AMENDMENT I
TO THE
BLUE SHIELD OF CALIFORNIA
FEE FOR SERVICE HOSPITAL AGREEMENT

THIS AMENDMENT No. 1 to the Blue Shield of California Fee For Service Hospital Agreement ("Agreement"), is entered into between Natividad Medical Center, a California Corporation ("Hospital") and California Physicians' Service, d.b.a., Blue Shield of California ("Blue Shield"). The Effective Date of this Amendment is December 1, 2004.

PURPOSE OF AMENDMENT

The purpose of this Amendment No. 1 is to memorialize the Compensation Amounts/Payment Schedule, as revealed in the attached Exhibit C-1, and to amend certain language provisions in the Fee-For-Service Hospital Agreement.

AMENDMENTS

Amendment No. 1

Section 2.10, Claims Submission, is hereby deleted in its entirety and replaced with:

2.10 Claims Submission. Hospital agrees that it shall submit billings to Blue Shield for Covered Services as follows:

(a) Hospital shall bill Blue Shield using the usual billing rate it charges the majority of patients at Hospital, not including patients entitled to receive services at discounted rates. Hospital shall, in accordance with the requirements of Section 2.12 hereof, advise Blue Shield when there is a change in its charge master. No modification in the charge master or in rates charged by Hospital shall be implemented for any Blue Shield Members nor shall it be effective with respect to this Agreement until after thirty (30) days prior written notice to Blue Shield, unless Hospital makes a decision to modify it chargemaster and implement such revised charge master less than thirty (30) days after such Hospital decision was made. In this scenario, where Hospital makes a decision to modify its chargemaster and implement such revised charge

master less than thirty (30) days after such Hospital decision was made, no modification in the charge master or in rates charged by Hospital shall be implemented for any Blue Shield Members nor shall it be effective with respect to this Agreement until after five (5) days prior written notice to Blue Shield.

(b) In the event of an individual or cumulative increase in Hospital's charge master during any Agreement Year that exceeds RATE REDACTED (the Chargemaster "Modification Allowance"), Blue Shield may, adjust any percentage compensation amounts set forth in the Exhibit C. in effect on the effective date of the increase, plus any subsequent Exhibit (s) C. added to the Agreement after the increase, in proportion to the percentage by which the charge master has increased. Such adjustment shall be calculated as follows:

[1.00/(1+Actual Charge Master Increase)]x(Current % of Billed Charges)= Adjusted % of Billed Charges

Example,
No modification to charge master allowed, 15% Actual Charge Master Increase, 55% of billed charge rate, [1.00/(1+.15)]x55.0%=**47.8%**

(c) Blue Shield will provide Hospital with an Addendum that includes revised Exhibit(s) C. to reflect the changes to the percentage compensation amounts resulting from Hospital's charge master increase. Such revised Exhibit(s) C. shall be effective the same date as the effective date of Hospital's charge master increase.

(d) Hospital shall bill Blue Shield every thirty (30) days while a Member is confined in Hospital's facility. If the Member's confinement or the end of the confinement was for less than thirty (30) days, then Hospital shall bill Blue Shield for that applicable period of time.

(e) Hospital shall submit billings to Blue Shield within sixty (60) days following discharge or the end of each period described in paragraph (b) above. Blue Shield may deny payment for any bills not received by Blue Shield within one hundred eighty (180) days and in such event, Hospital shall not bill the Member for such services. If Blue Shield is not the primary payor under the coordination of benefits rules, the periods in which claims must be submitted to Blue Shield shall run from the date payment or denial is received by Hospital from the primary payor. If Hospital fails to submit a billing in a timely fashion as set forth in this section, Hospital waives its right to any remedies and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Blue Shield and may not pursue the member for additional payment

(f) Hospital will submit billings using a Form UB 92 or any successor form approved by California Healthcare Association and which includes all required information as set forth in the Provider Manual;

(g) In the adjudication of claims for payment hereunder, Blue Shield may, as it reasonably deems necessary, obtain records regarding and confirm that individual billed service were rendered and were Medically Necessary.

(h) Hospital will, as required by Blue Shield, submit claims electronically, following procedures set forth in the Provider Manual.

Amendment No. 2

Section 2.12, Charge Master Notifications, is hereby deleted in its entirety and replaced with:

2.12 Charge Master Notifications. Hospital agrees to provide Blue Shield with notification relating to changes in Hospital's charge master as follows:

(a) Hospital shall give Blue Shield at least thirty (30) days notice prior to the implementation of any changes to Hospital's charge master, unless Hospital makes a decision to modify it chargemaster and implement such revised charge master less than thirty (30) days after such Hospital decision was made. In this scenario, where Hospital makes a decision to modify its chargemaster and implement such revised charge master less than thirty (30) days after such Hospital decision was made, hospital will provide notice to Blue Shield within five (5) after Hospital decision to modify its chargemaster. The notification shall include a detailed description of all changes to be made to the charge master, as well as the resulting percentage increase in the Hospital's overall charge master. Notification shall be in writing submitted to Blue Shield in accordance with the requirements of Paragraph (c) of this Section 2.12.

(b) Notwithstanding Hospital's obligation as set forth in 2.12(a) above, on the first business day of each calendar quarter, Hospital shall provide Blue Shield with written confirmation indicating whether Hospital did or did not implement any changes in its charge master during the prior calendar quarter. The notification shall be in writing, in a form provided to Hospital by Blue Shield, and shall be submitted to Blue Shield in accordance with the Requirements of Paragraph (c) of this Section 2.12

(c) All notices required under Paragraphs (a) and (b) of this Section shall be in writing and delivered to Blue Shield either personally or by First Class Mail addressed as indicated in the Address provision of Exhibit A hereto.

