

DBHDS Contract # 720C-04296-11R00

**ANTHEM BLUE CROSS AND BLUE SHIELD
FACILITY AGREEMENT**

WITH

**Commonwealth of VA Dept of Behavioral Health and
Developmental Services**

**ANTHEM BLUE CROSS AND BLUE SHIELD
FACILITY AGREEMENT**

This Facility Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Health Plans of Virginia, Inc. doing business as Anthem Blue Cross and Blue Shield (hereinafter "Anthem") and Commonwealth of VA Dept of Behavioral Health and Developmental Services (hereinafter "Facility"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

**ARTICLE I
DEFINITIONS**

"Affiliate" means those Virginia-based entities (i) that are owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or any entity which is under common control with Anthem; (ii) that access the rates, terms or conditions of this Agreement; and (iii) which are listed on the following web site: http://www.anthem.com/provider/va/f4/s0/10/pw_b145749.pdf?refer=ahpprovider&state=va.

"Anthem Rate" means the lesser of Facility's Charges for Covered Services, or the total reimbursement amount that Facility and Anthem have agreed upon as set forth in the Plan Compensation Schedule ("PCS"). The Anthem Rate shall represent payment in full to Facility for Covered Services.

"Case Rate" means the all inclusive Anthem Rate for an entire admission or one outpatient encounter including Covered Individual Cost Share.

"Chargemaster" or "Charges" means Facility's listing of Facility charges for products, services and supplies.

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by a facility for payment by a Plan for Health Services rendered to a Covered Individual. "Complete Claim" means, unless state law otherwise requires, an accurate Claim submitted pursuant to this Agreement, for which all information necessary to process such Claim and make a benefit determination is included.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services ("CMS") or other industry source, for reporting Health Services on the UB-04 claim form or its successor. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT@-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM"), National Drug Code ("NDC"), and Revenue Codes or their successors

"Cost Share" means all amounts which a Covered Individual is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Covered Individual payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Covered Individual.

"Covered Individual" means any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to this Agreement, the term "Covered Individual" may be used interchangeably with the terms Insured, Covered Person, Member, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each is synonymous with any such other.

"Covered Services" means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Covered Individual is eligible for coverage.

"DRG" means Diagnosis Related Group or its successor as established by CMS or other grouper as set forth in the PCS.

"DRG Weight" means the CMS cost weights for each DRG as published in the Federal Register to be effective on October 1st each year, or other cost weights used by Anthem, as set forth in the PCS.

"Emergency Condition" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably

be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Health Benefit Plan" means the document(s) describing the partially or wholly insured, underwritten, and/or administered, marketed health care benefits, or services program between the Plan and an employer, governmental entity, or other entity or individual.

"Health Service" means those services or supplies that a health care facility is licensed, equipped and staffed to provide and which it customarily provides to or arranges for individuals.

"HMO" means HealthKeepers, Inc. and shall be referred to here and after as "HMO".

"Inpatient Services" means Covered Services provided by Facility to a Covered Individual who is admitted and treated as a registered inpatient, is assigned a licensed bed within the Facility, remains assigned to such bed for twenty-four (24) hours and for whom a room and board charge is made.

"Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors. "Medically Necessary" or "Medical Necessity" shall be inapplicable to the extent that a different definition is required by government contract, or where any applicable law or regulation requires a different definition.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, some or all of the product(s) and/or program(s) in which Covered Individuals are enrolled.

"Network/Participating Provider" means a provider designated by Plan to participate in one or more Networks.

"Observation" means the services furnished by a Network/Participating Provider on the Facility's premises including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary after surgery or to evaluate an outpatient condition and determine the need for a possible admission to the Facility as an inpatient.

"Other Payors" means persons or entities, utilizing the Networks/Plan Programs pursuant to an agreement with Anthem, an Affiliate or any other company that owns or is under common ownership with Anthem, including without limitation: (i) Blue Cross and/or Blue Shield Plans that are under common ownership with Anthem (in addition to those Virginia-based entities that are included under the definition of "Affiliate"); (ii) Blue Cross and/or Blue Shield Plans that are not under common ownership with Anthem; and (iii) employers or insurers providing Health Benefit Plans pursuant to insured, self-administered or self-insured programs.

"Outpatient Services" means Covered Services other than Inpatient Services which are provided to a Covered Individual by Facility.

"Patient Day" means each approved calendar day of care that a Covered Individual receives in the Facility, to the extent such day of care is a Covered Service under the terms of the Covered Individual's Health Benefit Plan, but excluding the day of discharge.

"Percentage Rate" means the Anthem Rate that is expressed as a percentage of allowed Charges.

"Per Diem Rate" means the Anthem Rate that is expressed as an all inclusive fixed payment for each Patient Day of admission.

"Per Unit Rate" means the Anthem Rate that is applicable when payment is derived based on an increment or unit of service multiplied by the Anthem Rate in the applicable fee schedule(s).

"Per Visit Rate" means the Anthem Rate that is expressed as an all inclusive fixed payment rate for the service type designated under Outpatient Services.

"Physician Specialty Society" means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

"Plan" means Anthem, an Affiliate as designated by Anthem, and/or an Other Payor. For purposes of this Agreement, when the term "Plan" applies to an entity other than Anthem, "Plan" shall be construed to only mean such entity.

"Plan Compensation Schedule" means the document(s) attached hereto and incorporated herein by this reference and which sets forth the Anthem Rate(s) and compensation related terms for the Network(s) in which Facility has agreed to participate.

"Plan Program" means any program now or hereafter established, marketed, administered, sold, or sponsored by Plan, or Blue Cross Blue Shield Association ("BCBSA") (and includes the Health Benefit Plans that access, or are issued, or entered into in connection with such program). Plan Program shall include but is not limited to, a health maintenance organization(s), a preferred provider organization(s), a point of service product(s) or program(s), an exclusive provider organization(s), and an indemnity product(s) or program(s) and a quality program(s). The term Plan Program shall not include any program excluded by Plan or BCBSA.

ARTICLE II SERVICES/OBLIGATIONS

- 2.1 Covered Individual Identification. Anthem shall ensure that Plan provides a means of identifying Covered Individual either by issuing a paper, plastic, or other identification document to the Covered Individual or by a telephonic, paper or electronic communication available to Facility. This identification need not include all information necessary to determine Covered Individual's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Plan to determine Covered Individual's participation and the applicable Health Benefit Plan. Facility acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Covered Individual, nor does the lack thereof mean that the person is not a Covered Individual.
- 2.2 Facility Non-discrimination. Facility shall provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which Facility provides Health Services to any other individual. Facility will not differentiate, or discriminate against any Covered Individual as a result of his/her enrollment in a Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Facility shall not be required to provide any type or kind of Health Service to Covered Individuals that it does not customarily provide to others.
- 2.3 Publication and Use of Facility Information. For the term of this Agreement, Facility agrees that Anthem and Plans may use, publish, disclose, and display information and disclaimers, as applicable, relating to Facility. Anthem will make good faith efforts to share data with Facility prior to initial disclosure or publication of any information related to a procedure or service for its transparency initiative(s) impacting Facility, such as but not limited to, Anthem Care Comparison. Anthem agrees to publish, disclose and display information relating to Facility only if similar type of information is published, disclosed and displayed with respect to facilities participating in such transparency initiative(s) within Virginia.
- 2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Facility as a participant in the Network(s) in which it participates.
- 2.5 Submission and Payment of Claims. Facility shall submit Claims to Plan unless otherwise instructed, for

payment by Plan, using appropriate and current Coded Service Identifiers, within one (1) year from the date the Health Services are rendered, except where expressly otherwise set forth by federal or state law. Neither Plan nor the Covered Individual is responsible for making any payment for Claims submitted after this one (1) year period.

