Blue Shield of California

Fee For Service Hospital Agreement

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

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BLUE SHIELD OF CALIFORNIA
FEE FOR SERVICE HOSPITAL AGREEMENT

This Agreement is entered into between Natividad Medical Center, a California corporation (hereinafter "Hospital"), and California Physicians' Service, Inc., d.b.a., Blue Shield of California, a California nonprofit corporation (hereinafter "Blue Shield"). The Effective Date of this Agreement is the first day of the month following the 30th day after the signed Agreement is received from Hospital. Hospital and Blue Shield agree that, upon Blue Shield's receipt of this Agreement signed by Hospital, Blue Shield shall enter the effective date above the signature block.

RECITALS

A. Blue Shield is licensed as a prepaid health care service plan under the Knox-Keene Act of 1975 ("the Knox-Keene Act");

B. Blue Shield contracts with individuals, associations, employer groups and governmental entities to provide or to arrange for the provision of covered HMO and PPO health care services to Members of Blue Shield;

C. Hospital owns and operates an acute care hospital and is duly licensed and qualified to provide services to Members of Blue Shield;

D. Hospital and Blue Shield desire that Hospital provide services to Members in accordance with the terms of this Agreement;

E. Except as specifically noted, this Agreement is applicable to all Members enrolled under Blue Shield's Benefit Programs, including Medicare beneficiaries enrolled in Blue Shield's Medicare+Choice program. This Agreement shall not apply to Members enrolled in HMO nor Medicare+Choice programs for which Hospital receives capitation payments pursuant to a separate capitated hospital agreement, if any, between Hospital and Blue Shield.

I. DEFINITIONS

For the purposes of this Agreement, terms shall have the following meanings:

1.1 Agreement Year: is the twelve month period beginning at 12:01 a.m. on the Effective Date of this Agreement, and on each anniversary of the Effective Date.

1.2 Authorization: is the procedure for obtaining the prior approval of Blue Shield, or its delegatee, for the provision of Covered Services. Such approval shall be requested and

provided pursuant to authorization procedures established from time to time by Blue Shield as described in the Provider Manual and in Section 2.6 hereof.

1.3 Benefit Program: is a group or individual benefit program offered by Blue Shield through health services contracts (and riders thereto).

1.4 Blue Shield Providers(s): are those licensed healthcare providers, including acute care hospitals, which have entered into agreements with Blue Shield to provide Covered Services to Members.

1.5 Case Rate: is the all-inclusive rate, as set forth in Exhibit C., for specified types of care, which is paid regardless of the type or defined duration of services provided by the Hospital. For specified care/diagnoses, Blue Shield pays Hospital the stated Case Rate in lieu of the Per Diem rate.

1.6 Copayments: refers to any copayments, deductibles, and coinsurance which are specifically described as the financial responsibility of the Member for a Covered Service in the applicable Health Services Contract and/or Evidence of Coverage in effect as of the date of service. Any other amount which Hospital may seek to recover from Members for Covered Services constitutes a surcharge and is prohibited by both this Agreement and by the Knox-Keene Act.

1.7 Covered Services: are the Medically Necessary healthcare services which a Member is entitled to receive pursuant to the Health Services Contract and Evidence of Coverage applicable to the Member. Except as otherwise provided in the Member's Health Services Contract and Evidence of Coverage, Covered Services generally must be referred and authorized in conformity with Blue Shield's Utilization Management program.

1.8 Emergency Services: are Covered Services to address a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause the prudent layperson to conclude that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the Member's health in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part. For Blue Shield Medicare+Choice Members, Emergency Services also include any other services defined as emergency services in 42 C.F.R. §422.113.

1.9 Evidence of Coverage: is the document issued to the Member pursuant to California law which describes the benefits, limitations and other features of the Benefit Program in which the Member is enrolled.

1.10 Health Services Contract: is the group or individual contract, applicable to the Member, which sets forth the Benefit Program and the Covered Services to which the Member is entitled, as well as the Member's Copayment obligation.

1.11 Hospital Services: are those services which Hospital is licensed to provide and customarily provides and which are included in the Hospital Services Inventory, Exhibit B.

Hospital shall provide Blue Shield with timely notice of changes to and updates to the Hospital Service Inventory. Blue Shield shall be entitled to rely on the completeness of the Hospital Service Inventory provided by Hospital. If Hospital adds a category of service or a new unit, the terms of this Agreement will apply to such services, including the compensation amounts set forth in Exhibit C; for any new Inpatient unit or category of service, Hospital shall accept payment of the lower of Hospital's billed charges for the unit/service or the Medical/Surgical/Pediatric acute per diem rate set forth in Exhibit C. until such time as Blue Shield and Hospital shall have negotiated and agreed upon a separate reimbursement rate for such unit or service. Hospital Services shall not include physician services except as specifically set forth in Exhibit C. (physician services must be billed separately using a HCFA 1500 form with reimbursement based upon Blue Shield's physician allowance schedule).

1.12 Inpatient Services: are covered Hospital Services provided to a Member who (a) is admitted to Hospital as a registered bed patient with the expectation of staying overnight, and, (b) is receiving services which are ordered by and under the direction of a physician or other health care provider with appropriate medical staff membership and clinical privileges at Hospital, including services provided to the Member within twelve (12) hours prior to admission as an inpatient, if related to the condition for which the Member is admitted, and transportation services required for treatment of the Member following admission as an inpatient at Hospital and until discharge.

1.13 Medically Necessary: services or supplies means those medical services and supplies which are required by a Member, which are provided in accordance with recognized professional medical and surgical practices and standards which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; and (b) provided for the diagnosis and direct care and treatment of such medical condition; and (c) not furnished primarily for the convenience of the Member, the Member's family, or the treating provider or other provider; and (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) with respect to Inpatient Services, could not have been provided in a physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and (f) consistent with Blue Shield Medical Policy.

1.14 Member: is an individual who is, according to Blue Shield's rules and policies, eligible for and enrolled in a Blue Shield Benefit Program. Member includes an enrollee in the plan of an Other Payor as described in Article XII.

1.15 Outpatient Services: are covered Hospital Services provided to a Member by Hospital which are not Inpatient Services. If a Member remains in any emergency room(s) or outpatient department(s) of the Hospital for a period exceeding twenty-four (24) hours, the Member will be deemed to have been admitted and services shall be considered to be Inpatient Services.

1.16 Per Diem: is an established all-inclusive rate paid per day, agreed to in advance by the Hospital and Blue Shield, which Hospital will accept as payment in full, including deductibles and Copayments, for covered Inpatient Services provided to Blue Shield Members.

1.17 Provider Manual: refers to the manuals developed by Blue Shield which set forth the operational rules and procedures applicable to the Hospital and the performance of services hereunder, as well as to other documents utilized by Blue Shield to determine reimbursement rates under the terms of the Agreement (including but not limited to the following: Outpatient Surgical Grouper, APG Outpatient Surgical Services Grouper; Outpatient Radiology, Heart Catheterization, Angioplasty, and Pathology Schedule; Clinical Laboratory Schedule; and Outpatient Infusion Therapy Fee Schedule Pharmaceutical Fee Schedule; Blue Shield Outpatient Dialysis Pharmaceutical Fee Schedule.)

1.18 Urgent Care Services: are those Covered Services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness, injury, or medical condition with respect to which treatment can not reasonably be delayed. For Medicare+Choice Members, Urgent Care Services, at a minimum, include all services which are defined by Center for Medicare and Medicaid Services (CMS) as "Urgently Needed Services".

