Jessica Ceja

From: Jason Bleak
Sent: Saturday, September 6, 2025 3:27 PM
To: Lyle Lemaire; Lyle Farr (lylefarr@gmail.com); Shawn Mariluch; Alicia Price; Paula Tomera
Cc: Jessica Ceja; Jason Bleak; Wayne Allen; Jodi Price
Subject: Silver Summit Health Plan Medicaid Managed Care Contract
Attachments: Battle Mountain General Hospital 9.3.2025.docx

Good afternoon,

Please find attached the contract from Silver Summit Health Plan for Medicaid Managed Care services. This is one of two contracts that will link BMGH to the Medicaid program of Nevada. Jodi, Wayne and I have had a few meetings to get the verbiage to work. Though the whole contract is important, the critical area is from page 25 through the end. These are the exhibits that describe the reimbursement for our services. We were successful in getting them to reference the rate letters and methodologies that are provided by the State. These letters will instruct Silver Summit to adjust the "Allowable Amount" for reimbursement which are cost based. We have also been instructed by the Director of State Medicaid that if we find that we are not being reimbursed appropriately, that the State will require the correct cost based reimbursement.

We hope to get this approved so we can move into the next steps of credentialing each of our providers in advance of the 1-1-2026 go live. Credentialing usually takes several months to complete. If you have questions, please feel free to ask on an individual basis.

Thanks,

Jason Bleak
Administrator / CEO
Battle Mountain General Hospital

AMENDMENT NUMBER THREE
PARTICIPATING PROVIDER AGREEMENT

This Amendment Number Three ("Amendment") is entered into as of September 1, 2025 (the "Amendment Effective Date") by and between SilverSummit Healthplan, Inc. ("Health Plan") and Battle Mountain General Hospital ("Provider"), collectively referred to herein as the "Parties."

WHEREAS, Health Plan and Provider have previously entered into a Participating Provider Agreement (the "Agreement") effective as of January 1, 2022 (defined in the Agreement as the "Effective Date"); and

WHEREAS, the Parties desire to amend the Agreement in accordance with the amendment provisions of the Agreement;

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1. ~~[Insert name of existing Attachment, Addendum, Schedule or Exhibit] is hereby deleted from the Agreement in its entirety.~~ The existing Schedule C is hereby deleted from the Agreement in its entirety and replaced with a new Participating Provider Agreement, Schedule C, Contracted Providers, which is attached to this Amendment.

2. Attachment A: Medicaid, Medicaid Product Attachment, to this Amendment, which is inclusive of Schedule A, entitled "Governmental Program Requirements"; Schedule B, entitled "Regulatory Requirements"; and all Compensation Schedule Exhibit(s), attached hereto, is hereby added to the Agreement as Attachment A: Medicaid.

~~2. [Insert name of existing Article, Section or Paragraph within base agreement or any attachment] is hereby deleted from the Agreement in its entirety.~~

3. Pursuant to the provisions of the Agreement, Attachment A: Medicaid, Product Attachment, shall be identified on Schedule B, Product Participation, of the Agreement and, as such, Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment and will be considered to be and will be governed under this Product Attachment.

~~3. [Insert name(s) of attachment(s) to the Amendment] is hereby added to the Agreement as [Insert heading name of attachment(s)].~~

~~4. The following is hereby added to the Agreement as a new [Insert citation to new Article, Section or Paragraph within the base Agreement or any attachment to the Agreement]:~~

~~[NewLanguageCitation]: [Insert new language]~~

~~5. [Insert name of existing Attachment, Addendum, Schedule or Exhibit] is hereby deleted from the Agreement in its entirety and replaced with [Insert name of new Attachment, Addendum, Schedule, Exhibit], which is attached to this Amendment as [Insert name of attachment to the Amendment].~~

~~6. [Insert name of existing Article, Section or Paragraph within base agreement or any attachment] is hereby deleted from the Agreement in its entirety and replaced with the following:~~

~~[Insert new language]: [Insert new language]~~

~~7.~~4. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Amendment as of the date above.

Health Plan:	**PROVIDER:**
SilverSummit Healthplan, Inc.	Battle Mountain General Hospital
Authorized Signature	Authorized Signature
Printed Name: Sarah E. Fox	Printed Name:
Title: Vice President, Network Development & Contracting	Title:
Date:	Date:
ICM #: ICMProviderAgreementAmendment_230058	Tax ID Number: 88-0186024
	State Medicaid Number:
	NPI : ~~1245312321~~

PARTICIPATING PROVIDER AGREEMENT
SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME	Tax ID #	NPI #
Battle Mountain General Hospital - Critical Access (Inpatient)	88-0186024	1245312321
Battle Mountain General Hospital - Critical Access (Outpatient)	88-0186024	1487729083
Battle Mountain General Hospital - Swing bed	88-0186024	1104903103
Battle Mountain General Hospital - Skilled Nursing Facility	88-0186024	1366658809
Battle Mountain General Hospital – Rural Health Clinic (RHC)	88-0186024	1790851616
Battle Mountain General Hospital - Group	88-0186024	1740517887

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT
NEVADA

This MEDICAID PRODUCT ATTACHMENT ("***Product Attachment***") is made and entered between SilverSummit Healthplan, Inc. ("***Health Plan***") and Battle Mountain General Hospital ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain provider agreement, as the same may have been amended and supplemented from time to time ("***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, Contracted Providers will be designated and participate as Participating Providers in the Product described in this Product Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Product Attachment will have the meanings given to such terms in the Agreement. Citations to governmental authority requirements provided herein are for convenience only and shall not affect the meaning or interpretation of the terms of this Product Attachment. Such citations may become outdated as these requirements are amended from time to time.

1.1 "***Medicaid Product***" refers to those programs and health benefit arrangements offered by Health Plan or other Company pursuant to contract(s) with one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so (each a "***State Contract***"). The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

2. Medicaid Product.

2.1 Medicaid and/or CHIP Product. This Product Attachment constitutes the "***Medicaid Product Attachment***" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply to maintain such participation. This Product Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

2.2 Participation. Except as otherwise provided in this Product Attachment or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Medicaid Product and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This attachment constitutes the Product Attachment and compensation for the Medicaid Product.

2.4 Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement

will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from Health Plan. To the extent any provision of the Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Product Attachment will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

4. Governmental and State-Mandated Program Requirements. The schedules attached to this Product Attachment, incorporated herein by this reference, set forth provisions that are required by the applicable governmental authority or state law and contract to be included in the Agreement with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

5. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

This schedule sets forth special provisions specific to the Nevada Medicaid Product under the State regulations and State Contract.

1. Definitions. As used in this schedule, capitalized terms shall have the meaning as set forth in the "Definitions" section of the Scope of Work to the State Contract unless otherwise defined in the Agreement. For purposes hereof, "Participating Provider" has the same meaning as "Network Provider" and "Covered Person" has the same meaning as "Member" defined in the State Contract.

2. Compliance with State Contract. Provider and Contracted Providers shall familiarize themselves with all provisions of the State Contract applicable to the services provided and agree to be bound by the applicable terms and conditions of the State Contract relative to Provider's obligations under the Agreement whether or not expressly summarized herein. In the event of any conflict or inconsistency between the Agreement and this schedule, the terms and conditions of this schedule shall take precedence and control. In the event of any conflict or inconsistency between this schedule and the State Contract, the State Contract shall take precedence and control.

3. Compliance with Law. Provider and each Contracted Provider shall adhere to professional standards of medical or paramedical care and services, and comply with all local, state and federal statutes, rules and regulations relating to performance of Covered Services including, but not limited to, non-interference with recipient/health care provider communications and prohibitions against factoring and accepting or paying kickbacks for services provided to Covered Persons. Provider and Contracted Providers for themselves and their respective employees and agents shall comply with all applicable federal, State and local laws, rules, ordinances, regulations, orders, federal circulars and all license and permit requirements in the performance of the applicable State Contract and the Agreement.

4. Inspection and Audit of Records and Access to Facilities. Health Plan, the State, CMS, the Office of the Inspector General (OIG), the Comptroller General and their designees have the right to audit records or documents of Provider and each Contracted Provider for 10 years from the final date of the State Contract period or from the date of completion of any audit, whichever is later. These entities also may, at any time, inspect the premises, physical facilities and equipment where Medicaid- or Nevada Check Up-related activities or work is conducted. The aforementioned entities also have the right to inspect and audit any books or records of Provider and each Contracted Provider pertaining to the ability to bear the risk of financial losses and services performed or payable amounts under the State Contract pursuant to 42 CFR 438.3(h), 42 CFR 483.3(k), 42 CFR 457.1201 and 42 CFR 457.1233(b). (SOW §2.24)

5. Moral and Religious Objections. If Participating Provider elects not to provide, reimburse for or provide coverage of a counseling or referral service that would otherwise be required because of an objection on moral or religious grounds, Participating Provider shall promptly furnish information about the services it does not cover for this reason to Company so that Company may fulfill its obligations under the State Contract to the State and Covered Persons and shall also provide such information promptly to Company whenever it adopts such a policy during the term of the Agreement. (SOW §2.11)

6. Miscellaneous Federal Requirements. In accordance with 42 CFR 438.3(k), 42 CFR 457.1201(i), 42 CFR 438.230 and 42 CFR 457.1233(b), the following provisions apply to Provider and each Contracted Provider (SOW §3.2.1):

6.1 Comply with all applicable Medicaid and Children's Health Insurance Program (CHIP) laws, regulations, including applicable sub-regulatory guidance and contract provisions pursuant to 42 CFR 438.230(c)(2);

6.2 The State, CMS, the OIG, the Comptroller General, or their designees, have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of Provider and each

Contracted Provider that pertain to any aspect of services and activities performed or determination of amounts payable under the Company's agreement with the state pursuant to 42 CFR 438.230(c)(3)(i);

6.3 Make available its premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems relating to Covered Persons for purposes of an audit, evaluation, or inspection by the State, CMS, the OIG, the Comptroller General, or their designees, pursuant to 42 CFR 438.230(c)(3)(ii); and

6.4 The State, CMS or the OIG have the right to inspect, evaluate and audit Provider and each Contracted Provider if the State, CMS or the OIG determine that there is a reasonable possibility of fraud or similar risk pursuant to 42 CFR 438.230(c)(3)(iv).