- 2.5.1 Facility agrees to provide to Plan, unless otherwise instructed, at no cost to Plan or the Covered Individual, all information necessary for Plan to determine its liability. This includes, without limitation, accurate and Complete Claims for Covered Services.
 - 2.5.2 The Facility shall comply with Anthem Facility Billing and Payment Guidelines attached in the provider manual.
 - 2.5.3 When the Facility submits a Claim within one (1) year, and Plan asks for additional information, the Facility must provide that information within thirty (30) days or before the expiration of the one (1) year period referenced above, whichever is longer. If the Facility does not, Plan and the Covered Individual are not responsible for making any payment on the Claim.
 - 2.5.4 Facility agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically, or (b) if electronic submission is not available, utilizing paper forms. If Plan is the secondary payor, the three hundred sixty five (365) day period will not begin until Facility receives notification of primary payor's responsibility.
 - 2.5.5 In all events, Facility shall only look for payment (except for applicable Cost Share or other obligations of Covered Individuals) from the Plan that provides the Health Benefit Plan for the Covered Individual for Covered Services rendered.
 - 2.5.6 Facility agrees to provide Plan with information regarding material change(s) to billing practices or protocols at least sixty (60) days prior to the implementation of such change(s). For the purpose of this subsection 2.5.6, a "material change" includes, but is not limited to, those practices that impact the Facility's ability to submit a Claim to, and/or receive payment from, Plan (e.g., changes to tax identification number, banking relationships, or electronic clearing houses), or in any way has a material negative financial impact on Anthem. If Anthem objects to a proposed billing practice or protocol change, the parties agree to negotiate in good faith to resolve Anthem's objection. If Facility and Anthem cannot agree upon a resolution to accommodate Anthem's objection and the modification would have a material negative financial impact upon Anthem, Facility shall not implement the proposed change with respect to Claims submitted under this Agreement.
- 2.6 Plan Payment Time Frames. Except as otherwise required by law, Anthem shall require Plans or their designees to use best efforts to adjudicate or arrange for adjudication, and where appropriate make payment for all Complete Claims for Covered Services submitted by Facility within sixty (60) days, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of Plan's payment liability, if any, because of issues such as coordination of benefits or verification of coverage.
- 2.7 Payment in Full and Hold Harmless.
- 2.7.1 Facility agrees to accept as payment in full, in all circumstances, the applicable Anthem Rate. Facility shall bill, collect, and accept compensation for Cost Shares. Facility agrees to make reasonable efforts to verify Cost Shares prior to billing the Covered Individual for such Cost Share. In no event shall Plan be obligated to pay Facility or any person acting on behalf of Facility for services that are not Covered Services, or any amounts in excess of the Anthem Rate. Notwithstanding the foregoing, Facility agrees to accept the Anthem Rate as payment in full if the Covered Individual has not yet satisfied his/her deductible
 - 2.7.2 The Facility hereby agrees that in no event, including, but not limited to nonpayment by the Plan, insolvency of the Plan or breach of this Facility Agreement, shall the Facility bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Subscriber or persons other than the Plan for services provided pursuant to this Facility Agreement. This provision shall not prohibit collection of any applicable Cost Shares billed in accordance with the terms of the Subscriber agreement for the Plan.
The Facility further agrees that (1) this provision shall survive the termination of this Facility Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Subscribers; and (2), this provision supersedes any oral or written

agreement to the contrary now existing or hereafter entered into between the Facility and the Subscriber or persons acting on the Subscriber's behalf. Any modifications, additions or deletions to the provisions of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Virginia State Corporation Commission has received written notice of such proposed changes. The Facility will make no charge and render no bill to Anthem, any Plan, the Covered Individual, or the Covered Individual's guarantor for any Covered Services rendered for Inpatient Services unless such services are certified as Medically Necessary according to the terms of the utilization management program, a copy of which is attached in the provider manual, and any amendments, modifications or updates thereto, both as to the need for such Covered Services to be provided on an inpatient basis and as to the Medical Necessity of each day of care. The Facility also agrees that it will make no charge and render no bill to Anthem, any Plan, the Covered Individual, or the Covered Individual's guarantor for any penalty or reduction in benefits required under a Covered Individual's Health Benefit Plan for failure to request Medical Necessity pre-certification of Inpatient Services or Medical Necessity pre-certification of any extensions of an inpatient stay. The Facility will make no charge and render no bill to Anthem, any Plan, the Covered Individual, or the Covered Individual's guarantor for any Covered Services rendered for Outpatient Services unless such services are certified as Medically Necessary according to the terms of the utilization management program, a copy of which is attached in the provider manual, and any amendments, modifications or updates thereto. The Facility also agrees that it will make no charge and render no bill to Anthem, any Plan, the Covered Individual, or the Covered Individual's guarantor for any penalty or reduction in benefits required under a Covered Individual's Health Benefit Plan for failure to request pre-authorization of Outpatient Services.

Hold Harmless Exception. Notwithstanding any other provision of the above paragraphs, in the event Anthem or any Plan notifies a Covered Individual and the Facility in writing that an inpatient admission or Outpatient Service will not be considered Medically Necessary and therefore will not be covered, the Facility may bill such Covered Individual for such admission or Outpatient Service if and only if: (a) the Covered Individual is informed, in writing, by the Facility that the services or setting is not Medically Necessary in Anthems'/Plan's opinion and, therefore will not be covered; (b) following such notice, the Covered Individual acknowledges, in advance of receiving such services, his/her consent to receive or continue to receive such services and accept responsibility for payment; and (c) such acknowledgment shall be in writing and contain, at a minimum, the date, time, description of the services to be rendered, the estimated cost of the services to be rendered, and the Covered Individual's signature. The Facility shall make such written notice a part of the Covered Individual's medical record. Upon request, copies of the written notice to the Covered Individual by the Facility shall be provided to Anthem by the Facility. Nothing in the preceding sentences shall permit the Facility to bill Anthem or any Plan, for such admission or Outpatient Service. Any such written notice and acknowledgement must be obtained on a case-by-case basis.

2.8 Adjustments for Incorrect Payments. When the Facility receives an excessive or mistaken payment from Anthem or a Plan, the Facility must promptly notify Anthem or the Plan and reimburse the appropriate entity within thirty (30) days. Anthem or the Plan may recover the overpayment through remittance adjustment or other recovery action, subject to the restrictions set forth in the provider manual.

2.9 Facility Subcontractors.

2.9.1 In any subcontract or delegation agreement entered into between Facility and any other entity for the provision of services to Covered Individuals, Facility shall include the following hold harmless provision: Subcontractor hereby agrees that in no event, including, but not limited to non-payment by Plan or Facility, Plan or Facility insolvency or breach of this Agreement, shall [Subcontractor] bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Subscribers or persons other than Plan or Facility for services provided pursuant to the Agreement. This provision shall not prohibit collection of any applicable Cost Shares billed in accordance with the terms of the Subscriber agreement for the Plan. Subcontractor further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefits of the Plan's Subscribers; and (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontractor and the Subscribers or persons acting on the Subscriber's behalf. Any modifications, additions, or deletions to the provisions of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Virginia State

Corporation Commission has received written notice of such proposed changes.

- 2.10 Compliance with Provider Manual(s) and Policies, Programs, Procedures. Policies, programs and procedures included in the provider manual are incorporated by reference into this Facility Agreement and Facility agrees to adhere to the policies, programs and procedures stated therein.
- 2.11 In Network Referrals and Transfers. Facility shall, when medically appropriate, refer and transfer Covered Individuals to Network/Participating Providers.
- 2.12 Programs and Provider Panels. Facility acknowledges that Plan may have, develop or contract to develop various networks or programs that have a variety of provider panels, program components and other requirements, and that Plan may discontinue or modify such networks or programs in its discretion. If such provider panels or programs are developed, they may include economic and/or other incentives for Covered Individuals to use the providers in those provider panels or programs. Plan shall notify Facility of its inclusion in a Plan Program or Network in which Facility did not previously participate pursuant to this Agreement. Additionally, Plan shall notify Facility if it does not meet the criteria of a particular Plan Program or Network. Plan will give the Facility the opportunity to be included in these separate networks or sub-networks if Facility meets Plan's terms and conditions, as required by applicable Virginia law.
- 2.13 Facility's Inability to Carry Out Duties. Facility shall promptly send written notice, in accordance with the Notice section of this Agreement, to Anthem of:
- 2.13.1 Any change in Facility's business address;
- 2.13.2 Any legal, governmental, or other action involving Facility which could materially impair the ability of Facility to carry out its duties and obligations under this Agreement, except for temporary emergency diversion situations; or
- 2.13.3 Any change in accreditation, facility affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Facility's practice or status in the medical community.
- 2.14 Facility Staff Privileges. Facility agrees to facilitate Anthem's recruitment of Facility's medical staff, and to expeditiously grant admitting privileges to Network physicians who meet Facility's credentialing standards.
- 2.15 Facility-Based Providers. Facility agrees to require its contracted Facility-based providers or those with exclusive privileges at Facility to obtain and maintain Network and/or Participating Provider status with Anthem. Until such time as Facility-based providers enter into agreements with Anthem, Facility agrees to fully cooperate with Anthem to prevent Covered Individuals from being billed amounts in excess of the applicable Anthem non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.
- 2.16 Facility Accreditation. Facility agrees to meet any applicable accreditation requirements which Anthem may apply to participating facilities as set forth in the provider manual(s).
- 2.17 Adjustment Requests. If Facility believes a Claim has been improperly adjudicated for a Covered Service for which Facility timely submitted a Claim to Plan, Facility must submit a request for an adjustment with Plan within one (1) year from the date of Plan's payment or explanation of payment, unless otherwise set forth in the provider manual. The request must be submitted in accordance with Plan's payment adjustment process. Requests for adjustments submitted after this date may be denied for payment, and Facility will not be permitted to bill the Covered Individual for those services for which payment was denied.
- 2.18 Blue Cross Blue Shield Out of Area Program. Facility agrees to provide Covered Services to any person who is covered under another BCBSA out of area or reciprocal programs and to submit Claims for payment in accordance with current BCBSA Claims filing guidelines. Facility agrees to accept payment by Plan at the Anthem Rate for the equivalent Network as payment in full, except Facility may bill, collect and accept compensation for services for Cost Shares. The provisions of this Agreement shall apply to Charges for services under the out of area or reciprocal programs. Facility further agrees to comply with other similar programs of the BCBSA. For Covered Individuals who are enrolled under BCBSA out of area or reciprocal programs, Facility shall comply with the applicable Plan's utilization management policies.
- 2.19 Coordination of Benefits. In the event a Plan is the secondary payer for any Covered Individual under a

