

## **Fifth Amendment to Hospital Services Agreement**

WHEREAS, Cigna HealthCare of California, Inc. ("CHC") and Cigna Health and Life Insurance Company ("CHLIC") collectively "Cigna" ("Cigna") and the County of Ventura, which includes among its component parts, the Ventura County Medical Center ("VCMC") and the Santa Paula Hospital, a campus of VCMC (collectively referred to as "Hospital") have executed a Hospital Services Agreement dated December 1, 2006 (the "Agreement"); and

WHEREAS, Cigna and Hospital mutually desire to amend the Agreement;

NOW, THEREFORE, pursuant to the Amendment Sections of the Agreement and in consideration of the mutual promises contained herein, the parties hereby agree as follows:

1. The effective date of this Amendment is August 1, 2024 ("Amendment Effective Date") through July 31, 2026 unless the parties mutually agree otherwise in writing. Both parties agree that the Agreement cannot be terminated for the purpose of negotiating a change in contracted rates for the period of August 1, 2024 through July 31, 2026.
2. Rate Exhibit A2 of the Agreement is replaced in its entirety by the attached Exhibit A1 as of the Amendment Effective Date. The attached Exhibit A1 effective August 1, 2024 will then be replaced with the Attached Exhibit A2 effective August 1, 2025.
3. The following Section 1.4 shall be deleted in its entirety and replaced with the following as of the Amendment Effective Date:

**Cigna Affiliate**

Means any subsidiary or affiliate of The Cigna Group.

4. Except as modified herein, the Agreement remains in full force and effect. To the extent of a conflict between this Amendment and the Agreement, this Amendment shall control.
5. Any and all capitalized terms not defined herein shall have the same meaning as in the Agreement.

IN WITNESS WHEREOF the parties have caused this Amendment to be executed by their duly authorized representatives below.

AGREED AND ACCEPTED BY:

**Hospital**

**Cigna**

County of Ventura

Cigna HealthCare of California, Inc.  
("CHC") and Cigna Health and Life  
Insurance Company ("CHLIC") collectively  
"Cigna"

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Signature

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Signature

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Printed Name

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Printed Name

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Title

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Title

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Date Signed

\_\_\_\_\_  
Date Signed

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Federal Tax ID

\_\_\_\_\_  
National Provider Identifier

# Cigna

## Exhibit A1

### Fee Schedule and Reimbursement Terms

**This Rate Exhibit applies to the following Cigna Benefit Plans:**

**HMO Benefit Plans: Yes**

**Network Benefit Plans: Yes**

**Open Access Plus Benefit Plans: Yes**

**All Other: Yes**

This is an Exhibit to an Agreement between:

Provider: Ventura County Medical Center and Santa Paula Hospital

Cigna Party: Cigna HealthCare of California, Inc. ("CHC") and Cigna Health and Life Insurance Company ("CHLIC") collectively "Cigna"

Effective Date of Base Agreement: December 1, 2006

This Rate Exhibit:

Applies to: The County of Ventura d.b.a Ventura County Medical Center and Santa Paula Hospital

Federal Tax ID(s): 956000944

National Provider Identifier(s): 1629167457

Effective Date: August 1, 2024      Effective End Date: July 31, 2025

Payor will pay Hospital in accordance with the fee schedule and the reimbursement terms set forth herein for Covered Services rendered to Participants. Except where otherwise indicated, Cigna may adjust coding in its systems to remain consistent with the parties' intent to reimburse for the services listed in this Exhibit.

#### **I. Inpatient Services**

Hospital shall accept as full and final payment for all Covered Services provided to Participants who are admitted as inpatients the lesser of 97% of billed charges for the inpatient stay or the reimbursement specified in this Exhibit. Such reimbursement covers all inpatient Covered Services, including but not limited to, semi-private room and board, operating room, the services of nurses and other Hospital employees and permitted subcontractors, all supplies excluding personal convenience items, laboratory management and interpretation of test results, all ancillary services, pharmacy, and other Medically Necessary services provided to a Participant. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Hospital. References to DRG's in the inpatient chart below shall mean MS-DRG's.

The MS-DRG Case Rate for all inpatient admissions will be the conversion price, \$16,500, multiplied by the relative weights for each MS-DRG.

Inpatient Covered Services rendered to a Participant by multiple hospitals or facilities within the same hospital system and related to the same admission, including intra-hospital transfers, shall be considered as a single inpatient admission. Hospital agrees to bill and shall only be paid a single MS-DRG Case Rate that shall cover all Covered Services rendered to such Participant by all hospitals and facilities within the same hospital system.

Reimbursement for covered transplant services (other than corneal transplants) as well as Chimeric Antigen Receptor T cell therapy (CAR-T) MS-DRG 018 are specifically excluded from this Exhibit. Such services will be reimbursed according to Hospital's agreement with Cigna LifeSOURCE Transplant Network®, if applicable.

<b>Description</b>	<b>Coding</b>	<b>Reimbursement</b>
Room & Board-Hospital at Home	Revenue Code: 161	Services not available as of contract effective date. If service becomes available, Section III. E. applies.