II. OBLIGATIONS OF HOSPITAL

2.1 Hospital Services. Hospital shall provide all Medically Necessary Hospital Services to Members. Such services shall be provided at and be reasonably available at the locations set forth in Exhibit A.

2.2 Availability.

(a) Hospital shall provide to Members all Hospital Services as directed by Members' physicians or as otherwise Medically Necessary. Hospital must obtain prior Authorization for Hospital Services, as set forth in Section 2.6 hereof. Thereafter, prior Authorization must be obtained before providing any Hospital Services which are not to be compensated hereunder by any authorized per diem amounts, except with respect to Emergency Services.

(b) Subject to bed availability and compliance with its admission criteria, Hospital will accept authorized admissions of Members twenty-four (24) hours a day.

2.3 Licensure & Accreditation. Hospital shall be, and remain, licensed by the state of California, certified under Title XVIII of the Social Security Act, and accredited by the Joint Commission on Accreditation of Health Care Organizations (Joint Commission).

2.4 Standards For Provision of Care. Hospital shall maintain facilities and equipment which meet all applicable legal requirements. Hospital shall further comply with all federal and state laws, licensing requirements and professional standards and shall provide its services in accordance with generally accepted Hospital practices and standards prevailing in the applicable professional community at the time of treatment.

2.5 Quality Improvement/ Case Management/ Utilization Management Programs. Hospital shall fully cooperate with and participate in Blue Shield's quality improvement and utilization management programs, including its authorization procedures, as set forth herein and as described in the Provider Manual. Hospital shall cooperate fully with Blue Shield with regard to the Health Employer Data Information Sets (HEDIS) measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring and quality improvement studies and initiatives. Moreover, Hospital shall cooperate fully in the Patient's Evaluation of Performance in California ("PEP-C") consumer survey effort. Hospital shall comply with Blue Shield's Medical Policy. Hospital shall comply with and accept as final, the decisions of the Blue Shield Quality Improvement and Utilization Management program, and pending resolution of any dispute through the provider dispute resolution process, comply with the decisions of Blue Shield's Quality Improvement and Utilization Management program.

2.6 Service Authorization. Hospital shall comply with the Prior Authorization requirements as set forth in Exhibit D. hereto and in the Provider Manual. Hospital understands and agrees that, except in the case of an Emergency, Hospital Services must be Authorized in advance by Blue Shield or its delegatee in order for Hospital to be eligible for payment for Covered Services. In the case of an Emergency, Hospital shall obtain the authorization of Blue Shield or its delegatee as soon as possible, but in no event later than twenty-four (24) hours after any admission, or the next occurring non-holiday weekday, whichever is later. Provided Hospital has submitted full and accurate information to Blue Shield for review under its Quality Improvement and Utilization Management Program, Blue Shield will not retroactively deny Hospital's claims on the basis of Medical Necessary for services reviewed and authorized pursuant to the Program. If Hospital fails to obtain Authorization prior to providing Hospital Services to a Member, as required, or if Hospital provides services outside of the scope of the Authorization obtained, then Blue Shield, or its delegatee, shall have no obligation to compensate Hospital for such services; Hospital will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, from any delegatee or from the Member.

2.7 Physician Access. Hospital shall permit appropriate access to the Members' physicians who have medical staff membership to provide professional services to a Member at Hospital in accordance with the bylaws, rules and regulations established by the Hospital with the approval of Hospital's governing board. Members' physicians shall not be denied staff membership or clinical privileges on the basis of sex, race, age, religion, color or national original, sexual orientation, disability, or any other criteria lacking professional justification, nor will such privileges be arbitrarily delayed. Further, when a Participating Physician with active privileges at Hospital cannot be found in a specialty area, Hospital shall consider

requests from qualified persons for temporary privileges at Hospital in as rapid a manner as possible, taking into consideration possible emergency situations, provided such persons meet and conform to the requirements of Hospital's medical staff bylaws and rules and regulations for temporary privileges.

2.8 Cooperation with Discharge Planning. Hospital shall cooperate with Blue Shield or its delegatee in reasonable discharge planning of Members.

2.9 Disclosures.

Hospital shall notify Blue Shield immediately in writing if it becomes aware of the occurrence of any of the following events: (i) Loss or restriction of any license or certification required in order for Hospital to offer Hospital Services, (ii) Loss of accreditation by the Joint Commission on Accreditation of Health Care Organizations, (iii) Loss of certification as a Medicare provider under the Social Security Act, (iv) Hospital's liability insurance is canceled, terminated, not renewed, or materially modified; (v) Hospital has become a defendant in a lawsuit filed by a Member or is required or agrees to pay damages to a Member for any reason; (vi) any labor action or work stoppage which may materially impact Hospital's operations, (vii) an act of nature or any event occurs which has a materially adverse effect on Hospital's ability to perform its obligations hereunder; (viii) a petition is filed to declare Hospital bankrupt or for reorganization under the bankruptcy laws of the United States or a receiver is appointed over all or any portion of the Hospital's assets; or (ix) any other situation arises which could reasonably be expected to materially affect Hospital's ability to carry out its obligations under this Agreement. Hospital shall also provide Blue Shield with advance notice of any proposed material change in the ownership of Hospital, and/or the sale of all or substantially all of the assets of the Hospital and obtain Blue Shield's prior approval of same, which approval shall not be unreasonably withheld.

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.

(b) In the event of an overall increase in Hospital's charge master, 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%**

[(1+Actual Charge Master Increase)/1.00]x(Current Stoploss Threshold)=Adjusted Stop Loss Attachment Level

Example,
No modification to charge master allowed, 15% Actual, $70,000 current stop loss attachment level, [(1+.15)/1.00]x$70,000 = **$80,500**

(c) Blue Shield will provide Hospital with an Addendum that includes revised Exhibit(s) C. to reflect the changes to the percentage compensation amounts and Stop Loss Attachment Level 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.

2.11 Collection for Non-Covered Services. If Blue Shield denies Prior Authorization for a service, the Member may be held financially responsible provided Hospital informs the Member prior to rendering the service that Authorization has not been obtained or has been denied and obtains a written acknowledgment of financial liability from the Member or responsible party. The written acknowledgment must specify the services denied and for which the Member is agreeing to accept financial responsibility.

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. 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.

III. OBLIGATIONS OF BLUE SHIELD

3.1 Directory and Use of Names.

(a) Blue Shield shall develop a directory of healthcare providers participating in Blue Shield which shall be distributed to Members. Blue Shield may provide a draft of such directory to Hospital and Hospital may, within five (5) working days thereafter, submit to Blue Shield, any additions, deletions, or modifications to be included in the directory. Hospital, agrees that the following information may be included in Blue Shield's marketing materials, Blue Shield publications provided to present or potential Members and subscriber groups, and in other written or electronic information sources provided to current or potential Members and subscriber groups: (i) Hospital's name, address, phone number; and, (ii) such other types of information regarding Hospital which are reasonable to include in directories, marketing materials, or publications. Hospital agrees that in the event this Agreement is terminated, or the listing information is or becomes incorrect or incomplete, Blue Shield will have no obligation to correct, delete, or update such listing information until such time as Blue Shield, in its sole discretion, issues a new directory, marketing materials, or Blue Shield publication.

(b) Hospital may identify itself as a participating/contracting hospital with Blue Shield.

(c) Except as provided in subparts (a) and (b) above, neither Blue Shield nor Hospital shall use the other's name, trademark(s), or service mark(s), without the other's prior written consent, which consent shall not be unreasonably withheld.

