COVER PAGE TO FACILITY PARTICIPATION AGREEMENT

Please note regarding California:

The attached Facility Participation Agreement is a contract by and between United HealthCare Insurance Company, on behalf of itself and its affiliates, and your facility. PacifiCare of California (a United Affiliate and a California licensed healthcare service plan) is also a party to this Agreement. When Facility provides services to a PacifiCare of California Customer and those services are subject to this Agreement, all references to "United" in this agreement, in connection with those services, mean PacifiCare of California. PacifiCare of California is not responsible for services Facility provides to United Customers who are not PacifiCare of California Customers.

This agreement includes a California Regulatory Requirements Appendix. If there is any inconsistency between the California Regulatory Requirements Appendix and any term or condition contained in the Agreement, the terms of the California Regulatory Requirements Appendix will control, except with regard to benefit contracts outside the scope of the California Regulatory Requirements Appendix.

Facility may obtain additional details regarding items described in this agreement from United's website at www.unitedhealthcareonline.com (UnitedHealthcare Online®) and PacifiCare of California's website at www.pacificare.com. If Facility has any questions regarding this agreement, United or PacifiCare of California may be contacted at (888) 291-0404.

This Cover Page shall be deemed a part of the Agreement.

Facility Participation Agreement

This Agreement is entered into by and between United HealthCare Insurance Company and PacifiCare of California, contracting on behalf of themselves and the other entities that are United's Affiliates (collectively referred to as "United") and Natividad Medical Center ("Facility").

This Agreement is effective on 12/22/2009 (the "Effective Date").

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

United wishes to arrange to make Facility's services available to Customers. Facility wishes to provide such services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 **"Benefit Plan"** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **"Covered Service"** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **"Customary Charge"** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **"Customer"** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **"Payment Policies"** are the guidelines adopted by United outside of this Agreement for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 **"Payer"** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Facility's services under this Agreement.

1.7 **"Protocols"** are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Facility in providing services and doing business with United and Payers under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, concurrent review, or other similar United or Payer programs. The Protocols may change from time to time as discussed in section 4.4 of this Agreement.

1.8 **"United's Affiliates"** are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II.
Representations and Warranties

2.1 Representations and Warranties of Facility. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

a) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

b) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

c) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (i) the organizational documents of Facility, (ii) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (iii) applicable law.

d) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

e) Facility has been given an opportunity to review the Protocols and Payment Policies and acknowledges that it is bound by the Protocols and that claims under this Agreement will be paid in accordance with the Payment Policies. In the event that Facility believes that a change in the Protocols would result in significantly increased costs, Facility may provide written notice in accordance with section 4.4 of the Agreement.

f) Each submission of a claim by Facility pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to United that (i) the representations and warranties of it set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (ii) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (iii) the charge amount set forth on the claim is the Customary Charge and (iv) the claim is a valid claim.

2.2 Representations and Warranties of United. United, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

a) United is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

b) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

c) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (i) the organizational documents of United, (ii) any material agreement or instrument to which United is a party or by which United or any material part of its property is bound, or (iii) applicable law.

d) United has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III.
Applicability of this Agreement

3.1 Facility's Services. This Agreement applies to Facility's service locations set forth in Appendix 1. In the event Facility begins providing services at other locations (either by operating such locations itself, or by acquiring, merging or affiliating with an existing provider that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers), such additional locations will become subject to this Agreement only upon the written agreement of the parties.

In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Facility may transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, but only if Facility requests that United approve the assignment of this Agreement as it relates to those Covered Services and only if the other entity agrees to assume this Agreement. This paragraph does not limit United's right under Section 9.4 of this Agreement to elect whether to approve the assignment of this Agreement.

3.2 Payers and Benefit Plan types. United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

3.3 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Facility may seek and collect payment from a Customer for such services, provided that the Facility first obtains written consent to facility's usual conditions of admission, consent for treatment and financial agreement form.

This section does not authorize Facility to bill or collect from Customers for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in sections 6.5 and 6.8 of this Agreement.

3.4 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to such persons are inadvertently paid.

3.5 Health Care. Facility acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility's determination of what care to provide its patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility and with Customers and their physicians, and not with United or any Payer.

3.6 Communication with Customers. Nothing in this Agreement is intended to limit Facility's right or ability to communicate fully with a Customer and the Customer's physician regarding the Customer's health condition and treatment options. Facility is free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility is free to discuss with a Customer any financial incentives Facility may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement.

Article IV.
Duties of Facility

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(d) of this Agreement and credentialed by United or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 Nondiscrimination. Facility will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer.

4.3 Accessibility. Facility will be open 24 hours a day, seven days a week.

4.4 Cooperation with Protocols. Facility will cooperate with and be bound by United's and Payers' Protocols. The Protocols include but are not limited to all of the following:

1) Facility will use reasonable commercial efforts to direct Customers only to other providers that participate in United's network, except as permitted under the Customer's Benefit Plan or otherwise authorized by United or Payer.

2) Facility will make its best efforts to assure that all Facility-based physician groups participate in United's network as long as this Agreement is in effect.

In the event that a Facility-based physician group is not a participating provider with United, Facility's Chief Financial Officer or equivalent senior level officer ("Facility Representative") will assist United in its efforts to negotiate an agreement with such group. Upon request by United, Facility Representative will:

a) meet with Facility-based physician group to encourage participation. Facility Representative shall provide United with meeting minutes of any such meeting within 15 days. Meeting minutes will include a summary of the key discussion points and an outline of any actionable resolution options deemed by Facility Representative.

b) write letter(s) to Facility-based physician group encouraging the group to negotiate in good faith with United. The letter will also outline any contractual requirements in the agreement between Facility and Facility-based physician group that requires Facility-based physician group to (1) negotiate in good faith with third party payers, (2) participate in third party payer networks, and (3) other provisions related to Facility-based physician group's participation with third party payers.

c) invoke any applicable penalties or other contractual terms in its agreement with Facility-based physician group related to its non-participating status with a third party payer.

d) allow independent legal counsel (mutually agreeable to all relevant parties) to review Facility/Facility-based physician agreement to ensure Facility is fully invoking all the relevant terms and conditions of such agreement to require or promote Facility-based physician group's participation status with United.

United warrants that it will negotiate with Facility-based physician groups in good faith. Facility acknowledges that United will have no responsibility for the credentialing of any employed or sub-contracted Facility-based provider.