coordination of benefits ("COB") provision in the Covered Individual's Health Benefit Plan, the Plan will pay Facility for Covered Services furnished to the Covered Individual in accordance with the COB rules as provided in the Covered Individual's Health Benefit Plan and as set forth in the provider manual. Facility shall accept such payment as fulfilling the Plan's payment obligations under this Agreement for such Covered Services. In no event shall Facility ever collect from the Covered Individual for the Covered Services an amount which would result in the aggregate reimbursement payable from all sources to exceed the Anthem Rate. Nothing herein shall prevent Facility from collecting additional amounts from the primary payer.

- 2.20 Cost Effective Care. Facility shall provide Covered Services in the most cost effective setting and manner.
- 2.21 Covered Individual Grievances. Facility shall cooperate with Anthem in resolving any Covered Individual grievances related to the provision of Covered Services. Anthem will notify Facility concerning all Covered Individual complaints involving Facility. Facility shall, in accordance with its regular procedures, investigate such complaints. Facility shall use its best efforts to resolve them in a fair and equitable manner. Facility shall notify the applicable Plan within thirty (30) days after it receives notice of a complaint of any action taken or proposed with respect to the resolution of such complaint.
- 2.22 Ethics and Fairness in Carrier Business Practices. Anthem and Affiliates will comply with Section 38.2-3407.15 of the Code of Virginia (known as the Ethics and Fairness in Carrier Business Practices Act ("Act")) to the full extent that the Act is applicable to Anthem or the Affiliate. The Act, a copy of which is attached in the provider manual, sets forth certain provisions that are in effect as of the date of execution of this Agreement which are required to be included in this Agreement by the Act for applicable parties. If any provision of this Agreement is inconsistent with the Act as it may be updated or amended from time to time and impacts parties covered by the Act, then the Act shall control with respect to such parties and such provisions shall be construed and enforced in a manner consistent with the Act.
- 2.23 Patient Medical Options and Medical Management Decisions. As required by Virginia Code Section 38.2-3407.10 K., Facility shall freely communicate with Covered Individuals regarding the individual treatment options available to them, including alternative medications. Medical management decisions by Facility must be based on sound clinical judgments and the appropriateness of care and services. Nothing in this Agreement is intended to require Facility to deny or withhold Covered Services to Covered Individuals that Facility knows to be Medically Necessary and appropriate.

ARTICLE III CONFIDENTIALITY/RECORDS

- 3.1 Proprietary Information. All information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. Neither party shall disclose any information proprietary to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required by law or regulation, except that either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information.
- 3.2 Confidentiality of Personally Identifiable Information. Both parties agree to abide by state and federal laws and regulations regarding confidentiality of the Covered Individual's personally identifiable information.
- 3.3 Plan Access to and Requests for Facility Records. Facility shall comply with any applicable state and federal record keeping requirements and shall permit Plan or its designees, upon seventy-two (72) hours advance notice during normal business hours, to have, with appropriate working space and without charge, on site access to and the right to examine, audit, copy, excerpt and transcribe any books, documents, papers, and records related to Covered Individual's medical and billing information within the possession of Facility and inspect Facility's operations, which involve transactions relating to Covered Individuals and as may be reasonably required by Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity, appropriateness of care, accuracy of payment, compliance with this Agreement, and for research. In lieu of on site access, at Plan's request, Facility shall submit records to Plan, the Covered Individual or their respective designees via photocopy or electronic transmittal, at no charge, within fourteen (14) days following such request, unless a different time frame is reasonably requested by Plan, the Covered Individual or their respective designees. Facility shall make such records available to the state and federal authorities involved in assessing quality of care or investigating

Covered Individual grievances or complaints.

- 3.4 Transfer of Medical Records. Facility shall share Covered Individual's medical records, and forward medical records and clinical information in a timely manner to other health care providers treating a Covered Individual, at no cost to Anthem, Plan, a Covered Individual, or other treating healthcare providers.

ARTICLE IV INSURANCE

- 4.1 Anthem Insurance. Anthem shall self-insure or maintain insurance as shall be necessary to insure Anthem and its employees, acting within the scope of their duties.
- 4.2 Facility Insurance. Facility shall self-insure or maintain insurance in types and amounts acceptable to Anthem as set forth in the provider manual(s).

ARTICLE V RELATIONSHIP OF THE PARTIES

- 5.1 Relationship of the Parties. For purposes of this Agreement, Anthem and Facility are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Anthem or Plan be construed to be providers of Health Services or responsible for the provision of such Health Services. Facility shall be solely responsible to the Covered Individual for treatment and medical care with respect to the provision of Health Services. Facility may freely communicate with Covered Individuals regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- 5.2 Blue Cross Blue Shield Association (BCBSA). Facility hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Facility and Anthem, that Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans ("Association"), permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the state (or portion of the state) where Anthem is located, and that Anthem is not contracting as the agent of the Association. Facility further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem, and that no person, entity or organization other than Anthem shall be held accountable or liable to Facility for any of Anthem's obligations to Facility created under this Agreement. Facility has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Facility to use the Brands. Any references to the Brands made by Facility in its own materials are subject to review and approval by Anthem. This section shall not create any additional obligations whatsoever on the part of Plan other than those obligations created under other provisions of this Agreement.

ARTICLE VI INDEMNIFICATION AND LIMITATION OF LIABILITY

- 6.1 This provision intentionally left blank.
- 6.2 Limitation of Liability. This provision intentionally left blank.
- 6.3 Period of Limitations. This item intentionally left blank.

ARTICLE VII THIS ARTICLE INTENTIONALLY LEFT BLANK

ARTICLE VIII TERM AND TERMINATION

- 8.1 Term of Agreement. This Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect until June 30, 2016.
- 8.2 This provision intentionally left blank.

- 8.3 Future Negotiations. Notwithstanding any provision to the contrary contained in this Agreement, if the parties enter into discussions or negotiations concerning a new Facility Agreement which is to take effect subsequent to the termination or expiration of this Agreement and the parties are unable to reach agreement on the terms of the new Facility Agreement prior to the effective date of termination or expiration, the Facility shall accept as payment in full the Anthem Rate in effect under this Agreement on the day immediately prior to the termination or expiration until such time as a new Facility Agreement is effective, or until ninety (90) days after the date upon which either the Facility or Anthem gives written notice to the other terminating negotiations (such time period to be referred to as the "Interim Period"). During the Interim Period, the non-price terms, including but not limited to any hold harmless provisions of this Agreement shall be applicable, and any limitations contained in the Agreement by which Facility charge increases are capped when calculating payment under a percentage of charge methodology shall also be extended into the Interim Period, as follows. All of the charge capping percentages, measurement periods, notification requirements and methodologies in effect on the day immediately prior to termination or expiration of the Agreement shall be extended into, and through the end of, the Interim Period.
- 8.4 Breach of Agreement. Except for circumstances giving rise to the Termination With Cause section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.
- 8.5 Termination With Cause.
- 8.5.1 This Agreement may be terminated immediately by Anthem if:
- 8.5.1.1. Facility commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or
 - 8.5.1.2. Facility commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Anthem or to a third party; or
 - 8.5.1.3. Facility files for bankruptcy, or makes an assignment for the benefit of its creditors without Anthem's written consent, or if receiver is appointed; or
 - 8.5.1.4. Facility's insurance coverage as required by this Agreement lapses for any reason; or
 - 8.5.1.5. Facility fails to maintain Anthem's credentialing standards; or
 - 8.5.1.6. Anthem reasonably believes based on that Facility's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or
 - 8.5.1.7. Facility has been abusive to a Covered Individual.
- 8.5.2 This Agreement may be terminated upon at least sixty (60) days prior written notice by Facility if:
- 8.5.2.1. Anthem commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or
 - 8.5.2.2. Anthem commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Facility or to a third party; or
 - 8.5.2.3. Anthem files for bankruptcy, or if receiver is appointed; or
 - 8.5.2.4. Anthem's insurance coverage as required by this Agreement lapses for any reason.
- 8.6 Transactions Prior to Termination. Termination shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the date of such termination.

