) or licensed practical nurse (LPN).

³ Each unit for Revenue Code 0652 equates to 1 hour of Continuous Home Care – Hospice.

SECTION 3 Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix for the service categories listed in Tables 1 and 2 are all-inclusive, including without limitation applicable taxes, and represent the entire payment for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.

Services in the service categories listed in Tables 1 and 2 that are not rendered in accordance with the treatment plan requested or recommended by the Customer’s Physician are not subject to reimbursement under this Appendix. When these services are Covered Services, per the Customer’s Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Customer’s Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-9-CM codes or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

Dialysis All Payer Appendix

Facility Name(s): _____
Effective Date of this Appendix: _____

APPLICABILITY

Unless another Appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered by or at Facility when it is acting as a Dialysis provider to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1 Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services.

Institutional Claim: Any UB-04 or electronic version or successor form.

Payment Method: A Methodology for determining contract rates under this Appendix.

Per Visit: The flat rate Payment Method designated "Per Visit" in this Appendix and applicable to Covered Services rendered to a Customer for each unit of service performed within an Outpatient Dialysis Service Category for which a Per Visit Payment Method is indicated in the Outpatient Dialysis Services Category Table of this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, laboratory or pathology services (regardless of whether provided directly by Facility), durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and Facility and ancillary services. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

SECTION 2
Contract Rate for Covered Services

- 2.1 Contract Rate.** For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility’s aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2 and/or 3 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.
- 2.2 Outpatient Dialysis Covered Services.** For the provision of Outpatient Dialysis Covered Services rendered by Facility to a Customer on an outpatient basis, the contract rate will be determined according to this Section 2.2.

Table 1: Outpatient Dialysis Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Ultrafiltration (Revenue Code 0881)	Per Visit	\$ _____
Hemodialysis (Revenue Code 0821)	Per Visit	\$ _____
Peritoneal Dialysis, CAPD (Continuous Ambulatory Peritoneal Dialysis) (Revenue Code 0841)	Per Visit	\$ _____
Peritoneal Dialysis, CCPD (Continuous Cycling Peritoneal Dialysis) (Revenue Code 0851)	Per Visit	\$ _____

SECTION 3
Miscellaneous Provisions

- 3.1 Inclusive Rates.** The contract rates established by this Appendix for the service categories listed in Table 1 are all-inclusive, including without limitation applicable taxes, and represent the entire payment for the provision to the Customer of all Covered Services that are in the given service category, including but not limited to those Covered Services that are generally provided as a part of the service in the given service category. All items and nonphysician services provided to Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. No additional payments will be made for any services or items covered under the Customer’s Benefit Plan and billed for separately by Facility.
- 3.2 Payment Code Updates.** United will update CPT codes, HCPCS codes, ICD-9-CM codes or successor version, and/or revenue codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services, and (d) the latest revenue code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

SERFF Tracking #:

UHLC-128867987

State Tracking #:

Company Tracking #:

ALL PAYER APPENDICES, ETAL. (PPR PAYER A...

State:

Arkansas

Filing Company:

UnitedHealthcare Plan of the River Valley, Inc.

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002C Any Size Group - HMO

Product Name:

All Payer Appendices, etal. (PPR Payer Appendix v12

Project Name/Number:

All Payer Appendices, etal. (PPR Payer Appendix v12/All Payer Appendices, etal. (PPR Payer Appendix v12

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	01/30/2013
Bypass Reason:	Forms achieve a Flesch Score of 52.9		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/30/2013
Bypass Reason:	Not Applicable		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/30/2013
Bypass Reason:	Not Applicable		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/30/2013
Bypass Reason:	Not Applicable		