Blue Shield may, from time to time, change the addressee of such notice and will provide Hospital with written notice of such changes

(d) Failure by Hospital to provide Blue Shield with notice as required by Paragraph (b) of this Section shall constitute a breach, and Blue Shield will notify Hospital of such breach in accordance with Sections 10.3 and 10.4 of this Agreement.

Amendment No. 3

Section 5.3, Appeals of Payments and Denials, is hereby deleted in its entirety and replaced with:

5.3 Appeals of Payments or Denials. In the event that Hospital disagrees with a payment amount or denial from Blue Shield, Hospital must appeal that payment or denial following the procedures set forth in this Section 5.3. For the purposes of this Section 5.3 only, if Blue Shield has suspended payment determination pending receipt of additional information from Hospital, such suspension shall be deemed to be a denial of payment. Failure to timely comply with all of the procedures set forth herein will result in waiver by Hospital of its right to further appeal and pursue payment:

(a) Hospital must, within one hundred eighty (180) days of receipt of a payment or denial, submit a written appeal to Blue Shield which properly identifies the Member and claim involved, and sets forth the basis on which Hospital believes the payment amount or denial was incorrect. Initial appeals must be submitted to the address indicated on the back of the members I.D. card or to:

Blue Shield of California
Customer/Member Services
P.O. Box 272540
Chico, CA 95927-2540

Blue Shield will, within one hundred twenty (120) days of receipt of an appeal from Hospital, review the appeal and respond to Hospital in writing with either additional payment or an explanation;

(b) Hospital may further appeal the denial or payment amount by submitting a final appeal to Blue Shield. The appeal must be submitted in writing within one hundred eighty (180) days of receipt by Hospital of Blue Shield's written response to the initial appeal. The final appeal must clearly and properly identify the Member and claim involved and must set forth the basis on which Hospital believes the payment amount or denial is incorrect. That appeal must be submitted to and will be reviewed by:

Blue Shield of California
Provider Services: Hospital Network Manager
P.O. Box 629011
El Dorado Hills, CA 95762=9011

Blue Shield will, within one hundred twenty (120) days of receipt of the final appeal, review the appeal and respond to Hospital in writing with either additional payment or an explanation;

(c) If, following completion of the initial and final appeal process described above, Hospital continues to dispute the payment or denial by Blue Shield, Hospital may submit the matter to binding arbitration pursuant to Section 9.2 hereof;

(d) If Hospital fails to submit an initial or final appeal in a timely fashion as set forth in this section, Hospital waives its right to any remedies and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Blue Shield and may not pursue the Member for additional payment.

Amendment No. 4

Section 6.2, Charges to Members, is hereby deleted in its entirety and replaced with:

6.2 Charges to Members.

(a) In no event, including but not limited to nonpayment by Blue Shield or Blue Shield's insolvency or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration or reimbursement from or have any recourse against, Members or an individual responsible for their care for Covered Services. Hospital may bill Members for all non-Covered Services, including those denied as not Medically Necessary if Hospital first obtains written acknowledgment from the Member that the services are not Covered Services and will be the financial responsibility of the Member.

Whenever Blue Shield determines that a violation of this Section 6.2 has occurred, it shall take appropriate action (including without limitation the right to reimburse the Member the amount of any payment. Blue Shield will provide Hospital with an explanation of the violation and shall afford Hospital a reasonable opportunity to respond to allegation. If Hospital disputes the allegation, then Hospital shall, within 30 days of receipt of notice of the alleged violation, provide Blue Shield with a written explanation of Hospital's position and the parties shall seek to resolve the dispute pursuant to Article IX hereof. If Hospital does not provide timely written notice that the violation is disputed and does not repay to Blue Shield any amounts which Blue Shield has reimbursed the Member, then Blue Shield shall be entitled to off set such amount from any other amounts owing or becoming due to Hospital.

(b) Hospital shall not bill or collect from a Member any charges in connection with Non-Covered Services, non-Authorized services, or services determined not to be Medically Necessary unless Hospital has first obtained a written acknowledgment from the Member that such services are either not Covered Services, not Authorized, or not Medically Necessary, and that the Member, or the Member's legal representative, is financially responsible for the cost of such services. Such acknowledgment shall be obtained prior to the time that such services are provided to the Member and shall be in such form as meets the applicable requirements set forth in the Provider Manual.

(c) Hospital agrees that, in the event of Blue Shield's insolvency or other cessation of operations, Covered Services to Members shall continue through the period for which their premiums have been paid, and Covered Services to Members confined in an inpatient facility on the date of insolvency or other cessation of operations shall continue until the Member's discharge.

(d) The provisions of this Section 6.2 shall: (i) survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and, (ii) supersede any oral or written contrary agreement (now existing or hereafter entered into) between the Hospital and the Member.

(e) This Section 6.2 shall not be changed without the prior approval of the appropriate government regulatory agency.