7. Delegated Duties. To the extent Provider is delegated administrative functions (e.g., utilization management), Provider is also classified as a Subcontractor and the Agreement is subject to advance written approval by the State prior to the Agreement's effective date. (SOW §3.2.3)

8. Termination/Revocation for Inadequate or Substandard Performance. In the event a Participating Provider's performance is inadequate or substandard, Company may terminate the Agreement or revoke the specific function, the performance of which was found to be inadequate or substandard. (SOW §3.2.5)

9. Unreasonable Barrier and Segregation of Access – Prohibited. Notwithstanding anything contained in the Agreement to the contrary, in no event shall Provider or a Contracted Provider implement unreasonable barriers to care or segregate access to care for Covered Persons which are more restrictive than those set forth in the State Contract. (SOW §§3.2.7 and 8.2.5.G.)

10. No Incentives to Deny, Reduce or Limit Care. Notwithstanding anything contained in the Agreement to the contrary, in no event shall the compensation provisions of the Agreement be structured to incentivize the denial, reduction or limitation of Medically Necessary services. Should any such compensation provisions be found by a court of competent jurisdiction or regulatory authority to have such effect, then those provisions will be amended accordingly. (SOW §§3.2.8.B. and 8.2.5.E.)

11. Monitoring Provider Performance and Compliance. Company will monitor Provider's compliance with the Agreement and the State Contract as well as Provider's performance on a regular, on-going basis and will subject Provider to formal review according to periodic schedules established by the State. If Company identifies deficiencies or areas for improvement, Company will impose corrective action on Provider with which Provider shall comply. (SOW §§3.2.9 and 8.2.6.B)

12. Specific Covered Services. Provider and each Contracted Provider is expected to familiarize itself with those provisions of the State Contract applicable to the types of Covered Services provided and comply therewith. (SOW §5 et. seq.)

13. Behavioral Health Services. If Provider or Contracted Provider provides Behavioral Health Covered Services, that provider shall use the following behavioral health screening tools as part of Company's utilization management program (SOW §5.2.6):

i. The American Society for Addiction Medicine (ASAM) Criteria for substance abuse services, for Medical Necessity review for all populations except children ages 0 through 6;

ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria when evaluating service requests for children;

iii. Level of Care Utilization System (LOCUS) scores for Mental Health Services for Medical Necessity reviews for Covered Persons age 18 and older;

iv. Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) scores for Mental Health services for Medical Necessity reviews for children and adolescents age 6 through 17; and

v. Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for infants, toddlers and preschoolers to determine Medical Necessity for children ages 0 through 5 or another validated assessment tool with prior approval by the State.

14. Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI) Covered Persons. If Provider or Contracted Provider provides Covered Services to SED or SMI Covered Persons, that provider certifies (i) only qualified providers shall conduct Medically Necessary evaluations and render Medically Necessary medical and mental health services; (ii) the parent/guardian of a minor referred for SED/SMI assessments is fully informed of the reasons for the assessment; (iii) obtain prior authorization on State-prescribed forms from (A) a minor's parents/guardians or (B) the adult covered Persons (or his/her personal representative) to conduct the assessment and to release the determination to the State and/or its designee; (iii) Participating Provider shall comply with the State's and Company's requirements for data collection. (SOW §5.2.8)

15. Covered Persons with Special Health Care Needs. If Provider or Contracted Provider provides Covered Services to Covered Persons with Special Health Care Needs, that provider shall provide same in accordance with the treatment plan prepared by Company. (SOW §5.2.9)

16. Vaccinations. If Provider or Contracted Provider provides vaccinations, that provider shall use good faith efforts to do enroll and participate in the Vaccines for Children (VFC) Program administered by the Division of Public and Behavioral Health (DPBH). VFC-enrolled providers shall cooperate with DPBH for purposes of performing orientation and monitoring activities regarding VFC Program requirements. (SOW §5.2.10)

17. CLIA. If Provider or Contracted Provider is a Medicaid laboratory service, those testing sites must comply with the Clinical Laboratory Improvement Amendments (CLIA) regulations found at 42 CFR §493 and must possess a valid CLIA certificate or a waiver of certificate registration and a valid CLIA identification number. (SOW §5.2.11)

18. Pharmacies and PBMs. If and to the extent Provider or Contracted Provider provides Pharmacy Services or Pharmacy Benefit Management Services, that provider shall thoroughly review and familiarize itself with Sections 5.2.12 and 5.2.13 of the State Contract and comply therewith. (SOW §§5.2.12 and 5.2.13)

19. Payments to Providers – Emergency, Post-Stabilization Services. Company will not pay Provider or Contracted Provider for Post-Stabilization Services as a Covered Service except in the following situations: (A) such services are pre-approved by a Network Provider or other Company representative; (B) if not pre-approved as provided in (A), and provided such are administered to maintain, improve or resolve the Covered Person's stabilized condition: (i) Company did not respond to a request to authorize such services within one hour; (ii) Company could not be contacted; or (iii) Company and the treating physician cannot reach an agreement concerning the Covered Person's care and a Network Provider or other Company representative is not available for consultation. Pursuant to 42 CFR 438.114(e) and 42 CFR 422.113, Company's financial responsibility for post-stabilization care it has not pre-approved ends when (i) a Network physician with privileges at the treating hospital assumes responsibility for the Covered Person's care; (ii) a Network physician assumes responsibility for the Covered Person's care through transfer; (iii) Company and the treating physician reach an agreement concerning the Covered Person's care; or (iv) the Covered Person is discharged. (SOW §5.2.14)

20. Abortions. Company will not pay for abortion services unless, in accordance with 42 CFR 441.202, (i) the pregnancy is the result of an act of rape or incest; or (ii) in the case of a pregnant woman suffering from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the pregnant woman in danger of death unless an abortion is performed. (SOW §5.2.15)

21. Organ Transplants. Company will not pay for organ transplants unless Medically Necessary and which comply with the service limitations outlined in the Medicaid and Nevada Check Up State Plans and MSM Chapter 600. (SOW §5.2.16)

22. Excluded Services. Company will not pay for those services set forth in Section 5.6 of the State Contract as "Excluded Services." (SOW §5.6)

23. Prohibited Practices.

23.1 Except where medically indicated, neither Provider nor Contracted Providers may not consider race, national origin, creed, color, gender, gender identity, sexual orientation, religion, age, health status or disability in the provision of Covered Services. Prohibited practices include (i) denying or not providing Covered Services or available facility placement; (ii) providing Covered Persons with Covered Services which are different or provided at a different time or manner from that provided to private patients or members of the public; (iii) segregating or providing separate treatment in any manner related to the receipt of any covered Medically Necessary services, except where medically indicated; and (iv) providing a Covered Person with times or places for the provision of services on the basis of race, national origin, creed, color, gender, gender identity, sexual orientation, religion, age, health status or disability.

23.2 Pursuant to 42 CFR 438.102(a)(1) and 42 CFR 457.1222, Company may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Covered Person who is their patient (i) for the Covered Person's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) for any information the Covered Person needs in order to decide among all relevant treatment options; (iii) for the risks, benefits and consequences of treatment or non-treatment; and (iv) for the Covered Person's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

23.3 Neither Provider nor Contracted Providers shall charge a fee for a Medically Necessary Covered Service or attempt to collect a co-payment.

24. Transition of Care. Provider and each Contracted Provider shall cooperate with Company's transition of care policies including, but not limited to, promptly delivering a Covered Person's medical records as directed by and when requested by Company. (SOW §5.9)

25. Culturally Competent Services. Provider and each Contracted Provider shall cooperate with Company's efforts to provide Covered Services in a culturally competent manner which includes providing care responsive to the languages, health literacy and other communication needs of Covered Persons. Provider and each Contracted Provider shall consult Company if and when they are unclear or confused as to what this entails for specific individuals. Provider and each Contracted Provider shall reasonably participate in Company training/education relative to these obligations. (SOW §6.3)

26. Care Management. Provider and each Contracted Provider shall cooperate with Company's Care Management policies and procedures which such cooperation shall include, but is not limited to, ensuring Covered Services are rendered consistent with any person-centered plans specific to a given Covered Person. (SOW §7)

27. Provider Status. (SOW §§8.2.3 and 8.2.4)

27.1 Provider and each Contracted Provider covenants that for the entire term of the Agreement, it shall not be excluded from participation in the federal health care programs under Section 1128 of the Social Security Act (the "Act").

27.2 Provider and each Contracted Provider covenants that for the entire term of the Agreement, it shall be enrolled as a Medicaid and Nevada Check Up provider, for all provider types and specialties under which they intend to provide Covered Services, pursuant to 42 CFR 438.602(b)(1) and 42 CFR 457.1285 and will cooperate with

the State's fiscal agent for completion of the Medicaid and Nevada Check Up Provider enrollment process to ensure it meets the provider disclosure, screening and enrollment requirements of 42 CFR 438.608(b), 42 CFR 455 Subparts B and E and 42 CFR 457.1285. The Participating Provider is not required to provide services to Medicaid or Nevada Check Up FFS Recipients.

27.3 Pursuant to 42 CFR 438.602(b)(2) and 42 CFR 457.1285, Company may execute the Agreement for up to 120 calendar days pending the outcome of the State's screening, enrollment and revalidation process. Company must terminate a provider immediately upon notification from the State that the provider cannot be enrolled or upon the expiration of the 120 calendar day period without Medicaid/Nevada Check Up enrollment.

