Amendment Eight to the Facility Participation Agreement

This amendment number eight (this "Amendment") is to the Facility Participation Agreement, effective as of 01/01/2009 (the "Agreement"), between UnitedHealthcare Insurance Company, contracting on behalf of itself, UHC of California doing business as UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, and other entities that are United's Affiliates (collectively, "United") and County of Ventura, Owner and Operator of Ventura County Medical Center and Santa Paula Hospital (collectively referred to as "Facility").

The parties wish to modify certain provisions of this Agreement.

Now therefore, the parties hereby agree to amend the Agreement as follows:

1. The capitalized terms used in this Amendment, but not otherwise defined, will have the meanings ascribed to them in the Agreement.

2. This Amendment is effective on October 1, 2022.

3. Section 8.1 of the Agreement is hereby deleted in its entirety and replaced by the following:

   8.1 Term. This Agreement will have an initial term beginning on the Effective Date and ending on September 30, 2025. Notwithstanding the provisions of this Section 8.1, if the parties are not able to finalize the new All Payer Appendix with new rates effective October 1, 2024 (as contemplated under Section 5 below) due to parties not being in agreement around the calculation of the new All Payer Appendix rates, then the Agreement shall terminate on September 30, 2024.

4. The following payment appendices attached to the Agreement are hereby deleted in its entirety:

   - All Payer Appendix
   - Medicare Advantage Payer Appendix

   The following payment appendices are added to the Agreement:

   - All Payer Appendix – Effective October 1, 2022 through September 30, 2023
   - All Payer Appendix – Effective October 1, 2023 through September 30, 2024
   - Medicare Advantage Payer Appendix – Effective October 1, 2022

5. Parties are in agreement to implement a new All Payer Appendix Effective October 1, 2024 that is reflective of a _____ increase from the "All Payer Appendix – Effective October 1, 2023," which will also incorporate the new fixed-rate structure that has been shared between United and Facility. United and Facility will work together to incorporate the agreed upon new All Payer Appendix (Effective October 1, 2024) with a future amendment to this Agreement by no later than August 30, 2024.

All other provisions of the Agreement shall remain in full force and effect. In the event of a conflict between the terms of the Agreement and this Amendment, the Amendment will control.

UnitedHealthcare Insurance Company, on behalf of itself, UHC of California doing business as UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California and its other affiliates, as signed by its authorized representative	County of Ventura, Owner and Operator of Ventura County Medical Center and Santa Paula Hospital, as signed by its authorized representative
Signature:	Signature:
Print Name: _____	Print Name: Barry L. Zimmerman
Title: _____	Title: HCA Director
Date: _____	Date: _____
	TIN: 956000944

All Payer Appendix

Facility Name(s): Ventura County Medical Center and Santa Paula Hospital
Effective Date of this Appendix: 10/01/2022

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 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.

CMS: Centers for Medicare and Medicaid Services.

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 3.6 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

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.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated "Per Case" in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated "Per Diem" in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

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

PPR Per Case (Percentage Payment Rate Per Case): The Payment Method designated "PPR Per Case" in this Appendix is the percentage applied to Facility's total Eligible Charge during one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the PPR Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel employed or subcontracted by Facility (regardless of whether those services are characterized as professional services), nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

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 contract rate will be the lesser of (1) Facility's aggregate Eligible Charges, or (2) the aggregate applicable contract rate 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.

2.1.1 Optum Health. This Appendix does not apply when Facility has an agreement with Optum Health and the services are provided pursuant to an authorization or notification from Optum Health.

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.

Table 1A**: Inpatient Service Category Table**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Medical/Surgical ^ (see note ^ below) Includes the following Revenue Codes. Revenue Codes: 0100-0101, 0110-0113, 0117, 0119-0123, 0127, 0129-0133, 0137, 0139-0143, 0147, 0149-0153, 0157, 0159-0160, 0164, 0169, 0170-0174, 0179,	**Per Diem**	
ICU-Intermediate/CCU-Intermediate ^ (see note ^ below) Includes the following Revenue Codes. Revenue Codes: 0206, 0214	**Per Diem**	
ICU/CCU/PICU ^ (see note ^ below) Includes the following Revenue Codes. Revenue Codes: 0200-0203, 0207-0212, 0219	**Per Diem**	
Hospice ~ ^ (see notes ~ and ^ below) Revenue Codes: 0115, 0125, 0135, 0145, 0155, 0655-0656	**Per Diem**	
Nursery* (see note * below) Normal Newborn: MS-DRG: 795 Lower Level Neonate: MS-DRGs: 789, 792, 794 Higher Level Neonate: MS-DRGs: 791, 793 Severe Level Neonate: MS-DRG: 790	**Per Diem** **Per Diem** **Per Diem** **Per Diem**	