3.2 Provider Manual. Blue Shield shall develop a Provider Manual, and Hospital shall comply with its provisions. Blue Shield may, in its discretion, periodically modify the Provider Manual by written notice to Hospital. The Provider Manual, as so amended from time to time, is incorporated herein by reference. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. Blue Shield will provide Hospital with 60 days' advance notice of any proposed changes in the Provider Manual. In the event Hospital reasonably concludes that a change in the Provider Manual is material and would have an adverse financial impact on the Hospital, Hospital and Blue Shield shall confer in good faith regarding the change. If Hospital and Blue Shield are unable to reach agreement regarding the change, then Hospital may elect to terminate this Agreement for cause pursuant to Section 10.3 hereof, and the Provider Manual change to which Hospital objected shall not be effective as to Hospital during the termination notice period.

3.3 Administrative Services. Blue Shield shall perform those services incident to the administration of a health care service plan including, but not limited to, the processing of enrollment applications, and the administration of claims for Covered Services which are the payment responsibility of Blue Shield.

IV. ELIGIBILITY OF BLUE SHIELD MEMBERS

4.1 Identification Cards and Verification. Blue Shield shall issue identification cards to Members as set forth in the Provider Manual. Production of such identification cards shall be indicative of, but not conclusive of, a person's status as a Member. Blue Shield shall provide or shall make available to Hospital in formats that may be accessed by Hospital electronically or telephonically, information regarding Member status.

4.2 Verification of Eligibility. As set forth in the Provider Manual, Hospital shall verify the eligibility of Members. Hospital shall be entitled to reasonably rely on verification of Member eligibility as provided by Blue Shield and Blue Shield shall hold Hospital harmless if Hospital reasonably relies on that verification. In the event that Hospital fails to verify Member eligibility in accordance with procedures set forth in the Provider Manual, Blue Shield shall have no obligation to compensate Hospital for any services provided to patients who are not Members of Blue Shield at the time such services are rendered.

V. COMPENSATION & FINANCIAL TERMS

5.1 Compensation Amounts.

(a) In the event that Hospital provides Covered Hospital Services to Members for whom such services are not the financial responsibility of a provider (including Hospital) who is capitated by Blue Shield for such services as set forth in subpart (b), Hospital shall bill Blue Shield for the provision of such Hospital Services as set forth in the Provider Manual. 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. 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.

(b) Notwithstanding paragraph (a) above, 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 Exhibit C., or, (3) the reimbursement rates established by the Medicare program (inpatient and outpatient) 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.

(c) If the Member is enrolled in a Benefit Program for which Blue Shield pays capitation to a provider (including Hospital) for Covered Hospital Services, then Hospital agrees that Hospital shall submit billings to and seek payment from such capitated provider for Covered Services, in accordance with procedures set forth in the Provider Manual. In the event that Hospital is unable to obtain payment from such capitated provider, Hospital shall notify Blue Shield. Blue Shield shall, within sixty (60) days, seek to resolve the non-payment by the capitated provider. Hospital agrees that, in the event that another capitated provider is financially responsible for such Covered Services and that capitated provider does not have an agreement in effect with Hospital, payment by that capitated provider (or by Blue Shield on behalf of that capitated provider) may be made in accordance with the compensation terms set forth in this Agreement.

(d) Notwithstanding subparts (a) or (b) , in the event that Blue Shield is not the primary payor under the coordination of benefit rules, Hospital shall not make any demand for payment from Blue Shield until all primary sources of payment have been pursued. Blue Shield's obligation hereunder with respect to such Covered Services, shall be limited to the amount, if any, which when added to the amount obtained by Hospital from such primary payors, equals the amount of compensation to which Hospital is entitled under this Agreement for such services.

5.2 Copayments. Hospital shall collect and retain, as additional compensation, the Member's applicable Copayment for Covered Services provided. Such Copayment obligation shall not be waived by Hospital.

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 twenty (120) 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 twenty (120) 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.

5.4 Payment Audits & Overpayment Recoveries. Blue Shield shall have the right to audit payments made to Hospital. Such audits, if any, will be conducted within twelve (12) months of the date of payment by Blue Shield. In the event Blue Shield determines that it has made a payment to Hospital which exceeds the amount to which Hospital is entitled under this Agreement for Covered Services, then Blue Shield shall be entitled to off-set the payment from any other amounts owing or becoming due to Hospital. Unless the overpayment is the result of fraud or misrepresentation on the part of Hospital, Blue Shield shall off-set such overpayment within twelve (12) months of the date the payment was made. Blue Shield shall provide Hospital with an explanation as to the reasons and basis of calculation of all such adjustments and afford Hospital a reasonable opportunity to challenge such actions. In addition, if Blue Shield determines that Hospital has overcharged an individual properly identified as a Member of an Other Payor, as defined in Section 12.1, covered by this Agreement, Hospital shall promptly refund such overpayment to Blue Shield or to such Member, as applicable, upon notification by Blue Shield of such overcharge within twelve (12) months of the date the payment was made.

5.5 Late Charge Master Notification Recoveries: Notwithstanding the limitations of Section 5.4, if Hospital fails to give Blue Shield timely notice of changes to Hospital's charge master in accordance with Sections 2.10 and 2.12 hereof and such change results in a change in the percentage compensation amounts set forth in Exhibit C., Blue Shield shall have the right to recalculate all payments made to Hospital for services rendered after the date the charge master was implemented and to recover any overpayments resulting from the reduction in the percentage compensation within twelve (12) months of the date the payments were made, unless the overpayment is the result of fraud or misrepresentation on the part of Hospital. Blue Shield shall complete such calculations within 120 days of the date that Hospital provides Blue Shield with notice of the charge master change, and Blue Shield shall provide Hospital with a detailed accounting and reconciliation of all resulting overpayments. If Hospital fails within thirty (30) days to either repay the overpaid amounts or give written notice that the amount is in dispute, then Blue Shield shall have the right to recoup the overpayment amounts within twelve (12) months of the date the payments were made from subsequent payments to Hospital under this or any other agreement between Hospital and Blue Shield.

5.6 Right To Audit Charge Master Blue Shield shall have the right to audit the Hospital's charge master to enforce Hospital's obligations under Sections 2.10 and 2.12 hereof.

VI. PROTECTION OF MEMBERS

6.1 Non-discrimination. Except as otherwise provided in this Agreement, Hospital shall make Covered Services available to Members in the same manner, in accordance with the same standards, and with no less availability as Hospital provides services to their other patients. Hospital shall not discriminate against any Member in its provision of Covered Services on account of race, sex, color, religion, national origin, ancestry, age, physical or mental handicap, health status, disability, need for medical care, sexual preference, or veteran's status, or status as a Member of Blue Shield.

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. Nor shall Hospital seek payment from Members or individuals responsible for their care, for payments for Covered Services denied by Blue Shield because such bill or claim was not timely or properly submitted, or because the rendered services were not Medically Necessary or Authorized. Whenever Blue Shield receives notice of a violation of this Section 6.2, it shall take appropriate action (including without limitation the right to reimburse the Member the amount of any payment and offset the amount of such payment from any amounts then or thereafter owed by Blue Shield 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.

6.3 Benefits Determination. All final decisions regarding coverage are reserved to Blue Shield, and Hospital shall refer Members who have inquiries or disputes regarding such coverage to Blue Shield for resolution and response. This provision, however, does not and shall not be construed to prohibit any physician from providing any medical, treatment, or other advice which such physician believes to be in the best interest of the patient.

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. 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).

6.5 Medical Necessity Assistance. In all cases where Blue Shield or a delegatee has made a determination regarding the Medical Necessity of a medical service requested or provided to a Member, Hospital shall, upon the request of Blue Shield, assist Blue Shield in determining the Medical Necessity of such service and provide relevant medical records to Blue Shield and participate in any grievance, arbitration, and/or other proceedings in which such Medical

Necessity determination is an issue. Moreover, Hospital agrees to cooperate with and abide by the Medical Necessity determination of any external review entity to which Blue Shield is either obligated by law to submit such disputes or for which Blue Shield has implemented a program to submit such disputes to external review.