3) Facility will provide notification for certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information, as required by United or Payer as described in the Protocols.

The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. See Appendix 3 for additional information regarding the Protocols applicable to Customers enrolled in certain Benefit Plans.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if such change is applicable to all or substantially all of the facilities in United's network located in the same state as Facility. Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

In the event that Facility believes that a change in the Protocols would result in significantly increased costs for Facility, Facility may provide written notice to United of that belief; any such notice must explain and quantify the projected financial impact to Facility of the change in the Protocols. In the event Facility sends such a notice, Facility and United will consult together about the issue. Both parties shall work together in good faith to address the issues and resolve in a mutually satisfactory manner. If the issue is not resolved to Facility's satisfaction, Facility may initiate dispute resolution pursuant to Article VII of this Agreement. In the event the issue is arbitrated, the arbitration's scope will be limited to quantifying the financial impact to Facility of the change in the Protocols, and the arbitrator may award no more than the amount necessary to cover Facility's increased costs in light of that change; the change may be implemented while the dispute resolution process is proceeding, and the arbitrator cannot order that the change not take place or be reversed. The arbitrator may also consider the impact of other changes made by United in its Protocols that have reduced Facility's costs, and may balance any such reduction against the impact of the increased costs at issue.

4.5 **Employees and subcontractors.** Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to such services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 **Licensure.** Facility will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Facility to lawfully perform this Agreement. In addition, Facility shall either: (1) obtain and maintain JCAHO accreditation; or (2) in lieu of JCAHO accreditation, adopt CMS National Hospital Voluntary Reporting Initiative (NQF Core Measures).

4.7 **Liability Insurance.** Facility shall procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance shall be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility shall submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	One Million Dollars ($1,000,000.00) per occurrence and aggregate
Commercial general and/or umbrella liability insurance	Three Million Dollars ($3,000,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility shall maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility shall provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 **Notice.** Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or

Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in Facility being owned or controlled by an entity with which it was already affiliated prior to the change.

4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

4.10 Maintenance of and Access to Records. Facility will maintain adequate medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Facility will provide access to these records as follows:

i) to United or its designees, in connection with United's utilization management/ Care Coordination℠, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility will provide access during ordinary business hours within fourteen days after a request is made, except in cases of a United audit involving a fraud investigation or the health and safety of a Customer (in which case, access shall be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable United to reasonably meet the timelines for determining the appeal or grievance); and

ii) to agencies of the government, in accordance with applicable law, to the extent such access is necessary to comply with regulatory requirements applicable to Facility, United, or Payers.

Facility will cooperate with United on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an audit exit interview within 30 days of United's request.

Upon invoice from Facility, United will pay for copies of records requested by United in cases where United requests the records more than once and the records are requested for some other purpose than claims processing, coverage determinations, or other routine health benefits administration. Payment will be made at a rate of $.25 cents per page, not to exceed a total of $25.00 per record, unless a different rate is specified under state law.

4.11 Access to Data.
Facility will collect and provide to United aggregate, de-identified quality data relating to care rendered at the Facility for United's use in responding to requests for such data from recognized employer coalitions (e.g., Leapfrog) or other recognized organizations that focus on quality of care. Facility will also provide such data to United that Facility provides to other third parties, such as other insurers, employer coalitions, government agencies, and accrediting bodies.

4.12 Compliance with law. Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically. Facility will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by UnitedHealthcare Online® or other online resources as supported for additional products. Facility agrees to use www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Facility that such functionalities have become available for the applicable Customer.

4.14 This section intentionally left blank.

Article V.
Duties of United and Payers

5.1 Payment of Claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online or upon request. United may change its Payment Policies from time to time.

5.2 Liability Insurance. United will procure and maintain professional and general liability insurance and other insurance, as United reasonably determines may be necessary, to protect United and United's employees against claims, liabilities, damages or judgments that arise out of services provided by United or United's employees under this Agreement.

5.3 Licensure. United will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable United to lawfully perform this Agreement.

5.4 Notice. United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 Compliance with law. United will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims to the extent those requirements are applicable.

5.6 Electronic connectivity. United will do business with Facility electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those products supported by www.unitedhealthcareonline.com. United will communicate enhancements in www.unitedhealthcareonline.com functionality as they become available, as described in Section 4.13, and will make information available as to which products are supported by www.unitedhealthcareonline.com.

5.7 Employees and subcontractors. United will assure that its employees, affiliates and any individuals or entities subcontracted by United to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit United's obligations and accountability under this Agreement with regard to such services.

Article VI.
Submission, Processing, and Payment of Claims

6.1 Form and Content of Claims. Facility must submit claims for Covered Services in a manner and format prescribed by United, as further described in the Protocols. Unless otherwise directed by United, Facility shall submit claims using current UB04 or successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims as applicable, with applicable coding including, but not limited to, ICD-9-CM, CPT, Revenue and HCPCS coding.

6.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that United is able to accept electronically.

6.3 Time to file claims.
All information necessary to process a claim must be received by United no more than 120 days from the date of discharge or 120 days from the date all outpatient Covered Services are rendered.

In the event United requests additional information in order to process the claim, Facility will provide such additional information within 90 days of United's request. If Payer is not the primary payer, and Facility is pursuing payment from the primary payer, the 120 days filing limit will begin on the date Facility receives the claim response from the primary payer.

6.4 Payment of claims. Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable state and federal law.

The obligation for payment under this Agreement is solely that of Payer, and not that of United unless United is the Payer.

6.5 Denial of Claims for Not Following Protocols, Not Filing Timely, or Lack of Medical Necessity. Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim under section 6.3 of this Agreement. Payment may also be denied for services provided that are determined by United to be medically unnecessary, and Facility may not bill the Customer for such services unless the Customer has, with knowledge of United's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility appeals within 12 months after the date of denial and can show all of the following:

i) that, at the time the Protocols required notification or at the time the claim was due, Facility did not know and was unable to reasonably determine that the patient was a Customer,

ii) that Facility took reasonable steps to learn that the patient was a Customer, and

iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility shall ask the patient to present his or her Customer identification card. In addition, Facility may contact United to obtain the most current information on the patient as a Customer.