Vaginal Delivery – Mother Only Case Rate - Days 1 through 2	MS-DRG Codes: 768, 796, 797, 798, 805, 806, 807	\$4,239.00 Per Diem
C-Section Delivery – Mother Only Case Rate – Days 1 through 3	MS-DRG Codes: 783, 784, 785, 786, 787, 788	\$6,509.00 Per Diem
Maternity Additional Days	MS-DRG Codes: 768, 783, 784, 785, 786, 787, 788, 796, 797, 798, 805, 806, 807	\$2,271.00 Per Diem
Newborn Level I (Normal/Boarder)	Revenue Codes: 170, 171, 179	\$1,135.00 Per Diem
Newborn Level II (Premature)	Revenue Code: 172	\$3,936.00 Per Diem
Newborn Level III (Sick Neonate)	Revenue Code: 173	\$4,390.00 Per Diem
Newborn Level IV (NICU)	Revenue Code: 174	\$5,147.00 Per Diem

Rehabilitation Unit	Revenue Codes: 118, 128, 138, 148, 158	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level I	Revenue Codes: 190, 191, 199	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level II	Revenue Code: 192	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level III	Revenue Code: 193	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level IV	Revenue Code: 194	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Detoxification Unit	Revenue Codes: 116, 126, 136, 146, 156	\$2,950.00 Per Diem
Hospice - Room & Board and Nursing Services (Non-Respite)	Revenue Codes: 115, 125, 135, 145, 155, 656	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Transplants		Reimbursed under Cigna Lifesource contract if applicable
Trauma Services, Level II	Revenue Code: 681-684, 689	\$15,500.00 Per Diem

A. Inpatient Exclusions

If Hospital's total Billed Charges for a revenue code listed in the chart below for Covered Services rendered with respect to a particular Participant's continuous inpatient confinement exceed the threshold referenced in the chart below, Hospital shall be reimbursed separately for such revenue code as specified in the chart below, less applicable Copayments, Coinsurance and Deductibles. Hospital's total Billed Charges for the revenue codes listed in the chart below will be excluded from any and all calculations of reimbursement based upon the lesser of 97% of billed charges or the contract rate, whether or not Hospital's Billed Charges for such revenue codes exceeds the threshold in the chart below.

Prosthetics and Orthotics	Revenue Code: 274	Threshold for each revenue code: \$900.00 Reimbursement: 30.0% Reduction from Billed Charges
Pacemaker Supplies	Revenue Code: 275	Threshold for each revenue code: \$900.00 Reimbursement: 30.0% Reduction from Billed Charges
Implants	Revenue Code: 278	Threshold for each revenue code: \$900.00 Reimbursement: 30.0% Reduction from Billed Charges
Drugs Requiring Detailed Codes	Revenue Code: 636	Threshold for each revenue code: \$1,236.00 Reimbursement: 46.7% Reduction from Billed Charges
Inpatient Dialysis	Revenue Codes: 800, 801, 802, 803, 804, 809	\$2,500.00 Per Treatment

Dialysis Services billed with Revenue Codes 800-803 as stated in Inpatient Exclusions will be reimbursed at the rates set forth above. Claim submissions for more than one dialysis treatment per day may be appealed by the Hospital to obtain reimbursement. Detailed clinical notes must

accompany the appealed claim with a copy to the Cigna Medical Director and Contracting Department to be considered for payment. Hospital understands that Cigna’s claim system cannot be automated to accommodate multiple dialysis treatments in one day, and that Cigna will work with Hospital to reimburse for the medically qualified dialysis treatments.

**B. Stop Loss**

1. Notwithstanding the foregoing, if a particular Participant’s continuous acute inpatient confinement exceeds 13 days (the “Stop Loss Day Threshold”), Hospital will be reimbursed for Covered Services rendered to such Participant at the applicable case rate/per diem, less applicable Copayments, Coinsurance and Deductibles, through the date the Stop Loss Day Threshold is met (the “Threshold Date”) and at \$4,500.00 per day, less applicable Copayments, Coinsurance and Deductibles, for Covered Services rendered after Threshold Date with respect to the same continuous acute inpatient confinement.
2. The following inpatient services as determined by the derived CMS MS-DRG will not be included in stop loss: OB, NICU, TRAUMA. Payment in full for these services will be at the inpatient services and rate(s) listed above in this rate exhibit.
3. Hospital shall only be entitled to the additional reimbursement provided pursuant to this stop loss provision if, within (180) days after the date of the applicable Participant’s discharge from Hospital, Hospital provides Cigna with an itemized bill for its total Billed Charges for Covered Services rendered through the Threshold Date and through the date of discharge with respect to the applicable Participant.

**II. Outpatient Services**

Hospital shall accept as full and final payment for all Covered Services provided to Participants on an outpatient basis of the lesser of 97% of billed charges for the episode of care or the reimbursement specified in this Exhibit. Such reimbursement covers all outpatient Covered Services, including but not limited to, all facility services, the services of all nurses and other Hospital employees and permitted subcontractors, laboratory management and interpretation of test results, ancillary, diagnostic, and pharmacy charges, and other Medically Necessary services provided in relation to the outpatient categories specified below. The applicable rate includes all Medically Necessary services that Hospital customarily provides to outpatients. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Hospital.

Description	Coding	Reimbursement***
Ambulatory Surgery – Cigna Grouper Schedule*	Revenue Codes: 360, 361, 369, 490, 499, 750, 761, 790;	

<b>Description</b>	<b>Coding</b>	<b>Reimbursement***</b>
Grouper 1	CPT Codes: 10004-36299, 36420-69999, applicable CPT Category III surgical T codes, and applicable HCPCS surgery codes unless specified below.  Note: only surgical CPT/HCPCS codes billed with these Revenue Codes will be reimbursed at the rates in this table.	\$1,094.00 Case Rate
Grouper 2		\$1,597.00 Case Rate
Grouper 3		\$2,010.00 Case Rate
Grouper 4		\$2,566.00 Case Rate
Grouper 5		\$3,002.00 Case Rate
Grouper 6		\$3,722.00 Case Rate
Grouper 7		\$4,400.00 Case Rate
Grouper 8		\$4,800.00 Case Rate
Grouper 9		\$6,500.00 Case Rate
Grouper 79		\$134.00 Case Rate
Default Rate**	\$2,900.00 Case Rate	