27.4 In accordance with 42 CFR 438.12(a) and 42 CFR 457.1208, Company will not discriminate for the participation, reimbursement or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license, specialty or certification.

27.5 Company will not discriminate against Provider if Provider serves high-risk populations or specialized conditions that require costly treatment.

27.6 Company is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty and is not precluded from establishing measures that are designed to maintain quality of services and control costs and that are consistent with its responsibilities to Covered Persons.

27.7 Provider and each Contracted Provider covenants that for the entire term of the Agreement it shall maintain its credentials as required by the State Contract and the Agreement. Provider and each Contracted Provider shall comply with Company's and the State's credentialing and recredentialing policies and procedures.

27.8 Provider and each Contracted Provider covenants that, upon implementation of the Public Option, it must also be enrolled as a participating provider in at least one network of providers established for the Public Option in accordance with NRS 695K.230.

28. Miscellaneous Termination. In accordance with NRS 687B.692, Health Plan may terminate the Agreement for any grounds authorized under the State Contract. Such grounds may include, without limitation, issues of inconsistency with other participating Network Providers with regard to (i) Covered Person access to Covered Services rendered by Provider; (ii) the cost of the services of Provider; (iii) the quality of care provided by Provider; or (iv) issues relating to the utilization of the services of Provider. (SOW §8.2.3.I)

29. Qualifications. Throughout the term of the Agreement, Provider and each Contracted Provider shall be appropriately licensed, credentialed and enrolled with Medicaid or Nevada Check Up for the Covered Services which is provides to Covered Persons. (SOW §8.2.5.B)

30. Review and Approval of Agreement by State. Provider acknowledges the State has review authority for the Agreement. In addition, prior to distributing or executing any substantive changes or amendments to the Agreement, Company will submit drafts of standard language of the Agreement to the State for review. The Agreement must meet all state and federal requirements. The Agreement is subject to amendment to comply with requirements or directives of the State. (SOW §§8.2.5.C. and D.)

31. No Restraint of Trade. Any provision of the Agreement determined by a court of competent jurisdiction or regulatory authority to restrain trade shall be deemed amended only to the extent to eliminate such restraint on trade. Nothing herein shall be interpreted or construed to (i) require Health Plan or Provider to contract with a business entity affiliated with the other as a condition of entering into the Agreement; (ii) require Provider to offer Health Plan the lowest payment rates of all the managed care organizations with which it has contracted, or alternatively, require Health Plan to offer Provider the highest payment rates of all Participating Providers with which it has contracted; (iii) prohibit Health Plan or Provider from contracting with another provider or health managed care organization which is not a party to the Agreement or penalizes Health Plan or Provider for entering into such a contract; and (iv) impose a "gag" clause. (SOW §8.2.5.F)

32. Provider Changes. If Provider or a Contracted Provider experiences a change in its operations, staffing or facility(ies) such that its delivery of Covered Services or the ability of Covered Persons to access services will or may likely be materially affected including, but not limited to, situations where Provider or Contracted Provider is not actively serving Covered Persons, Provider or Contracted Provider, as appropriate, shall promptly notify Company in writing with information about the nature of the change and how it will or may likely affect the delivery of Covered Services. (SOW §§8.2.6.J. and K. and 8.3.5.)

33. Hours of Operation, Emergency Service Availability and Appointment Times. (SOW §§8.2.6.C and 8.3.3)

a. Provider and each Contracted Provider must offer hours of operation no less than those offered to commercial patients or comparable to Medicaid/Nevada Check Up FFS, if Provider or Contracted Provider services only Medicaid/Nevada Check Up Recipients. When Medically Necessary, Covered Services must be available 24 hours per day, 7 days per week. Emergency services shall be accessible immediately on a 24/7 basis with unrestricted access to Covered Persons who present at any qualified Provider. Provider and each Contracted Provider shall comply with the following Maximum Appointment Wait Time standards:

Service Type	**Maximum Appointment Wait Time from the Day of Request**		
	Urban	**Rural**	**Frontier**
Primary Care (adult)*	10 business days	15 business days	15 business days
Primary Care (pediatric)*	10 business days	15 business days	15 business days
Outpatient Mental Health and SUD Treatment (adult)	10 business days	10 business days	10 business days
Outpatient Mental Health and SUD Treatment (pediatric)	10 business days	10 business days	10 business days
Obstetrics/Gynecology, other than prenatal care	10 business days	15 business days	15 business days
Prenatal Care in 1st and 2nd trimester	7 calendar days	10 calendar days	10 calendar days
Prenatal Care in 3rd trimester or for high-risk pregnancies	3 calendar days	5 calendar days	5 calendar days
Physical, Occupational or Speech Therapy	15 business days	20 business days	20 business days

*The appointment wait time standards for primary care do not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than would be allowed by the standards.

b. Provider and each Contracted Provider must ensure that Covered Persons have access to timely appointments for urgent health care needs, as well as situations in which treatments are more medically effective when delivered more quickly than routine care pursuant to 42 CFR 438.206(c) and 457.1230(a).

c. A Covered Person's waiting time at a primary care physician's (PCP) or specialist's office shall be no more than one hour from the scheduled appointment time, except when that provider is unavailable due to an emergency or when that provider is working in an urgent case or when a serious problem is found.

d. Company will monitor Provider's and each Contracted Provider's compliance with all the above and will implement a corrective action plan or Plan of Correction.

34. Primary Care Providers. If Provider or Contracted Provider is a PCP, that provider is responsible for the following (SOW §8.4):

a. Delivering covered Medically Necessary primary care services and preventive services, including EPSDT screening services and Well Baby/Child services;

b. Providing reasonable and adequate hours of operation, including 24-hour availability of information, referral and treatment for emergency medical conditions, in accordance with 42 CFR 438.3(q)(1) and 42 CFR 457.1201(m);

c. Making referrals for specialty care and other Medically Necessary Covered Services in the managed care benefit package;

d. Ensuring continuity and coordination of the Covered Person's health care; and

e. Maintaining a current medical record for the Covered Person, including documentation of all services provided by the PCP, specialists and Out-of-Network Providers, including family planning and emergency services.

35. Provider Manual and Training. Provider and each Contracted Provider shall obtain and use Company's Provider Manual to access to pertinent Company's policies and procedures. Provider and each Contracted Provider shall reasonably participate in Company's training on applicable program requirements and operational requirements. (SOW §§8.10 and 8.11)

36. Practice Guidelines. Provider and each Contracted Provider shall use and comply with Company's Practice Guidelines and protocols. (SOW §8.15.4)

37. Medical Records. (SOW §8.16)

a. Provider and each Contracted Provider shall maintain complete medical records for each Covered Person in a legible, current, detailed, organized and comprehensive manner that permits effective Covered Person care and quality review. The medical records must be available for review by duly authorized representatives of the State and CMS upon request.

b. The medical record is the property of Provider or Contracted Provider who generates the medical record and shall share the Covered Person's medical records in accordance with professional standards pursuant to 42 CFR 438.208(b)(5) and 42 CFR 457.1230(c). Medical records must be furnished in a timely manner upon receipt of such a request but not more than 30 calendar days from the date of the request. The Covered Person may request that such records be supplemented or corrected. Upon request, each Covered Person or parent/legal guardian of the Covered Person shall receive one free copy of the medical records. The fee for additional copies shall not exceed the actual cost of time and materials to make the copy and furnish such records.

c. When a Covered Person changes PCPs and or health plans, that provider must forward all medical records in their possession to the new provider within 10 business days from receipt of the request.

d. Provider and each Contracted Provider shall comply with Company's and the State's maintenance and contents standards for medical records. Minimum content requirements include (i) patient identifying information; (ii) personal/demographic information; (iii) allergies; (iv) past medical history; (v) vaccinations for pediatric records; (vi) diagnostic information; (vii) medication information; (viii) identification of current problems; (ix) alcohol or substance use disorder (SUD) information; (x) consultations, referrals and specialist reports; (xi) emergency care; (xii) hospitals, including mental hospitals (and pertinent information relating thereto including physician name; date of admission; initial and subsequent stay review dates; reasons and plan for continued stay, if applicable; date of operating room reservation, if applicable; justification for emergency admission if applicable; and discharge summaries.); (xiii) advance directives; (xiv) patient visit data (including history and physical examination; plan of treatment; diagnostic tests; therapies and other prescribed regimens; follows ups; referrals and results thereof; all other aspects of patient care); (xv) date of entries; (xvi) identification of provider entering information; and (xvii) legibility.

e. Consistent with the intention of NRS 439.581 through 439.595 and applicable federal law, Participating Provider shall reasonably initiate measures to, or, if already participating, continue to, contribute Covered Person clinical data to the statewide HealtHIE Nevada Health Insurance Exchange (HIE) according to policies and standards set forth by the HIE.