Amendment No. 5

Section 6.4, Member Complaints and Grievances, is hereby deleted in its entirety and replaced with:

6.4 Member Complaints and Grievances. Hospital shall promptly notify Blue Shield of receipt of any claims, including professional liability claims filed or asserted by a Member against Hospital, when Hospital becomes aware of such actions. Hospital shall cooperate with Blue Shield in identifying, processing, and resolving all Member grievances and other complaints in accordance with Blue Shield's complaint/grievance process and time limits set forth in the Provider Manual, as well as in accordance with such time limits as required by state and/or federal law. Hospital shall comply with Blue Shield's resolution of any such complaints or grievances including specific findings, conclusions and orders of the Department of Managed Health Care ("DMHC") (or any successor agency).

Amendment No. 6

Section 8.1, Disclosure of Records, is hereby deleted in its entirety and replaced with:

8.1 Disclosure of Records.

(a) Hospital shall comply with all provisions of the Omnibus Reconciliation Act of 1980 regarding access to books, documents, and records. Without limiting the foregoing, Hospital shall maintain such records and provide such information to Blue Shield, the California Department of Managed Health Care ("DMHC") (or any successor agency), the Centers for Medicare and Medicaid Services ("CMS"), any Peer Review Organization ("PRO") with which Blue Shield contracts as required by CMS, the U.S. Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Governmental Officials") as required by law and as may be necessary for compliance by Blue Shield with the provisions of all state and federal laws governing Blue Shield. Blue Shield and Government Officials shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to Hospital's provision of health care services to Members, the cost of such services, and payment received by Hospital from the Member (or from others on the Member's behalf), and to the financial condition of the provider. Such records described herein shall be maintained at least six (6) years from the end of each Agreement Year, and, if this Agreement is applicable to Blue Shield's Medicare+Choice program, six (6) years from the close of CMS's fiscal year in which the contract was in effect (or for a particular record or group of records, a longer time

period when CMS or DMHC requests such longer record retention and Hospital is notified of such request by Blue Shield), and in no event for a shorter period than as may be required by the Knox-Keene Act and the regulations promulgated thereunder. All records of Hospital shall be maintained in accordance with the general standards applicable to such book or record keeping and shall be maintained during any governmental audit or investigation.

(b) Hospital shall, on request, disclose to Government Officials the method and amount of compensation or other consideration to be received by it from Blue Shield or payable by Hospital to its subcontractors. Hospital shall maintain and make available to Government Officials: (1) its subcontracts, and (2) compensation/financial records relating to such subcontracts and compensation from Blue Shield.

(c) Upon forty-eight (48) hours notice, Hospital shall make any records of its quality improvement and utilization review activities pertaining to Members available to Blue Shield's quality and utilization review committee. Such sharing of records between the two committees shall be in accordance with, and limited as required by, Sections 1157 of the California Evidence Code and 1370 of the California Health and Safety Code and shall not be construed as a waiver of any rights or privileges conferred on either party by those statutes. Except as necessary to Blue Shield's performance hereunder or as required by law, Blue Shield shall maintain the confidentiality of all Hospital medical information to which it may gain access under this Agreement. Blue Shield shall not disclose (other than to Government Officials or to Other Payors) any medical information received from the Hospital hereunder unless expressly approved by the Hospital or as required by applicable law.

Amendment No. 7

Section 10.1, Term, is hereby deleted in its entirety and replaced with:

10.1 Term. When executed by both parties, this Agreement shall become effective as of the Effective Date, and shall continue in effect for two (2) years thereafter, unless earlier terminated as set forth below. Unless either party notifies the other party at least one hundred twenty (120) days prior to the expiration of said initial two (2) year term, this Agreement shall, following expiration of the initial term, continue in effect for additional one (1) year terms until terminated as set forth below.

Amendment No. 8

Section 10.2, Termination Without Cause, is hereby deleted in its entirety and replaced with:

10.2 Termination Without Cause. During the initial term, neither party may terminate this Agreement without cause. Thereafter, either party may terminate this Agreement without

cause by giving to the other party at least one hundred twenty (120)calendar days written notice of termination. The termination shall become effective the first day of the month following the expiration of the notice period.

Amendment No. 9

Exhibit C is hereby deleted in its entirety and replaced with the Attached Exhibit C-1.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their authorized representatives:

BLUE SHIELD OF CALIFORNIA

Signature: Lisa Farnan

Print Name: Lisa Farnan

Title: Vice President, Provider Relations

Date: 11-1-04

NATIVIDAD MEDICAL CENTER

Signature:

Print Name: Lloyd Pshrowick

Title: CEO

Date: 10/29/04

Tax ID #: 94-6000524

Blue Shield of California
An Independent Member of the Blue Shield Association

Exhibit C-1

Fee for Service Hospital Agreement

COMPENSATION AMOUNTS/PAYMENT SCHEDULE

Natividad Medical Center

Effective Date: first day of the month following the 30th day after the signed Agreement is received from Hospital.

All Inpatient and Outpatient Services cited in this Exhibit C exclude physician professional services. The actual provider of service must bill these services on CMS1500 claim form or its successor, in order to receive applicable reimbursement.