Cardiac Catheterization Lab Services	Revenue Code: 481	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
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Observation	Revenue Code: 762	48.6% Reduction from Billed Charges up to \$7,163.00 Maximum
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Emergency Department Services	Revenue Codes: 450, 451, 452, 459	48.6% Reduction from Billed Charges up to \$3,104.00 Maximum
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Urgent Care	Revenue Code: 456	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
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Urgent Care Services (Free Standing Center)	Revenue Codes: 516, 526	\$220.00 Per Visit
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Clinic Visit	Revenue Codes: 510-515; 517; 519; 520-525; 527-529	\$220.00 Per Visit
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Chemotherapy Administration Services	Revenue Codes: 331, 332, 335	48.6% Reduction from Billed Charges up to \$1,487.00 Maximum
Radiation Therapy Services	Revenue Code: 333	48.6% Reduction from Billed Charges up to \$1,487.00 Maximum
CT/CTA Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 350, 351, 352, 359	\$1,190.00 Per Visit
MRI/MRA Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 610, 611, 612, 614, 615, 616, 618, 619	\$1,785.00 Per Visit
PET Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Code: 404	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
Nuclear Medicine Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 340, 341, 342, 349	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
Radiology Services not otherwise listed herein	CPT Codes: 70000-79999, 92229, 93880, 93882, 93886, 93888, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93985, 93986, 93990  All applicable CPT Category III T codes	298% of Cigna Market Fee Schedule

	All applicable HCPCS codes	
Clinical and Anatomical Laboratory Services	CPT Codes: 36410, 36415, 36416, 80000-89999  All applicable HCPCS codes	298% of Cigna Market Fee Schedule
Physical Therapy	Revenue Codes: 420, 421, 422, 423, 424, 429	\$275.00 Per Visit
Occupational Therapy	Revenue Codes: 430, 431, 432, 433, 434, 439	\$275.00 Per Visit
Speech Therapy	Revenue Codes: 440, 441, 442, 443, 444, 449	\$275.00 Per Visit
Respiratory Therapy	Revenue Codes: 410, 412, 419	\$275.00 Per Visit
Dialysis	Revenue Codes: 821, 831, 841, 851	\$2,500.00 Per Treatment
Fetal Non Stress Test	CPT Code: 59025	48.6% Reduction from Billed Charges
Trauma, includes Trauma Activation  Rate applies to Activation/Response billed with Outpatient services when there is no Inpatient Stay.  The applicable Outpatient reimbursement will not apply; the entire claim will be paid at the rate listed here.	Revenue Codes: 681-684, 689	\$25,000.00 Per Visit
Ambulance service, conventional air services, transport, one way (rotary wing)	HCPCS Code: A0431	Services not available as of effective date. If service become available, Provider

		will contact Cigna to amend contract.
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Injectable drugs not otherwise listed herein	All applicable injectable CPT and HCPCS codes excluding gene therapy injectables, assigned an industry CPT and HCPC code	250% ASP Fee Schedule or 48.6% Reduction from Billed Charges if no fee available on Cigna ASP Fee Schedule
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The above reimbursement excludes gene therapy injectables. The Cigna National Injectable and Immunization Fee Schedule is updated quarterly with current coding and reimbursement without notice to Hospital.

**Injectable Drugs Payment Rules**

Injectable Drugs and Chemotherapy Administration Services	Both Chemotherapy Administration Services rate and Injectable Drugs rate apply
Injectable Drugs and any other Outpatient Covered Service reimbursed at per visit, per case rate, or per stay	Applicable outpatient per visit, per case, or per stay rate applies only (does not apply to Clinic Visit rate)
Injectable Drugs and any other Outpatient Covered Service reimbursed at a reduction from Billed Charges rate	Both Injectable Drugs rate and applicable discount rate apply
Injectable Drugs and any other Outpatient Covered Service reimbursed on a Cigna Market or RBRVS Fee Schedule	Both Injectable Drugs rate and Cigna Market or RBRVS Fee Schedule rate apply.

All Other Outpatient Covered Services	CPT Codes: 90000-99999 not otherwise listed above	298% Cigna Market Fee Schedule or 48.6% Reduction from Billed Charges if no fee available on Cigna Market Fee Schedule
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**A. Outpatient Exclusions**

If Hospital's total Billed Charges for a code listed in the chart below for Covered Services rendered with respect to a particular Participant's outpatient service exceed the threshold referenced in the chart below, Hospital shall be reimbursed separately for such code as specified in the chart below, less applicable Copayments, Coinsurance and Deductibles. Hospital's total Billed Charges for the codes listed in the chart below will be excluded from any and all calculations of reimbursement based upon the lesser of 97% of billed charges or contract rate, whether or not Hospital's Billed Charges for such codes exceeds the threshold in the chart below.

Prosthetics and Orthotics	Revenue Code: 274	Threshold for each revenue code: \$900.00 Reimbursement: 30.0% Reduction from Billed Charges
Pacemaker Supplies	Revenue Code: 275	Threshold for each revenue code: \$900.00 Reimbursement: 30.0% Reduction from Billed Charges
Implants	Revenue Code: 278	Threshold for each revenue code: \$900.00 Reimbursement: 30.0% Reduction from Billed Charges

\*Cigna Grouper Schedule is Cigna's ambulatory surgical schedule that employs logic to not reimburse for procedures that are incidental to the surgical procedure. The Cigna Grouper Schedule means Cigna's current year ambulatory surgical schedule which is updated annually with new and deleted codes including those procedures that are incidental to the surgical procedure as the basis for payment.

Cigna updates the Cigna Grouper Schedule on an annual basis. Codes introduced in a given year will be reimbursed at the Default Grouper rate indicated above until such time as all updates have been loaded into the appropriate Cigna claims systems. At the time of the system update, Hospital will be reimbursed the appropriate Grouper for the new code and claims will be processed according to the updated Cigna Grouper Schedule on a prospective basis.

\*\*The Default Rate applies to industry valid procedure codes in the ambulatory surgery range (10004-36299, 36420-69999), applicable CPT Category III surgical T codes, and applicable HCPCS surgery codes on the date of service of the procedure that are not assigned to one of the groupers listed above and are not listed separately in the above rate table.

\*\*\*Per visit rate means the flat rate applicable to a particular type of service, such as therapeutic, rehabilitative or diagnostic services, and all codes associated with that type of service performed on the same day.