6.6 Free Exchange of Information. No provision of this agreement shall be construed to prohibit, nor shall any provision in any contract between Hospital and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's health plan, and the Member's right to appeal any adverse decision made by Hospital or Blue Shield regarding coverage of treatment which has been recommended or rendered. Moreover, Hospital shall neither penalize nor sanction any health care provider in any way for engaging in such free, open and unrestricted communication with a Member or for advocating for a particular service on a Member's behalf.

6.7 Insurance.

(a) Hospital shall maintain professional liability (malpractice) insurance and general liability insurance coverage in the minimum amount of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate. If Hospital has a claims made malpractice insurance policy, it agrees to keep the policy in effect for at least five (5) years past any termination of this Agreement or purchase extended reporting coverage (tail insurance).

(b) Hospital shall maintain Workers' Compensation insurance covering all employees of Hospital.

(c) Hospital shall notify and provide evidence to Blue Shield at the time of any amendment, change or modification to such insurance coverage and at any time on reasonable request by Blue Shield during the term of this Agreement.

VII. MEDICAL RECORDS & CONFIDENTIALITY

7.1 Medical Records. Hospital shall maintain the usual and customary records for Members in the same manner as for other patients of Hospital. Hospital will require that all physicians treating Members at Hospital's facility establish and maintain in an accurate and timely manner for each Member who has obtained care from such physician a medical record which is organized in a manner which contains such demographic and clinical information as is necessary, in the opinion of the Blue Shield medical director and the Hospital medical director, to provide documentation as to the medical problems and medical services provided to the Member. Such records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the provider.

Such records shall be in such a form as to allow trained health professionals, other than the provider, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the care provided. Such records shall, upon request, and within reasonable time requirements, be made available without charge to Blue Shield and its designated agents. Without limiting the foregoing, Hospital shall, without charge, transmit Member's medical records information to a Member's other providers, to Government Officials, and to Blue Shield for purposes of utilization management, quality improvement and other Blue Shield administrative purposes. Hospital shall secure from the Member on admission a release of medical information in the event such a release is required by law.

7.2 Confidentiality. Hospital shall comply with all applicable state and federal laws regarding privacy and confidentiality of medical information and records, including mental health records. Hospital shall develop policies and procedures to ensure that Member medical records are not disclosed in violation of Cal. Civ. Code §§ 56, et seq and all other applicable state and federal law. To the extent Hospital receives, maintains or transmits medical or personal information of Members electronically, Hospital shall comply with all state and federal laws relating to protection of such information including, but not limited to the Health Insurance Portability & Accountability Act (HIPAA) provisions on security and confidentiality and any CMS regulations or directives relating to Medicare beneficiaries.

7.3 Member Access to Records. Hospital shall ensure that Members have access to their medical records in accordance with the requirements of state and federal law.

VIII. COOPERATION WITH AUDITS & CERTIFICATIONS

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 and provider credentialing files 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.

(d) Blue Shield, at its sole cost and expense, and with reasonable prior notice to Hospital, may from time to time audit the books and records of Hospital as they relate to its services, claims payments, reporting, and billings under this Agreement.

8.2 Site Evaluations. Hospital shall permit Government Officials and Blue Shield to conduct periodic site evaluations and inspections of their facilities and records. In the event that Government Officials or Blue Shield find any deficiencies in such facilities or records, Hospital shall have thirty (30) days to substantially correct such deficiencies which are identified by such Government Officials or Blue Shield.

8.3 Accreditation Surveys. Hospital shall cooperate in the manner described in Sections 8.1 and 8.2 hereof with respect to surveys and site evaluations relating to accreditation of Blue Shield by NCQA or any other accrediting organization. Hospital further agrees to promptly implement any changes reasonably required as a result of all such surveys.

8.4 Compliance Monitoring. Hospital shall cooperate with Blue Shield in the performance of any monitoring, studies, evaluations analyses or surveys required by Government Officials or accrediting organizations of Hospital's performance of services hereunder.

IX. RESOLUTION OF DISPUTES

9.1 Provider Dispute Resolution Procedure. Blue Shield and Hospital agree to meet and confer in good faith to resolve any disputes that arise under this Agreement. Except for disputes relating to payment amounts which disputes shall be governed exclusively by Section 5.3 hereof, and the procedure whereby this Agreement may be terminated, which disputes shall be governed exclusively by Section 9.2 hereof, if a dispute remains unresolved, it may be referred to the Blue Shield Provider Dispute Resolution Committee. Disputes may be submitted in writing addressed to Blue Shield Dispute Resolution Committee, Attn: Network Manager, Provider Services, P. O. Box 629011, El Dorado Hills, CA 95762-9011. Disputes referred to the Blue Shield Provider Dispute Resolution Committee shall be decided within thirty (30) days of referral. If such disputes cannot be resolved by the Blue Shield Provider Dispute Resolution Committee, Blue Shield and Hospital agree to submit the dispute to binding arbitration pursuant to Section 9.2 of this Agreement. Pursuit by Hospital of a dispute through the processes described in this Article IX. shall neither modify nor relieve Hospital of any obligations to continue to provide services to Members in accordance with and to comply with all terms of this Agreement.

9.2 Arbitration of Disputes. If any dispute or controversy (other than a claim of medical malpractice) arises between the parties to this Agreement which exceeds the jurisdiction of Small Claims Court, which was not resolved in the payment appeals procedure set forth in Section 5.3 or in the Provider Dispute Resolution procedure set forth in Section 9.1, and which may directly or indirectly concern or involve any term, covenant, or condition hereof, the parties shall settle the dispute by final and binding arbitration in San Francisco, Los Angeles, San Diego or Sacramento, California, whichever city is closest to the Hospital. Arbitration shall be conducted under the Commercial Rules of the American Arbitration Association. The arbitration decision shall be binding on both parties. It is agreed that the arbitrator shall be bound by applicable state and federal law and that the arbitrator shall issue written findings of fact and conclusions of law. The arbitrator shall have no authority to award damages or provide a remedy which would not be available to such prevailing party in a court of law nor shall the arbitrator have the authority to award punitive damages. The cost of the arbitration shall be shared equally by Hospital and Plan. Each party shall be responsible for its own attorneys' fees.

9.3 Limitation of Actions. A Demand for Arbitration pursuant to Section 9.2 hereof must be filed within twenty-four (24) months of the alleged breach. Should the aggrieved party fail to file a Demand for Arbitration of the dispute within the time-frame set forth herein, the aggrieved party shall have waived its rights and remedies with respect to the alleged breach. The aggrieved party shall have no right to pursue any remedy with respect to such alleged breach, including, but not limited to, initiation of any civil action in state or federal court, and, if the aggrieved party is Hospital, Hospital shall have no right to pursue payment of any disputed amounts from the Member.

X. TERM & TERMINATION

10.1 Term. When executed by both parties, this Agreement shall become effective as of the Effective Date, and shall continue in effect for three (3) years thereafter, unless earlier terminated as set forth below. Unless either party notifies the other party at least one hundred eighty (180) days prior to the expiration of said initial three (3) 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.

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 eighty (180) calendar days written notice of termination. The termination shall become effective the first day of the month following the expiration of the notice period.