I. Inpatient Services

Acute Per Diem Allowances	Year 1	Year 2
Medical/Surgical/Pediatrics	RATES REDACTED	
ICU/CCU		
NICU Level 1		
NICU Level 2		
NICU Level 3		
NICU Level 4		
Acute Rehab		
Burn		
Trauma		

Acute Case Rate Allowances	Attachment Days	Year 1	Year 2
Maternity/Delivery			
Normal Delivery	1		
Additional Days Normal			
C-Section	3		
Additional Days C Section			
Coronary Surgery[1]	15		
Percantaneous Cardiovascular Procedure (PTCA)[1]	8	RATES REDACTED	
Cardiac Catheterization[1]	8		
Intracardiac Ablation (EPS studies included.)[1]	8		
Electro Physiology Services (EPS when done separately)[1]	5		
Lithotripsy (3 categories)[1]			
Unilateral	1		
Bilateral	1		
Repeat	1		
[1]Additional Days		NA	NA

Sub-Acute/SNU/Transitional Care/Swing-bed Per Diem Allowances	Year 1	Year 2
Level 1 - Skilled Care	NA	NA
Level 2 – Comprehensive Care	NA	NA
Level 3 – Complex Care	NA	NA
Level 4 – Intensive Care	NA	NA

Psychiatric and Substance Abuse

A.

Psychiatric Services Per Diem Allowances	Year 1	Year 2
Full Hospitalization	RATES REDACTED	
Acute		
Residential		
Partial Hospitalization		
Full Day		
Half Day		

B.

Substance Abuse Services Per Diem Allowances	Year 1	Year 2
Full Hospitalization		
Acute	NA	NA
Residential	NA	NA
Partial Hospitalization		
Full Day	NA	NA
Half Day	NA	NA

Outpatient Services

A. SURGICAL SERVICES

If multiple procedures are performed, reimbursement will be made at the single highest surgical rate for the procedures performed. Outpatient surgical rates include emergency room services performed at the same time as outpatient surgery, inpatient hold-over observational time, and all other facility and technical costs including without limitation, supplies and drugs. If, however, a Member remains in Hospital's Outpatient Department for a period exceeding twenty-four (24) hours, the Member shall be deemed to have been admitted to Hospital and all such services shall be considered to be Inpatient Services and shall be reimbursed pursuant to the Inpatient Service rates set forth in this Exhibit C.

1. Blue Shield will pay the April 2004 Outpatient Surgical Group Index Fee (described below) multiplied by the Region Factor for the region in which the Hospital facility providing the service is located (described below) multiplied by:

Multiplier:

Year 1	Year 2
5.70	6.10

To determine the applicable Index Fee, the following chart will be utilized. Surgeries shall be assigned to the Outpatient Surgical Groups set forth below based on the Blue Shield Outpatient Surgical Grouper set forth in the Provider Manual.

Outpatient Surgical Group	Index Fee
0	RATES REDACTED
1	
2	
3	
4	
5	
6	
7	
8	
9	
Ungrouped	

*See Notes to Outpatient Services: Surgical Services for additional explanation.

To determine the Region Factor, the following chart will be utilized:

County	Factor	County	Factor
Alameda	1.176	Orange	1.051
Alpine	0.999	Placer	1.064
Amador	0.999	Plumas	0.999
Butte	1.007	Riverside	1.046
Calaveras	0.999	Sacramento	1.064
Colusa	0.999	San Benito	0.999
Contra Costa	1.176	San Bernardino	1.046
Del Norte	0.999	San Diego	1.040
El Dorado	1.064	San Francisco	1.156
Fresno	1.005	San Joaquin	1.014
Glenn	0.999	San Luis Obispo	1.049
Humboldt	0.999	San Mateo	1.156
Imperial	0.999	Santa Barbara	1.015
Inyo	0.999	Santa Clara	1.159
Kern	0.999	Santa Cruz	1.101
Kings	0.999	Shasta	1.047
Lake	0.999	Sierra	0.999
Lassen	0.999	Siskiyou	0.999
Los Angeles	1.063	Solano	1.118
Madera	1.005	Sonoma	1.099
Marin	1.156	Stanislaus	1.044
Mariposa	0.999	Sutter	1.007
Mendocino	0.999	Tehama	0.999
Merced	0.999	Trinity	0.999
Modoc	0.999	Tulare	0.999
Mono	0.999	Tuolumne	0.999
Monterey	**1.149**	Ventura	1.037
Napa	1.118	Yolo	0.999
Nevada	0.999	Yuba	1.007

B. EMERGENCY SERVICES AND URGENT CARE SERVICES

Blue Shield shall pay the applicable Per Case Rate, as described below, multiplied by:

Multiplier:

Year 1	Year 2
2.07	2.21

Outpatient Service	Payment Method	Rate
Emergency (Revenue Codes 450 or 451 or 452 or 459) Level 1: Limited CPT Codes: 99281, 99282 Level 2: Intermediate CPT Codes: 99283 Level 3: Comprehensive CPT codes: 99284, 99285 Level 4: Critical Care CPT Codes: 99291 **Note:** In the event Hospital does not specify the CPT code, the reimbursement will default to Level 1: Limited	Per Case By Level	RATES REDACTED
Urgent Care (Revenue Code 456) **Note:** Hospital must bill with appropriate Revenue Code and CPT-4/HCPCS code in order to receive payment for these services	Per Case	Case Rate: N/A

Emergency Services and Urgent Care Services rates include the Observation services (Revenue Code 760-769, G0244), facility/technical, laboratory, radiology, supplies, equipment use, pharmaceutical, and other services and supplies related to the encounter.