- 8.7 Continuance of Care-Termination. Facility shall, upon termination of this Agreement for reasons other than the grounds set forth in the "Termination With Cause" section of this Agreement, provide and be compensated for inpatient Covered Services rendered to Covered Individuals receiving treatment at the time of termination, under the terms and conditions of this Agreement until the earlier of ninety (90) days after the effective date of such termination or until such inpatient Covered Individuals are discharged from Facility. For purposes of this section, "discharge" shall mean the Covered Individual's physical release from Facility. Covered Services that are part of the all inclusive charge for the Health Services which caused an admission for such Health Services shall continue to be rendered and subject to the all inclusive charge in accordance with the Agreement, even though the Covered Individual has been discharged from Facility. In addition, Facility agrees to accept payment under the terms of this Agreement for those Covered Individuals receiving outpatient treatment at the time of termination until the earlier of ninety (90) days after the effective date of such termination or until such outpatient treatment ends. Notwithstanding the foregoing, for Covered Individuals who: (i) have entered the second or third trimester of pregnancy at the time of such termination, or (ii) are defined as terminally ill under § 1861 (dd) (3) (A) of the Social Security Act at the time of such termination, this continuance of care section and all other provisions of this Agreement shall remain in effect for such pregnant Covered Individuals through the provision of postpartum care directly related to their delivery, and for such terminally ill Covered Individuals for the remainder of their life for care directly related to the treatment of the terminal illness.
- 8.8 Survival. In the event of termination of the Agreement, the following provisions shall survive:
- 8.8.1 Payment in Full and Hold Harmless (Section 2.7);
 - 8.8.2 Adjustments for Incorrect Payments (Section 2.8);
 - 8.8.3 Confidentiality/Records (Article III);
 - 8.8.4 Indemnification and Limitation of Liability (Article VI);
 - 8.8.5 Continuance of Care-Termination (Section 8.7).
- 8.9 Advance Notice of Termination. Notwithstanding any other provision in this Article VIII to the contrary, if the Facility terminates the Agreement for any reason, the Facility shall give Anthem at least sixty (60) days advance notice of termination.
- 8.10 Notice of Termination to Covered Individual. As required by Virginia Code Section 38.2-3407.10D, if Facility terminates this Agreement, Facility must furnish reasonable notice of such termination to Facility's patients who are Covered Individuals.

ARTICLE IX GENERAL PROVISIONS

- 9.1 Amendment. This document may only be amended by a written agreement between the parties hereto. Notwithstanding any provision to the contrary contained herein, Anthem may amend any attachments (including allowance schedules) and any policies, programs or procedures included in the provider manual by providing Facility with a written copy of the applicable portion of the amendment. If Facility is unwilling to accept the amendment, it shall notify Anthem in writing within forty (40) calendar days after the marked date associated with the corresponding delivery method of the amendment. If Facility gives such notice to Anthem, Anthem shall have the option, for a period of thirty (30) calendar days after the expiration of the forty (40) calendar day period, to terminate this Agreement. If Anthem chooses to exercise this termination option, it shall give the Facility written notice, and such termination shall become effective ninety (90) calendar days after Anthem's notice is given to the Facility. If Facility does not give Anthem notice that an amendment is unacceptable within the forty (40) calendar day period, then the amendment will become effective ninety (90) calendar days after the expiration of this forty (40) calendar day period.
- 9.2 Assignment. This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the parties. However, neither this Agreement, nor any rights or obligations hereunder may be assigned, either by operation of law or otherwise, delegated, or transferred in whole or in part, without the prior written consent of the other party, except that Anthem retains the right to assign, either by operation of law or otherwise, delegate, or transfer in whole or in part, this Agreement to an Affiliate. Consent to assignment shall not be unreasonably withheld.

- 9.3 Scope/Change in Status. Anthem and Facility agree that this Agreement applies to Health Services rendered at the locations as set forth on the Facility Locations/Networks Attachment of this Agreement. Anthem may limit this Agreement to Facility's locations, operations or business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the following events:
- 9.3.1 Facility changes its locations, business or operations, or business or corporate form or status; or
 - 9.3.2 Facility is acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or
 - 9.3.3 Facility acquires or controls any other medical facility, service or beds through any manner, including but not limited to asset only purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or
 - 9.3.4 Facility (a) sells, transfers or conveys its business or any substantial portion of its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; or (b) enters into a management contract with another entity.
 - 9.3.5 If Anthem consents in writing not to limit the Agreement to the original corporate entity, then Facility warrants and covenants that this Agreement will be assumed by the new entity unless the new entity already has an agreement with Anthem, in which case the agreement currently in place for that new entity will prevail. Facility shall provide Anthem one hundred twenty (120) days prior written notice of any change described in this section 9.3.
- 9.4 Definitions. Unless otherwise specifically noted, the definitions set forth in this Agreement will have the same meaning when used in any attachment, the provider manual(s) and/or Participation Attachment(s).
- 9.5 Entire Agreement. This Agreement (including items incorporated herein by reference) constitutes the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein.
- 9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, floods, strikes or work stoppages, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.
- 9.7 Compliance with Federal and State Laws. Anthem and Facility agree to comply with all requirements of the law relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations, and as to Facility, its agents and employees, they shall be and remain licensed and certified (including Medicare certification in unqualified, unrestricted status) in accordance with all state and federal laws and regulations (including those applicable to utilization review and Claims payment) relating to the provision of Facility services to Covered Individuals. Facility shall supply evidence of such licensure, compliance and certifications to Anthem upon request. From time to time legislative bodies, boards, departments or agencies may enact, issue or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all said laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by said laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this section and any other provision in this Agreement, this section shall control.
- 9.7.1 In addition to the foregoing, Facility warrants and represents that at the time of entering into this Agreement, neither it nor any of its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at <http://www.epls.gov/> or its successor) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at <http://www.oig.hhs.gov/fraud/exclusions.asp> or its successor), or as otherwise designated by the Federal government. If Facility or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Facility shall have an obligation to (1) immediately notify Anthem of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or

involvement with, the Facility's business operations related to this Agreement.

- 9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where Anthem is located, as identified by the legal entity name in the preamble, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.
- 9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent Anthem utilizes a designee, which in such event shall give rights only within the scope of such designation, and to the extent specified in the Payment in Full and Hold Harmless section of this Agreement.
- 9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Facility or Plan from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Facility acknowledges that Plan does not warrant or guarantee that Facility will be utilized by any particular number of Covered Individuals.
- 9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by electronic mail, by facsimile, by hand, or sent by mail. Unless specified otherwise in writing by a party, Anthem shall send Facility notice to an address that Anthem has on file for the Facility, and notice initiated by Facility shall be sent to Anthem's address as set forth on the signature page. Notice shall be effective upon the marked date associated with the corresponding delivery method noted above. Notwithstanding the foregoing, Anthem may post non-material updates to its provider manual on its web site.
- 9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.
- 9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.
- 9.14 Participation. Facility understands and acknowledges that it has the right to refuse participation in any Networks or Plan Programs at the time this Agreement is executed.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THE EFFECTIVE DATE OF THIS AGREEMENT IS: July 1, 2011

FACILITY LEGAL NAME: Commonwealth of VA Dept of Behavioral Health and Developmental Services

By: Joy S Lazarus 4/20/11
Signature, Authorized Representative of Facility(s) Date

Printed: Joy S. Lazarus Director, Administrative Services
Name Title

Address 1220 Bank Street Richmond, VA 23219-3645
Street City State Zip

Tax Identification Number (TIN): Various

(Note: if any of the following is not applicable, please leave blank)