38. Provider Grievance and Appeals. Provider and each Contracted Provider shall utilize and exhaust Company's process to resolve Grievances and Appeals before seeking a State Fair Hearing for eligible disputes. (SOW §8.17)

39. Miscellaneous Payment Provisions.

a. Unless a shorter period is set forth in the base of Agreement or the Provider Manual, in-state providers shall up to 180 calendar days from the last date of service and out-of-state providers shall have up to 365 calendar days from the last date of service within which to submit claims. (SOW §9.1.4)

b. In accordance with federal regulations, Nevada Medicaid and Check Up are the payers of last resort. Thus, Company will deny claims covered by other pertinent insurance, including Medicare. (SOW §9.2.2)

c. Company will deny claims (or recoup payments made) for Provider Preventable Conditions and Other Provider Preventable Conditions. Provider and each Contracted Provider is required to identify and report all Provider Preventable Conditions associated with claims for Medicaid payment or with a course of treatment furnished to a Covered Person for which Medicaid payment would be otherwise available. (SOW §9.3)

d. The length of time that a pregnant woman is enrolled with Company is not a determining factor in payment to the obstetrician/nurse midwife. Company must determine payment to the delivering obstetrician/nurse midwife for normal routine pregnancy based upon the services and number of visits provided by the obstetrician/nurse midwife to the Covered Person throughout the course of pregnancy. Company must determine the services and number of visits provided by the obstetrician/nurse midwife using Current Procedural Terminology (CPT) codes submitted by Provider or Contracted Provider, as applicable. Company must provide separate payment for covered Medically Necessary services required as a result of a non-routine pregnancy. Unless the requirements of Section 9.7.3 of the State Contract have been met, the health plan with whom the Covered Person is enrolled at delivery must pay a global payment to the delivering obstetrician/nurse midwife, regardless of Network affiliation, when the Covered Person has been seen seven or more times by the delivering obstetrician/nurse midwife. If the delivering obstetrician/nurse midwife has seen the Covered Person less than seven times, the obstetrician/nurse midwife may be paid according to a negotiated rate of no less than the Fee-for-Service (FFS) rates established for pregnancy-related CPT codes in accordance with Section 9.4.2 of the State Contract. Company may use an alternative payment model (APM) other than the obstetrical global payment described in Section 9.7.2 of the State Contract with Provider and Contracted Providers if such methodology covers the same services covered by the obstetrical global payment, is designed to improve health outcomes and the quality of care delivered to Covered Persons and has been approved by the State as an acceptable APM. APMs, as defined in Section 9.5 of the State Contract, may include, but are not limited to, payments per episode of care, pay for performance and pregnancy medical home models. The State reserves the right to modify the requirements for the obstetrical global payment at any time, including modifications that tie the obstetrical global payment to plan performance on maternal and child health quality measures. (SOW §9.7)

e. Company is responsible for services rendered during a period of retroactive enrollment in situations where eligibility errors have caused an individual to not be properly and timely enrolled with Company. In such cases, Company shall only be obligated to pay for such services that would have been authorized by Company had the individual been enrolled at the time of such services. For in-state providers in these circumstances, Company shall pay the providers for such services only in the amounts that would have been paid to a Network Provider in the applicable specialty. Out-of-State providers in these circumstances will be paid according to a negotiated rate between Company and the Out-of-State provider. The timeframe to make such corrections will be limited to 180 calendar days from the incorrect enrollment date. (SOW §9.8.1)

f. Company will not pay for items or services provided under the Medicaid or Nevada Check Up State Plans or under a waiver to any financial institution or entity located outside of the United States. Moreover, Company will not pay telemedicine providers or pharmacies located outside of the United States. For purposes of implementing this provision, Section 1101(a)(2) of the Act defines the term "United States" when used in a geographical sense, to mean the "States." Section 1101(a)(1) of the Act defines the term "State" to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa, when used under Title XIX. (SOW §9.9)

g. Company will not pay for the following items or services (other than an emergency item or service, not including items or services furnished in an emergency room or hospital): (i) those furnished by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, XIX or XX, pursuant to Section 1128, 1128A, 1156 or 1842(j)(2); (ii) those furnished at the medical direction or on the prescription of a Physician, during the period when such Physician is excluded from participation under Title V, XVIII, XIX or XX, pursuant to Section 1128, 1128A, 1156 or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion; (iii) those furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments; or (iv) an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997. (SOW §9.10)

40. Physician Incentive Plans. All physician incentive plans must comply with Section 1876 of the Act, 42 CFR 422.208, 42 CFR 422.210, 42 CFR 438.3(i) and 42 CFR 457.1201(h). (SOW §9.6)

41. Covered Person Rights. Pursuant to 42 CFR 438.100 and 42 CFR 457.1220, Provider and each Contracted Provider must reasonably ensure the following Covered Person rights are protected from and against any adverse action by that Provider: (i) to be treated with respect, and recognition of their dignity and need for privacy; (ii) to participate in decision-making regarding their health care, including the right to refuse treatment; (iii) to pursue resolution of Grievances and Appeals about Company or care provided; (iv) to formulate advance directives; (v) to have access to their medical records in accordance with applicable federal and state laws and to request that they be amended or corrected as specified in 45 CFR Part 164; (vi) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; (vii) to receive information on available treatment options and alternatives, presented in a manner appropriate to the Covered Person's condition and ability to understand; and (viii) to ensure the Covered Person is free to exercise their rights without Provider or Contracted Provider treating the Covered Person adversely. (SOW §10.1)

42. Covered Persons Not Liable. Neither Provider nor Contracted Provider shall not hold Covered Person's liable for any of the following: (i) Company's debts, in the event of Company's insolvency; (ii) services provided to the Covered Person in the event of Company failing to receive payment from the State for such services; (iii) services provided to a Covered Person in the event a Provider or Contracted Provider with a contractual, referral or other arrangement with Company fails to receive payment from the State or Company for such services; or (iv) payments to Provider or Contracted Provider who furnishes covered services under a contractual, referral or other arrangement with Company or Subcontractor in excess of the amount that would be owed by the Covered Person if Company had directly provided the services per 42 CFR 438.230(c) and 42 CFR 457.1233(b). (SOW §10.6)

43. Advance Directives. Provider and each Contracted Provider shall respect the Advance Directive of a Covered Person and shall not condition the provision of care or otherwise discriminate against a Covered Person based on whether or not the Covered Person has executed an advance directive. In the event Provider or Contracted Provider cannot implement an advance directive on the basis of conscience, that Provider shall immediately notify Company in writing of such objection(s). The notice shall clarify any difference between institution-wide conscience objections and those that may be raised by an individual provider and shall further identify the State legal authority pursuant to NRS 449.628 permitting each objection and describe the range of medical conditions or procedures affected by the conscience objection. (SOW §10.7)

44. Provider Directory. Provider and each Contracted Provider shall promptly upon request of Company provide such information necessary for Company to comply with its obligations relative to maintaining and publishing a provider directory. (10.13)

45. Covered Person Grievances and Appeals. Company's procedures and timeframes relative to Covered Person Grievances and Covered Person Appeals which includes access to the State Fair Hearing system have been established pursuant to 42 CFR 438.402, 438.228 and 457.1260 and are set forth in Company's Provider and Member/Enrollee (Covered Person) Manuals. Company's system as aforesaid includes (i) the Covered Person's right to file Grievances and Appeals at any time and the requirements and timeframes for filing pursuant to 42 CFR 438.402(c) and 42 CFR 457.1260(b); (ii) the availability of assistance with filing per 42 CFR 438.406(a), 438.228(a) and 457.1260(d); (iii) pursuant to 42 CFR 438.414, 42 CFR 438.10(g)(2) and 42 CFR 457.1260(g), the Covered Person's right to request a State Fair Hearing after Company makes a determination on a Covered Person's Appeal that was adverse to the Covered Person; (iv) pursuant to 42 CFR 438.414, 438.10(g)(2) and 457.1260(g), the Covered Person's right to request continuation of benefits during an Appeal or State Fair Hearing although the Covered Person may be liable for the cost of any continued benefits if the Adverse Benefit Determination is upheld; (v) a toll-free number to file verbal Grievances and Appeals per 42 CFR 438.406(a), 42 CFR 438.228(a) and 42 CFR 457.1260(d); and (vi) the Appeal rights of a provider, as determined by the State, to challenge the failure of Company to cover a service. (SOW §10.14)

46. Quality Improvement, Performance and Assessment. Provider and each Contracted Provider shall cooperate with Company's policies and procedures relative to quality improvement, performance and assessment (also known as the Internal Quality Assurance Program (IQAP)). Provider and each Contracted Provider shall allow Company access to the medical records of Covered Persons in furtherance of Company's IQAP. (SOW §11.4.11)

47. Performance Improvement Projects (PIPs). Provider and each Contracted Provider shall cooperate with Company's PIPs. (SOW §11.5)

48. Confidentiality and HIPAA.

a. Provider and each Contracted Provider shall protect confidentiality of patient information and records in accordance with all applicable federal and state laws including, but not limited to, 42 CFR 457.1233(e) and 42 CFR 457.1110. Provider and each Contracted Provider shall comply with Company's policies and procedures relative to confidentiality of patient information including the Health Insurance Portability and Accountability Act (HIPAA) requirements included in 45 CFR Parts 160 and 164. (SOW §11.7)

b. Provider and each Contracted Provider shall encrypt confidential personal data. Any electronic transmission of personal information shall comply with NRS 603A.215(2&3) (RFP Terms and Conditions for Services § 3.5)

49. Utilization Management. Provider and each Contracted Provider shall cooperate with Company's Utilization Management policies and procedures. (SOW §11.10)

50. Critical Incidents. (SOW §11.12)

a. Immediately following their occurrence, Provider and each Contracted Provider shall report in writing to Company, in the form and format reasonably required by Company, the following events of which Provider or Contracted Provider, as applicable, is aware: (i) a major injury or trauma that has the potential to cause prolonged disability or death of a Covered Person and occurs in a facility licensed by the State to provide publicly funded behavioral health services; (ii) an unexpected death of a Covered Person that occurs in a facility licensed by the State to provide publicly funded behavioral health services; (iii) abuse, neglect, exploitation or unexpected death of a Covered Person (not to include child abuse) that is receiving Long-Term Services and Supports (LTSS) (e.g., personal care, nursing facility, private duty nursing or home health services); (iv) unauthorized leave of a mentally ill, sexual or violent offender from a mental health facility or secure Community Transition Facility (i.e., Evaluation and Treatment Centers, ICSS units, Secure Detox Units and Triage Facilities) that accept involuntary admissions; and (v)

any event involving a Covered Person that has attracted or is likely to attract media attention related to their care and/or services covered under the State Contract.

b. The report must include (i) the date of the incident; (ii) a description of the incident; (iii) the name of the facility where the incident occurred or a description of the incident location; (iv) the name(s) and age(s) of Covered Person(s) involved in the incident; (v) the name(s) and title(s) of facility personnel or other staff involved; (vi) the name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement; (vii) the Covered Person's whereabouts at the time of the report if known (e.g., home, jail, hospital, etc.) or actions taken by Provider or Contracted Provider, as appropriate, to locate the Covered Person if their location is unknown; and (viii) actions planned or taken by Provider or Contracted Provider, as appropriate, to minimize harm resulting from the incident.