C. Dialysis Services (Not Applicable)

1. For each day of, or visit for, Medically Necessary covered dialysis therapy provided on an outpatient basis by Hospital to a Member, Blue Shield will pay Hospital the Per Visit rate set below. The Per Visit rate is exclusive of infused drugs and vaccines:

Outpatient Service	Payment Method	Hospital Per Visit Rate
Hemodialysis (Revenue Code 821 with CPT 90935, 90937)	Per Visit	NA
CAPD (Revenue Code 841 with CPT 90945, 90947)	Per Visit	NA
CAPD Training (Revenue Code 845 with CPT 90989, 90993)	Per Visit	NA
CCPD (Revenue Code 851 with CPT 90945, 90947)	Per Visit	NA
CCPD Training (Revenue Code 855 with CPT 90989, 90993)	Per Visit	NA
Mobil Dialysis (Revenue Code 829 with CPT 90999) **Note:** Hospital must bill with appropriate Revenue Code and CPT-4/HCPCS code in order to receive payment for these services	Per Visit	NA

2. Blue Shield will pay Hospital for infused drugs and vaccines administered as a part of the Outpatient Dialysis Pharmaceutical Fee Schedule as set forth in the Provider Manual. Payment shall be made as follows:

Blue Shield Outpatient Dialysis Pharmaceutical Fee Schedule (Not Applicable)

Blue Shield Outpatient Dialysis Pharmaceutical Fee Schedule reimburses at AWP less fifteen (15) percent. AWP refers to the average wholesale price of the pharmaceuticals dispensed per NDC code, based upon Hospital's purchased package size, as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

D. Infusion Therapy Services

1. For each day of, or visit for, Medically Necessary covered infusion therapy provided on an outpatient basis by Hospital to a Member, Blue Shield will pay Hospital, exclusive of the pharmaceuticals:

Service Type	Payment Method	Year 1	Year 2
Infusion Therapy (Revenue Codes 260-269, 335) Note: Hospital must bill with applicable Revenue code and CPT-4/HCPCS code in order to receive payment for these services.	Per Visit	RATES REDACTED	

2. Blue Shield will pay Hospital for pharmaceuticals administered as a part of outpatient infusion therapy as set forth in the Provider Manual. Payment shall be made as follows:

Blue Shield Outpatient Infusion Therapy Pharmaceutical Fee Schedule.

Blue Shield Outpatient Infusion Therapy Pharmaceutical Fee Schedule is set to reimburse at AWP less fifteen (15) percent. AWP refers to the average wholesale price of the pharmaceuticals dispensed per NDC code, based upon Hospital's purchased package size, as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

Compensation for Hospital's provision of outpatient infusion therapy provided to HMO and Medicare+ Choice Members is generally the financial responsibility of the Member's IPA or Medical Group.

E. Physical, Respiratory, Speech, and Occupational Therapies

For all covered outpatient physical, respiratory, speech, and occupational therapies provided by Hospital to a Member, Blue Shield shall compensate Hospital by the following per visit rates:

Outpatient Service	Payment Method	Year 1	Year 2
Physical Therapy (Revenue Code 420-424, 429)	Per Visit	RATES REDACTED	
Occupational Therapy (Revenue Code 430-434, 439)	Per Visit		
Speech Therapy (Revenue Code 440-444, 449)	Per Visit		
Respiratory Therapy (Revenue Code 410, 412, 419) Note: Hospital must bill with appropriate Revenue Code and CPT-4/HCPCS code in order to receive payment for these services	Per Visit		

Physical, Respiratory, Speech and Occupational therapy per visit rates include the facility/technical, professional, laboratory, radiology, supplies, equipment use, pharmaceutical, and other services and supplies related to the visit.

Note: Compensation for Hospital's provision of physical, respiratory, speech, and occupational therapy provided to HMO and Medicare+ Choice Members is the financial responsibility of the Member's IPA or Medical Group.

F. Outpatient Radiology, Pathology, Cardiac Cath, Angioplasty, and Diagnostic Tests

For the facility and technical component of covered outpatient radiology, pathology, and diagnostic tests provided by Hospital to a Member, Blue Shield will pay the Hospital in accordance with the following formula (a+b) X $40.6978 X multiplier, where:

1) (a) is equal to The Practice Expense Technical Component based on the April 2004 Outpatient radiology, pathology and diagnostic tests schedule multiplied by the Practice Regional Factor.

2) (b) is equal to Malpractice Expense Technical Component based on the April 2004 Outpatient radiology, pathology, and diagnostic tests schedule multiplied by the Malpractice Regional.Factor.

3) The conversion factor is equal to RATES REDACTED

4) The result will be multiplied by the multiplier

Multiplier:

Year 1	Year 2
2.76	2.95

The Practice and the Malpractice Regional Factors are based on the County in which the Hospital facility providing the service is located, determined as follows:

County Name	Practice Regional Factor	Mal-Practice Regional Factor	County Name	Practice Regional Factor	Mal-Practice Regional Factor
ALAMEDA	1.235	0.669	ORANGE	1.184	0.955
ALPINE	1.034	0.740	PLACER	1.034	0.740
AMADOR	1.034	0.740	PLUMAS	1.034	0.740
BUTTE	1.034	0.740	RIVERSIDE	1.034	0.740
CALAVERAS	1.034	0.740	SACRAMENTO	1.034	0.740
COLUSA	1.034	0.740	SAN BENITO	1.034	0.740
CONTRA COSTA	1.235	0.669	SAN BERNARDINO	1.034	0.740
DEL NORTE	1.034	0.740	SAN DIEGO	1.458	0.669
EL DORADO	1.034	0.740	SAN FRANCISCO	1.034	0.740
FRESNO	1.034	0.740	SAN JOAQUIN	1.034	0.740
GLENN	1.034	0.740	SAN LUIS OBISPO	1.432	0.663
HUMBOLDT	1.034	0.740	SAN MATEO	1.034	0.740
IMPERIAL	1.034	0.740	SANTA BARBARA	1.380	0.622
INYO	1.034	0.740	SANTA CLARA	1.034	0.740
KERN	1.034	0.740	SANTA CRUZ	1.034	0.740
KINGS	1.034	0.740	SHASTA	1.034	0.740
LAKE	1.034	0.740	SIERRA	1.034	0.740
LASSEN	1.034	0.740	SISKIYOU	1.248	0.669
LOS ANGELES	1.139	0.955	SOLANO	1.034	0.740
MADERA	1.034	0.740	SONOMA	1.034	0.740
MARIN	1.248	0.669	STANISLAUS	1.034	0.740
MARIPOSA	1.034	0.740	SUTTER	1.034	0.740
MENDOCINO	1.034	0.740	TEHAMA	1.034	0.740
MERCED	1.034	0.740	TRINITY	1.034	0.740
MODOC	1.034	0.740	TULARE	1.034	0.740
MONO	1.034	0.740	TUOLUMNE	1.125	0.763
MONTEREY	1.034	0.740	VENTURA	1.034	0.740
NAPA	1.248	0.669	YOLO	1.034	0.740
NEVADA	1.034	0.740	YUBA		

G. Clinical Laboratory Services

For the facility and technical component of all Medically Necessary covered outpatient laboratory services provided by Hospital to a Member, Blue Shield shall compensate Hospital by the April 2004 Clinical Laboratory Schedule multiplied by:

Multiplier:

Year 1	Year 2
3.33	3.56

H. Other Outpatient Services

For other outpatient covered hospital services provided to a Member which have not been specified in any of the foregoing provisions, or by reference files available on the corresponding diskettes, Blue Shield shall compensate Hospital for such services at allowed charges minus the following percentages:

Discount: RATES REDACTED

In no event will Blue Shield pay Hospital an amount for any outpatient services under this Section H which exceeds:

Year 1	Year 2
RATES REDACTED	

Reimbursement Notes

INPATIENT SERVICES

Notes to Acute Per Diem Rates:

NICU/Neonatal Services: While the mother is an inpatient of the Hospital, Blue Shield will pay a NICU/Neonatal rate only for a neonate placed in a licensed Level 2, 3, or 4 level unit. Blue Shield will pay a Level 1 rate only for a neonate placed in the Level 1 unit following the date of the mother's discharge from the Hospital.

"Level 1" refers to a licensed unit, sometimes referred to as a "Newborn Nursery" that provides routine care of apparently normal full-term newborn, or pre-term, non-NICU newborn (also known as a boarder baby) who is not discharged with the mother. **(Revenue code 171)**

"Level 2" refers to a licensed unit, sometimes referred to as "Continuing Care", for low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates. **(Revenue code 172)**

"Level 3" refers to a licensed unit, sometimes referred to as "Intermediate Care", for sick neonates who do not require intensive care but require 6-12 hours of nursing each day. **(Revenue code 173)**

"Level 4" refers to a licensed unit, sometimes referred to as "Intensive Care", for constant nursing and continuous cardiopulmonary and other support for severely ill infants. **(Revenue code 174)**

Burn Services: Blue Shield will pay a separate burn rate only when Hospital is a Certified Hospital for burn and has received Certification of Verification from the American Burn Association and American College of Surgeons. Such rate will be paid only when the burn patient is in the licensed burn unit. Upon transfer of the patient to a medical surgical or other unit, Blue Shield will pay the applicable level of care per diem rate.

Trauma Services: Blue Shield will pay a separate trauma rate only when Hospital is certified by the Emergency Medical Services EMS Authority as a Level 1, Level 2 or Level 3 Trauma Center. Blue Shield shall make the trauma determination based upon the medical records submitted with the claim, using criteria set forth in the Trauma Triage Criteria adopted by the Emergency Services Agency for the county or region where the incident occurred, or if the county or region has not adopted such criteria, by the then current Trauma Triage Criteria of the American College of Surgeons (Resource for the Optimal Care of the Injured Patient "ROCIP"). Such trauma rates

shall only be payable when the patient is reasonably receiving and in need of acute trauma service. Upon the placement of the patient in a medical surgical unit or unit for the provision of non-trauma services (as indicated by the medical records), hospital reimbursement will be at the applicable level of care per diem. Blue Shield will not pay the trauma per diem/rate for patients stabilized at another facility and subsequently transferred to the facility and the patient does not require trauma services at the facility. Such admission to the facility will be paid at the appropriate level of care per diem or applicable case rate.

The per diem rates and case rates set forth in this Exhibit C includes the cost of any medical transportation provided to a Member subsequent to the Member's admission and prior to the Member's discharge from the Hospital. Hospital shall timely pay the medical transportation provider for such services during the admission.

Notes to Acute Case Rates:

If multiple case rate services are performed, the reimbursement will be based on the single highest case rate for the procedures and services performed. The case rates set forth in this Exhibit C include inpatient/outpatient procedures as applicable.

If a Member is admitted for a service covered by a case rate, Hospital will be compensated solely on the basis of the applicable case rate -- not a per diem rate set forth in this Exhibit, whether or not the Member receives Hospital Services in addition to the case rate services during such admission.