Facsimile number: _____

Email address: _____

Website: _____

Facility's Fiscal Year Is: July 1 through June 30

Anthem Health Plans of Virginia, Inc. doing business as Anthem Blue Cross and Blue Shield

By: John B Syer Jr. 5/16/11
Signature, Authorized Representative of Anthem Date

Printed: John B. Syer, Jr. Vice President, Provider Engagement & Contracting
Name Title

Address 2221 Edward Holland Drive Richmond, VA 23230
Street City State Zip

FACILITY LOCATIONS/NETWORKS ATTACHMENT

<u>Name</u>	<u>Street Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>
Catawba Hospital	5525 Catawba Hospital Drive	Catawba	VA	24070
Central State Hospital	26317 West Washington Street	Petersburg	VA	23803
Central Virginia Training Center	East End 210 Colony Road	Madison Heights	VA	24572
Commonwealth Center for Children and Adolescents	1355 Richmond Road	Staunton	VA	24401
Eastern State Hospital	4601 Ironbound Road	Williamsburg	VA	23188
Hiram Davis Medical Center	26317 Washington Street	Petersburg	VA	23188
Northern Virginia Mental Health Institute	3302 Gallows Road	Falls Church	VA	22042
Northern Virginia Training Center	9901 Braddock Road	Fairfax	VA	22032
Piedmont Geriatric Hospital	5001 Patrick Henry Highway	Burkeville	VA	23922
Southeastern Virginia Training Center	2100 Steppingstone Square	Chesapeake	VA	23320
Southern Virginia Mental Health Institute	382 Taylor Drive	Danville	VA	24541
Southside Virginia Training Center	26307 Washington Street	Petersburg	VA	23803
Southwestern Virginia Mental Health Institute	340 Bagley Circle	Marion	VA	24354
Southwestern Virginia Training Center	Route 1	Hillsville	VA	24343
Western State Hospital	1301 Richmond Avenue	Staunton	VA	24401

As of the Effective Date of this Agreement, Facility will be designated as Network/Participating Provider in the following Networks:

Commercial lines of business:

Health Benefit Plans in which Covered Individuals have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Network/Participating Providers regardless of product licensure status or funding source.

- Preferred Provider Organization Network(s) (PPO)
- Participating Indemnity/Traditional Network(s) (PAR)

The parties agree that, notwithstanding any provision to the contrary in this Agreement, the Facility will not be held out or represented as a Network/Participating Provider for the HMO in any Plan materials or media, including written or electronic provider directories. Additionally, Plans shall not take any other actions to steer HMO members to receive services at the Facility except in emergencies or as required by law.

Nothing in this Agreement shall obligate Anthem to include Facility in the Network of Participating Providers for the following services. Facility must sign separate agreements with Anthem and bill separately to be included as a Network/Participating Provider for such services.

- home health care services or supplies
- hospice care services or supplies
- skilled nursing facility services or supplies
- home infusion services or supplies
- prescription drugs
- durable medical equipment
- air ambulance
- physician or professional provider services covered under provider agreements between physicians and/or professional providers and Anthem
- ambulatory infusion therapy

- ground ambulance
- free-standing dialysis

PLAN COMPENSATION SCHEDULE ("PCS")

I. REIMBURSEMENT METHODOLOGY

The applicable Anthem Rates for each period under this Agreement are set forth on the attached Rate Sheet(s).

"Period One" shall mean the period beginning on July 1, 2011 and ending on June 30, 2012.

"Period Two" shall mean the period beginning on July 1, 2012 and ending on June 30, 2013.

"Period Three" shall mean the period beginning on July 1, 2013 and ending on June 30, 2014.

"Period Four" shall mean the period beginning on July 1, 2014 and ending on June 30, 2015.

"Period Five" shall mean the period beginning on July 1, 2015 and ending on June 30, 2016.

- a) The parties agree that any prior agreement(s) which may still be in effect between the parties shall terminate as of the date immediately preceding the beginning of the period covered by this Agreement.

1) Inpatient and Outpatient Services.

- a) Anthem Rate: means full payment, including Cost Share amounts, for Covered Services provided to Covered Individuals. The Anthem Rate shall be the rate in effect as of the date of admission.
 - i) For Covered Services paid according to a Per Diem Rate and OHAS, Facility shall be paid the lesser of (i) the Anthem Rate(s) as set forth on the Rate Sheet or (ii) Facility's Charges for Covered Services.

2) Inpatient Services.

- a) This provision intentionally left blank.
- b) This provision intentionally left blank.
- c) Per Diem Methodology:
 - i) Per Diem Rate payment: Per Diem Rate payment will be the specified rate per day multiplied by the number of Patient Days, for each type of service. Any exceptions to this section 2 c i) shall be as set forth in this PCS. Neither the day of delivery nor a day of nursery care for a newborn infant shall be counted as a Patient Day if the same calendar day is also counted as part of the mother's stay. If the Per Diem Rate changes during a Covered Individual's admission, the Per Diem Rate payable as of the first day of such admission shall be applicable to all Patient Days in such admission.
- d) Pre-admission testing: Pre-admission testing services performed within three (3) days prior to an inpatient admission, and all services rendered to a Covered Individual by the Facility on the day of admission, shall be included on Facility's charges for Inpatient Services, and shall be included in the determination of the Anthem Rate for the Inpatient admission.
- e) Mother and Baby Claims: When a Covered Individual gives birth at the Facility, and her newborn(s) receive(s) nursery care, the consecutive days that the mother and the newborn(s) spend as inpatients in the Facility shall be considered, and paid as, a single admission.
- f) Blue Distinction Centers for Transplant ("BDCT"): Notwithstanding any provision in this Agreement to the contrary, if the Facility renders inpatient Covered Services and the Facility also is party to a BDCT contract, those Covered Services included in the BDCT contract will be reimbursed in accordance with the terms contained in the BDCT contract rather than pursuant to the reimbursement terms set forth in this Agreement.

3) Outpatient Services.

- a) "Outpatient Hospital Allowance Schedule" ("OHAS") shall mean the OHAS schedule or schedules (as specified on the attached Rate Sheet(s)) of the maximum amounts that Anthem will pay for Covered Services under Health Benefit Plans subject to the following provisions:
Outpatient Payment: For each outpatient Covered Service rendered by the Facility, during the term of this Agreement, Anthem shall pay or administer payment to the Facility in the amount of either

one hundred percent (100%) of the amount allowable for such Covered Service under the OHAS or one hundred percent (100%) of the Facility's usual charges for such Covered Service, whichever is the lesser, reduced by one hundred percent (100%) of the applicable Cost Share Plan agrees to increase the OHAS fees by the factors specified on the attached Rate Sheet(s).

MEDICAL POLICIES FOR DETERMINING FACILITY REIMBURSEMENT FOR OUTPATIENT SERVICES The Anthem's fee schedules represent the maximum amounts for each Covered Service that corresponds to a single Coded Service Identifier. For Covered Services represented by a single code, the maximum amount is the OHAS fee schedule amount determined by Anthem in its sole discretion. Most Anthem fees are based upon external benchmarks of relative value, for example, the Federal Resource Based Relative Value Scale ("RBRVS"), Average Wholesale Price ("AWP"), American Society of Anesthesiologists ("ASA") relative value and Medicare's laboratory and Durable Medical Equipment ("DME") fees. When more than one service (represented by more than one Coded Service Identifier) is provided to the same Covered Individual on the same day (or sometimes within the same episode of care), the total allowance for the combined codes may be less than the sum of OHAS fees for individually billed Coded Service Identifiers. Aggregations of different Coded Service Identifiers may be subject to bundling via the Anthem's multiple, incidental, combination and global processing rules. The concepts of quantity limits as well as multiple, incidental, combination and global processing are industry standards employed by most Plans, as well as CMS. Such measures are necessary to protect Covered Individuals from prevalent coding practices that are abusive or fraudulent.