51. External Quality Review. Provider and each Contracted Provider shall cooperate with the State by providing access to records, facilities and sufficient information for the purpose of an annual external, independent professional review of Company's compliance with all applicable State and federal rules and the requirements of the State Contract. (SOW §11.13.2)

52. Program Integrity. Provider and each Contracted Provider shall comply and cooperate with the following: (SOW §12 et. seq.)

a. All federal and state regulations (including Nevada Medicaid and Nevada Check Up policies) related to "Program Integrity." These include (i) Sections 1128, 1156, and 1902(a)(68) of the Social Security Act; (ii) 42 CFR 438 Subpart H; (iii) 42 CFR 455 Subparts A, B and E; (iv) 42 CFR Parts 1000 through 1008; (v) 42 CFR 456.3, 42 CFR 456.4 and 42 CFR 456.23; (vi) 42 CFR 457.1285; (vii) Nevada Revised Statutes, Chapter 422; (viii) The State's MSM; and (ix) the State's Medicaid and Nevada Check Up billing guidance.

b. In accordance with law including, but not limited to, 42 CFR 438.608(d)(1)(i) and 457.1285, Company will recoup any payments obtained by fraud, waste, abuse or improper billing. A provider shall report any and all overpayments and return same within 60 calendar days after the date of the overpayment has been identified and shall identify in writing the reason for the overpayment pursuant to 42 CFR 438.608(c)(3) and 42 CFR 457.1285.

c. Company's compliance program for detecting and preventing fraud, waste and abuse including *Whistleblower* protection policies and procedures.

d. Promptly report any allegations of fraud, waste, abuse or improper payments to Company.

e. Company will suspend claims payments upon credible allegations of fraud and when instructed by the State. A provider shall promptly upon demand provide Company or the State, as applicable, such information relative to the payment suspension as requested.

f. Reasonably cooperate with any review, investigation or audit undertaken by Company (including its Program Integrity Unit (PIU)).

53. Suspension, Termination and Other Actions (SOW §§12.11 – 12.13).

a. Company will check the OIG website and the State's excluded provider list at least monthly to confirm Provider and/or Contracted Provider has not been sanctioned. If Company is notified or discovers that the OIG, the State, another state Medicaid and/or CHIP agency, or a certification/licensing entity has taken an action or imposed a sanction against a provider, Company will review that provider's performance and take any action or impose any sanction, including disenrollment from the network.

b. Company may terminate or refuse to renew the Agreement if (i) any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP; (ii)

Company determines Provider did not fully and accurately make any required disclosure; (iii) Provider is excluded from participation in federal healthcare programs pursuant to 42 CFR 438.214(d)(1) and/or 42 CFR 457.1233(a); (iv) Provider has been terminated from participation in federal healthcare programs pursuant to 42 CFR438.214(d)(2); (v) Provider has been convicted of certain crimes as described in Section 1128(b)(8)(b) of the Act; (vi) Provider is excluded from participation in any federal health care program under Section 1128 or 1128a of the Act; (vii) Provider is (or is affiliated with a person or entity that is) debarred, suspended or excluded from participating in non-procurement activities under regulations issued under Executive Order no. 12549 or under its implementing guidelines.

c. Provider shall promptly notify Company in writing of any fact or circumstance bearing on the facts and circumstances described in subsection (b) immediately above and such other disclosures relative to its business transactions, ownership and management to allow Company to comply with Company's disclosure obligations to the State.

d. In accordance with 42 CFR 455.106, Provider shall upon request of Company disclose to Company the identity of any person who (i) has ownership or control interest in Provider, or is an agent or managing employee of Provider; and (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or CHIP since the inception of those programs.

54. Information Technology and Management Information System. Where necessary for compliance with the State Contract, Provider and each Contracted Provider shall reasonably cooperate with the IT and MIS systems employed by Company. (SOW §14)

55. Encounter Data and Claims Management. Provider and each Contracted Provider shall submit information and encounter data to Company in the form and format reasonably required by Company. Provider and each Contracted Provider certifies that all such data submitted shall be accurate and timely. Provider and each Contracted Provider shall be registered with the State as a Medicaid/Nevada Check Up Provider. If Provider or Contracted Provider submits claims on paper, a NPI must be included even where that provider has obtained a taxonomy code in addition to its National Provider Identifier (NPI). If the submitting provider is an Atypical Provider, that provider must have an Atypical Provider Identifier as issued by the State's fiscal agent before any payment can be made by Company to that provider. (SOW §§14.3 – 14.5)

56. Electronic Visit Verification (EVV). If Provider or Contracted Provider provides personal care services (PCS), home health, and private duty nursing (PDN) services, or any other services identified by the State or CMS, that provider shall use the EVV system as reasonably directed by Company. Neither Provider nor Contracted Provider shall pass any EVV-related costs to Covered Persons. (SOW §14.6)

57. Reporting Requirements. Provider and each Contracted Provider shall deliver to Company such information and documentation as is required by the State Contract or reasonably requested to enable Company to comply with its reporting obligations to the State. (SOW §16)

58. Record Retention Requirements. If and to the extent Provider or Contracted Provider generates, possesses or maintains the following records, those records shall be retained for a period of no less than 10 years: (SOW §16.10.1)

a. Covered Person Grievance and Appeal records developed in accordance with 42 CFR 438.416;

b. Encounter data and audited financial reports;

c. MLR reports developed in accordance with *Section 13.5* of the State Contract;

d. Data on the basis of which the State determines Company has made adequate provision against the risk of insolvency;

e. Documentation supporting Company's compliance with the Network adequacy and availability and accessibility of services requirements of the State Contract;

f. Disclosures on information and control as required per 42 CFR 455.104 for Company and any Subcontractors;

g. The annual report of overpayment recoveries required per 42 CFR 438.608(d)(3) and *Section 12.10.4*; and

h. Any data and documentation related to Company's obligations pursuant to 42 CFR 438.608 and any prohibited affiliations as specified in 42 CFR 438.610.

Any other data, documentation or information created by Company and any Subcontractors pursuant to the State Contract is subject to the State's record retention period of 10 years as required by 42 CFR 438.3(u) and 42 CFR 457.1201(q).

59. Cooperation-Related Contracts. Provider shall cooperate fully with contractors under any supplemental contracts awarded by the State for work related to the State Contract. (Terms and Conditions for Services §3.3)

60. Non-Discrimination. Pursuant to NRS Chapter 613 in connection with the performance of work under the State Contract, Provider agrees not to unlawfully discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, sexual orientation or age including, without limitation, with regard to employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training including, without limitation, apprenticeship. (Terms and Conditions for Services §3.4)

Attachment A: Medicaid

SCHEDULE B
REGULATORY REQUIREMENTS
Nevada

This schedule sets forth provisions required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person or Provider, is subject to the law cited in the parenthetical at the end of a provision on this schedule, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person or Provider, as applicable.

NV-1 Parties' Responsibilities. The Parties agree that the Agreement, together with its Attachments and the Provider Manual, adequately and completely describes the responsibilities of Company, Provider and each Contracted Provider. (NEV. ADMIN. CODE § 695C.190.1)

NV-2 Hold Harmless.

A. Provider and each Contracted Provider release Covered Persons from liability for the cost of Covered Services rendered pursuant to the Coverage Agreement, except for any nominal payment made by the Covered Person for a service that is not covered under the Coverage Agreement. (NEV. ADMIN. CODE § 695C.190.2)

B. Provider and each Contracted Provider agree that in no event including, but not limited to, nonpayment by the Payor or intermediary (as that term is defined at Nev. Rev. Stat. § 687B.630), insolvency of the Payor or intermediary or breach of the Agreement, shall Provider or Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against, a Covered Person or a person (other than the Payor or intermediary) acting on behalf of the Covered Person for health care services provided pursuant to the Agreement. The Agreement does not prohibit Provider or a Contracted Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the Coverage Agreement, or fees for un-Covered Services delivered on a fee-for-service basis to Covered Persons. The Agreement does not prohibit Provider or a Contracted Provider (except for a provider of health care who is employed full-time on the staff of the health carrier and has agreed to provide health care services exclusively to the health carrier's covered persons and no others) and a Covered Person from agreeing to continue health care services solely at the expense of the Covered Person, as long as Provider or Contracted Provider, as applicable, has clearly informed the Covered Person that the Payor may not cover or continue to cover a specific health care service or health care services. Except as provided herein, the Agreement does not prohibit Provider or Contracted Provider from pursuing any available legal remedy. (NEV. REV. STAT. § 687B.690)

C. In the event of the insolvency of Payor or any applicable intermediary, or in the event of any other cessation of operations of Payor or intermediary, Provider and Contracted Provider will continue to deliver Covered Services to a Covered Person without billing the Covered Person for any amount other than coinsurance, deductibles or copayments, as specifically provided in the Coverage Agreement, until the earlier of (i) the date of the cancellation of the Covered Person's coverage under the network plan pursuant to NEV. REV. STAT. 687B.310 including, without limitation, any extension of coverage provided pursuant to (a) the terms of the contract between the Covered Person and the Payor, (b) NEV. REV. STAT. §§ 689A.04036, 689B.0303, 695B.1901, 695C.1691 and 695G.164, as applicable, or (c) any applicable federal law for Covered Persons who are in an active course of treatment or totally disabled; or (ii) the date on which the contract between Company and Provider would have terminated if Company, Payor or intermediary, as applicable, had remained in operation including, without limitation, any extension of coverage provided pursuant to (a) the terms of the contract between the Covered Person and the Payor, (b) NEV. REV. STAT. §§ 689A.04036, 689B.0303, 695B.1901, 695C.1691 and 695G.164, as applicable, or (c) any applicable federal law for Covered Persons who are in an active course of treatment or totally disabled. (NEV. REV. STAT. § 687B.700)