Obstetrics (Mother Only)* (see note * below) **Vaginal Delivery** MS-DRGs: 768, 796-798, 805-807 2 day stay case rate w/ Per Diem for additional days **Cesarean Section** MS-DRGs: 783-785, 786-788 4 day stay case rate w/ Per Diem for additional days	**Per Case up to 2 days.** **Per Diem beginning on day 3.** **Per Case up to 3 days.** **Per Diem beginning on day 4.**	
False Labor MS-DRGs: 817-819, 831-833 WITH PRINCIPAL ICD-10-CM DIAGNOSIS CODES O47.00-O47.03; O47.1; or O47.9	**Per Diem**	
Rehabilitation ~ ^ (see notes ~ and ^ below) Revenue Codes: 0118, 0128, 0138, 0148, 0158	**Per Diem**	
Hospital Sub-Acute Revenue Codes: 0190-0194, 0199 However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.6	**Per Diem**	
Inpatient Skilled Nursing Services~ (see note ~ below) Bill Types: 211-219	**Per Diem**	
Trauma Care Unit +Revenue Code: 0682	**Per Diem**	

Notes to Table 1A

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

^ However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by MS-DRGs or any service category defined by Bill Types on this Inpatient Service Category Table or Section3.6 .

+The Trauma Care Unit Per Diem is applicable for the entire admission (and applies only to Ventura County Medical Center).

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 will 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.

2.2.1 Transfer of Customer. This Section applies only when a Per Case, Per Case plus Per Diem after Threshold or MS-DRG Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by CMS except for MS-DRGs designated by CMS as "special pay" MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the "Imputed Per Diem Rate") as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as "special pay" MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an Imputed Per Diem Rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is _____ of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

(a) Based on CMS readmission guidelines; and

(b) To readmissions with a related diagnosis (as determined by United); and

(c) To the determination of the contract rate for the subsequent Admission.

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.2.4 Inpatient High Cost Implantable Pass Through

The contract rate for Inpatient High Cost Implantable (Revenue Code 0274, 0275, 0276, 0278) that are Covered Services and that have Eligible Charges greater than ____ ("Pass Through Threshold") cumulative total for all applicable revenue codes, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be a PPR of ____ of the Eligible Charge for that Inpatient High Cost Implantable Covered Service. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.2.

2.2.5 Inpatient High Cost Drug Pass Through

The contract rate for Inpatient High Cost Drugs (Revenue Codes 0343, 0344, 0636, and 0891) that are Covered Services and that have Eligible Charges greater than ____ ("Pass Through Threshold") per applicable revenue code, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be a PPR of ____ of the Eligible Charge for that Inpatient High Cost Drug Covered Service, not to exceed a contract rate of ____ ("Pass Through Fixed Cap") per applicable revenue code. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.2.

2.2.6 Inpatient Dialysis Pass Through

The Contract rate for Inpatient Dialysis (Revenue Codes 0800- 0804, 0809) that are Covered Services, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be ____ per diem.

2.3 Outpatient Covered Services. For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

2.3.1 Observation, Outpatient Therapeutic, Diagnostic, Emergency, Urgent Care Covered Services. For the provision of Observation, therapeutic, diagnostic, Emergency, and Urgent Care Covered Services rendered by Facility to a Customer on an outpatient basis (except for Outpatient Procedures addressed in Section 2.3.2 of this Appendix), the contract rate will be determined according to this Section 2.3.

If more than one type of Covered Service for which a Payment Method applies are provided to a Customer during one calendar day, each of the applicable Payment Methods will be considered in calculating the aggregate contract rate for those Covered Services; provided, however, if the Customer receives any Covered Service for which a Per Case or PPR Per Case to a fixed cap or a PPR Per Case Payment Method applies, all Covered Services which would otherwise be paid pursuant to a Per Visit, Per Unit via Facility Fee Schedule, or PPR Payment Method, will instead be included in the Per Case or PPR Per Case to a fixed cap or PPR Per Case contract rate and will not be separately reimbursed except for Covered Services eligible for reimbursement as a pass through under Section 2.3.5 or 2.3.6.

The contract rate for outpatient diagnostic and therapeutic Covered Services rendered by Facility to a Customer, for which a Payment Method is detailed on Table 2 below, will be determined according to the table.