### III. Miscellaneous Terms

#### A. Chargemaster Increases

1. Notification of Chargemaster Increases. Hospital shall provide Cigna with thirty-(30) days prior written notice, or as soon as reasonably possible if earlier notification cannot be made due to pending Hospital's governing board, via written notification signed by Hospital's Chief Financial Officer (or other responsible officer of Hospital) should any charges increase by more than the percentage amount specified in Section 2 below, during the term of this Agreement. Hospital will also provide Cigna with an electronic file of Hospital's new chargemaster list at that time. The electronic file will contain the following data split between inpatient and outpatient chargemaster codes: a) all chargemaster codes and descriptions; b) chargemaster unit prices in effect; and c) UB revenue/CPT codes. Additionally, Hospital shall furnish Cigna with an electronic file of Hospital's chargemaster list containing the data elements specified above on the Effective Date of this Agreement, 6 months from the Effective Date, and annually thereafter.
2. Adjustment to Reimbursement Rates. Any increase for a given reimbursement amount(s) in excess of 5 percent during any 12-month period of this Agreement may result in an adjustment to the reimbursement rate(s). The reimbursement amount(s) may be changed appropriately to ensure that Payor's reimbursement to Hospital for a given service does not increase by more than 5 percent during any twelve month period of this Agreement. If applicable, any stop loss or exclusion threshold may also be adjusted by the amount by which Hospital's chargemaster has increased in excess of 5 percent since the Effective Date of this Agreement.
3. Right to Audit. Cigna shall have the right to audit Hospital's records relating to Hospital's billed charges in order to assure compliance with and to enforce this provision. Cigna may also audit its records relating to Hospital's billed charges. If audit findings indicate a change in billed charges, Cigna shall notify Hospital of such findings, any adjustments to the percentage discount, and the effective date of such adjustments.

- B. When a Participant is admitted as an inpatient after receiving outpatient services on the same calendar day/same episode, or when 2 or more Primary Services are performed on the same calendar day/same episode, the following Payment Rules apply:

When one of the Primary Services listed are performed, all Covered Services will be reimbursed at the applicable Payment Rule rate.

When no Primary Services are performed, reimbursement for Covered Services will be at the individual rate associated with the service as listed in this Exhibit

<b>Primary Service</b>	<b>Payment Rule</b>
Ambulatory Surgery with MRI, CT or PET Scan	Ambulatory Surgery rate applies only
Ambulatory Surgery with Observation	Ambulatory Surgery rate applies only
Ambulatory Surgery transfer to Inpatient	Inpatient rate(s) applies only
Emergency Department Services with or transfer to Ambulatory Surgery	Ambulatory Surgery rate applies only
Emergency Department Services with or transfer to Observation	Observation rate applies only
Emergency Department Services with or transfer to Cardiac Catheterization Lab Services	Cardiac Catheterization Lab Services rate applies only
Emergency Department Services with MRI, CT or PET Scan	Emergency Department Services rate applies only
Emergency Department Services transfer to Inpatient	Inpatient rate(s) applies only
Observation with MRI, CT or PET Scan	Observation rate applies only
Observation transfer to Inpatient	Inpatient rate(s) applies only
Observation with or transfer to Cardiac Catheterization Lab Services	Cardiac Catheterization Lab Services rate applies only
Cardiac Catheterization Lab Services with MRI, CT or PET Scan	Cardiac Catheterization Lab Services rate applies only
Cardiac Catheterization Lab Services with Cardiac Catheterization Procedures or PTCA and Other Percutaneous Cardiac Procedures	Cardiac Catheterization Procedures or PTCA and Other Percutaneous Cardiac Procedures rate applies only
Cardiac Catheterization Procedures with PTCA and Other Percutaneous Cardiac Procedures	PTCA and Other Percutaneous Cardiac Procedures rate applies only
Cardiac Catheterization Lab Services transfer to Inpatient	Inpatient rate(s) applies only
Any other outpatient service that converts to an inpatient admission	Inpatient rate(s) applies only
Any outpatient service that converts to Hospital in the Home	Hospital in the Home rate applies only

If the primary reason for admission from the ambulatory surgery facility is associated with Hospital's scheduling or administrative procedures, the ambulatory surgery rate will apply.

The parties agree that Hospital will monitor the frequency and duration of Observation Services provided to Cigna Members for the purpose of validating that Observation Services are not being misused as a way of avoiding inpatient admissions. In the event, Hospital determines that Observation Services are consistently approved by Cigna in lieu of inpatient care, and/or that Observation Services consistently exceed twenty-four (24) hours, the parties shall enter into good faith negotiations to revisit the compensation rates for inpatient services.

- C. Hospital's reimbursement for its costs pertaining to a Participant's diagnostic testing and procedures occurring within 3 days of an elective admission or ambulatory surgery is included in the compensation for inpatient or outpatient services set forth above, if such services are directly associated to the elective admission or ambulatory surgery diagnosis.
- D. Multiple outpatient procedures performed in the same surgical session, including but not limited to, procedures in the CPT code range 10004-36299 and 36420-69999, applicable CPT Category III surgical T codes, and applicable HCPCS surgery codes will be reimbursed at 100% of the agreed upon reimbursement for the highest allowable procedure, 50% of the agreed upon reimbursement for the second highest allowable procedure and 25% of the agreed upon reimbursement for the third highest allowable procedures. Payor will reimburse for a maximum of 3 procedures per surgical session. Any and all additional procedures performed during the same surgical session will not be separately reimbursed, but will be considered paid, as included in and part of the reimbursement amount of the first 3 procedures, and Participants may not be billed for such additional procedures.
- E. New Service/Technology. The rates in this compensation Exhibit shall not apply to any new service or technology ("New Service/Technology") that is added by Provider in the future. For purposes of this Agreement, New Service/Technology is defined as "a service, procedure, device, test, or other Covered Service that, as of the first effective date of this Attachment, is not performed by Provider." The addition of a new code that is assigned as a change to an existing service, procedure, device, test, or Covered Service, does not constitute a New Service/Technology. If Provider offers a New Service/Technology, Provider shall notify Health Plan within thirty (30) days of adding such New Service/Technology. The parties shall enter into good faith negotiations to add new rate(s) and applicable "qualifier" code(s) for the New Service/Technology, as deemed necessary.
- F. Reimbursement for in-patient and/or out-patient services covered by a Participant's mental health/substance abuse benefit plan will be according to Hospital's agreement with Cigna Behavioral Health, as applicable.