D. Sections NV-2(B) and NV.2(C) will be construed in favor of the Covered Person, will survive termination of the Agreement regardless of the reason for the termination including, without limitation, the insolvency of a Payor or any applicable intermediary, and will supersede any oral or written contrary agreement between Provider or Contracted Provider and a Covered Person if the contrary agreement is inconsistent with Sections NV-2(B) and NV.2(C), which have been included in the Agreement to comply with the requirements set forth in NEV. REV. STAT. §§ 687B.690 and 687B.700. (NEV. REV. STAT. § 687B.710)

NV-3 Term. As set forth in the "term and termination" provisions of the Agreement, the term of the Agreement is for not less than one year, subject to any right of termination stated in the Agreement. (NEV. ADMIN. CODE § 695C.190.3)

NV-4 Quality Assurance Program. Provider and each Contracted Provider shall participate in the programs of Company and Payor to assure the quality of health care provided to Covered Persons by Provider. (NEV. ADMIN. CODE § 695C.190.4)

NV-5 Provision of Services. Provider and each Contracted Provider shall provide all Medically Necessary services required by the Coverage Agreement and the Agreement to each Covered Person for the period for which a premium has been paid to Payor. (NEV. ADMIN. CODE § 695C.190.5)

NV-6 Insurance. Provider and each Contracted Provider shall provide evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of his or her profession or a reasonable substitute for it as determined by Company. (NEV. ADMIN. CODE § 695C.190.6)

NV-7 Records.

A. Provider and each Contracted Provider, who is a physician, shall transfer or otherwise arrange for the maintenance of the records of Covered Persons who are his or her patients if Provider or Contracted Provider leaves the panel of physicians associated with Company. (NEV. ADMIN. CODE § 695C.190.7)

B. Provider and each Contracted Provider will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Persons and will comply with the applicable state and federal laws related to the confidentiality of medical and health records and the Covered Person's right to see, obtain copies of or amend their medical and health records. (NEV. REV. STAT. § 687B.760)

NV-8 Schedule for Claims Payment. Payors and Provider agree to the schedule for the payment of claims set forth in NEV. REV. STAT. § 695C.185. (NEV. REV. STAT. § 695C.187.1)

NV-9 Amendments. The Agreement may be modified at any time pursuant to a written amendment executed by both Parties. Except as otherwise provided by this "Amendments" section, the Agreement may be modified by Company by giving Provider at least 45 days' written notice of the modification of the schedule of payments, including any changes to the Compensation Schedule applicable to Provider's practice. If Provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If Provider objects in writing to the modification within the 45-day period, the modification will not become effective unless agreed to by both Parties in writing. (NEV. REV. STAT. §§ 689A.035; 689B.015; 689C.435; 695C.125; 695G.430)

NV-10 Continuation of Care. Subject to the conditions described in NEV. REV. STAT. §§ 689A.04036.2(a) and 689A.04036.4 (individual health insurance), those described in NEV. REV. STAT. §§ 689B.0303.2(a) and 689B.0303.4 (group health insurance), those described in NEV. REV. STAT. §§ 695C.1691.2(a) and 695C.1691.4 (coverage by a health maintenance organization) or those described in NEV. REV. STAT. §§ 695G.164.2(a) and 695G.164.4 (coverage by a managed care plan), as applicable, if a Covered Person is receiving medical treatment for a medical condition from Provider or Contracted Provider and the Agreement, or Provider's or Contracted Provider's participation under the Agreement or in a particular Product, is terminated during the course of the medical treatment,

such provider agrees (a) to provide medical treatment with regard to the Covered Person under the terms of the Agreement including, without limitation, the rates of payment for providing medical service, as those terms existed before such termination; (b) to not to seek payment from the Covered Person for any medical service provided by that provider that the provider could not have received from the Covered Person if that provider were still a Participating Provider; and (c) the coverage required by this "Continuation of Care" section will be provided until the later of the 120th day after the date of termination or, if the medical condition is pregnancy, the 45th day after (i) the date of delivery; or (ii) if the pregnancy does not end in delivery, the date of the end of the pregnancy. (NEV. REV. STAT. §§ 689A.04036; 689B.0303; 695C.1691; 695G.164)

NV-11 Notice of Termination or Insolvency.

A. Either party must give the other party at least 90 days prior notice of termination of the Agreement. (NEV. ADMIN. CODE § 689B.160)

B. Written notice will be provided to Provider or Contracted Provided, as applicable, as soon as practicable with respect to a Payor in the event (i) that a court determines such Payor or any applicable intermediary to be insolvent; or (ii) of any other cessation of operations of a Payor or any applicable intermediary. (NEV. REV. STAT. § 687B.720)

NV-12 Intermediary Contracts. If Provider is a Delivery System Intermediary that accepts risk and assumes financial liability from Company for any Covered Services provided to Covered Persons, this "Intermediary Contracts" section applies. A "***Delivery System Intermediary***" has the definition set forth at NEV. ADMIN. CODE § 695C.025, which is as follows, with certain exclusions: a partnership, association, corporation or other legal entity which enters into a contract with a health maintenance organization to provide health care services, including an entity jointly owned and controlled by a hospital and a physician and an entity primarily owned and controlled by physicians. The Contracted Providers with which the Delivery System Intermediary contracts to furnish health care services to Covered Persons of the health maintenance organization are referred to in this "Intermediary Contracts" section as "***DSI Providers***."

A. Provider shall provide to Company a written report, at least quarterly, which identifies the total payments made or owed by Provider to DSI Providers in sufficient detail to enable Company or Payor and the Nevada Commissioner of Insurance to determine whether the payments have been made in a timely manner and in compliance with the applicable provisions of Nevada law. Company will review such reports. (NEV. ADMIN. CODE §§ 695C.505.1 - 695C.505.2)

B. Company or Payor and the Nevada Commissioner of Insurance are authorized, upon reasonable prior notice, to audit, inspect and copy Provider's books, records and any other evidence of its operations to determine whether it has complied with the applicable provisions of Nevada law, including any regulations adopted pursuant thereto. (NEV. ADMIN. CODE §§ 695C.505.3- 695C.505.4)

C. Provider shall maintain working capital in the form of cash or equivalent liquid assets in an amount equal to at least the lesser of (a) $500,000; or (b) the operating expenses paid for two months, calculated by using the monthly average of the operating expenses for the prior six months. As used in this subsection, "operating expenses" means the expenses of Provider, except money paid or owed to DSI Providers for health services provided pursuant to the Agreement. (NEV. ADMIN. CODE § 695C.505.5)

D. Payor will assume financial responsibility for any Clean Claims that are presented for payment to Provider by DSI Providers for Covered Services and not paid by Provider as provided by law and the Agreement. (NEV. ADMIN. CODE § 695C.505.6)

E. Each contract with a Covered Person will be entered into directly with Company or Payor, and not with Provider. (NEV. ADMIN. CODE § 695C.505.7)

F. The responsibilities that Provider assumes are set forth in the Agreement. Provider shall comply with the requirements of the quality assurance programs established by Company or Payors pursuant to NEV. ADMIN. CODE § 695C.400. (NEV. ADMIN. CODE § 695C.505.8)

G. Company shall review, not less than quarterly, Provider's compliance with the provisions of the Agreement. (NEV. ADMIN. CODE § 695C.505.9)

H. If Provider provides health care services on behalf of more than one entity, Provider shall maintain separate records for each entity. (NEV. ADMIN. CODE § 695C.505.10)

I. Company may terminate its relationship with any DSI Provider with appropriate notice as specified in the Agreement. (NEV. ADMIN. CODE § 695C.505.11)

J. Each contract between Provider and a DSI Provider will be assigned to Company if Provider fails to pay for Covered Services. (NEV. ADMIN. CODE § 695C.505.12)

K. Any DSI Provider who has a financial interest of more than 10 percent in Provider is prohibited from participating on a utilization review committee or taking any action to change an authorization made by the utilization review committee or an authorized physician. (NEV. ADMIN. CODE § 695C.505.13)

L. Provider shall provide Company, the Commissioner and the State Board of Health with a list of the names of those persons who have a financial interest in Provider and the amount of each person's financial interest. Any change in the financial interests of Provider must be reported to Company, the Commissioner and the State Board of Health within 10 working days after the change. (NEV. ADMIN. CODE § 695C.505.14)

M. Provider is prohibited from assigning the Agreement to any other organization without the prior approval of Company, which is subject to the filing of a material modification of operation pursuant to NEV. REV. STAT. § 695C. 140. (NEV. ADMIN. CODE § 695C.505.15)

N. If Provider hires a company to manage its affairs, Provider or that company shall provide Company with a surety bond or deposit of cash or securities in the amount of $250,000 for the faithful performance of the obligations of the company. (NEV. ADMIN. CODE § 695C.505.16)

O. If, pursuant to the Agreement, Provider evaluates the credentials of Participating Providers, Provider shall comply with the requirements established by Company for evaluating the credentials of providers. (NEV. ADMIN. CODE § 695C.540)

NV-13 Notice of Administrative Policies and Programs. The Agreement and the Provider Manual set forth the responsibilities of Provider and each Contracted Provider with respect to applicable administrative policies and programs, which include, without limitation, compliance with administrative policies and programs concerning terms of payment, utilization review, quality assessment and improvement, credentialing, procedures for grievances and appeals, requirements for data reporting, requirements for timely notice to Company in the practices of Provider and each Contracted Provider, requirements for confidentiality and any applicable federal or state programs. (NEV. REV. STAT. § 687B.730)

NV-14 Notice Regarding Cost-Sharing Amounts and Non-Covered Services. Provider and each Contracted Provider must collect applicable coinsurance, copayments or deductibles from a Covered Person pursuant to the Coverage Agreement. Provider and each Contracted Provider must notify a Covered Person of the personal financial obligations of the Covered Person for health care services that are not Covered Services. (NEV. REV. STAT. § 687B.790)

NV-15 Prohibited Acts.