However, Facility acknowledges that such information provided by United is subject to change retroactively, under the following circumstances, (1) if United has not yet received information that an individual is no longer a Customer; (2) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (3) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (4) if eligibility information United receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services shall not be eligible for payment under this Agreement and any claims payments made with regard to such services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for such services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, United, Payer or anyone acting in their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether such amount is less than Facility's billed charge or Customary Charge.

6.8 Customer "Hold Harmless." Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Facility's failure to comply with the Protocols,

ii) Facility's failure to file a timely claim,

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances, or

vi) a denial based on medical necessity or prior authorization, except as provided in section 6.5.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that United or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against United or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by clause v) of this Section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility may do so only if it first inquires in writing to United as to whether the Payer has defaulted and, in the event that United confirms that Payer has defaulted (which confirmation will not be unreasonably withheld), Facility then gives United 15 days prior written notice of Facility's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility shall be in breach of this Agreement. This section 6.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is provided for under this Agreement, either party may seek correction of the payment, except that Facility may not seek correction of a payment more than 12 months after it was made.

Undisputed underpayments or overpayments will be repaid within 45 days of notice of the underpayment or overpayment. Facility will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return such overpayment to United within 45 days after posting it as a credit balance.

Subject to the following sentence, Facility agrees that recovery of overpayments may be accomplished by offsets against future payments. United will provide written or electronic notice to Facility before using an offset as a means to recover an overpayment, and will not implement the offset if, within 45 days after the date of the notice, Facility refunds the overpayment or initiates an appeal.

Article VII.
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration before a panel of three arbitrators in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see http://www.adr.org). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

Any arbitration proceeding under this Agreement shall be conducted in San Francisco County, CA. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief.

The parties expressly intend that any dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the dispute. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event that any portion of this Article or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Article or Agreement. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through arbitration under this Article VII. While such arbitration remains pending, the termination for breach will not take effect.

This Article VII governs any dispute between the parties arising before or after execution of this Agreement, and shall survive any termination of this Agreement.

Article VIII.
Term and Termination

8.1 Term. This Agreement shall take effect on the Effective Date 12/22/2009. This Agreement shall have an initial term of one year and renew automatically for renewal terms of one year effective January 1, 2011, until terminated pursuant to section 8.2.

8.2 Termination. This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 90days prior written notice, effective at the end of the initial term (12/31/2010) or 120 days prior written notice effective at the end of any renewal term;

iii) by either party upon 60 days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VII of this Agreement;

iv) by either party upon 10 days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement;

v) by United upon 10 days written notice in the event Facility loses accreditation; or

vi) by United, upon 90 days notice, in the event:

a) Facility loses approval for participation under United's credentialing plan, or

b) Facility does not successfully complete the United's re-credentialing process as required by the credentialing plan.

8.3 Ongoing Services to Certain Customers After Termination Takes Effect. In the event a Customer is receiving any of the Covered Services listed below, as of the date the termination takes effect, Facility will continue to render those Covered Services to that Customer, and this Agreement will continue to apply to those Covered Services, after the termination takes effect, for the length of time indicated below:

Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Circumstances where Payer is required by applicable law to provide transition coverage of services rendered by Facility after Facility leaves the provider network accessed by Payer.	As applicable

Article IX.
Miscellaneous Provisions

9.1 Entire Agreement. This Agreement is the entire agreement between the parties with regard to the subject matter herein, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

9.2 Amendment. This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by United upon written notice to Facility in order to comply with applicable regulatory requirements. United will provide at least 30 days days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance.

9.3 Nonwaiver. The waiver by either party of any breach of any provision of this Agreement shall not operate as a waiver of any subsequent breach of the same or any other provision.

9.4 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by United to any of United's Affiliates.

9.5 Relationship of the Parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 No Third-Party Beneficiaries. United and Facility are the only entities with rights and remedies under the Agreement.

9.7 Delegation. United may delegate (but not assign) certain of its administrative duties under this Agreement to one or more other entities. No such delegation will relieve United of its obligations under this Agreement.

9.8 Notice. Any notice required to be given under this Agreement shall be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. All written or electronic notices shall be deemed to have been given when delivered in person, by electronic communication, by facsimile or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth on the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested. Each party shall provide the other with proper addresses, facsimile numbers and electronic mail addresses of all designees that should receive certain notices or communication instead of that party.

9.9 Confidentiality. Neither party will disclose to a Customer, other health care providers, or other third parties any of the following information (except as required by an agency of the government):

a) any proprietary business information, not available to the general public, obtained by the party from the other party; or

b) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will attempt to give the other party a copy of the material the party intends to issue.

9.10 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory Appendices. One or more regulatory appendix may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction shall not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 Survival. Sections 4.10, 6.7, 6.8, Article VII and sections 8.3 and 9.9 (except for the last paragraph) of this Agreement will survive the termination of this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

	Address to be used for giving notice to Facility under the Agreement:
Signature	Street PO Box 80007
Print Name	City Salinas
Title	State CA Zip Code 93912-0007
Date 12/22/09	Email

United HealthCare Insurance Company, on behalf of itself, PacifiCare of California, and its other affiliates, as signed by its authorized representative:

Signature	
Print Name	Janet Lundbye
Title	VP; Network Mgmt
Date	12-23-09

[Address to be used for giving notice to United under the Agreement]
Street 2300 Clayton Road, Suite 10000
City Concord
State CA Zip Code 94520
IN THE EVENT THIS AGREEMENT INCLUDES TWO SIGNATURE BLOCKS FOR UNITED, THIS AGREEMENT IS NOT BINDING UPON UNITED UNLESS EACH OF THE TWO UNITED SIGNATURE BLOCKS ARE EXECUTED.
For Plan Use Only:
Month and year in which agreement is first effective: 12/22/2009

Attachments

__X__ Appendix 1: Facility Location and Service Listings

__X__ Appendix 2: Benefit Plan Descriptions

__X__ Appendix 3: PacifiCare Protocols

__CA__ State Regulatory Requirements Appendix (list all states as applicable)

__ __ Fee Schedule Samples (1500 billers only)

__ __ All Payer Appendix (Appendices)

__ __ Medicare Advantage Regulatory Requirements Appendix

__ __ Medicare Advantage Payment Appendix

__ __ Medicare Select Payment Appendix

__ __ Medicaid Regulatory Requirements Appendix

__ __ Medicaid Payment Appendix

__ __ Other:

__ __

Appendix 1
Facility Location and Service Listings

IMPORTANT NOTE: Facility acknowledges its obligation under Section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