Table 2: Outpatient Diagnostic and Therapeutic Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Observation (Revenue Code: 0762)	**Per Case**	
Emergency (Revenue Codes: 0450-0452, 0459) **(1)**	**PPR Per Case to a fixed cap**	
Trauma Care Unit **Revenue Code: 0682**	**Per Case**	
Urgent Care (Revenue Code: 0456)	**PPR Per Case to a fixed cap**	
Other Outpatient, Diagnostic and Therapeutic Services Revenue Codes: 0260, 0269, 0280, 0289, 0300-0307, 0309, 0310-0312, 0314, 0319, 0320-0324, 0329, 0330, 0331, 0332, 0333, 0335, 0339, 0340,-0342, 0349, 0350-0352, 0359, 0380-0389, 0390-0392, 0399, 0400, 0401, 0402,0403, 0404, 0409, 0410, 0412, 0413, 0419, 0420-0424, 0429, 0430-0434, 0439, 0440-0444, 0449, 0460, 0469, 0470-0472, 0479, 0480, 0482, 0483, 0489, 0540, 0542, 0543, 0545, 0546-0549, 0610-0612, 0614-0616, 0618-0619 0720-0722, 0724, 0729, 0730, 0731, 0732, 0739, 0740, 0820-0825, 0829, 0830-0835, 0839-0845, 0849-0855, 0859, 0860-0861, 0900, 0917-0918, 0920, 0921, 0922, 0923, 0924, 0925, 0929, 0940, 0942, 0943, 0948, 0949	**PPR Per Case to a fixed cap**	

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission.

(1) Facility's Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OPPS/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change.

2.3.2 Outpatient Procedures. This Section 2.3.2 applies to Covered Services rendered to a Customer that involve an Outpatient Procedure, as listed in the UHC OPG (Outpatient Procedure Grouper) Exhibit to this Appendix, performed in an outpatient unit of Facility ("Outpatient Procedure"). For Outpatient Procedures, the contract rate will be paid as a PPR Per Case to a fixed cap, as set forth below and as further described in this Section 2.3.2. Unless otherwise specified in this Appendix, payment under this contract rate, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to a Customer during an Outpatient Procedure. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. United may revise the information in the UHC OPG Exhibit based on updated Outpatient Procedure grouping information developed by CMS and newly published codes, which may be modified by United to include procedures that are not maintained by CMS, but are considered for payment under this Appendix. The codes indicated with a "Y" under the "OPG Eligible" column in the UHC OPG Exhibit that corresponds to the date of service, that are Covered Services, are considered eligible for payment under this Section 2.3.2. Updates to the information in the UHC OPG Exhibit can be accessed at www.UHCprovider.com or its successor website.

The UHC OPG Exhibit includes a comprehensive list of revenue codes and CPT/HCPCS codes for which the contract rate is determined according to the Outpatient Procedures table below. The "OPG Group Number" column in the UHC OPG Exhibit does not apply to this Appendix. In the event a revenue code from the table below is billed with a CPT/HCPCS code indicated with an "N" under the "OPG Eligible" column in the UHC OPG Exhibit that corresponds to the date of service, the detail line item that includes that revenue code and CPT/HCPCS code is not eligible for consideration for reimbursement. However, if that detail line item is the only detail line item that has a revenue code from the table below, then the parties will consult as needed, at an operational level, to review the circumstances of the claim and assign appropriate CPT/HCPCS coding. Facility may resubmit the claim with the corrected coding information for consideration for reimbursement pursuant to this Appendix.

Table 3: Outpatient Procedures

OUTPATIENT SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE

Outpatient Procedures CPT/HCPCS Codes: All appropriate outpatient procedure codes Revenue Codes: 0360-0361, 0369, 0481, 0490, 0499, 0750, 0790 See the UHC OPG Exhibit for Revenue Code and CPT or HCPCS code criteria	**PPR Per Case to a fixed cap**	

*The PPR Per Case contract rate listed above is subject to change under Section 4 as a result of changes to Facility's Customary Charges. Additionally, adjustments to the PPR Per Case contract rate pursuant to Section 4 of this Appendix will carry forward into subsequent years.