10.3 Termination for Cause. Either party may, subject to the cure period set forth in Section 10.4, terminate this Agreement for material cause after written notice as set forth hereinafter. The following shall constitute a material cause for termination:

(a) By Hospital (i) revocation of Blue Shield's license necessary for the performance of this Agreement; or, (ii) Blue Shield breaches any material term, covenant, or condition of this Agreement.

(b) By Blue Shield (i) the filing of bankruptcy by Hospital, a parent or subsidiary or substantial deterioration in the financial condition of a parent, affiliate or subsidiary, or, (ii) Hospital fails to provide quality medical services consistent with the standards set forth in this Agreement and in the Provider Manual, or, (iii) any license required in order for Hospital to provide Covered Services hereunder is revoked, terminated or restricted in any way, or, (iv) Hospital breaches any material term, covenant, or condition of this Agreement, including repeated failure to comply with procedures set forth in the Provider Manual.

Notwithstanding any provision of Section 10.4 to the contrary, Blue Shield may immediately terminate this Agreement in the event that Hospital is excluded from participation in Medicare or Hospital fails to maintain all insurance required herein, or if Blue Shield, after consultation with Hospital, determines in good faith that continuation of this Agreement may reasonably be expected to jeopardize the health, safety, or welfare of Members, or if Blue Shield reasonably determines, after consulting with Hospital, that Hospital is likely to be financially unable to provide Covered Services in a competent and timely manner.

10.4 Notice and Cure Period. A party seeking to terminate this Agreement for material breach shall notify the other party in writing of the nature of the breach and the other party shall have thirty (30) days from the receipt of such notice to cure or otherwise eliminate such cause. If the other party does not remedy the breach, to the reasonable satisfaction of the non-breaching party, this Agreement shall terminate at the end of the thirty (30) day period.

10.5 Termination Not an Exclusive Remedy. The termination of this Agreement by either party pursuant to this Article X. is not an exclusive remedy and such terminating party retains whatever rights in law or equity as may be necessary to enforce its rights under this Agreement.

10.6 Effect of Termination. As of the date of termination, this Agreement shall be considered of no further force or effect whatsoever, and each of the parties shall be relieved and discharged herefrom, except that:

(a) Termination shall not affect any rights or obligations hereunder which have previously accrued, or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Agreement.

(b) Hospital shall, at Blue Shield's option, continue rendering Covered Services to Members undergoing medical treatment after the termination of this Agreement at the rates in effect immediately prior to the date of termination, for the duration of the contracts in effect with Blue Shield through which Members are enrolled with Blue Shield for which dues or subscription charges are paid to Blue Shield, or until such time as Blue Shield has arranged for an alternative source of services for each such Member from other contracting providers.

(c) Hospital shall, in the event of Blue Shield's insolvency, continue rendering Covered Services to any Member who is a patient in Hospital's facility until such Member's discharge or transfer to another appropriate facility.

(d) The following Sections of this Agreement shall survive the termination of this Agreement, whether such termination is the result of rescission or otherwise: Sections 2.10, 5.1, 5.4, 6.2, 6.4, 6.5, 7.1, 7.2, 7.3, 8.1, 9.1, 9.2, 9.3, 10.6 and 12.2.

XI. COMPLIANCE WITH LEGAL REQUIREMENTS

11.1 Consistency with State Law. This Agreement shall be governed and construed according to the laws of the State of California. This Agreement is subject to the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Act) and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by either of the above Codes shall bind Blue Shield and Hospital, whether or not provided in this Agreement.

11.2 Consistency with Federal Law. For Blue Shield's Medicare+Choice program, Hospital shall comply with the statutes and regulations and CMS instructions which govern Blue Shield's Agreement with CMS. Moreover, Hospital shall comply with the additional obligations set forth in Exhibit E. hereto. Hospital also agrees that, to the extent ERISA

statutes and regulations apply to the claims payment and Member complaint functions performed by Hospital, Hospital shall comply with all such requirements.

11.3 Coordination of Benefits. Hospital agrees that coordination of benefits, benefit determinations under the Medicare Secondary Payor rules, and Workers' Compensation recoveries shall be conducted by Hospital in accordance with the procedures set forth in the Provider Manual.

11.4 Third Party Liens. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's Evidence of Coverage and by state and federal law, Hospital shall have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Hospital for the injuries caused by the third party. Hospital's pursuit and recovery under third party liens shall be conducted in strict accordance with the procedures set forth in the Provider Manual. Blue Shield shall similarly have the right to assert a lien for and recover for payments made by Blue Shield for such injuries. Hospital shall cooperate with Blue Shield in identifying such third party liability claims and in providing such information, within such time frames, as set forth in the Provider Manual.

XII. OTHER PAYORS

12.1 Blue Shield may contract with employers, insurance companies, associations, health and welfare trusts or other organizations to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield (including both local and Blue Cross/Blue Shield National Accounts Programs). In addition, Blue Shield may extend this Agreement to managed care arrangements established by Blue Shield subsidiaries, or by persons or entities utilizing the network which Blue Shield has established pursuant to agreements with CareTrust Networks and California Physicians' Insurance Corporation . All such entities shall be referred to as "Other Payors". Blue Shield shall require that the health programs of Other Payors include provisions to encourage the use of Blue Shield contracting providers.

12.2 Hospital agrees that, in the event that Blue Shield is not the underwriter of the health plan for the Other Payor, Hospital shall look solely to Other Payor for payment for services. However, if Hospital is unable to obtain payment from any Other Payor, Blue Shield shall, upon notice from Hospital, make reasonable efforts to assist Hospital in obtaining such payment.

12.3 The provisions of this Agreement shall apply to services rendered to Members of Plans operated by Other Payors. Blue Shield will periodically give Hospital notice of the identity of Other Payors.

XIII. GENERAL PROVISIONS

13.1 Waiver of Breach. The waiver of any breach of this Agreement by either party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provisions of this Agreement. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy relating thereto.

13.2 Amendments. Except as provided in this Section 13.2 and in Section 3.2, this Agreement may be amended only by mutual, written consent of Blue Shield and Hospital's duly authorized representatives. Notwithstanding the foregoing, if Blue Shield's legal counsel determines in good faith that this Agreement must be modified to be in compliance with applicable federal or state law or to meet the requirements of accreditation organizations which accredit Blue Shield and its providers, Blue Shield may amend this Agreement by delivering to Hospital (the "Notice Date") a copy of the modifications (the "Legally-Required Modifications") along with the reasons therefore, and such modification(s) shall be deemed accepted by Hospital and an amendment to this Agreement if Hospital does not, within sixty (60) days following said Notice Date, deliver to Blue Shield its written objection of such Legally-Required Modification(s). In the event that Hospital timely objects to such Legally-Required Amendment, then Hospital and Blue Shield shall confer in good faith regarding the amendment. In the event Hospital and Blue Shield cannot resolve Hospital's objection, Hospital may terminate this Agreement on ninety (90) days prior written notice to Blue Shield, and the amendment to which Hospital objected shall not be effective as to Hospital during the termination notice period.

13.3 Entire Agreement. This Agreement, all attachments and Exhibits referenced in this Agreement and attached hereto, and the Provider Manual, as amended from time to time, are incorporated herein by reference, and constitute the entire understanding between the parties relating to the subject matter hereof. However, this Agreement shall neither supercede nor replace any capitated HMO hospital agreement which may exist between Hospital and Blue Shield, which agreement shall solely apply with respect to any HMO Members for whom Hospital has financial responsibility for Covered Services under such capitated agreement.

13.4 Independent Contractors. In the performance of each party's work, duties, and obligations pursuant to this Agreement, each of the parties shall at all times be acting and performing as an independent contractor, and nothing in the Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venturer or principal and agent. Each party agrees to indemnify, defend and hold harmless the other party from any claims, causes of action or costs, including reasonable attorneys' fees, arising out of the indemnifying party's alleged or actual negligence or otherwise improper performance of its obligations hereunder.