BILLING ADDRESS

Facility Name: Natividad Medical Center
Street Address: PO Box 80007
City: Salinas State: CA Zip: 93912-0007
Tax ID Number (TIN): 94-6000524
National Provider ID (NPI): 1205863255

FACILITY LOCATIONS (complete one for each service location)		
Facility Name	**Facility Name**	**Facility Name**
Natividad Medical Center		
Street Address	**Street Address**	**Street Address**
1441 Constitution Blvd		
City	**City**	**City**
Salinas		
State and Zip Code	**State and Zip Code**	**State and Zip Code**
CA		
Phone Number	**Phone Number**	**Phone Number**
831-755-4120		
TIN (*If different from above*)	**TIN (*If different from above*)**	**TIN (*If different from above*)**
94-6000524		
National Provider ID (NPI)	**National Provider ID (NPI)**	**National Provider ID (NPI)**
1205863255		

OTHER SERVICE LOCATIONS		
Facility Name	**Facility Name**	**Facility Name**
Street Address	**Street Address**	**Street Address**
City	**City**	**City**
State and Zip Code	**State and Zip Code**	**State and Zip Code**
Phone Number	**Phone Number**	**Phone Number**
TIN (*If different from above*)	**TIN** (*If different from above*)	**TIN** (*If different from above*)
National Provider ID (NPI)	**National Provider ID (NPI)**	**National Provider ID (NPI)**

Appendix 2
Benefit Plan Descriptions

United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types listed below:

- Benefit Plans where Customers are offered a network of participating providers and must select a primary physician. Such Benefit Plans may or may not include an out-of-network benefit.

- Benefit Plans where Customers are offered a network of participating providers but are not required to select a primary physician. Such Benefit Plans may or may not include an out-of-network benefit.

- Benefit Plans where Customers are not offered a network of participating providers from which they may receive Covered Services.

However, this Agreement does **not** apply to the following:

- Benefit Plans sponsored, issued or administered by any Payer where the Benefit Plan is intended to replace, either partially or in its entirety, the traditional Medicare coverage (Medicare Part A and Medicare Part B) issued to beneficiaries by the Centers for Medicare and Medicaid Services

- Knox-Keene capitation arrangements. Knox-Keene capitation arrangements are when all of the following apply:

i) Facility is part of a network for a United Affiliate; and

ii) As part of that network, Facility arranges with a medical group, an IPA, a hospital or other provider organization for certain designated services to be provided to members covered by that United Affiliate under benefit plans subject to the Knox-Keene Act (including Medicare Advantage plans) who are assigned to that medical group, IPA, hospital or other provider organization and under which either:

a. Facility (directly by the United Affiliate or through another entity) is capitated or otherwise has financial responsibility; or

b. Facility is paid on a fee-for-service basis directly by the medical group, IPA, or hospital which has financial responsibility for the service, at a rate agreed upon by Facility and that medical group, IPA or hospital; and

iii) Facility provides those designated services to one of those assigned members.

In such cases, the obligation for payment will be solely that of the medical group, IPA, hospital or other provider organization that has financial responsibility for the service, and not that of United or the United Affiliate.

It is not a Knox-Keene capitation arrangement when:

1) A medical group, IPA, hospital or other provider organization is not affiliated with Facility, and is capitated by a United Affiliate for designated Covered Services rendered to assigned Customers covered by a Benefit Plan subject to the Knox-Keene Act issued by that United Affiliate; and

2) Facility provides those designated Covered Services to one of those assigned Customers, without having a contract or other arrangement with the medical group, IPA, hospital or other provider organization for the terms under which those designated Covered Services are provided.

In such cases, this Agreement will apply and the medical group, IPA, hospital or other provider organization that has financial responsibility for the Covered Service will be considered the Payer.

Note: Although Knox-Keene capitation arrangements are excluded from this Agreement, there can be a separate agreement providing for Facility's participation in a network in connection with a Knox-Keene capitation arrangement.

· Benefit Plans for Medicaid Customers. Note: Although Medicaid Benefit Plans are excluded from this Agreement, there can be a separate agreement between the parties or between United Affiliates and the affiliates of Facility or other entity authorized to contract on behalf of Facility (such as an IPA agreement) providing for Facility's participation in a network for those Benefit Plans.

· Medicare Advantage Private Fee-For-Service Plans

Appendix 3
PacifiCare Protocols

For Customers enrolled in Benefit Plans issued or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC ("PacifiCare Customers"), Facility will be subject to the Protocols described in or made available through the PacifiCare Provider Policy and Procedure Manual ("PacifiCare Manual"). When this Agreement refers to the Administrative Manual or Guide, it is also referring to the PacifiCare Manual. The PacifiCare Manual will be made available to Facility on line or upon request. In the event of any conflict between this Agreement or the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide or other UnitedHealthcare administrative protocols, and the PacifiCare Manual, in connection with any matter pertaining to a PacifiCare Customer, the PacifiCare Manual will govern, unless applicable statutes and regulations dictate otherwise. United may make changes to the Administrative Manual or Guide or PacifiCare Manual or other administrative protocols upon 30 days' electronic or written notice to Facility.

California Regulatory Requirements Appendix

This California Regulatory Requirements Appendix (this "Appendix") is made part of the Agreement entered into between United HealthCare Insurance Company, contracting on behalf of itself, PacifiCare of California, and the other entities that are United's Affiliates (collectively referred to as "United") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to insurance products regulated under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 of Division 2 of the California Health & Safety Code) and its implementing regulations (Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations) (the "Knox-Keene Act") or insurance products regulated under the California Insurance Code which are insured, sponsored, issued or administered by or accessed through United to the extent such products are subject to regulation under California laws and regulations; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

United and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix will control except with regard to Benefit Plans outside the scope of this Appendix.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in this Appendix will be defined as set forth in the Agreement.

The California Department of Managed Health Care ("DMHC") regulates products governed by the Knox-Keene Act. The DMHC's address is 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725, and the DMHC's website is www.dmhc.ca.gov.

Provisions applicable to products regulated by the DMHC and governed by the Knox-Keene Act:

1. **Customer Confidentiality.** Provider will not disclose medical information regarding a Customer unless such disclosure complies with the requirements of California Civil Code §56.10 and §56.104, as amended.