2.3.3 This Section Intentionally Left Blank.

2.3.4 Multiple Per Case Covered Services.

If the Customer receives any Covered Services for which a Per Case or PPR Per Case to a fixed cap or PPR Per Case Payment Method applies, all Covered Services during a single Outpatient Encounter that would otherwise have a contract rate pursuant to a Per Visit, Per Unit via Facility Fee Schedule, PPR to a fixed cap, PPR or Per Unit Payment Method will instead be included in the Per Case or PPR Per Case to a fixed cap or PPR Per Case contract rate except for Covered Services eligible for reimbursement as a pass through under Section 2.3.5 or 2.3.6.

If more than one Covered Service subject to a Per Case or PPR Per Case to a fixed cap or PPR Per Case Payment Method applies during a single Outpatient Encounter (as specified in Section 2.3), the contract rate will be the rate applicable to the Covered Service with the highest ranking, as indicated in the Case Rate Service Ranking table below. No additional payments for additional Covered Services provided during that same single Outpatient Encounter, for which a Per Case or PPR Per Case to a fixed cap or PPR Per Case Payment Method applies, will be made; instead, such additional Covered Services will be considered to have been included in the contract rate for the Covered Service with the highest ranking on the table below.

Services on the Case Rate Service Ranking table below are ranked from the highest ranking to the lowest ranking, with Outpatient Trauma Care Unit, as identified in Section 2.3.1, having the highest ranking.

Case Rate Service Ranking
Trauma Care Unit
Outpatient Procedures, as identified in Section 2.3.2
Observation
Emergency
Urgent Care
Other Outpatient, Diagnostic and Therapeutic Services

2.3.5 Outpatient High Cost Drugs Pass Through

The contract rate for Outpatient High Cost Drugs (Revenue Codes 0343, 0344, 0636, and 0891) that are Covered Services and that have Eligible Charges greater than ____ ("Pass Through Threshold") per applicable revenue code, will be calculated in addition to the contract rates set forth elsewhere in this Appendix, at a PPR of ____ of the Eligible Charge

for that Outpatient High Cost Drug Covered Service, not to exceed a contract rate of ____ ("Pass Through Fixed Cap") per applicable revenue code. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.3.

2.3.6 Outpatient High Cost Implantable Pass Through
The contract rate for Outpatient High Cost Implantables (Revenue Code 0274, 0275, 0276, 0278) that are Covered Services and that have Eligible Charges greater than ____ ("Pass Through Threshold") cumulative total for all applicable revenue codes, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be at a PPR of ____ of the Eligible Charge for that Outpatient High Cost Implantable Covered Service. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.3.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, 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. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for implantable prosthetic devices performed at Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Notwithstanding the foregoing, Facility will only bill for inpatient and outpatient laboratory services provided by Facility. Facility will not bill, nor be reimbursed for laboratory/pathology services performed by another provider entity and not by Facility.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-10-CM codes or successor version, 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 CMS, (c) the latest edition of the ICD-10-CM manual, or successor version, 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 reasonable efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

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, including the calculation of 'lesser of' determinations under Section 2.1 of this Appendix. 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. In these cases the contract rate applicable to the Admission or Outpatient Encounter is considered payment in full. 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 4: 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 that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes, when they are Covered Services billed with a Covered Service subject to a Per Case, Per Diem, , PPR to a fixed cap, Payment Method under this Appendix, are always considered included in other services. These Covered Services are therefore not subject to additional payment.

Services or items listed in the table below and billed with indicated codes, when they are Covered Services billed with a Covered Service subject to a PPR Per Case to a fixed cap or PPR Per Case Payment Method under this Appendix, are subject to that PPR Per Case to a fixed cap or PPR Per Case contract rate and will not be paid pursuant to this Section.

Services or items billed with listed codes in the table below, when they are Covered Services, but are not billed with a Covered Service subject to a Per Case, Per Diem, PPR Per Case to a fixed cap, PPR Per Case Payment Method under this Appendix, are subject to a PPR of ____ of Eligible Charges for the Covered Service, less any applicable Customer Expenses. However, this PPR is subject to change under Section 4 as a result of changes to Facility's Customary Charges. Additionally, adjustments to the PPR rate pursuant to Section 4 of this Appendix will carry forward into subsequent years.

Regardless of which of the above paragraphs apply, the Eligible Charges for the services or items listed in the table below are considered in other calculations for payment, including the calculation of "lesser of" determinations under Section 2.1 of this Appendix. 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, as permitted under the Agreement.