13.5 Notices. Any notices or other communication made or contemplated by this Agreement to be in writing shall be deemed to have been received by the party to whom it is addressed three (3) days after it is deposited in the United States mail, certified postage prepaid, return receipt requested, or the date of delivery by Federal Express or similar commercial courier service, and addressed as set forth in Exhibit A., or to such other address as either party from time to time informs the other in writing. Further, notice may be given during normal business hours by facsimile transmission to the number set forth in Exhibit A. which shall be deemed received upon facsimile transmission confirmation, or by personal delivery to the address set forth in Exhibit A. which shall be deemed received upon receipt of a signature from the person or office at the designated address.

13.6 Third Party Beneficiaries. Except as specifically set forth in Article XII. hereof, neither Members nor any other third parties are intended by the parties hereto to be third party beneficiaries under this Agreement, and no action to enforce the terms of this Agreement may be brought against either party by any person who is not a party hereto.

13.7 Assignment. Neither Blue Shield nor Hospital shall assign, transfer, or subcontract its rights, duties, or obligations under this Agreement without the prior written consent of the other party.

13.8 Interpretation of Agreement. In the event of any ambiguity in this Agreement, this Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of which party drafted the Agreement. This Agreement shall be governed in all respects, whether as to validity, construction, capacity, performance or otherwise, by the laws of the State of California and such federal laws as are applicable to Blue Shield. If for any reason any provision of this Agreement is held invalid, the remaining provisions shall remain in full force and effect. The captions herein are for convenience only and shall not affect the meaning or interpretation of the Agreement.

13.9 Confidentiality/Trade Secrets. Except as necessary to Hospital's and Blue Shield's performance hereunder or as required by law, the compensation terms of this Agreement and all terms relating to compensation shall be confidential. Neither Hospital nor Blue Shield shall disclose such terms (other than to Government Officials or to Other Payors) except with the prior written consent of the other party. However, nothing herein shall prohibit Hospital from disclosing to Members and others the method by which they are compensated (e.g., capitation, fee-for-service, etc.); it is the precise compensation amounts for which confidential treatment is required by this provision.

13.10 Non-Solicitation. During the term of this Agreement, and for one (1) year thereafter, Hospital shall not solicit, induce, or encourage any Member to disenroll from Blue Shield or select another health care service plan for healthcare services. Notwithstanding the foregoing, Hospital shall be entitled to freely communicate with Members regarding any aspect of their health status or treatment.

13.11 Association Disclosure. Hospital hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Hospital and Blue Shield, that Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans ("the Association") permitting Blue Shield to use the Blue Shield Service Mark in the State of California, and that Blue Shield is not contracting as the agent of the Association. Hospital further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity, or organization other than Blue Shield shall be held accountable or liable to Hospital for any of Blue Shield's obligations to Hospital created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Shield other than those obligations created under other provisions of this Agreement.

In accordance with the preamble of the Agreement, the Effective Date is December 1, 2004. (Date to be entered by Blue Shield.)

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: [illegible]

Title: CEO

Date: 10/29/04

Tax ID #: 94-6000524

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

Exhibit A

Fee for Service Hospital Agreement

HOSPITAL INFORMATION

Natividad Medical Center

Effective Date: 12-1-04

1. Address for Notice:

If to Blue Shield	If to Hospital
Blue Shield of California	Natividad Medical Center
50 Beale Street	1441 Constitution Blvd.
San Francisco, CA 94105	Salinas, CA 93906
Attn: Vice President, Provider Relations	Attn: Administration
Fax No.: 415-229-6290	Fax No: (831) 759-6536

2. Hospital Tax Identification Number: 94-6000524

3. Hospital Location(s):

Multiple Locations?: No

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

Exhibit B

Fee for Service Hospital Agreement

HOSPITAL SERVICE INVENTORY

Natividad Medical Center

Effective Date: 12-1-04

[Attach service inventory list.]

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

Exhibit C

Fee for Service Hospital Agreement

COMPENSATION AMOUNTS/PAYMENT SCHEDULE

Natividad Medical Center

Effective Date: 12/1/04

I. Inpatient Services

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

Acute Case Rate Allowances	Attachment Days	Rate
Maternity/Delivery		
Normal Delivery	2	
C-Section	4	
Additional Days		
Coronary Surgery[1]	15	
Percantaneous Cardiovascular Procedure (PTCA)[1]	8	
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		

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

Psychiatric and Substance Abuse

A.

Psychiatric Services Per Diem Allowances	Rate
Full Hospitalization	
Acute	
Residential	
Partial Hospitalization	
Full Day	
Half Day	

B.

Substance Abuse Services Per Diem Allowances	Rate
Full Hospitalization	
Acute	
Residential	
Partial Hospitalization	
Full Day	
Half Day	

Stop Loss Coverage

Compensation payable hereunder on the basis of a per diem or a case rate is subject to the following stop loss protection:

1. Stop Loss in Respect to Per Diem Compensation:

(a) In the event that allowed charges for the acute care inpatient services compensated by a per diem rate exceed $100,000 for a single admission (the "Attachment Level"), Blue Shield will pay Hospital, for those services provided after the date the Attachment Level has been reached and during the remainder of such single admission, one and one-half (1.5) times the applicable acute care per diem rate (based on the Medically Necessary level of care, e.g., ICU/CCU or medical surgical). Interim bills will be paid at the level of care per diem. As used herein, such single acute care admission commences with the provision of Hospital services covered by the first day's per diem and ends when the patient is either discharged or transferred to an acute rehabilitation, skilled nursing, sub-acute, transitional or swing-bed care unit or other facility.

(b) In determining the Attachment Level under Paragraph 1(a) above, charges shall be allowed only for Medically Necessary covered hospital services, based on the Hospital's charge master in effect on the date of service subject to Section 2.10 (a) and Exhibit C (General Notes: Compensation Amounts), and Blue Shield shall subtract from such amount any coordination of benefits to which Hospital receives or is reasonably likely to receive for such services as well as the Member's applicable copayment, deductible, or co-insurance obligation. In

addition, disallowed charges will not be considered in determining the Attachment Level. Charges for agreed upon exceptions (carve-outs) will not be considered in determining the Attachment Level nor be paid according to stop loss calculations. Exceptions will be reimbursed according to the agreed upon methodologies set forth in this Exhibit C.

(c) Claims covered by stop loss must be submitted directly to:

Blue Shield of California
Hospital Exception Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Claims for Medicare+Choice Members covered by stop loss must be submitted directly to:

Blue Shield of California
Medicare Claims Department
P. O. Box 5014
Woodland Hills, CA 91365

2. Stop Loss in Respect to Case Rate Compensation. In the event that a single admission for services is compensated hereunder on the basis of a case rate, once such admission reaches the number of continuous Medically Necessary inpatient days set forth above ("Attachment Days"), Blue Shield will compensate Hospital the case rate, plus, for all Medically Necessary days following the date such Attachment Level is reached (during such continuous single admission), the medical/surgical/pediatrics per diem rate set forth in this Exhibit. Blue Shield, however, shall deduct from such payments the amount of any coordination of benefits payments which Hospital has received or is reasonably likely to receive for its services as well as the Member's applicable copayment, deductible, or co-insurance obligation. If Applicable: Charges for agreed upon exceptions (carve-outs) will be reimbursed according to the agreed upon methodologies set forth in this Exhibit C.