- b) Limits, Secondary, and Subsequent Procedures ("LSS"): Multiple units of the same Coded Service Identifiers may be subject to limits and to fractional payments for secondary and subsequent units of service. For some Coded Service Identifiers which may be provided multiple times to a single Covered Individual on a single day, Anthem allows a fraction (typically one-half, one-third, or one-fourth) of the usual fee schedule amount for secondary and subsequent units of service. For some such Coded Service Identifiers, the Plan establishes a maximum total amount (limit), notwithstanding the number of units provided. An example of a service limited in this way is cryoablation of small skin lesions. LSS defines the maximum number of times a procedure will be reimbursed and the percentage payment for the second and subsequent occurrences of the same procedure, when rendered on the same day. For Limit, a "U" means reimbursement will be made for an unlimited number of units of that procedure. For Secondary and Subsequent reimbursement a one (1) equals one hundred percent (100%), a two (2) equals fifty percent (50%) and a four (4) equals twenty-five percent (25%). For example, an LSS of "324" mean the maximum units allowed equals three, where the first unit is reimbursed at one hundred percent (100%), the second unit is reimbursed at fifty percent (50%), and the third unit is reimbursed at twenty-five percent (25%).
- c) Revenue Code Bundling for Outpatient Facility Claims:
 - i) If at least one primary Revenue Code from a Claim is approved for greater than \$0.00 payment, non-primary Revenue Codes, that are also approved for greater than \$0.00 payment, will bundle to the approved primary code.
 - ii) If more than one primary Revenue Code is billed on the same Claim, the primary codes with the lesser allowances will bundle to the primary code with the greatest allowance.
 - iii) If all primary Revenue Codes from a Claim are denied, all services on the Claim will be denied.
 - iv) If there are no primary Revenue Codes on a Claim, but there are lab and/or x-ray lines, the following guidelines apply:
 - a) If at least one lab or x-ray revenue code from a Claim is approved for greater than \$0.00 payment, services that are associated with lab and x-ray will be approved per a Covered Individual's Health Benefit Plan.
 - b) If all lab and x-ray Revenue Codes from a Claim are denied, and, the only other services on the Claim are those that are associated with lab and x-ray, the entire Claim will be denied.
 - v) Eligibility: The above policy is applicable to all outpatient Claims billed by providers with an OHAS agreement.

Primary Revenue Codes

OR	360	361	369
CARDIOLOGY	480	481	489
AMB SURG	490	499	
CAST RM	700	709	
GASTRO	750	759	
OBSERVATION RM762			
LITHOTRIPSY	790	799	

Non-Primary Revenue Codes

PHARMACY	250	251	252	253	256	257	258		
	259	630	631	632	633	634	635	636	
MED/SURG SUP	270	271	272	273	274	275	276	277	278 279
ANESTHESIA	370	371	372	374	379				
BLOOD	381	382	383	384	385	386	387	389	
BLOOD STOR	390	391	399						
RECOVERY	710	719							

Lab, Radiology and Other Diagnostics

300	301	302	303	304	305	306	307	309	925	971
310	311	312	314	319			460	469	471	482
483	730	731	732	739	740	749	921	924	922	929
985	986		401	403			320	321	322	323
324	329	350	351	352	359	400	402	404	409	610
611	612	619	972		341	342	349	973	974	

Non-Primary Revenue Codes Associated with Lab, Radiology and Other Diagnostics

PHARMACY	254	255
MED/SURG SUP	621	622

Revenue Codes Associated with Lab and X-ray

DRUGS	250	251	252	253	256	257	258	259
SUP/EQP	291	292	293	299	946			
SUPPLIES	270	271	272	273	274	275	277	279

- d) Incidental Processing: When multiple Coded Service Identifiers are billed together, some Coded Service Identifiers may be considered incidental to other codes and may contribute nothing to the total payment for the aggregation of billed codes. A code which is a subset of another code per reasonable interpretation of CPT-4 verbiage will be incidental to the latter code. Further, Coded Service Identifiers which are "components" of "comprehensive" codes per the CMS Correct Coding Initiative will be incidental to the latter. In addition, Anthem will consider a Coded Service Identifier incidental to another if the incremental value of the former is less than one-fourth of its usual value when provided in combination with the latter. This will typically be the case when the lesser services do not pertain to different routes of access, different organ systems, different pathological processes, or to multiple trauma.
- e) Age/Sex Restrictions: Some services (e.g., hysterectomy) are allowed for only one sex. Some services (e.g., neonatal intensive care) are allowed only for certain age ranges. Age/Sex restrictions follow CPT-4 coding guidelines.
- f) Non-Covered: Certain services and supplies are non-covered and/or specifically excluded. Examples are acupuncture and services for weight loss. Different Health Benefit Plans may have different lists of exclusions.
- g) Experimental/Investigation: Services or supplies must meet all of the following coverage eligibility criteria. If they do not, they are considered to be experimental/investigational.
 - i) Drugs and devices must have final market approval from the Food and Drug Administration ("FDA").
 - ii) There must be sufficient information in the peer-reviewed medical and scientific literature to enable Anthem to make conclusions about safety and efficacy.

- iii) The available scientific evidence must demonstrate a net beneficial effect on health outcomes. That is, the technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes. Diagnostic test must be explicitly linked to therapeutic decisions that improve outcomes.
 - iv) Drugs, devices and procedures must be as safe and effective as existing diagnostic or therapeutic alternatives.
 - v) Drugs, devices and procedures should reasonably be expected to satisfy criteria iii) and iv) when applied outside the research setting.
 - vi) A drug, device, procedure, or other service will be experimental or investigation if Anthem decides that any of the five (5) criteria is not met. Experiment or investigational services are non-covered.
- h) Preauthorization: Some Health Services may be non-covered, or only partially covered if they are not preauthorized.
 - i) Screening and Preventive Services: Screening and preventive services are provided in the absence of signs or symptoms of illness, injury or pregnancy. Some Health Benefit Plans do not cover these services and many Health Benefits Plans have an annual cap for these services.
 - j) Direct Payment for Laboratory Services: Laboratory services must be billed to Anthem by the provider of service. This means that lab services provided in the Facility should continue to be billed to Anthem by the Facility. However, services provided by an outside or reference lab must be billed directly to Anthem by the lab.
 - k) Pharmacy Revenue Code Billing Guidelines: The following policy is applicable to all Claims for outpatient services submitted on a UB-04 claim form or its successor or electronic equivalent Claim format under the terms of this Agreement.

Specific HCPCS code level detail is required to be reported for pharmacy revenue codes:
 251, 252, 253, 254, 255, 256, 257, 258, 259
 630, 631, 632, 633, 634, 635, 636

Facility should report the applicable Revenue Code and HCPCS code (e.g., A, J, Q, S codes) or CPT-4 code (e.g., 90281 - 90399, 90476 - 90749) and the appropriate number of units for each specific drug or biological that is provided to Covered Individual. For example, if the specific Coded Service Identifier nomenclature defines mg of a specific drug and provider has provided fifty (50) mg of that drug to the Covered Individual, then the appropriate units would be five (5).

Code J9999 should only be reported for antineoplastic (e.g., chemotherapy) drugs that are not otherwise specifically identified with a HCPCS code.

Code J3490 should only be reported for drugs administered by injection or infusion and that are not otherwise specifically identified with a HCPCS code.

All oral drugs and medications that are not specifically identified with a HCPCS code should be aggregated and reported on a separate Claim line by date of service with a Revenue Code of 25x. Examples of oral drugs and medications would be pain medications, fever reducers, or other over the counter drugs and medications.

- l) Policy for Physical Medicine Modalities and Procedures: For CPT-4 codes 97032 - 97036, 97110 - 97124, 97140, 97530 - 97542, 97760 - 97762, Anthem will reimburse a fifteen (15) minute unit of direct treatment service when the duration of direct treatment is greater than or equal to eight (8) minutes, and less than twenty-three (23) minutes. Facility should not bill, and will not be reimbursed, for services performed for less than eight (8) minutes. If the duration of a single modality or procedure is between twenty-three (23) minutes and less than thirty-eight (38) minutes, then the provider may bill two (2) fifteen (15) minute units. Time intervals for larger numbers of units are as follows:

3 units equal to or greater than thirty-eight (38) minutes but less than fifty-three (53) minutes

- 4 units equal to or greater than fifty-three (53) minutes but less than sixty-eight (68) minutes
- 5 units equal to or greater than sixty-eight (68) minutes but less than eighty-three (83) minutes
- 6 units equal to or greater than eighty-three (83) minutes but less than ninety-eight (98) minutes

The pattern remains the same for treatment times in excess of ninety-eight (98) minutes. The expectation (based on the CMS work relative values for these codes) is that Facility's time for each unit will average fifteen (15) minutes in length. If Facility provider has a practice of billing for units where the duration of direct treatment averages less than fifteen (15) minutes, Facility will be highlighted for review.