2. **Network Participation.** Upon PacifiCare of California's receipt of Provider's signed copy of the Agreement and upon any renewal of the Agreement, PacifiCare of California will furnish Provider with the disclosures described in California Health & Safety Code §1395.6, as amended and as applicable, and will otherwise comply with the requirements of this law with respect to the sale, leasing or transfer of the Agreement to a payor other than PacifiCare of California. This provision specifically supersedes any conflicting requirements in section 3.2 of the Agreement.

3. **Amendment and Termination Due to Amendment.** Any amendment proposed by PacifiCare of California to change a material term of the Agreement must be negotiated and agreed to by Provider. However, if the change is not material or is made to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization, PacifiCare of California may amend the Agreement without Provider's consent. If PacifiCare of California makes a change to a material term of the Agreement PacifiCare of California will provide at least 45 business days' notice to Provider, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization require a shorter timeframe for compliance. If PacifiCare of California amends a manual, policy, or procedure document referenced in the Agreement, PacifiCare of California will provide at least 45 business days' notice to Provider, and Provider will have the right to negotiate and agree to the change. If the parties cannot agree to the change to a manual, policy, or procedure document, Provider will have the right to terminate the Agreement prior to the implementation of the change. The 45 business days' notice requirements set forth in this section may be waived if the parties mutually agree. Except for changes that are not material or are made to comply with state or federal law or regulations or accreditation requirements, a provider has the right to negotiate and agree to any proposed change on a case-by-case basis at any time after Provider has received notice of the proposed change. For purposes of this section only, the term "material," means a change to which a reasonable person would attach importance in determining the action to be taken upon the provision. This provision specifically supersedes any conflicting requirements in sections 1.5, 1.7, 3.2, 4,4, 5.1, 9.2 and Appendix 3 of the Agreement.

4. **Continuation of Care after Termination for Certain Conditions.** If the Agreement is terminated by PacifiCare of California for any reason other than those relating to a medical disciplinary cause or reason, or fraud or other criminal activity, Provider will, at the request of the Customer and PacifiCare of California, continue to provide Covered Services to Customers with certain medical conditions as described in and pursuant to the California Health & Safety Code §1373.96, as amended, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Customers with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation. Upon termination of the Agreement, PacifiCare of California is liable for the Covered Services rendered by Provider (other than co-payments, coinsurance or deductibles, as set forth in the Customer's Benefit Plan) to a Customer who retains eligibility under the applicable Benefit Plan or by operation of law and who is under Provider's care at the time of termination of the Agreement until the Covered Services Provider renders to the Customer are completed or until PacifiCare of California makes reasonable and medically appropriate provisions for the assumption of such services by another contracted provider. This provision specifically supersedes any conflicting requirements in section 8.3 of the Agreement.

5. **No Action at Law Against a Customer; Use of Surcharges.** Neither Provider nor Provider's agent, trustee or assignee may maintain any action at law against a Customer to collect sums owed by PacifiCare of California or Payer to Provider for services provided to the Customer pursuant to the Agreement. Upon notice of any such

action or upon notice that Provider has imposed surcharges for Covered Services, PacifiCare of California will take appropriate action. As used in this Appendix, the term "surcharges" means an additional fee which is charged to a Customer for a Covered Service but which is not approved by the Director of the DMHC, provided for in the Benefit Plan and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage. This provision specifically supersedes any conflicting requirements in section 6.8 of the Agreement.

6. **Maintenance and Access to Records.** Provider will prepare and maintain such records and provide such information to PacifiCare of California or to the Director of the DMHC as may be necessary for PacifiCare of California's compliance with the provisions of the Knox-Keene Act and the rules thereunder. Such records must be maintained for at least two years, except that if PacifiCare of California's agreement requires a longer retention period, that longer period will apply. This obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise. In addition, Provider will permit PacifiCare of California to access at reasonable times upon demand Provider's books, records and documents relating to the Covered Services provided to Customers, to the cost thereof and to payments Provider received from Customers (or from others on their behalf) for such services. This provision specifically supersedes any conflicting requirements in section 4.10 of the Agreement.

7. **Access to Services.** Provider's hours of operation and provision for after-hour services will be reasonable. PacifiCare of California will have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which will include, but is not limited to, waiting times and appointments. In addition, Provider will provide or arrange for the provision of emergency health care services 24 hours a day, 7 days a week.

8. **Authorization of PacifiCare of California's Right to Offset any Uncontested Notice of Overpayment.** In the event of an overpayment and prior to any adjustment PacifiCare of California makes in future claims payments to Provider, PacifiCare of California will furnish Provider with a separate written notice of the overpayment of a claim or claims which clearly identifies the overpaid claim or claims, Customer's name and dates of service and explains the basis of PacifiCare of California's request for reimbursement of the overpayment. PacifiCare of California will furnish Provider such notice of overpayment within 365 calendar days after the date of the overpayment, unless the overpayment was caused in whole or in part by Provider's fraud or misrepresentation. If Provider intends to contest PacifiCare of California's notice, Provider must send written notice of Provider's intent to contest within 30 business days of Provider's receipt of PacifiCare of California's notice. If PacifiCare of California does not receive a notice of intent to contest PacifiCare of California's notice of the overpayment of a claim or claims or the requested reimbursement from Provider within the above timeframes, Provider authorizes PacifiCare of California to offset the requested reimbursement amount from PacifiCare of California's current claims payments to Provider. Additional information regarding this process is included in the PacifiCare Manual. This provision specifically supersedes any conflicting requirements in section 6.10 of the Agreement.

9. **Submission of a Provider Dispute.** Provider may obtain specific information regarding PacifiCare of California's provider dispute resolution mechanism in the

PacifiCare Manual. Provider may submit information regarding provider disputes to PacifiCare of California by calling [list telephone number] or by writing to [list address.] PacifiCare of California will inform Provider of any changes to PacifiCare of California's provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. Provider will receive the rights listed in California Health & Safety Code §1375.7, as amended, if PacifiCare of California makes any changes to the provider dispute resolution mechanism. This provision specifically supersedes any conflicting requirements in Article VII of the Agreement.

10. Appeals and Grievances of Customers. PacifiCare of California will be responsible for resolving Customer appeals and grievances pursuant to California Health & Safety Code §1368, as amended, and Title 28 of the California Code of Regulations §1300.68 as amended. Provider will assist PacifiCare of California in the handling of complaints, grievances and appeals of Customers consistent with PacifiCare of California's Customer appeals and grievances policies and procedures.