- G. The applicable reimbursement rate for Covered Services shall be that rate applicable to the level of care which is Medically Necessary notwithstanding the level of care actually provided.
- H. For workers' compensation Benefit Plans, Hospital's reimbursement shall not exceed the state fee schedule.
- I. When initiated by Cigna, the parties agree to meet and negotiate in order to restructure the outpatient rates listed in Exhibit A to an Ambulatory Payment Classification (APC) equivalent reimbursement and to put into effect as soon as possible. Upon mutual agreement, the parties shall amend the Agreement on a prospective basis.

## Cigna

### Exhibit A2

#### Fee Schedule and Reimbursement Terms

**This Rate Exhibit applies to the following Cigna Benefit Plans:**

**HMO Benefit Plans: Yes**

**Network Benefit Plans: Yes**

**Open Access Plus Benefit Plans: Yes**

**All Other: Yes**

This is an Exhibit to an Agreement between:

Provider: Ventura County Medical Center and Santa Paula Hospital

Cigna Party: Cigna HealthCare of California, Inc. ("CHC") and Cigna Health and Life Insurance Company ("CHLIC") collectively "Cigna"

Effective Date of Base Agreement: December 1, 2006

This Rate Exhibit:

Applies to: The County of Ventura d.b.a Ventura County Medical Center and Santa Paula Hospital

Federal Tax ID(s): 956000944

National Provider Identifier(s): 1629167457

Effective Date: August 1, 2025

Payor will pay Hospital in accordance with the fee schedule and the reimbursement terms set forth herein for Covered Services rendered to Participants. Except where otherwise indicated, Cigna may adjust coding in its systems to remain consistent with the parties' intent to reimburse for the services listed in this Exhibit.

#### **IV. Inpatient Services**

Hospital shall accept as full and final payment for all Covered Services provided to Participants who are admitted as inpatients the lesser of 97.2% of billed charges for the inpatient stay or the reimbursement specified in this Exhibit. Such reimbursement covers all inpatient Covered Services, including but not limited to, semi-private room and board, operating room, the services of nurses and other Hospital employees and permitted subcontractors, all supplies excluding personal convenience items, laboratory management and interpretation of test results, all ancillary services, pharmacy, and other Medically Necessary services provided to a Participant. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Hospital. References to DRG's in the inpatient chart below shall mean MS-DRG's.

The MS-DRG Case Rate for all inpatient admissions will be the conversion price, \$16,995, multiplied by the relative weights for each MS-DRG.

Inpatient Covered Services rendered to a Participant by multiple hospitals or facilities within the same hospital system and related to the same admission, including intra-hospital transfers, shall be considered as a single inpatient admission. Hospital agrees to bill and shall only be paid a single MS-DRG Case Rate that shall cover all Covered Services rendered to such Participant by all hospitals and facilities within the same hospital system.

Reimbursement for covered transplant services (other than corneal transplants) as well as Chimeric Antigen Receptor T cell therapy (CAR-T) MS-DRG 018 are specifically excluded from this Exhibit. Such services will be reimbursed according to Hospital's agreement with Cigna LifeSOURCE Transplant Network®, if applicable.

<b>Description</b>	<b>Coding</b>	<b>Reimbursement</b>
Room & Board-Hospital at Home	Revenue Code: 161	Services not available as of contract effective date. If service becomes available, Section III. E. applies.

Vaginal Delivery – Mother Only Case Rate - Days 1 through 2	MS-DRG Codes: 768, 796, 797, 798, 805, 806, 807	\$4,366.00 Per Diem
C-Section Delivery – Mother Only Case Rate – Days 1 through 3	MS-DRG Codes: 783, 784, 785, 786, 787, 788	\$6,704.00 Per Diem
Maternity Additional Days	MS-DRG Codes: 768, 783, 784, 785, 786, 787, 788, 796, 797, 798, 805, 806, 807	\$2,339.00 Per Diem
Newborn Level I (Normal/Boarder)	Revenue Codes: 170, 171, 179	\$1,169.00 Per Diem
Newborn Level II (Premature)	Revenue Code: 172	\$4,054.00 Per Diem
Newborn Level III (Sick Neonate)	Revenue Code: 173	\$4,521.00 Per Diem
Newborn Level IV (NICU)	Revenue Code: 174	\$5,301.00 Per Diem

Rehabilitation Unit	Revenue Codes: 118, 128, 138, 148, 158	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level I	Revenue Codes: 190, 191, 199	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level II	Revenue Code: 192	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level III	Revenue Code: 193	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Sub-Acute Level IV	Revenue Code: 194	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Detoxification Unit	Revenue Codes: 116, 126, 136, 146, 156	\$3,039.00 Per Diem
Hospice - Room & Board and Nursing Services (Non-Respite)	Revenue Codes: 115, 125, 135, 145, 155, 656	Services not available as of contract effective date. If service, becomes available, Section III. E. applies.
Transplants		Reimbursed under Cigna Lifesource contract if applicable
Trauma Services, Level II	Revenue Code: 681-684, 689	\$18,000.00 Per Diem

A. Inpatient Exclusions

If Hospital's total Billed Charges for a revenue code listed in the chart below for Covered Services rendered with respect to a particular Participant's continuous inpatient confinement exceed the threshold referenced in the chart below, Hospital shall be reimbursed separately for such revenue code as specified in the chart below, less applicable Copayments, Coinsurance and Deductibles. Hospital's total Billed Charges for the revenue codes listed in the chart below will be excluded from any and all calculations of reimbursement based upon the lesser of 97.2% of billed charges or the contract rate, whether or not Hospital's Billed Charges for such revenue codes exceeds the threshold in the chart below.