A. Company may not terminate the Agreement, demote, refuse to contract with or refuse to compensate a Provider or Contracted Provider solely because such provider, in good faith, (i) advocates in private or in public on behalf of a patient; (ii) assists a patient in seeking reconsideration of a decision by Company to deny coverage for a health care services; or (iii) reports a violation of law to an appropriate authority. (NEV. REV. STAT. § 695G.410)

B. Company may not penalize Provider or Contracted Provider for, in good faith, reporting to state or federal authorities any act or practice by Company that jeopardizes the health or welfare of a Covered Person. (NEV. REV. STAT. § 687B.800)

C. Company may not offer an inducement to Provider or Contracted Provider that would encourage or otherwise incent that provider to deliver health care services to a Covered Person that are less than those that are Medically Necessary. (NEV. REV. STAT. § 687B.740)

D. Company may not prohibit Provider or a Contracted Provider from (i) discussing any specific treatment option or all treatment options with a Covered Person irrespective of the position of Company on the treatment options; (ii) advocating on behalf of a Covered Person within any utilization review process or any process for grievances or appeals established by Payor or a person contracting with Payor; or (iii) advocating on behalf of a Covered Person in accordance with any rights or remedies available under applicable state or federal law. (NEV. REV. STAT. § 687B.750)

E. Except as otherwise set forth in the Agreement, Company and Provider are prohibited from assigning or delegating the rights and responsibilities of either party under the Agreement without the prior written consent of the other Party. (NEV. REV. STAT. § 687B.770)

NV-16 All Covered Persons. Provider and each Contracted Provider is responsible for furnishing Covered Services to all Covered Persons without regard to the participation of the Covered Person under a Coverage Agreement as a private purchaser or in a publicly financed program of health care services. This section does not apply to circumstances when Provider or Contracted Provider should not render services due to limitations arising from lack of training, experience or skill, or licensing restrictions. (NEV. REV. STAT. § 687B.780)

NV-17 Network Plans. Any provision set forth in the Agreement or this schedule that conflicts with the requirements of NEV. REV. STAT. §§ 687B.600 to 687B.850 will be superseded by those Nevada requirements. The Agreement specifies all provisions of the Agreement and all documents incorporated by reference into the Agreement. Company shall provide timely notice, as defined in the Agreement or the Provider Manual, to Provider of any changes to the Agreement or documents incorporated by reference into the Agreement that would result in a material change in the Agreement. A change that is "material" is one that Company considers, as such, in its reasonable discretion. (NEV. REV. STAT. § 687B.830)

NV-18 Access to Services and Contractual Discounts. Company may enter into an agreement with a third party allowing the third party to obtain the rights and responsibilities of Company under the Agreement as if the third party were Company. Such third party will be contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement. (NEV. REV. STAT. § 687B.694.1)

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
FACILITY AND PROFESSIONAL SERVICES
RURAL HEALTH CLINIC

Battle Mountain General Hospital

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Outpatient Services. The maximum compensation for facility and professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for facility and professional Covered Services is 100% (the "Percentage"): (a) for the Encounter rate, is the Percentage of the all-inclusive Medicaid Prospective Payment System ("PPS"); and, if applicable, (b) for services not included and billed separately from the PPS Encounter rate, is 100% of the Nevada Medicaid fee schedule. If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

Additional Provisions:

1. Adjustment of Rates. Provider agrees to provide Payor with a copy of all Fiscal Intermediary Rate Letters applicable to Provider within 30 days of Provider's receipt of such Letter. The contract rates shall be updated by Payor within 60 days after Provider provides Payor with the Fiscal Intermediary Rate Letter then in effect. Provider shall not have the right to request any corrective adjustments to claims incurred prior to the date that is 60 days after Provider provided Payor with the Fiscal Intermediary Rate Letter then in effect.

Commented [LB1]: Provider receives a rate later.

~~1.~~2. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

~~2.~~3. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee

Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

~~3.~~4. Encounter Updates. Updates to Contracted Provider-specific Encounter rates shall become effective ("Encounter Update Effective Date") as of the later of: (i) the first day of the month following thirty (30) days after Payor receives notification from Contracted Provider of such Encounter rate updates; or (ii) the effective date of such code updates, as determined by the State. Claims processed prior to the Encounter Update Effective Date shall not be reprocessed to reflect any Encounter rate updates.

~~4.~~5. Primary Contact Billing. If Covered Person sees more than one health care professional during an encounter, the NPI billed on the CMS-1500 claim form, or its successor, should indicate the primary contact. The primary contact is defined as the health care professional who spends the greatest amount of time with the client during services.

~~5.~~6. Provider Type. Services must be provided by the appropriate provider type or specialty as defined in the Provider Manual. The Allowed Amount may be reduced based on the Contracted Provider's specialty, provider type, licensing/certifications or education as set forth in the Provider Manual.

~~6.~~7. Modifiers. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Modifiers must be used as appropriate and be specific to primary contact, as applicable.

~~7.~~8. Claim Form - Professional. Contracted Provider when submitting outpatient or professional claims (billed on a CMS-1500 claim form, or its successor) spanning multiple dates of service: (i) is required to identify each date of service; and (ii) must contain modifiers as identified in the Provider Manual. Applicable modifiers should be placed in the first modifier field for claims payment.

~~8.~~9. Authorizations. Authorization requirements are as defined in this Agreement or in the Provider Manual. Service limits, unless specified in this Compensation Schedule, are as defined by the Provider Manual.

~~9.~~10. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Payor.

~~10.~~11. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

~~11.~~12. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments. The Allowed Amount shall be adjusted periodically according to the

reimbursement methodologies established in the rate letters produced by the Nevada Division of Health Care Financing and Policy for Critical Access Hospitals and Rural Health Clinics.

Commented [LB2]: Adding language provider requested to match the rate letter.

2. **Allowable Charges** means the Contracted Provider's charges that qualify as Medically Necessary Covered Services and are eligible for reimbursement under the Plan.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 2
COMPENSATION SCHEDULE
FACILITY SERVICES
SKILLED NURSING

Battle Mountain General Hospital

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein, less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for skilled nursing Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for skilled nursing Covered Services is ~~the lesser of (i) Allowable Charges or (ii)~~ 100% of the ~~Payor's~~ Nevada Medicaid fee schedule in effect on the date of service. ~~:~~

Additional Provisions:

1. Level of Care and Description of Care. Reimbursement under this Compensation Schedule is conditioned on prior authorization at the applicable Level of Care (I - IV as set forth below). The medical decision criteria used to support the skilled Levels of Care are based on Medical Necessity for Covered Services rendered to a Covered Person on the date of service and such criteria may be updated from time to time in accordance with applicable professional, regulatory and industry standards. Authorization of level of care is not a guarantee of payment. Claims payments shall be subject to adjustment by Payor based on retrospective review and confirmation of Medical Necessity.

Commented [LB3]: Adding description of the SNF Levels requested by Provider.

Level of Care	Description
Level I	***Skilled Care*** reflects minimal skilled nursing intervention. Co-morbidities do not complicate treatment plan. Assessment of vitals and body systems required one to two times per day.
Level II	***Comprehensive Care*** reflects moderate to extensive skilled nursing intervention. Active treatment of condition and related co-morbidities. Assessment of vitals and body systems required two to three times per day.
Level III	***Complex Care*** reflects moderate to extensive skilled nursing intervention. Active medical care and treatment of condition and related co-morbidities. Potential for co-morbidities to affect the treatment plan. Assessment of vitals and body systems required three to four times per day.
Level IV	***Intensive Care*** reflects extensive skilled nursing and technical intervention. Active medical care and treatment of condition and related co-morbidities. Potential for co-morbidities to affect the treatment plan. Assessment of vitals and body systems required four to six times per day. Five or more hours of skilled nursing care and/or three or more hours of therapeutic intervention. Level IV intensive care conditions include but are not limited to Ventilator Dependent, Wandering Dementia Program, Behavioral Health, Dialysis Services Program, Troublesome Behavior, Dementia, High Acuity Dementia, Trach Non Vent, Bariatric Unit, Complex Subacute, and High Acuity Non-Dementia, and may be changed from time to time by Payor.

~~1. Level of Care. Reimbursement under this Compensation Schedule is conditioned on prior authorization at the applicable "Level of Care" based on nationally accepted clinical care guidelines and Health Plan's clinical coverage guidelines. The medical decision criteria used to support the skilled Levels of Care are based on Medical Necessity for Covered Services rendered to a Covered Person on the date of service and such criteria may be updated from time to time in accordance with applicable professional, regulatory and industry standards. Authorization of level of care is not a guarantee of payment. Claims payments shall be subject to adjustment by Payor based on retrospective review and confirmation of Medical Necessity.~~

2. Multiple Dates of Service on a Single Claim Form. Contracted Provider is required to identify each date of service when submitting claims spanning multiple dates of service.