Exception Payments

Claims for the following exception payment arrangements must be submitted directly to:

Blue Shield of California
Hospital Exception Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Claims for the following exception payment arrangements for Medicare+Choice Members must be submitted directly to:

Blue Shield of California
Medicare Claims Department
P. O. Box 5014
Woodland Hills, CA 91365

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: _____

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

County	Factor	County	Factor
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

OR,

2. Blue Shield will pay Hospital in accordance with the attached and incorporated APG Payment Schedule and APG Outpatient Surgery Services Grouper set forth in the Provider Manual. As indicated by the APG Payment Schedule, the value of APG at 1.000 is $_____.

B. EMERGENCY SERVICES AND URGENT CARE SERVICES

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

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

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	RATES REDACTED
CAPD (Revenue Code 841 with CPT 90945, 90947)	Per Visit	
CAPD Training (Revenue Code 845 with CPT 90989, 90993)	Per Visit	
CCPD (Revenue Code 851 with CPT 90945, 90947)	Per Visit	
CCPD Training (Revenue Code 855 with CPT 90989, 90993)	Per Visit	
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	

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

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	Rate
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	$_____

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	Rate
Physical Therapy (Revenue Code 420-424, 429)	Per Visit	$ _____
Occupational Therapy (Revenue Code 430-434, 439)	Per Visit	$ _____
Speech Therapy (Revenue Code 440-444, 449)	Per Visit	$ _____

Outpatient Service	Payment Method	Rate
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 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 RATE REDACTED

4) The result will be multiplied by the multiplier

Multiplier:_____

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: _____

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: _____%

In no event will Blue Shield pay Hospital an amount for any outpatient services under this Section H which exceeds the medical/surgical/pediatric per diem services set forth in this Exhibit C.

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 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. In the event of an overall increase in Hospital's charge master, Blue Shield may adjust any percentage compensation amounts set forth in this 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. In the event of an overall increase in Hospital's charge master, 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, in proportion to the percentage by which the charge master has increased.

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.

Exhibit D

Fee For Service Hospital Agreement

UTILIZATION MANAGEMENT/PRIOR AUTHORIZATION

Natividad Medical Center

Effective Date: 12/1/04

Introduction: The Blue Shield of California Quality and Utilization Management program is designed to assist Blue Shield members, physicians, and hospitals in ensuring that medical services are:

(a) Covered under the member's health benefit plan.

(b) Provided at the most cost effective level, consistent with accepted standards of medical practice.

(c) Appropriate and medically necessary.

(d) Consistent with the patient's diagnosis and level of care required.

To accomplish this, the program requires systematic monitoring and evaluation of the medical necessity and level of care of the services requested and provided. Medical necessity and level of care appropriateness will be determined by prospective review of care requested and concurrent and retrospective review of care provided. The goal of Blue Shield's program is to identify and correct inappropriate utilization.

The Utilization Management process includes, but is not limited to, the following functions:

- Ambulatory Care Review
- Case Management
- Concurrent Review
- Medical Records/Claims Review
- Pre-admission/Admission Authorization
- Pre-service Review
- Quality Review
- Retrospective Review

Blue Shield's peer review activities are conducted in accordance with California Health and Safety Code Section 1370 and are afforded protection from discovery under both Section 1370 and California Evidence Code Section 1157.

Pre-admission/Admission Authorization and Length of Stay Assignment: Authorization for all Blue Shield hospital admissions must be obtained by the physician or Hospital prior to an elective admission/transfer or, in the case of an emergency admission, within 24 hours or as soon as possible. Weekend admissions are to be called in on Monday. Blue Shield will review the request for admission within one business day following receipt of all necessary information. Admissions will be reviewed for medical necessity, level of care, appropriateness and benefit determination. After the review has been completed, the Hospital, member and attending physician will be notified by phone and in writing of the approval including the initial length of stay or denial of the authorization request.

Concurrent Review: The Blue Shield Utilization Management nurse or designee may conduct concurrent review throughout the admission to determine level of care and medical necessity. The reviews will be conducted by phone or on-site, as appropriate. The Utilization Management reviewers use severity of illness/intensity of service guidelines to determine medical necessity and appropriateness of the level of care and may require supporting medical documentation from the Hospital. Industry standard-approved protocols and guidelines will be used in the admission and concurrent review process. Authorization for additional days must be obtained from the Utilization Management department one day prior to the end of the initial assigned length of stay. The hospital, admitting physician and member will be notified in writing of the continuation of the approved length of stay. For HMO Members, the Independent Practice Association (IPA) or Medical Group (MG) will also be notified.

Denials: When a hospital admission or continued stay is determined not to be medically necessary or covered under the member's plan, written notification of the denial, via certified mail, will be sent to the Blue Shield member or responsible party. The attending physician and the hospital billing/utilization department for Preferred Members and the IPA/MG and the personal care physician for HMO Members will also be notified by phone or in writing.

If authorization for an admission or an extension of days is not obtained or is denied by Blue Shield on the grounds that the proposed services are not Medically Necessary, neither Blue Shield nor the member will be financially responsible for the denied days. The member may be held financially responsible if the Hospital obtains in writing an acknowledgment of financial liability from the member or responsible party prior to rendering the service. This acknowledgment must be specific to the admission or days denied by Blue Shield. A period not to exceed 24 hours will be given to the patient after receipt of the denial letter to allow the patient to make discharge arrangements.

Appeals: The hospital or the attending physician may appeal the authorization decision of Blue Shield or its designee by filing a written request for reconsideration to the Blue Shield Utilization Management Department. In the case of a patient who is hospitalized at the time of the appeal, Blue Shield will render a decision on the appeal within one working day of receipt of the written

request. If the patient is no longer in the hospital, Blue Shield will make a decision within 30 days of receipt of the written request.

Decisions following reconsideration may be appealed to the Blue Shield Medical Director by filing a written request for review with the Medical Director (or his/her designee). The hospital will not take any action to collect on behalf of the denied services while an appeal is pending. Addresses and telephone numbers are listed below:

1)	HMO and HMO+ Members (Northern California)	Blue Shield of California Medical Director 50 Beale Street, San Francisco, CA 94105-1808 **800 - 444 - 0402**
2)	HMO and HMO+ Members (Southern California)	Blue Shield of California Medical Director 6701 Center Drive West, Los Angeles, CA 90009-2945 **800 - 213 - 3465**
2)	Medicare + Choice Members (Statewide)	Blue Shield of California Medical Director P.O. Box 284, Woodland Hills, CA 91367-9772 **800 – 684 - 3332**
4)	PPO and All Other Members (Statewide)	Blue Shield of California Medical Director 4203 Town Center Blvd. El Dorado Hills, CA 95762 **800 - 343 - 1691**

Exhibit E

Fee For Service Hospital Agreement
BLUE SHIELD 65+ PROVISIONS

Natividad Medical Center

Effective Date: 12/1/04

Hospital specifically agrees to serve Blue Shield Medicare+ Choice Members pursuant to the terms and conditions of this Agreement and the following requirements:

1. This Agreement shall apply to Blue Shield Medicare+Choice Enrollees who are enrolled in Blue Shield's Medicare+ Choice Plan.

2. **DEFINITIONS** – In addition to the Definitions set forth in Article I of the Agreement, the following definitions shall also apply:

   A. "Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

   B. "Emergency Services" shall mean those medical and hospital services required that are (i) furnished by a Physician qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

   C. "Enrollee" shall mean a Medicare beneficiary who is enrolled in Blue Shield's Medicare+Choice program who is assigned to a Hospital Physician and Hospital.

   D. "Urgently Needed Services" will mean medical services received outside of the Service Area which are, in the judgment of a prudent layperson, required without delay in order to prevent serious deterioration of Enrollee's health as a result of an illness, injury, or medical condition.