Prosthetics and Orthotics	Revenue Code: 274	Threshold for each revenue code: \$927.00 Reimbursement: 27% Reduction from Billed Charges
Pacemaker Supplies	Revenue Code: 275	Threshold for each revenue code: \$927.00 Reimbursement: 27% Reduction from Billed Charges
Implants	Revenue Code: 278	Threshold for each revenue code: \$927.00 Reimbursement: 27% Reduction from Billed Charges
Drugs Requiring Detailed Codes	Revenue Code: 636	Threshold for each revenue code: \$1,273.00 Reimbursement: 43.6% Reduction from Billed Charges
Inpatient Dialysis	Revenue Codes: 800, 801, 802, 803, 804, 809	\$2,575.00 Per Treatment

Dialysis Services billed with Revenue Codes 800-803 as stated in Inpatient Exclusions will be reimbursed at the rates set forth above. Claim submissions for more than one dialysis treatment per day may be appealed by the Hospital to obtain reimbursement. Detailed clinical notes must

accompany the appealed claim with a copy to the Cigna Medical Director and Contracting Department to be considered for payment. Hospital understands that Cigna’s claim system cannot be automated to accommodate multiple dialysis treatments in one day, and that Cigna will work with Hospital to reimburse for the medically qualified dialysis treatments.

**B. Stop Loss**

1. Notwithstanding the foregoing, if a particular Participant’s continuous acute inpatient confinement exceeds 13 days (the “Stop Loss Day Threshold”), Hospital will be reimbursed for Covered Services rendered to such Participant at the applicable case rate/per diem, less applicable Copayments, Coinsurance and Deductibles, through the date the Stop Loss Day Threshold is met (the “Threshold Date”) and at \$4,635.00 per day, less applicable Copayments, Coinsurance and Deductibles, for Covered Services rendered after Threshold Date with respect to the same continuous acute inpatient confinement.
2. The following inpatient services as determined by the derived CMS MS-DRG will not be included in stop loss: OB, NICU, TRAUMA. Payment in full for these services will be at the inpatient services and rate(s) listed above in this rate exhibit.
3. Hospital shall only be entitled to the additional reimbursement provided pursuant to this stop loss provision if, within (180) days after the date of the applicable Participant’s discharge from Hospital, Hospital provides Cigna with an itemized bill for its total Billed Charges for Covered Services rendered through the Threshold Date and through the date of discharge with respect to the applicable Participant.

**V. Outpatient Services**

Hospital shall accept as full and final payment for all Covered Services provided to Participants on an outpatient basis of the lesser of 97.2% of billed charges for the episode of care or the reimbursement specified in this Exhibit. Such reimbursement covers all outpatient Covered Services, including but not limited to, all facility services, the services of all nurses and other Hospital employees and permitted subcontractors, laboratory management and interpretation of test results, ancillary, diagnostic, and pharmacy charges, and other Medically Necessary services provided in relation to the outpatient categories specified below. The applicable rate includes all Medically Necessary services that Hospital customarily provides to outpatients. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Benefit Plan from payment due to Hospital.

Description	Coding	Reimbursement***
Ambulatory Surgery – Cigna Grouper Schedule*	Revenue Codes: 360, 361, 369, 490, 499, 750, 761, 790;	

Description	Coding	Reimbursement***
Grouper 1	CPT Codes: 10004-36299,	\$1,127.00 Case Rate
Grouper 2	36420-69999, applicable CPT	\$1,645.00 Case Rate
Grouper 3	Category III surgical T codes,	\$2,070.00 Case Rate
Grouper 4	and applicable HCPCS	\$2,642.00 Case Rate
Grouper 5	surgery codes unless	\$3,092.00 Case Rate
Grouper 6	specified below.	\$3,845.00 Case Rate
Grouper 7		\$4,806.00 Case Rate
Grouper 8	Note: only surgical	\$5,398.00 Case Rate
Grouper 9	CPT/HCPCS codes billed	\$7,727.00 Case Rate
Grouper 79	with these Revenue Codes	\$138.00 Case Rate
Default Rate**	will be reimbursed at the rates in this table.	\$3,232.00 Case Rate

Cardiac Catheterization Lab Services	Revenue Code: 481	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
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Observation	Revenue Code: 762	45.6% Reduction from Billed Charges up to \$7,378.00 Maximum
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Emergency Department Services	Revenue Codes: 450, 451, 452, 459	45.6% Reduction from Billed Charges up to \$3,197.00 Maximum
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Urgent Care	Revenue Code: 456	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
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Urgent Care Services (Free Standing Center)	Revenue Codes: 516, 526	\$227.00 Per Visit
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Clinic Visit	Revenue Codes: 510-515; 517; 519; 520-525; 527-529	\$227.00 Per Visit
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Chemotherapy Administration Services	Revenue Codes: 331, 332, 335	45.6% Reduction from Billed Charges up to \$1,532.00 Maximum
Radiation Therapy Services	Revenue Code: 333	45.6% Reduction from Billed Charges up to \$1,532.00 Maximum
CT/CTA Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 350, 351, 352, 359	\$1,225.00 Per Visit
MRI/MRA Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 610, 611, 612, 614, 615, 616, 618, 619	\$1,838.00 Per Visit
PET Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Code: 404	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
Nuclear Medicine Scan(s) includes contrast materials and other radiologic supplies and all of the same scan type billed for that day.	Revenue Codes: 340, 341, 342, 349	Services not available as of contract effective date. If service becomes available, Section III. E. applies.
Radiology Services not otherwise listed herein	CPT Codes: 70000-79999, 92229, 93880, 93882, 93886, 93888, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93985, 93986, 93990  All applicable CPT Category III T codes	301% of Cigna Market Fee Schedule