3. National Provider Identifier/Effect of Exclusion or Suspension. Notwithstanding anything to contrary contained herein, Payor shall not pay, and shall have no obligation to pay, any claim submitted by a Contracted Provider based on an order or referral that does not include the National Provider Identifier ("NPI") for the ordering or referring physician. Neither a Payor nor Covered Person shall have any obligation to pay any claim submitted by a Contracted Provider if the Contracted Provider has been excluded or suspended from participation in Medicare, Medicaid, CHIP or any other federal or state health care program.

4. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of (i) the first day of the month following 60 days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates; (ii) the effective date of such code updates as determined by such governmental agency; or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

5. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e., the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of (i) the first date on which Payor is reasonably able to implement the update in the claims payment system or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

6. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in the Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

7. Payment Under This Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to, UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claims processing policies.

~~7.~~8. Adjustment of Rates. Provider agrees to provide Payor with a copy of all Fiscal Intermediary Rate Letters applicable to Provider within 30 days of Provider's receipt of such Letter. The contract rates shall be updated by Payor within 60 days after Provider provides Payor with the Fiscal Intermediary Rate Letter then in effect. Provider shall not have the right to request any corrective adjustments to claims incurred prior to the date that is 60 days after Provider provided Payor with the Fiscal Intermediary Rate Letter then in effect.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to the Agreement or its Attachments. The Allowed Amount shall be adjusted periodically according to the reimbursement methodologies established in the rate letters produced by the Nevada Division of Health Care Financing and Policy for Critical Access Hospitals and Rural Health Clinics.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 3
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES

Battle Mountain General Hospital

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is ~~is the lesser of: (i) Allowable Charges; or (ii)~~ 100% of the ~~Payor's~~ Nevada Medicaid fee schedule in effect on the date of service.~~.~~

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

6. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

7. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments. The Allowed Amount shall be adjusted periodically according to the reimbursement methodologies established in the rate letters produced by the Nevada Division of Health Care Financing and Policy for Critical Access Hospitals and Rural Health Clinics.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 4
COMPENSATION SCHEDULE
CRITICAL ACCESS HOSPITAL SERVICES

Battle Mountain General Hospital

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

Inpatient Services. The maximum compensation for Covered Services rendered to a Covered Person during an inpatient stay shall be the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient Covered Services is ~~the lesser of: (i) Allowable Charges; or (ii)~~ 100% of the ~~Payor's~~ Nevada Medicaid fee schedule in effect on the date of service.~~-~~ Such payment shall be inclusive of all services rendered.

Outpatient Services. The maximum compensation for outpatient Covered Services is the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for outpatient Covered Services is ~~the lesser of (i) Allowable Charges; or (ii)~~ 100% of the Nevada ~~Payor's~~ Medicaid fee schedule in effect on the date of service. Such payment shall be inclusive of all services rendered.

Additional Provisions:

1. Adjustment of Rates. Provider agrees to provide Payor with a copy of all Fiscal Intermediary Rate Letters applicable to Provider within 30 days of Provider's receipt of such Letter. The contract rates shall be updated by Payor within 60 days after Provider provides Payor with the Fiscal Intermediary Rate Letter then in effect. Provider shall not have the right to request any corrective adjustments to claims incurred prior to the date that is 60 days after Provider provided Payor with the Fiscal Intermediary Rate Letter then in effect.

~~1.~~2. Disproportionate Share Hospital ("DSH"), Direct Graduate Medical Education ("GME"), Indirect Medical Education ("IME") or any other "add-on." Notwithstanding anything to the contrary contained herein, in no event will the Contracted Rate, Allowable Charges or any other cost calculations hereunder include DSH, GME, IME or any other "add-on" for any inpatient admission.

~~2.~~3. Cost-to-Charge Ratio. Payment for outpatient services as indicated above shall constitute the final payment from Payor to Contracted Provider. No reconciliation or settlement of the Contracted Provider's Cost-to-Charge Ratio shall occur at year-end.

~~3.~~4. Critical Access Hospital Status. In the event Contracted Provider no longer meets the current criteria set forth by CMS for being designated as a Critical Access Hospital ("CAH") or is no longer designated by CMS as a CAH, Contracted Provider shall immediately notify Payor in writing of the failure to meet criteria or loss of designation, and as a result, effective as of the date Contracted Provider ceases to hold such designation or such later date as specified by Payor in its sole discretion, the rates and payment methodology of the terms of this Compensation Schedule shall not apply to Covered Services rendered by Contracted Provider to Covered

Persons. Upon notice to Payor of Contracted Provider's loss of CAH status, the Parties shall negotiate in good faith for a period of sixty (60) days for the purpose of agreeing upon non-CAH Contracted Provider rates.

~~4.~~5. Application of 72-Hour Rule. Payments made to any Contracted Provider for inpatient Covered Services shall constitute payment for all such Contracted Provider's charges relating to a Covered Person's pre-admission testing and procedures occurring within seventy-two (72) hours prior to an admission, including, but not limited to, charges for laboratory services, pathology services, radiology services, and medical/surgical supplies. If the admitting hospital is a CAH, the payment window policy does not apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window. The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.

~~5.~~6. Admissions for Same or Related Diagnoses. Inpatient admissions for the same or a related diagnoses occurring within thirty (30) days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

~~6.~~7. Hospital-Acquired Conditions and Provider Preventable Conditions. Payment to a Contracted Provider under this Compensation Schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a Contracted Provider for "Hospital-Acquired Conditions" and for "Provider Preventable Conditions" as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

~~7.~~8. Never Events. Each Contracted Provider shall use best efforts to comply with applicable state and federal reporting or other requirements relating to Never Events and/or Serious Adverse Events, as the applicable term is defined by the National Quality Forum or by state or federal law. Contracted Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Payor, Company or Covered Person for any charges associated with Never Events and/or Serious Adverse Events. To the extent a Contracted Provider receives any payment in connection with a Never Event or Serious Adverse Event, the Contracted Provider shall promptly refund such amount.

~~8.~~9. Chargemaster Updates. Each Contracted Provider shall provide Payor with at least sixty (60) days written notice prior to the effective date of any increase to the Contracted Provider's Chargemaster ("Chargemaster Increase"). Such written notice shall include the effective date of the Chargemaster Increase and the percentage increase (the "Chargemaster Increase Percentage") for each of the following categories: (i) inpatient charges, (ii) outpatient charges, and (iii) all charges (i.e., the aggregate percentage increase for both inpatient and outpatient charges).

Payor and each Contracted Provider agree that, with respect to payments made hereunder by Payor under an Allowable Charges reimbursement methodology, the combined Chargemaster Increases for each consecutive twelve-month period during the term of this Attachment will not exceed three percent (3%) (the "Chargemaster Limit"). Where the combined Chargemaster Increases for a specific Covered Service exceed the Chargemaster Limit during such time period, the current Allowable Charge percentage applicable to such Covered Service will be adjusted to the percentage represented by the following formula, rounded to the second decimal point:

$$\frac{\text{Current Percentage of Allowable Charges}}{1 + (\text{Chargemaster Increase Percentage} - \text{Chargemaster Limit})}$$

Payor will give written notice to the Contracted Provider of any adjustments to payments made pursuant to the above, along with supporting calculations, and such adjustments will be effective as of the effective date of the Chargemaster Increase that causes the total Chargemaster Increases for the applicable consecutive twelve-month period to exceed the Chargemaster Limit. Unless Provider notifies Health Plan in writing of its objection to such adjustment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall

be deemed to have accepted the notice and the adjustment will become effective as of the effective date of the Chargemaster Increase.

The Contracted Provider shall provide Payor with a copy of the Contracted Provider's Chargemaster in a mutually agreed upon format at the following times: (i) as of the Effective Date of this Agreement, (ii) within sixty (60) days of the Contracted Provider's notice to Payor of any Chargemaster Increase, and (iii) at any time upon Payor's written request. If at any time Payor determines, based on review of the Chargemaster and/or claims or other data, that (a) the Contracted Provider has failed to provide written notice of a Chargemaster Increase as required above, or (b) the Chargemaster Increase Percentage for which Payor received notice from the Contracted Provider was not the Chargemaster Increase Percentage implemented by the Contracted Provider, Payor may retroactively adjust payments to the Contracted Provider using the methodology set forth above and may recoup as overpayments the difference between the amounts paid to the Contracted Provider for Covered Services and the amounts that would have been paid to Contracted Provider for Covered Services had the payment adjustments as set forth herein been made.

~~9.~~10. Provider-Based Billing. Provider-Based Billing (as defined herein) will not be reimbursed under this Compensation Schedule as they are included as part of the compensation for professional fees under this Agreement. Neither the Payor nor Covered Person shall be responsible for such Provider-Based Billing. "Provider-Based Billing" are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and include but are not limited services billed using Revenue Codes 0510-0519.

~~10.~~11. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

~~11.~~12. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

~~12.~~13. Encounter Payment. Encounter is defined as the same treatment for the same diagnosis in the same treatment setting without being discharged, released, or transferred within the same 48 hour period.

~~13.~~14. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

~~14.~~15. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS

guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amounts** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments. The Allowed Amount shall be adjusted periodically according to the reimbursement methodologies established in the rate letters produced by the Nevada Division of Health Care Financing and Policy for Critical Access Hospitals and Rural Health Clinics.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable

4. **Cost-to-Charge Ratio** or **CCR** means the Contracted Provider-specific cost-to-charge ratios as defined by CMS that are applied to the Allowed Amount.

5. **Per Diem** means a pricing method (i) that, for an inpatient stay, is based on each "Inpatient Day" of an inpatient stay and includes all Covered Services provided to a Covered Person during the inpatient stay, and (ii) that, for outpatient or intermediate services, includes all Covered Services provided to a Covered Person for one calendar day of service. For purposes hereof, an "Inpatient Day" means a calendar day when a Covered Person receives Covered Services as a registered bed patient; to qualify as an Inpatient Day, the Covered Person must be present at the midnight census.