11. Quality Assurance Program. PacifiCare of California will be responsible for maintaining a quality assurance program in compliance with Title 28 of the California Code of Regulations §1300.70, as amended. Provider will assist PacifiCare of California in maintaining PacifiCare of California's quality assurance program, as applicable consistent with PacifiCare of California's quality assurance program policies and procedures.

12. No Balance Billing. Except for applicable co-payments, coinsurance and deductibles, Provider will not invoice or balance bill any Customers for the difference between Provider's Customary Charges and the reimbursement paid for any Covered Service. In addition, in the event PacifiCare of California or Payer, as applicable, fails to pay for Covered Services as set forth in the Benefit Plan, the Customer will not be liable to Provider for any sums owed by PacifiCare of California or such other Payer. This provision specifically supersedes any conflicting requirements in section 6.8 of the Agreement.

13. Applicable Laws. PacifiCare of California is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code, as amended, and Chapter 1 of Title 28 of the California Code of Regulations, as amended, and any provision required to be in the Agreement by either of the above will bind PacifiCare of California whether or not provided for in the Agreement. Provider may obtain additional information about California law and the Knox-Keene Act by referencing the PacifiCare Manual.

14. Reporting or Surcharges and Co-Payments. Provider will report to PacifiCare of California all surcharge and co-payment moneys paid by Customers directly to Provider.

15. Payment of Claims. Payer will pay claims in accordance with California Health & Safety Code §1371 *et seq.*, as amended, and Title 28 of the California Code of Regulations §1300.71, as amended. Accordingly, without limitation: (a) in the event a claim is denied because it was filed beyond the claim filing deadline, PacifiCare of

California will, upon Provider's submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the claim in accordance with Health & Safety Code §§1371 or 1371.35, as amended, whichever is applicable, and applicable regulations; and (b) for each Complete Claim, as defined in Title 28 of the California Code of Regulations §1300.71(a)(2), as amended, submitted by Provider which PacifiCare of California or Payer does not deny or contest, Payer will pay the amount due to Provider within 45 working days following receipt of the Complete Claim by PacifiCare of California. In the event it is determined that a claim is not a Complete Claim, PacifiCare of California will, within the timeframe set forth above for the payment of a Complete Claim, advise Provider of the basis upon which a claim is not eligible for payment and specify any additional information required for Payer to pay the amount due with respect to the applicable claim. Additional information regarding this process is included in the PacifiCare Manual. This provision specifically supersedes any conflicting requirements in sections 6.3, 6.4 and 6.5 of the Agreement.

16. Block Transfer Filing Requirements. PacifiCare of California will comply with the block transfer filing requirements set forth in California Health and Safety Code Section 1373.65, as it may be amended. For any Benefit Plans in which a block transfer notice is required, the effective date of termination for such Benefit Plans will be 90 days following the receipt of termination notice, unless a longer period is required by this Agreement. The 90-day termination notice period will not impact the termination date for Benefit Plans in which a block transfer notice is not required. This provision specifically supersedes any conflicting requirements in section 8.2 of the Agreement.

17. Termination For Cause. As directed by the DMHC, in the event PacifiCare of California seeks to terminate this Agreement for cause, pursuant to Section 8.2(iii), on the basis of Provider's breach of Section 6.2, PacifiCare of California shall provide Provider with 180 days prior written notice and Provider shall have 180 days from the receipt of such notice to cure the deficiency in order to avoid termination.

18. Cooperation with Protocols. As instructed by the DMHC, Section 4.4(2) of the Agreement shall be replaced in its entirety with the following: Provider will use reasonable commercial efforts to assist PacifiCare of California in contracting with Facility-based providers, if requested by PacifiCare of California to do so. In the event Provider enters into a new contract with a Facility-based provider, Provider will provide written notice to PacifiCare of California of the new contract and such new contract will require the Facility-based provider to negotiate in good faith with PacifiCare of California concerning participation in PacifiCare of California's network. Provider acknowledges that PacifiCare of California shall have no responsibility for the credentialing of any employed or subcontracted Facility-based provider. PacifiCare of California will negotiate with Facility-based physician groups in good faith.

19. Services Provided to Ineligible Individuals. If Provider provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services shall be eligible for payment under this Agreement upon the occurrence of all of the following events: (1) the individual was identified as a Customer by PacifiCare of California, (2) the health care services were authorized by PacifiCare of California or its authorized designee, (3) PacifiCare of California received proof that Provider timely billed such individual or such

individual's legal guardian for such services two (2) times, not less than thirty (30) days apart, and (4) Provider has not received payment for such services from another party within thirty (30) days following delivery of the second billing. Provider shall be entitled to submit a claim for such services upon the expiration of thirty (30) days following the second billing for amounts that have not been paid. If Provider receives any payment from such individual or another source for such services subsequent to payment by PacifiCare of California, Provider will reimburse PacifiCare of California the amount received from the other source, not to exceed the amount received from PacifiCare of California. This provision specifically supersedes any conflicting requirements in section 6.6 of the Agreement.

20. **Language Assistance Program Standards.** Provider will comply with PacifiCare of California's language assistance program standards developed pursuant to California Health and Safety Code Section 1367.04 and Title 28 of the California Code of Regulations Section 1300.67.04.

Provisions applicable to products regulated by the California Department of Insurance ("DOI") and governed by the California insurance laws:

1. **Customer Confidentiality.** Provider will not disclose medical information regarding a Customer unless such disclosure complies with the requirements of California Civil Code §56.10 and §56.104, as amended.

2. **Network Participation.** Upon United's receipt of Provider's signed copy of the Agreement and upon any renewal of the Agreement, United will furnish Provider with the disclosures described in California Business & Professions Code §511.1 or California Insurance Code §10178.3, as amended and as applicable, and will otherwise comply with the requirements of these laws, as applicable, with respect to the sale, leasing or transfer of this Agreement to a payor other than United.

3. **Amendment and Termination Due to Amendment.** United may make a change to its quality improvement or utilization management program at any time without Provider's consent if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. In addition, United may amend the Agreement. If United's proposed amendment involves a material change to the Agreement or to United's quality improvement or utilization management programs, United will provide at least 45 business days' notice to Provider, and Provider may terminate the Agreement by providing written notice to United of Provider's intent to terminate this Agreement, as further described in the Agreement. Nothing in this section limits the ability of the parties to mutually agree to the proposed material change at any time after Provider has received notice of the proposed material change. For purposes of this section only, the term "material" means a change to which a reasonable person would attach importance in determining the action to be taken upon the provision.