	All applicable HCPCS codes	
Clinical and Anatomical Laboratory Services	CPT Codes: 36410, 36415, 36416, 80000-89999  All applicable HCPCS codes	301% of Cigna Market Fee Schedule
Physical Therapy	Revenue Codes: 420, 421, 422, 423, 424, 429	\$283.00 Per Visit
Occupational Therapy	Revenue Codes: 430, 431, 432, 433, 434, 439	\$283.00 Per Visit
Speech Therapy	Revenue Codes: 440, 441, 442, 443, 444, 449	\$283.00 Per Visit
Respiratory Therapy	Revenue Codes: 410, 412, 419	\$283.00 Per Visit
Dialysis	Revenue Codes: 821, 831, 841, 851	\$2,575.00 Per Treatment
Fetal Non Stress Test	CPT Code: 59025	45.6% Reduction from Billed Charges
Trauma, includes Trauma Activation  Rate applies to Activation/Response billed with Outpatient services when there is no Inpatient Stay.  The applicable Outpatient reimbursement will not apply; the entire claim will be paid at the rate listed here.	Revenue Codes: 681-684, 689	\$25,750.00 Per Visit
Ambulance service, conventional air services, transport, one way (rotary wing)	HCPCS Code: A0431	Services not available as of effective date. If service become available, Provider

		will contact Cigna to amend contract.
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Injectable drugs not otherwise listed herein	All applicable injectable CPT and HCPCS codes excluding gene therapy injectables, assigned an industry CPT and HCPC code	253% ASP Fee Schedule or 45.6% Reduction from Billed Charges if no fee available on Cigna ASP Fee Schedule
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The above reimbursement excludes gene therapy injectables. The Cigna National Injectable and Immunization Fee Schedule is updated quarterly with current coding and reimbursement without notice to Hospital.

**Injectable Drugs Payment Rules**

Injectable Drugs and Chemotherapy Administration Services	Both Chemotherapy Administration Services rate and Injectable Drugs rate apply
Injectable Drugs and any other Outpatient Covered Service reimbursed at per visit, per case rate, or per stay	Applicable outpatient per visit, per case, or per stay rate applies only (does not apply to Clinic Visit rate)
Injectable Drugs and any other Outpatient Covered Service reimbursed at a reduction from Billed Charges rate	Both Injectable Drugs rate and applicable discount rate apply
Injectable Drugs and any other Outpatient Covered Service reimbursed on a Cigna Market or RBRVS Fee Schedule	Both Injectable Drugs rate and Cigna Market or RBRVS Fee Schedule rate apply.

All Other Outpatient Covered Services	CPT Codes: 90000-99999 not otherwise listed above	301% Cigna Market Fee Schedule or 45.6% Reduction from Billed Charges if no fee available on Cigna Market Fee Schedule
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A. Outpatient Exclusions

If Hospital’s total Billed Charges for a code listed in the chart below for Covered Services rendered with respect to a particular Participant’s outpatient service exceed the threshold referenced in the chart below, Hospital shall be reimbursed separately for such code as specified in the chart below, less applicable Copayments, Coinsurance and Deductibles. Hospital’s total Billed Charges for the codes listed in the chart below will be excluded from any and all calculations of reimbursement based upon the lesser of 97.2% of billed charges or contract rate, whether or not Hospital’s Billed Charges for such codes exceeds the threshold in the chart below.

Prosthetics and Orthotics	Revenue Code: 274	Threshold for each revenue code: \$927.00 Reimbursement: 27% Reduction from Billed Charges
Pacemaker Supplies	Revenue Code: 275	Threshold for each revenue code: \$927.00 Reimbursement: 27% Reduction from Billed Charges
Implants	Revenue Code: 278	Threshold for each revenue code: \$927.00 Reimbursement: 27% Reduction from Billed Charges

\*Cigna Grouper Schedule is Cigna's ambulatory surgical schedule that employs logic to not reimburse for procedures that are incidental to the surgical procedure. The Cigna Grouper Schedule means Cigna's current year ambulatory surgical schedule which is updated annually with new and deleted codes including those procedures that are incidental to the surgical procedure as the basis for payment.

Cigna updates the Cigna Grouper Schedule on an annual basis. Codes introduced in a given year will be reimbursed at the Default Grouper rate indicated above until such time as all updates have been loaded into the appropriate Cigna claims systems. At the time of the system update, Hospital will be reimbursed the appropriate Grouper for the new code and claims will be processed according to the updated Cigna Grouper Schedule on a prospective basis.

\*\*The Default Rate applies to industry valid procedure codes in the ambulatory surgery range (10004-36299, 36420-69999), applicable CPT Category III surgical T codes, and applicable HCPCS surgery codes on the date of service of the procedure that are not assigned to one of the groupers listed above and are not listed separately in the above rate table.

\*\*\*Per visit rate means the flat rate applicable to a particular type of service, such as therapeutic, rehabilitative or diagnostic services, and all codes associated with that type of service performed on the same day.

## VI. Miscellaneous Terms

### A. Chargemaster Increases

1. Notification of Chargemaster Increases. Hospital shall provide Cigna with thirty-(30) days prior written notice, or as soon as reasonably possible if earlier notification cannot be made due to pending Hospital's governing board, via written notification signed by Hospital's Chief Financial Officer (or other responsible officer of Hospital) should any charges increase by more than the percentage amount specified in Section 2 below, during the term of this Agreement. Hospital will also provide Cigna with an electronic file of Hospital's new chargemaster list at that time. The electronic file will contain the following data split between inpatient and outpatient chargemaster codes: a) all chargemaster codes and descriptions; b) chargemaster unit prices in effect; and c) UB revenue/CPT codes. Additionally, Hospital shall furnish Cigna with an electronic file of Hospital's chargemaster list containing the data elements specified above on the Effective Date of this Agreement, 6 months from the Effective Date, and annually thereafter.
2. Adjustment to Reimbursement Rates. Any increase for a given reimbursement amount(s) in excess of 5 percent during any 12-month period of this Agreement may result in an adjustment to the reimbursement rate(s). The reimbursement amount(s) may be changed appropriately to ensure that Payor's reimbursement to Hospital for a given service does not increase by more than 5 percent during any twelve month period of this Agreement. If applicable, any stop loss or exclusion threshold may also be adjusted by the amount by which Hospital's chargemaster has increased in excess of 5 percent since the Effective Date of this Agreement.
3. Right to Audit. Cigna shall have the right to audit Hospital's records relating to Hospital's billed charges in order to assure compliance with and to enforce this provision. Cigna may also audit its records relating to Hospital's billed charges. If audit findings indicate a change in billed charges, Cigna shall notify Hospital of such findings, any adjustments to the percentage discount, and the effective date of such adjustments.