All treatment time, including the beginning and ending time of the direct treatment, should be recorded in the Covered Individual's medical record along with the note describing the specific modality or procedure. If more than one (1) modality or procedure is rendered during a calendar day, then the total number of fifteen (15) minute direct treatment units that can be billed, and will be reimbursed, are based on the total direct treatment time for all modalities and/or procedures rendered.

For example, if Facility renders five (5) minutes of 97035 (ultrasound), six (6) minutes of 97110 (therapeutic procedure), and ten (10) minutes of 97140 (manual therapy techniques), then the total minutes of direct treatment is twenty-one (21) minutes, and only one unit will be reimbursed. Facility should bill the CPT-4 code that had the longest time, along with the single unit. The Covered Individual's medical record should document that all three (3) modalities and procedures were rendered and include the direct treatment time for each.

- m) Multiple Surgery: When two (2) or more surgical codes are billed on the same day by the Facility for the same Covered Individual, then the highest paying procedure is reimbursed at one hundred percent (100%) of the OHAS fee schedule, and up to an additional seven (7) surgeries will auto pay. Payment for the ninth procedure and beyond may require further medical review. Each of the additional seven (7) surgeries will reimburse at fifty percent (50%) of the fee schedule, unless a service is incidental to another procedure or subject to LSS frequency limitations.

Legend: ("IC") - Stands for individual consideration. If a procedure is listed with an IC, then reimbursement is individually considered and may require the submission of medical records prior to payment.

This schedule represents Anthem's base schedule of allowances as of the Effective Date of this Agreement and applies only to non-capitated services. The inclusion of an allowance does not imply that the service is covered. Also, there are many factors that may impact the actual amount reimbursed for a service. The Covered Individual's contract benefits will be applied (e.g., Cost Shares). All contract payment rules and medical policies affecting reimbursement also apply. Global time period, multiple surgery payment rules, incidental processing, limits on the service, medical necessity, and pre-existing review may be applied. Lastly, the procedure description presented here is not complete. For complete nomenclature, the then current, or any successor editions of the AMA CPT-4 or HCPCS manual should be used. Reproduction of this schedule is strictly forbidden.

- n) This provision intentionally left blank.
- o) Percentage of Covered Charge Payments: In those instances (if any) where the Facility is to be paid a Percentage Rate expressed as a Percentage of Covered Charges (as specified on the attached Rate Sheet(s)) for Covered Services. "Covered Charges" are defined as the Facility's actual Charges for Covered Services rendered to a Covered Individual, minus all Cost Share amounts applicable to such Covered Services. Under this payment formula, the percentage of the Facility's charge owed by the Plan is calculated after Cost Shares are subtracted.

Below is an example of payment where a Facility Agreement provides for a payment of sixty percent (60%) of Covered Charges:

Plan Payment	
\$1,000	Charges Billed by Facility
-100.00	Charge for non-Covered Services
-100.00	Deductible
-200.00	Co-payment

600.00 Covered Charges
 x 60%Percentage Rate
 \$360.00Plan Payment

In the above example, the Covered Individual would be responsible for payment to the Facility in the amount of \$400 and Plan would be responsible for payment of \$360 (all subject to the other terms and conditions of the Facility Agreement).

When a Covered Individual has a percentage Cost Share (coinsurance) requirement instead of a specified fixed Cost Share (co-payment) amount, the pricing calculation becomes more complicated. For example, in the case of a Facility Agreement that provides for payment of sixty percent (60%) of Covered Charges, and where the Covered Individual's Health Benefit Plan includes a twenty percent (20%) coinsurance requirement, the payment calculation would be as follows:

Plan Payment
 \$1,000Charges Billed by Facility
 -100.00Charge for non-Covered Services
 -100.00Deductible
 -104.3520% Coinsurance
 695.65Covered Charges
 x 60%Percentage Rate
 \$417.39Plan Payment

In the example above, the \$104.35 coinsurance amount was calculated using a formula (the "Coinsurance Formula") shown below which formula shall be utilized in all instances where payment to the Facility is to be calculated under a percentage of Covered Charges provision and the Covered Individual's benefits include a coinsurance requirement for such services.

In this example, the sum of the Covered Individual's coinsurance and the Plan payment is \$521.74 (\$104.35 + \$417.39). The Covered Individual's coinsurance portion of \$104.35 is exactly twenty percent (20%) of \$521.74, and Anthem's portion of \$417.39 is exactly eighty percent (80%) of \$521.74. Anthem's payment to the Facility is exactly sixty percent (60%) of Covered Charges.

Coinsurance Formula:

The first step is to determine an allowable charge using the following formula:

$$BC - BNC - \{ [(HD\% - (HD\% \times CO\%)) / (1 - (HD\% \times CO\%))] \times (BC - BNC - D) \}$$

 BC = Charges Billed by Facility
 BNC = Billed Non-Covered Charges
 HD% = Facility Discount Percent Per Agreement (i.e. 100% - Percentage Rate)
 CO% = Covered Individual Coinsurance Percent Benefit
 D = Covered Individual Deductible Benefit

Utilizing the assumptions of the previous example, the Coinsurance Formula is applied as follows:

$$\$1000 - \$100 - \{ [(40\% - (40\% \times 20\%)) / (1 - (40\% \times 20\%))] \times (\$1000 - \$100 - \$100) \}$$

 This equation results in an allowable charge of \$621.74.

The amount of the Covered Individual's coinsurance is then calculated by subtracting the Covered Individual's deductible and then applying the Covered Individual's coinsurance percentage factor.

For the above example, the following calculation of coinsurance results:

\$621.74 Allowable Charge
 -100.00 Deductible
 x 20% Coinsurance percentage factor
 \$104.35 Coinsurance amount

- p) Clinic Charges/Physician Offices: If Covered Services are rendered to a Covered Individual by a professional provider at any clinic owned, operated or controlled by the Facility, the Facility agrees that it will seek reimbursement for any claimed technical or overhead component of the clinic charges (e.g., UB-04 Revenue Codes 510-529 or any successor codes) only from such professional provider, and not from Plan or the Covered Individual. Facility further agrees that the technical component of any Covered Service(s) provided in physician or professional provider offices or clinics owned, operated, or controlled to any degree by the Facility will be billed by such

physician or professional provider or clinic using the office place-of-service code for professional Claims as listed in the current procedural terminology "CPT" codebook published by the American Medical Association. For purposes of this paragraph, the term "clinic" shall mean a center for physical examination and treatment of ambulant Covered Individuals who are not hospitalized and who are not treated in an emergency, ambulatory surgery, or other outpatient Facility setting.

- q) Non OHAS Percent of Charge Limits: For those Outpatient Services rendered to each Covered Individual by Facility during the term of this Agreement, which are not identified on the OHAS, or if Plan does not administer the OHAS, such Plan will pay or administer payment to the Facility at the Anthem Rate expressed as a Percentage Rate on the attached Rate Sheet(s), as calculated by the Plan, subject to the following limitation to charges: (1) the Facility shall accept a limit to Charges subject to reimbursement during Period One of the Charges in effect the day immediately preceding the beginning of Period One increased by the allowable Charge increase percentage, if any, specified for Period One on the attached Rate Sheet(s); (2) the Facility shall accept a limit to Charges subject to reimbursement during Period Two of the Charges in effect the day immediately preceding the beginning of Period Two increased by the allowable Charge increase percentage, if any, specified for Period Two on the attached Rate Sheet(s); (3) the Facility shall accept a limit to Charges subject to reimbursement during Period Three of the Charges in effect the day immediately preceding the beginning of Period Three increased by the allowable Charge increase percentage, if any, specified for Period Three on the attached Rate Sheet(s); (4) the Facility shall accept a limit to Charges subject to reimbursement during Period Four of the Charges in effect the day immediately preceding the beginning of Period Four increased by the allowable Charge increase percentage, if any, specified for Period Four on the attached Rate Sheet(s); (5) the Facility shall accept a limit to Charges subject to reimbursement during Period Five of the Charges in effect the day immediately preceding the beginning of Period Five increased by the allowable Charge increase percentage, if any, specified for Period Five on the attached Rate Sheet(s); (6) the required notification and calculation of the Anthem Rate shall be as set forth below.

4) This provision intentionally left blank.

- 5) Coding Updates. Each year Coded Service Identifier additions are published in official Coded Service Identifier publications. When such additions are made, they will automatically be added to the Anthem OHAS fee schedule (subject to Covered Individual's Health Benefit Plan) effective on the first day of the calendar quarter (e.g. January, April, July or October 1st) immediately following such publication. Payment hereunder for such added codes shall equal the Anthem conversion factor as of that date multiplied by the CMS relative value unit, which has been assigned to the new code. All surgical procedures will be multiplied by the APC relative weight. The Plan will implement such added codes with frequency limits, and multiple procedure, incidental, and global processing rules analogous to those used for established codes.

