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

I. Inpatient Services:

Type of Hospitalization	Per Diem
Inpatient, Days 1 & 2	$3,297.00
Inpatient, Days 3 & up	$2,884.00
Rehabilitation Services	$1,317.00
Psychiatric Services	$969.000

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

Medical devices listed under revenue codes 274, 275, 276, or 278 shall be paid additionally at Hospital's total (including shipping and taxes) cost + 15%. If aggregate charges for implants are more than $500 an invoice will be required. If aggregate charges for implants are less than $500 no invoice will be required.

II. Outpatient Services:

A. Emergency Room Services:
For all services, treatments, supplies, expenses, or other charges related to Emergency Room Services, Hospital will be reimbursed a global fee of $1,424.00 per outpatient visit. The global fee is to include all charges related to Hospital services, but not limited to Emergency Room, diagnostics, lab, or other charges. The global fee does not include any physician fees, as they are billed directly.

B. Outpatient Surgery Services:
For all services, treatments, supplies, expenses, or other charges related to Outpatient Surgery Services, Hospital will be reimbursed at a rate equal to 35% of billed charges. Medical devices listed under revenue codes 274, 275, 276, or 278 shall be paid additionally at Hospital's total (including shipping and taxes) cost + 15%. If aggregate charges for implants are more than $500 an invoice will be required. If aggregate charges for implants are less than $500 no invoice will be required.

C. Outpatient Physical Therapy and Rehabilitation Services:
For all services, treatments, supplies, expenses or other charges related to Outpatient Physical Therapy and Rehabilitation Services, Hospital will be reimbursed for the lesser of billed charges or a rate equal to 80% of the State of Alabama Department of Labor (DOL) Workers' Compensation fee schedule.

D. Outpatient Diagnostic Services:
For all services, treatments, supplies, expenses, or other charges related to Outpatient Diagnostic Services, Hospital will be reimbursed as follows:

Service	Revenue Codes	Methodology	Rate
CT Scan	350-352	Per Unit	$1,066.00
MRI	610-612, 614-616, 618-619	Per Unit	$1,138.00

E. All Other Outpatient Services:
For all services, treatments, supplies, expenses or other charges related to all other Outpatient Services, Hospital will be reimbursed at a rate equal to 35% of billed charges.

****Note:** Effective each anniversary date, all fixed rates will be increased by 4%.

**Note: To calculate the AlaMed rate, first calculate the state rate and then apply the applicable discount. Reimbursement will not exceed the Alabama Department of Labor fee schedule.