Provider: St. Vincent's Chilton
TIN: 81-0935368
Effective: 05/21/2019

2030 Lay Dam Road
Clanton, AL 35045
(205)258-4400

Hospital agrees to accept the following rates as payment in full for services provided:

I. **Inpatient Services:** A rate equal to 70% of the rate extended to the State of Alabama Department of Labor (DOL) pursuant to the Negotiated Participating Agreement between the DOL and the individual Hospital in effect at the date of discharge. The calculation for the AlaMed inpatient rate shall be inclusive of all methods of calculation in the Hospital's inpatient state fee schedule, including but not limited to the stop-loss provisions in the event the state fee schedule includes a stop-loss.*

Medical devices listed under revenue codes 274, 275, 276, or 278 shall be paid additionally at cost + 15% and Hospital shall furnish the invoice with its bill.

II. **Outpatient Services Not Provided in Paragraphs III or IV below:** A rate equal to 85% of the rate extended to the State of Alabama Department of Labor (DOL) pursuant to the Negotiated Participating Agreement between the DOL and the individual Hospital in effect at the date of discharge.*

Medical devices listed under revenue codes 274, 275, 276, or 278 shall be paid additionally at cost + 15% and Hospital shall furnish the invoice with its bill.

III. **Outpatient Physical Therapy:** A rate equal to 85% of the State of Alabama Department of Labor (DOL) workers' compensation fee schedule.

IV. **Physician Services:** If billed by the Hospital, Provider will be reimbursed for the lesser of billed charges or a rate equal to 103% of the BlueCross BlueShield of Alabama Preferred Medical Doctor (PMD) fee schedule.

V. **Stop-Loss:** When total charges exceed $30,000, reimbursement will convert to 50% of billed charges.

VI. **Emergency Room Services**: PROVIDER agrees to a global reimbursement fee of $1,400.00 per visit to include all charges related to Hospital services, including but not limited to: E.R., diagnostics, lab, and other charges. Charges made by physician are not included, as they are billed directly by other parties.

VII. **Pain Management**: PROVIDER agrees to accept $3,700 as payment in full for all pain blocks services.

VIII. **Wound Care:** For all services regarding wound care, treatments, supplies, expenses or other charges, PROVIDER will be reimbursed at a rate of 55% of billed charges.

IX. **Outpatient Diagnostic Services:** For all services, treatments, supplies, expenses, or other charges, PROVIDER agrees to accept the following rates as payment in full:

Description	Reimbursement
MRI	
MRI, without contrast	$600.00
MRI, with contrast	$675.00
MRI, with/without contrast	$750.00
CT	
CT, without contrast	$550.00
CT, with contrast	$625.00
CT, with/without contrast	$700.00

*Note: To calculate the AlaMed rate, first calculate the state rate and then apply the applicable discount.