3. **OBLIGATIONS OF HOSPITAL** – The Obligation set forth in Article II. Section 2.4 of the Agreement is modified to add the following at the end of current text of Section 2.4 and shall apply to Blue Shield Medicare+Choice Members:

"Hospital will comply with state and federal laws and regulations including but not limited to physician incentives, and stop loss insurance requirements. Hospital shall include in its contracts with Hospital Providers all provisions required by federal and state laws, including the BBA and related regulations. Hospital shall ensure that all contracts with Hospital Providers comply with all applicable Medicare+Choice regulations as described in this Exhibit E. and as outlined in the Provider Manual."

4. **COMPLIANCE WITH LEGAL REQUIREMENTS** – In addition to the requirements set forth in Article XI. of the Agreement, the following new Sections shall also apply:

"11.5 Medicare+Choice. Hospital shall include in its contracts with Hospital Providers all provisions required by federal and state laws, including the BBA and related regulations. Hospital shall ensure that all contracts with Hospital Providers comply with all applicable Medicare+Choice regulations as described in this Amendment and as outlined in the Provider Manual.

Hospital understands that payments made by Blue Shield are, in whole or in part, derived from federal funds, and therefore provider and its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds. Hospital agrees to comply with all applicable Medicare laws, regulations and CMS instructions including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and to require their subcontractors to do the same. Hospital agrees to include the requirements of this section in its contracts or subcontracts with other providers or entities.

11.6 CMS Participation Requirements. Hospital is prohibited from employing or contracting with an individual who is excluded from participation in Medicare for the provision of any of the following: healthcare services, utilization review services, medical social work services and administrative services. In the event Hospital fails to comply with the above, Blue Shield reserves the right to pass through to the Hospital any sanctions imposed by CMS for violation of this prohibition.

11.7 Private Contract. Hospital understands that Blue Shield is prohibited by CMS from paying compensation to, or including in its network, any provider that has entered into a private contract with a Member for the provision of services. Blue Shield

reserves the right to terminate any such provider from its network. This provision shall remain in effective for a period of two (2) years from the time that all direct contracts between provider and Member have been terminated.

11.8 Health Assessment. Blue Shield must conduct a health assessment of all Members within ninety (90) days of the effective date of Member's enrollment with Blue Shield. Hospital agrees to cooperate in such health assessment process."

5. **PLAN QUALITY IMPROVEMENT** – Following Section 2.5 of the Agreement, the following provisions shall also apply.

"Blue Shield retains responsibility for Quality Improvement and Quality Management Programs. Quality Improvement and Quality Management Programs are not delegated to Hospital. Hospital however agrees to comply with Blue Shield's Quality Improvement Program for Hospital-based care. Blue Shield's Quality Improvement Program shall be developed in consultation with Blue Shield providers to ensure that practice guidelines of quality improvement and quality management pursuant to Medicare regulations and CMS instructions are met. Hospital agrees to maintain a Quality Management Program which states that Hospital will review on a prospective, concurrent and retrospective basis the quality, appropriateness, level of care. The Quality Management Program will include among others an annual evaluation, annual quality management goals, proposed quality management studies, a description of the quality management committee and frequency of meetings. Hospital shall notify Blue Shield of any changes to the quality management plan which shall be subject to prior approval by Blue Shield."

6. **PROVIDER MANUAL** – In Article III. of the Agreement, the following provisions shall be added to the end of Section 3.2:

Precedence. The Provider Manual and all revisions thereto shall be consistent with the laws and regulations governing the Medicare+Choice program, the regulations established by CMS, the Knox-Keene Act and the provisions of this Agreement. In the event of any conflict or inconsistency between the Provider Manual, the Agreement, and/or any of the cited state or federal laws and regulations, the provision which governs shall be determined by applying the following order of precedence: the BBA, CMS regulations and instructions, the Knox-Keene Act and regulations, the Agreement and, then, the Provider manual.

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

ADDENDUM

to

Fee-for-Service Hospital Agreement

Natividad Medical Center

Effective 12/1/04

I. Claims Settlement Practices & Dispute Resolution Mechanism:

The provisions of the Agreement relating to submission and payment of claims, and to dispute resolution are hereby amended. If the term below is in conflict with any existing provision of the Agreement, then that provision is deemed modified by the new term. If the term below is not in conflict with any existing provision of the Agreement, then the new term is deemed to be added to the Agreement.

A. CLAIMS:

1. Blue Shield's requirements for a complete claim shall be set forth in the Provider Manual and on its website and be in accordance with the regulations at 28 Cal. Code of Regulations Section 1300.71.

2. Blue Shield's procedures for submission of manual and electronic claims shall be set forth in the Provider Manual and on its website and shall be in accordance with the regulations at 28 Cal. Code of Regulations Section 1300.71.

3. Blue Shield shall have a process by which Hospital can confirm receipt of a claim filed either electronically or manually. Such process shall be described in the Provider Manual and on Blue Shield's website.

4. The provision in the Agreement granting Blue Shield the right to identify and seek refund of overpayments is amended to limit that right to requests for refund which are initiated by Blue Shield within 365 days of the date the payment was made, unless the overpayment is the result of fraud or misrepresentation on the part of Hospital.

5. Blue Shield's procedures for notification of overpayments and notification of recovery of overpayments shall be in accordance with the regulations at 28 Cal. Code of Regulations Section 1300.71(d).

B. APPEALS:

6. The complete dispute resolution process set forth in the Agreement for claims and payment disputes shall apply to any and all disputes arising under the Agreement, not just claims payments or denials. Appeals shall no longer be submitted to the Dispute Resolution Committee referenced in the Agreement, if any.

7. Time for Submission – The time period for submission of initial appeals only shall be the longer of 365 days or the time period set forth in the Agreement.

8. A description of the appeal process and information to be provided shall be set forth in the Provider Manual and on Blue Shield's website.

9. Acknowledgment – Blue Shield will acknowledge receipt of Hospital's written appeal within 15 working days.

10. Blue Shield shall investigate and provide a written response to Hospital's appeal with 45 working days of receipt.

C. DISCLOSURE OF INFORMATION:

11. Blue Shield shall make available to Hospital, upon contracting and upon request as well as continuously available on-line, such information as is required by the regulations at 28 Cal. Code of Regulations Section 1300.71(l). The information shall be made available in the Provider Manual and on the provider portal of Blue Shield's website at www.mylifepath.com.

II. Continuity of Care:

The provisions of the Agreement relating to continuity of care in the event of termination of the Agreement are hereby amended. If the term below is in conflict with any existing provision of the Agreement, then that provision is deemed modified by the new term. If the term below is not in conflict with any existing provision of the Agreement, then the new term is deemed to be added to the Agreement.

A. TERM & TERMINATION

1. In the event of termination of the Agreement, Provider shall comply with all applicable requirements of the Knox-Keene Health Care Services Act of 1975, including but not limited to those set forth in Cal. Health & Safety Code § 1373.65.

2. If the Agreement permits either party to terminate the Agreement without cause in less than 90 days, it is hereby amended to permit said notice on 90 days' notice.

3. All written, printed, or electronic communications to Members concerning termination of the Agreement shall comply with Cal. Health & Safety Code § 1373.65(f).

4. Following termination, Hospital agrees to continue rendering Covered Services to Members who qualify for completion of covered services under Cal. Health & Safety Code § 1373.96(c) in accordance with the provisions therein at the post-termination rates set forth in the Agreement.

The terms of this Amendment do not apply to any agreement or portions of any agreement under which Hospital provides services to Member's enrolled in Blue Shield's Medicare+Choice plan(s).