4. **Continuation of Care after Termination for Certain Conditions.** If the Agreement is terminated by United for any reason other than those relating to a medical disciplinary cause or reason, or fraud or other criminal activity, Provider will, at the request of the Customer and United, continue to provide Covered Services to Customers

with certain medical conditions as described in and pursuant to the California Insurance Code §10133.56, as amended, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Customers with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation.

5. **Dispute Procedure.** United will inform Provider of any changes to United's provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted.

6. **Required Provisions for Agreements with Network Providers.** As provided in Title 10 of the California Code of Regulations §2240.4, as amended, Provider shall not make any additional charge to Provider's patient except as provided for in the group contract. United's Agreement includes the entire agreement between the parties regarding Provider's provision of Covered Services to Customers. Provider's primary concern will be the quality of health care services rendered to patients. Provider shall not discriminate against any Customer in the provision of Covered Services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health services or supplies, or other unlawful basis including without limitation, the filing by such patient of any complaint, grievance, or legal action against Provider.

7. **Payment of Claims.** Payer will pay claims in accordance with Chapter 1 of Part 2 of Division 2 of the California Insurance Code, as amended. Accordingly, without limitation: (a) in the event a claim is denied because it was filed beyond the claim filing deadline, United will, upon Provider's demonstration of good cause for the delay, accept and adjudicate the claim in accordance with Insurance Code §§10123.13 or 10123.147, as amended, whichever is applicable; and (b) for any claim or portion of any claim submitted by Provider that is not contested or denied by United or Payer, Payer will pay the amount due to Provider within 30 working days following United's receipt of the claim. In the event that a claim is contested or denied by United or Payer, United will, within the timeframe set forth above, furnish Provider the information required by Insurance Code §§10123.13 or 10123.147, as amended, as applicable. If a claim or portion thereof is contested on the basis that United has not received information reasonably necessary to determine Payer's liability for the claim or portion thereof, then United will have 30 working days after receipt of this additional information to complete reconsideration of the claim; and (c) "Complete Claim" as used in the Agreement will have the meaning set forth in Insurance Code §10123.147(c), as amended.

8. **Reimbursement Requests for the Overpayment of a Claim.** United will not request reimbursement for the overpayment of a claim unless United sends a written request for reimbursement to Provider within 365 days of the date of payment of the overpaid claim. The written notice will clearly identify the claim, the name of the patient, and the date of service, and will include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365 day time limit will not apply if the overpayment was caused in whole or in part by Provider's fraud or misrepresentation.

9. **Language Assistance Program Standards.** Provider will comply with United's language assistance program standards developed pursuant to California Insurance Code Sections 10133.8 and 10133.9 and Title 10 of the California Code of Regulations, Section 2538.3

10. **Authorized Services.** United shall not rescind or modify an authorization for a specific type of treatment after Provider has rendered health care services in good faith and pursuant to the authorization for any reason, including, but not limited to, United's subsequent rescission, cancellation, or modification of the Customer's contract or United's subsequent determination that it did not make an accurate determination of Customer's eligibility. This provision shall not be construed to expand or alter the benefits available to the Customer.

11. **Access to Services.** Provider's hours of operation and provision for after-hour services will be reasonable and consistent with California law. United will have a documented system for monitoring and evaluating accessibility of care, which will include monitoring of waiting times for appointments. In addition, Provider will provide or arrange for the provisions of emergency health care services 24 hours a day, 7 days a week.

PPR All Payer Appendix

Facility Name(s): Natividad Medical Center

Effective Date of this Appendix: 12/22/2009

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

SECTION 1
Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix shall have the meanings assigned to them in the Agreement.

Admission: The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

Customary Charge: The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

Customer Expenses: Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

Eligible Charges: The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.5 of this Appendix.

MS-DRG (Medicare Severity Diagnosis-Related Groups): A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status.

Observation: Services furnished by Facility on the Facility's premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility's nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

PPR (Percentage Payment Rate): The percentage applied to Facility's Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

Physician: A Doctor of Medicine ("M.D.") or a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to a Customer, the applicable contract rates will be determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.

2.2 Inpatient Covered Services. For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. The contract rate for an Admission is the contract rate in effect on the date the Admission begins.

RATES
REDACTED

If Facility has a separate inpatient skilled nursing unit, hospice unit, or rehabilitation unit, the charges for the skilled nursing, hospice, or rehabilitation stay are to be submitted separately from the acute hospital stay.

Additional information regarding MS-DRGs under this Appendix
The following applies to MS-DRGs as used in this Appendix:
-United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement.

-The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

-All changes in the definition of MS-DRGs specified in the Final Rule shall be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the definition are implemented under this Appendix, the previous definitions will apply. Claims with discharge dates 10/1 and later, that are processed during the period in between the CMS effective date and United's implementation date will continue to have the previous MS-DRG grouper applied. Claims with discharge dates 10/1 and later that are processed following United's implementation date for the MS-DRG grouper updates will have the new grouper applied.

RATES REDACTED

SECTION 3
Miscellaneous Provisions.

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive for the provision of all Covered Services to the Customer that are in the service category that corresponds to the contract rate

and which are generally provided as a part of the service category. No additional payments shall be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

3.2 Payment Code Updates. United will update CPT Codes, HCPCS Codes, ICD-9-CM Codes, and/or Revenue Codes according to Health Insurance Portability and Accountability Act requirements based on (a) the latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association, (b) the latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS), (c) the latest edition of the ICD-9-CM manual which is issued by the U.S. Department of Health and Human Services, and (d) the latest Revenue Code guidelines from the National Uniform Billing Committee. Unless specified elsewhere in this Appendix, the contract rate for a new, replacement, or modified code(s) will be at the existing contract rate for the appropriate code(s) it replaced or modified.