Case Rate ICD-9 Procedure and CPT –4 code inclusions:

DESCRIPTION	CPT PROCEDURES	ICD9 PROCEDURES
Coronary Surgery	33240, 33245, 33246, 33247, 33249, 33400, 33401, 33403, 33405, 33406, 33411, 33412, 33413, 33414, 33415, 33417, 33422, 33430, 33460, 33463, 33464, 33465, 33468, 33472, 33474, 33475, 33476, 33478, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33545, 33572, 33600, 33602, 33610, 33612, 33614, 33641, 33645, 33647, 33660, 33665, 33670, 33681, 33684, 33688, 33702, 33710, 33720, 33722, 33735, 33736, 33737, 33776, 33780, 33860, 33861, 33999, 92993	3510, 3511, 3512, 3513, 3514, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3531, 3532, 3533, 3534, 3535, 3539, 3541, 3542, 3550, 3551, 3552, 3553, 3554, 3560, 3561, 3562, 3563, 3570, 3571, 3572, 3573, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3794, 3795, 3796, 3797, 3798
PTCA	92975, 92982, 92984, 92986, 92990, 92995, 92996	3596, 3601, 3602, 3605

DESCRIPTION	CPT PROCEDURES	ICD9 PROCEDURES
Cardiac Cath	36013, 93501, 93505, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93561, 93562, 95303	3721, 3722, 3723, 8852, 8853, 8854, 8855, 8856, 8857, 8858
Intracardiac Ablation (EPS Studies incl.)	93650-93652	3734
Electro Physiology Services (EPS done separately)	93600 – 93649 93654 – 93660	
Lithotripsy	50590	985 – 9859

[Note – In the event that any listed CPT or ICD9 code is modified by the industry, then Blue Shield may make conforming modifications to the above list.]

Maternity/Delivery: This case rate covers both a vaginal delivery or C-Section delivery and all complications therefrom and delivery related services. Mother and Level 1 baby(s) are included in the Maternity/Delivery case rate, except that a Level 1 rate will be paid for a neonate in such unit following the date of mother's discharge. Maternity/Delivery case rate also includes one (1) home nursing visit.

Lithotripsy: These case rates apply to inpatient removal of kidney stones using ESWL. The categories of Lithotripsy, for purposes of these case rates, are as follows:

"Unilateral/Bilateral" applies to a one-day inpatient procedure or a subsequent repeat procedure performed more than 30 days after the initial treatment.

"Repeat" applies to a one-day inpatient procedure (unilateral or bilateral) performed within 30 days of the initial treatment.

Notes to Sub-Acute Rates:

Blue Shield shall reasonably determine which sub-acute levels of care are applicable to the sub-acute services provided by Hospital. As used herein:

"Level 1" refers to the following care or care for the following conditions (Rev. Code 191):

(1) 24-Hour skilled nursing care observation and management;
(2) Routine oral, Intra-Muscular (I.M.), Injection and subcutaneous drug administration;
(3) Insulin dependent;
(4) Nasogastric (N.G.) or Gastric (G) tube (enteral feeding services and supplies included);
(5) Colostomy/ileostomy care;
(6) Foley catheter care (with daily irrigations); and/or
(7) Wound care (State I, II) decubitus post-surgical would/dressing care.

"Level 2" refers to the care/conditions set forth in Level 1, plus the following additional care or conditions (Revenue Code 192):

(1) Intravenous administration; and/or
(2) Up to two (2) hours of therapy per day, up to six (6) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:
    (a) Physical therapy;
    (b) Occupational therapy;
    (c) Speech therapy; and
    (d) Respiratory therapy.

"Level 3" refers to the care/conditions set forth in Levels 1 and 2, plus the following additional care or conditions (Revenue Code 193):

(1) Major wound care (Stage III, Intravenous (I.V.) decubitus);
(2) Permanent tracheostomies (includes supplies);
(3) Isolation;
(4) Tracheostomy requiring enteral feeding;
(5) Third generation antibiotics; and/or
(6) Mutually agreed upon diagnoses requiring extensive skilled nursing care.

"Level 4" refers to the care/conditions set forth in Levels 1, 2, and 3, plus the following additional care or conditions (Revenue Code 194):

(1) Ventilator dependent (including supplies and maintenance);
(2) Hemodialysis;
(3) Plasmapheresis;
(4) Specialty bed (e.g., Clinitron, Kin-aire, Medicus) and other specialized Durable Medical Equipment (D.M.E.);
(5) Any combination of therapy disciplines in Level 2 up to three (3) hours of therapy per day, up to six (6) days per week;
(6) Total Parenteral Nutrition (T.P.N.) and Lipids administration, supplies and solutions;
(7) Chemotherapy Intravenous (I.V.) administration, supplies and drugs; and/or
(8) Sub-acute patients which Hospital and Blue Shield mutually agree are Level 4.

OUTPATIENT SERVICES

Notes to Surgical Services:

Outpatient Surgical "Group 0"

Blue Shield considers Outpatient Surgical "Group 0" services as minor procedures, which should be performed in the physician's office. However, if Hospital can demonstrate Medical Necessity for the provision of "Group 0" Surgical Services as an Outpatient Service via an appeal to Blue Shield, in accordance with the provision set forth in Section 5.3 herein, Blue Shield shall pay Hospital in such instances for services at the lessor of Billed Charges or $200.

Hospital must bill Outpatient Surgical Services using Revenue Codes 360-369, 480, 481, 490-499, 700-709, 750-759, 790-799, or their successors, as applicable, with the appropriate surgical CPT-4 or HCPCS procedure codes.