Each year, Coded Service Identifier deletions are also published in official Coded Service Identifier publications. When such deletions are made, those procedure codes will automatically be cancelled from the OHAS fee schedule on the effective date of such publication. Claims incurred after the cancellation date, for those deleted codes, will no longer be accepted or processed, but will instead be rejected.

If during the course of any year a service moves from the inpatient setting to the outpatient setting, fees will be established based on the above methodology and added to the OHAS fee schedule.

The matters described above concerning code additions and deletions shall take place automatically and do not require any notice or disclosure to the Facility or any Agreement amendment.

- a) DRG Implementation Period Terms: Each year, a variety of changes are made on or about October 1st that will affect DRG-based payments made under this Facility Agreement, including:

CMS adjustments to the relative weights associated with DRG codes
CMS changes to DRG groupers
CMS additions, deletions and modifications to DRG codes

American Medical Association additions and deletions to ICD-9-CM diagnosis and procedure codes. (All references to ICD-9-CM codes in this section shall refer to ICD-9-CM codes and all successor codes that may replace them in the future.)

The above changes shall be referred to as the "DRG-Related Changes," and the point at which all

such DRG Related Changes have been made by the above referenced organizations shall be referred to as the "DRG Modification Date".

The parties recognize and agree that Anthem payment systems cannot be modified immediately when the above DRG Related Changes are made, but must instead be modified during a time-frame of sufficient length to allow for the loading of payment system changes and updates, including changes and updates that allow for the recognition of new DRG and ICD-9-CM codes and DRG groupers and/or the application of new relative weights. Anthem shall use reasonable efforts to load such payment system changes as quickly as is practicable following the DRG Modification Date. The point at which all necessary Anthem payment system changes/updates have been loaded and completed shall be referred to as the "System Modification Point". During the period between the DRG Modification Date of each year and the System Modification Point of such year (the "Update Period"), the parties understand and agree to the following, notwithstanding any contrary provision contained herein:

Any Claim processed by Anthem during each Update Period during the term of this Agreement which Claim has an admission date of October 1st or later, will be processed and paid using the grouper version in effect on the September 30th immediately prior to such October 1st (the "Processing System Date"), assign the DRG code in effect on such Processing System Date, and apply the relative weights (if relative weights are a component of any payment methodology under the terms of this Agreement) in effect on such Processing System Date, and such payment shall satisfy all Anthem payment obligations hereunder (e.g., Facility shall accept such payment as payment in full subject to the other terms of this Facility Agreement). Notwithstanding the provisions of the previous sentence, this provision shall not preclude Facility from submitting a Claims adjustment request in accordance with section 2.17 of the Agreement, if Facility disputes the accuracy of such payment.

Prior to the System Modification Point, any ICD-9-CM diagnosis and procedure code changes that became effective as of the DRG Modification Date will not be accepted by Anthem. Facility shall make best efforts to hold any Claims containing such ICD-9-CM code changes until it receives notification from Anthem that the System Modification Point has been reached. If Claims containing any such ICD-9-CM diagnosis and procedure code changes are filed prior to the System Modification Point, the Claims will not be accepted by Anthem and Facility agrees to hold rejected Claims until it receives notification from Anthem that the System modification Point has been reached.

Once the System Modification Point has been reached, Claims shall be submitted by Facility, and paid/administered by Anthem consistent with the DRG Related Changes.

- 6) This provision intentionally left blank.
- 7) This provision intentionally left blank.
- 8) Applicability of this Agreement to Certain HMO Members. If a member enrolled with a health maintenance organization ("HMO Member") which is an Affiliate of Anthem Health Plans of Virginia ("Affiliated HMO") receives services from Facility which are covered under the terms of such HMO Member's evidence of coverage ("HMO Covered Services") at any time when the Facility is not a party to an HMO network agreement with, or on behalf of, such Affiliated HMO applicable to the HMO Member, then the Facility agrees to the following:
 - a) the Facility shall apply all discounts in this Agreement to all HMO Covered Services which are rendered to the HMO Member as if such HMO Member were a Covered Individual receiving Covered Services, and Facility shall accept such discounted amounts as payment in full;
 - b) with respect to goods and services provided by the Facility to the HMO Covered Individuals referenced above, the Facility shall comply with and accept Medical Necessity determinations made by Plans and/or Affiliated HMOs, and shall hold harmless Plans, Affiliated HMOs and HMO Members for those goods and services determined to be not Medically Necessary; and
 - c) any amounts payable to Facility under the terms of this paragraph and this Agreement for HMO Members shall be in lieu of any other amounts payable for HMO Members under any other agreements between Anthem Health Plans of Virginia and any of its Affiliates and the Facility.

Notwithstanding the above, if a Medicaid Member (as defined below) receives services from Facility that are covered under the terms of such Medicaid Member's evidence of coverage at any time when the Facility is not a party to an HMO network agreement with, or on behalf of, such Affiliated HMO applicable to Medicaid Members, then the Facility agrees to accept the then current DMAS Facility reimbursement rates as payment in full for such services. A "Medicaid Member" is any HMO Member enrolled under an Affiliated HMO's contract with the Virginia Department of Medical Assistance Services ("DMAS") including those enrolled in the Family Access to Medical Insurance Security (FAMIS) Plan.

- 9) Preventable Adverse Events ("PAEs"). Notwithstanding any provision in this Agreement to the contrary, when any CMS-adopted Never Event or CMS-defined Hospital Acquired Condition (collectively referred to as a Preventable Adverse Event or "PAE") that was not present on admission, occurs with respect to a Covered Individual, the Facility shall neither bill, nor seek to collect from, nor accept any payment from Plan or Covered Individual for the Charges and/or days which are the result of the PAE. If Facility receives any payment from Plan or Covered Individual for such events, it shall refund such payment to the entity making the payment within ten (10) business days of becoming aware of such receipt. Further, Facility shall cooperate with Anthem, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such PAEs. Facility must populate the Present on Admission (POA) indicator on all inpatient acute care Claims which are billed to Plan.

II. SPECIFIC REIMBURSEMENT TERMS

Q-HIP Administration Guidelines:

This provision intentionally left blank as Q-HIP is not applicable at this time.

- 1) This provision intentionally left blank.
- 2) This provision intentionally left blank.
- 3) This provision intentionally left blank.
- 4) This provision intentionally left blank.
- 5) This provision intentionally left blank.

III. ADDITIONAL FACILITY SERVICES

STOP LOSS:

- 1) This provision intentionally left blank.
- 2) This provision intentionally left blank.
- 3) This provision intentionally left blank.

PLAN COMPENSATION SCHEDULE
RATE SHEET FOR: FACILITY NAME: Commonwealth of VA Dept of Behavioral Health and Developmental Services
 Preferred Provider Organization Network(s) (PPO)
 Participating Indemnity/Traditional Network(s) (PAR)

INPATIENT SERVICES						
Method of Reimbursement	Period One Anthem Rate 7/1/11-6/30/12	Period Two Anthem Rate 7/1/12-6/30/13	Period Three Anthem Rate 7/1/13-6/30/14	Period Four Anthem Rate 7/1/14-6/30/15	Period Five Anthem Rate 7/1/15-6/30/16	Criteria
Inpatient, Per Diem Rate	\$552	\$563	\$574	\$585	\$597	Revenue Codes 110 – 179, 190 – 219
Medical Inpatient						

OUTPATIENT SERVICES							
Service	OHAS Schedule	OHAS Factor Period One 7/1/11-6/30/12	OHAS Factor Period Two 7/1/12-6/30/13	OHAS Factor Period Three 7/1/13-6/30/14	OHAS Factor Period Four 7/1/14-6/30/15	OHAS Factor Period Five 7/1/15-6/30/16	Criteria
OHAS Lab	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - H
OHAS Radiology	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - G, GK
OHAS Surgery	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - C, D, F, NT, O
OHAS Diagnostic	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - A, J, M, P, W
CRNA	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - B
OHAS Professional	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - AP, CP, DP, FP, GP, HP, KP, MP, PP, RP, RP, TP, WP
OHAS Diabetic Counseling	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - Z
OHAS Therapies	005	1.00	1.00	1.00	1.00	1.00	Service Indicator(s) - K, R, T
Non-OHAS Outpatient Services	Percentage of Covered Charges	50.0%	50.0%	50.0%	50.0%	50.0%	