3.3 Facility-based Physician and Other Provider Charges.
Facility will make its best efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

At any time after 12/22/2009, the current contract rates for all Covered Services under this Appendix will be reduced by United by , for each specialty type for which the Facility-based Physician or other provider group is not a participating provider (unless charges for the services of those Physicians or providers are included in Facility's charges under this Appendix). However, in the case of Emergency Physicians where the Facility-based Physician or other provider group is not a participating provider the contract rates for Emergency Room Services will be reduced by %. The reductions will be cumulative up to a maximum of (so that if two Facility-based Physicians or provider groups are non-participating, for instance, the reduction would be), as further illustrated in the Rate Reduction Table below. The reductions described in this paragraph will be implemented with 30 days written notice and would apply to claims for services rendered on or after the effective date of the reduction. These reductions will remain in effect until the Facility-based Physician or provider group becomes a participating provider or is replaced at Facility by another Facility-based Physician or provider group that is a participating provider. United warrants that it will negotiate with each Facility-based Physician and provider group in good faith.

The following calculation will be used to determine the contract rates going forward to account for the percentage reduction:
[Current Contract Rate – (Current Contract Rate x Percentage Reduction) = New Contract Rate]

Rate Reduction Table.

Facility-Based Physician Group	**Contract Rates Reduced**
Anesthesiologists	All contract rates for Covered Services of any kind
Emergency Physicians	Emergency Room Services
Pathologists	All contract rates for Covered Services of any kind
Radiologists	All contract rates for Covered Services of any kind

RATES REDACTED

3.4 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment.
Services or items listed in the table below and billed with indicated codes are not subject to additional payment and are not considered in any calculation for payment. When these services are Covered Services, per the Customer's Benefit Plan, Facility will not bill and collect from the Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per

the Customer's Benefit Plan, Facility may bill and collect from the Customer for the services, to the extent permitted under the Agreement.

Table 2 Services Always Included Within the Contract Rate for Other Covered Services and Not Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0167	Self Care	0277	Oxygen/Take Home
0180-0189	Leave of Absence	0624	FDA Invest Device
0220-0229	Special Charges	0670-0679	Outpatient Special Residence
0253	Drugs/Take Home	0931-0932	Med Rehab Day Program
0256	Drugs/Experimental	0990-0999	Patient Convenience
0273	Supply/Take Home	2100, 2102, 2104-2109	Alternative Therapy Services

3.5 Services Not Payable Under This Appendix But May Be Payable Under Another Appendix To The Agreement Or Under Another Agreement.
Services or items billed with listed codes in the table below are not subject to payment under this Appendix. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to those services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer the services below may be payable under that agreement or appendix.

Table 3: Services Not Payable Under This Appendix But May be Payable Under Another Appendix To The Agreement Or Under Another Agreement.

Revenue Code	Description	Revenue Code	Description
0114	Psych/Room & Board/Private	0560-0569	Home Health – Medical Social Services
0116	Detox/Private	0570-0579	Home Health – Home Health Aide
0124	Psych/2bed	0580-0589	Home Health – Other Visits
0126	Detox/2bed	0590	Home Health – Units of Service
0134	Psych/3&4 bed	0600-0609	Home Health Oxygen
0136	Detox/3&4 bed	0640-0649	Home IV Therapy Services
0144	Psych/Room & Board Pvt/Deluxe	0650-0654, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819	Donor Bank/ Bone, Organ, Skin, Bank
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant	0944	Drug Rehab
0367	OR/Kidney Transplant	0945	Alcohol Rehab
0512	Clinic – Dental Clinic	0960-0989	Professional Fees

0513	Clinic – Psychiatric Clinic	1000-1005	Behavioral Health Accommodations
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic(RHC)/Federally Qualified Health Clinics(FQHC)	3101-3109	Adult Care
0550-0559	Home Health - Skilled Nursing		
MS-DRGs	**Description**	**MS-DRGs**	**Description**
001-002 w/o ICD9 37.52, 37.63-37.66	Heart Transplant	009	Bone Marrow Transplant
005-006	Liver Transplant	010	Pancreas Transplant
007	Lung Transplant	652	Kidney Transplant
008	Pancreas/Kidney Transplant		

SECTION 4

Adjustment to Contract Rates Resulting from Changes to Facility's Customary Charges

Charge Description Master ("CDM") Limitation /Audit Provision: Facility agrees to provide United, at least annually, notice in writing of the percentage change in its CDM. Facility agrees that if the cumulative aggregate increases in any calendar year of its CDM exceeds ten percent (10%) compared to the CDM rates in place as of the same time period during the previous year, that the Facility contract rates, including the PPR rates, shall be adjusted to negate the impact of such changes in excess of the allowed annual ten percent (10 %) increase. Such contract rate changes shall be retroactive to the effective date of the CDM increase that occurred which was above the allowed annual amount of ten percent (10%). Upon receiving such change in CDM notice from Facility in excess of the annual allowed amount of ten percent (10%), United shall prepare an amendment to the Agreement containing such rate changes as are required and send it to the Facility for their review. Examples of such adjustments are provided in the table below. Unless the Facility objects to the amendment within 30 days of United having sent it, this amendment shall become effective as of the effective date of the CDM increase that was above the allowed annual amount of ten percent (10%).

In the event that United makes an overpayment to Facility as the result of Facility's failure to give timely notice as required under this section, or as the result of Facility's providing inaccurate information, or Facility's failure to promptly agree to adjustments as described in this section, United may recover those overpayments as provided for in the Agreement.

United reserves the right to audit Facility CDM during the term of the Agreement, upon ten (10) business days prior notice to Facility. Failure by Facility to comply with the CDM provision of the Agreement shall constitute a material breach of the Agreement. In the event Facility disagrees with United as to an amendment resulting from the application of this CDM /Audit provision, the existence of an overpayment, or the amount of the overpayment, such issue will be resolved through the dispute resolution process and other remedies provided to the Facility as set forth in the Agreement.

Illustration of CDM indexing examples:

Example 1: Adjustment to Contracted Billed Charge Percentages

[A] Contracted Percentage of Billed Charges

RATES REDACTED

[B] Target CDM Increase
[C] Actual CDM Increase

[D] % Adjustment to Contract Percentage of Billed Charges = 1- [(1+B)/(1+C)]
[E] Adjusted Contracted Billed Charges = (1-D) * A

Proof of Calculation Methodology - Service with Line Item Charges of $1,000 at initial period

Billed Charge for Service at next period at Target CDM Increase
Billed Charge for Service at next period at Actual CDM Increase
Paid Amount for Service at next period @ Target CDM Increase

RATES REDACTED

Paid Amount for Service at next period @ Actual CDM Increase (
Paid Amount for Service at next period @ Adjusted % of Billed C
1,150