Notes to Dialysis Services:

Hospital must bill using Revenue Codes 821, 829, 841, 845, 851, 855, or their successors, as applicable, with appropriate CPT-4/HCPCS code in order to receive applicable per visit payment.

Hospital must bill using Revenue Code 634, 635, 636, or their successors, as applicable, with appropriate J Code (HCPCS) and units of service to receive applicable payment for pharmaceuticals administered as a part of outpatient dialysis.

For new drugs or drugs that are unclassified Hospital must bill using the appropriate revenue code, unclassified J Code (HCPCS) and NDC code with description in order to receive payment. Blue Shield shall reimburse Hospital at AWP less fifteen (15) percent. AWP refers to the average

wholesale price of the pharmaceuticals dispensed per NDC code, based upon Hospital's purchased package size, as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

Notes to Infusion Therapy Services:

Hospital must bill using Revenue Codes 260-269, or 335, or their successors as applicable, in order to receive applicable per visit payment.

Hospital must bill using Revenue Code 634, 635, 636, or their successors, as applicable, with appropriate J Code (HCPCS) and units of service to receive applicable payment for pharmaceuticals administered as part of outpatient infusion therapy.

For new drugs or drugs that are unclassified Hospital must bill using the appropriate revenue code, unclassified J Code (HCPCS) and NDC code with description in order to receive payment. Blue Shield shall reimburse Hospital at AWP less fifteen (15) percent. AWP refers to the average wholesale price of the pharmaceuticals dispensed per NDC code, based upon Hospital's purchased package size, as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

Notes to Outpatient Radiology, Pathology, and Diagnostic Tests:

Hospital must bill Outpatient Radiology, Pathology, and Diagnostics services using Revenue Codes 310-321, 324, 329-330, 333, 339, 340-359, 400-403, 409, 460, 469, 480-483, 489, 610-619, 730-759, or their successors, as applicable, with the appropriate diagnostic CPT-4 or HCPCS procedure codes.

Notes to Clinical Laboratory:

Hospital must bill Outpatient Clinical Laboratory services using Revenue Codes 300-309, 923-925, or their successors, as applicable, with the appropriate CPT-4 or HCPCS procedure codes.

General Notes:

Compensation Amounts: Blue Shield shall pay Hospital for the Covered Hospital Services actually provided to Members enrolled in Blue Shield's commercial benefit plans at the lesser of: (1) Hospital's billed charges, or (2) the rates and terms set forth in Exhibit C. hereto, minus any applicable Copayment. Blue Shield shall pay Hospital for the Covered Hospital Services actually provided to Members enrolled in Blue Shield's Medicare+Choice program the lesser of: (1) Hospital's billed charges, (2) the compensation rates set forth in Exhibit C., or (3) the reimbursement rates established by the Medicare program (inpatient and outpatient) for such services minus any applicable Copayment. Copayments shall be calculated based on the lesser of Hospitals' usual billing rate or the negotiated rate under this Agreement. Payment shall be made by Blue Shield within

the time-frames mandated by applicable state or federal law following receipt of all reasonably necessary information. Hospital shall accept the compensation amounts set forth herein as full and complete payment for all Covered Hospital Services rendered to Members, with the exception of authorized Copayments.

Allowed Charges: Prior to calculating the reimbursement amount, Blue Shield reviews hospital billed charge invoices to determine which charges are "allowed." The parties hereto agree that, as part of the review process, Blue Shield may disallow the following types of charges:

- Patient comfort/convenience items
- Daily or bundled supply charges
- Incremental nursing special or personnel charges
- Ventilator/respiratory charges in the ICU context
- Daily or per diem equipment fees, collection charges
- Draw Fees, venipuncture fees, collection charges
- Stat charges, after hour charges, "emergency use of" charges
- Portable fees/transportation charges
- Monitoring fees/charges
- Services/supplies considered as included in a global procedure charge(s)
- Set-up charges
- Duplicate charges
- "Miscellaneous" charges/supplies not specifically identified or described
- Stand-by charges
- Late charges, audit rebill charges, corrected billings submitted after the original claim has been processed or paid for which no documentation is submitted to substantiate them or to identify what has been corrected.

1. No modification in the charge master or in rates charged by Hospital for Blue Shield Members shall be implemented for Blue Shield Members nor shall it be effective with respect to this Agreement until after thirty (30) days prior written notice to Blue Shield. In the event of an individual or cumulative increase in Hospital's charge master during any Agreement Year that exceeds RATES REDACTED the Charge Master "Modification Allowance"), Blue Shield may adjust any percentage compensation amounts set forth in the Exhibit C. in effect on the effective date of the increase, plus any subsequent Exhibit(s) C. added to the Agreement after the increase, by the amount of the increase, less the Modification Allowance. In the event of an individual or cumulative increase in Hospital's charge master during any Agreement Year that exceeds the Charge Master "Modification Allowance", Blue Shield may increase the Stop Loss Attachment Level set forth in the Exhibit C. in effect on the effective date of the increase, plus any subsequent Exhibit(s) C. added to the Agreement after the increase, by the amount of the increase, less the Modification Allowance.

2. For Members enrolled in Blue Shield's Medicare+Choice program, Hospital agrees to accept as payment in full from Blue Shield, minus applicable copayments, the lesser of: (1) Hospital's billed charges, (2) the compensation rates set forth in this Exhibit C., or, (3) the reimbursement rates established by the Medicare program for such services. Determination of the applicable reimbursement methodology shall be based on the complete bill submitted by Hospital and not on an individual portion thereof or interim bill.