- B. When a Participant is admitted as an inpatient after receiving outpatient services on the same calendar day/same episode, or when 2 or more Primary Services are performed on the same calendar day/same episode, the following Payment Rules apply:

When one of the Primary Services listed are performed, all Covered Services will be reimbursed at the applicable Payment Rule rate.

When no Primary Services are performed, reimbursement for Covered Services will be at the individual rate associated with the service as listed in this Exhibit

<b>Primary Service</b>	<b>Payment Rule</b>
Ambulatory Surgery with MRI, CT or PET Scan	Ambulatory Surgery rate applies only
Ambulatory Surgery with Observation	Ambulatory Surgery rate applies only
Ambulatory Surgery transfer to Inpatient	Inpatient rate(s) applies only
Emergency Department Services with or transfer to Ambulatory Surgery	Ambulatory Surgery rate applies only
Emergency Department Services with or transfer to Observation	Observation rate applies only
Emergency Department Services with or transfer to Cardiac Catheterization Lab Services	Cardiac Catheterization Lab Services rate applies only
Emergency Department Services with MRI, CT or PET Scan	Emergency Department Services rate applies only
Emergency Department Services transfer to Inpatient	Inpatient rate(s) applies only
Observation with MRI, CT or PET Scan	Observation rate applies only
Observation transfer to Inpatient	Inpatient rate(s) applies only
Observation with or transfer to Cardiac Catheterization Lab Services	Cardiac Catheterization Lab Services rate applies only
Cardiac Catheterization Lab Services with MRI, CT or PET Scan	Cardiac Catheterization Lab Services rate applies only
Cardiac Catheterization Lab Services with Cardiac Catheterization Procedures or PTCA and Other Percutaneous Cardiac Procedures	Cardiac Catheterization Procedures or PTCA and Other Percutaneous Cardiac Procedures rate applies only
Cardiac Catheterization Procedures with PTCA and Other Percutaneous Cardiac Procedures	PTCA and Other Percutaneous Cardiac Procedures rate applies only
Cardiac Catheterization Lab Services transfer to Inpatient	Inpatient rate(s) applies only
Any other outpatient service that converts to an inpatient admission	Inpatient rate(s) applies only
Any outpatient service that converts to Hospital in the Home	Hospital in the Home rate applies only

If the primary reason for admission from the ambulatory surgery facility is associated with Hospital's scheduling or administrative procedures, the ambulatory surgery rate will apply.

The parties agree that Hospital will monitor the frequency and duration of Observation Services provided to Cigna Members for the purpose of validating that Observation Services are not being misused as a way of avoiding inpatient admissions. In the event, Hospital determines that Observation Services are consistently approved by Cigna in lieu of inpatient care, and/or that Observation Services consistently exceed twenty-four (24) hours, the parties shall enter into good faith negotiations to revisit the compensation rates for inpatient services.

- C. Hospital's reimbursement for its costs pertaining to a Participant's diagnostic testing and procedures occurring within 3 days of an elective admission or ambulatory surgery is included in the compensation for inpatient or outpatient services set forth above, if such services are directly associated to the elective admission or ambulatory surgery diagnosis.
- D. Multiple outpatient procedures performed in the same surgical session, including but not limited to, procedures in the CPT code range 10004-36299 and 36420-69999, applicable CPT Category III surgical T codes, and applicable HCPCS surgery codes will be reimbursed at 100% of the agreed upon reimbursement for the highest allowable procedure, 50% of the agreed upon reimbursement for the second highest allowable procedure and 25% of the agreed upon reimbursement for the third highest allowable procedures. Payor will reimburse for a maximum of 3 procedures per surgical session. Any and all additional procedures performed during the same surgical session will not be separately reimbursed, but will be considered paid, as included in and part of the reimbursement amount of the first 3 procedures, and Participants may not be billed for such additional procedures.
- E. New Service/Technology. The rates in this compensation Exhibit shall not apply to any new service or technology ("New Service/Technology") that is added by Provider in the future. For purposes of this Agreement, New Service/Technology is defined as "a service, procedure, device, test, or other Covered Service that, as of the first effective date of this Attachment, is not performed by Provider." The addition of a new code that is assigned as a change to an existing service, procedure, device, test, or Covered Service, does not constitute a New Service/Technology. If Provider offers a New Service/Technology, Provider shall notify Health Plan within thirty (30) days of adding such New Service/Technology. The parties shall enter into good faith negotiations to add new rate(s) and applicable "qualifier" code(s) for the New Service/Technology, as deemed necessary.
- F. Reimbursement for in-patient and/or out-patient services covered by a Participant's mental health/substance abuse benefit plan will be according to Hospital's agreement with Cigna Behavioral Health, as applicable.

- G. The applicable reimbursement rate for Covered Services shall be that rate applicable to the level of care which is Medically Necessary notwithstanding the level of care actually provided.
- H. For workers' compensation Benefit Plans, Hospital's reimbursement shall not exceed the state fee schedule.
- I. When initiated by Cigna, the parties agree to meet and negotiate in order to restructure the outpatient rates listed in Exhibit A to an Ambulatory Payment Classification (APC) equivalent reimbursement and to put into effect as soon as possible. Upon mutual agreement, the parties shall amend the Agreement on a prospective basis.