Table 5: Services that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0230-0239	Nursing Increment	0541	Ambulance/Supply
0240-0249	All Inclusive Ancillary	0544	Ambulance/Oxygen
0250	Pharmacy	0621	Med-Surg Sup/Incident Radiology
0251	Drugs/Generic	0622	Med-Surg Supplies Incident ODX
0252	Drugs/ Non Generic	0623	Surgical Dressing
0254	Drugs/Incidental Other DX	0631	Single Source Drug

0255	Drugs/Incidental Radiology	0632	Multiple Source Drug
0257	Drugs/Nonprescription	0633	Restrictive Prescription
0258	IV Solutions	0634	EPO < 10,000 Units
0259	Drugs/Other	0635	EPO 10,000 or More Units
0261	IV Therapy/Infusion Pump	0636 *	Drugs Requiring Detailed Coding
0262	IV Therapy/RX Svs	0637	Self Administrable Drugs Not Requiring Detailed Coding
0263	IV Therapy/Drug/Supply Delv	0681	Trauma Level 1
0264	IV Therapy/Supplies		
0270	Medical Surgical Supplies	0683-0689	Trauma Response
0271	Non Sterile Supply	0690-0696, 0699	Pre-hospice/Palliative care services
0272	Sterile Supply	0700	Cast Room
0274 ~	Prosthetic/Orthotic Device	0710	Recovery Room
0275 ~	Pacemaker	0723	Circumcision
0276 ~	Intraocular Lens	0760-0761, 0769	Specialty Services/Treatment Room
0278 ~	Supply/Implants	0770	Preventive Care Svr/General
0279	Supply/Other	0780	Telemedicine
0343-0344 *	Nuclear Medicine Diagnostic/Therapeutic Radiopharmaceuticals		
0370-0379	Anesthesia	0810-0819 w/HCPCS Code V2785	Donor Bank/Corneal Tissue
0500	OP Service	0880-0881, 0889	Dialysis Miscellaneous
0509	OP/Other	0891 *	Special Processed Drugs FDA Approved Cell Therapy
0510-0511, 0514-0520, 0523, 0526, 0529	Clinic	0946	Complex Med Equip
0530-0539	Osteopathic Services	0947	Complex Med Equip/Ancillary
		0950-0952	Other Therapeutic Services
		2101	Acupuncture
		2103	Massage

~ If Eligible Charges are not given an additional contract rate as an Inpatient or Outpatient High Cost Implantable Pass Through under this Appendix, then the contract rate will be determined according to this Section 3.5.

* If Eligible Charges are not given an additional contract rate as an Inpatient or Outpatient High Cost Drug Pass Through under this Appendix, then the contract rate will be determined according to this Section 3.5.

3.6 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 6: 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/2 bed	0580-0589	Home Health - Other Visits
0126	Detox/2 bed	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	0650-0652, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819 w/o HCPCS Code V2785	Donor Bank/Bone, Organ, Skin, Bank *@ (see note @ below)*
0156	Detox/Ward	0870-0875	Cell/Gene Therapy *@ (see note @ below)*
0204	ICU/Psych	0882	Dialysis/Home Aid Visit
0213	CC/Transplant *@ (see note @ below)*	0901-0907	Psychiatric/Psychological Treatments
0290-0299	Durable Medical Equipment	0911-0916, 0919	Psychiatric/Psychological Services
0362	OR/Organ Transplant *@ (see note @ below)*	0941	Recreation/RX
0367	OR/Kidney Transplant *@ (see note @ below)*	0944	Drug Rehab
0512	Clinic - Dental Clinic	0945	Alcohol Rehab
0513	Clinic - Psychiatric Clinic	0953	Chemical Dependency (Drug and Alcohol)
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic (RHC)/ Federally Qualified Health Center (FQHC)	0960-0989	Professional Fees
0550-0559	Home Health - Skilled Nursing	1000-1006	Behavioral Health Accommodations
		3101-3109	Adult Care

MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD-10-PCS Codes 02HA0QZ, 02HA0RZ, 02HA3QZ, 02HA4QZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02RK0JZ, 02RL0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ	Heart Transplant [+] *(see note + below)*	014	Allogeneic Bone Marrow Transplant
005-006	Liver Transplant	016-018	Autologous Bone Marrow Transplant with CC/MCC; Autologous Bone Marrow Transplant without CC/MCC; Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies, respectively
007	Lung Transplant	019	Pancreas/Kidney Transplant with Hemodialysis
008	Pancreas/Kidney Transplant	650-652	Kidney Transplant
010	Pancreas Transplant		

[+] Services related to implant of heart assist systems (MS-DRGs 001 & 002 with ICD-10-PCS Codes 02HA0QZ, 02HA0RZ, 02HA3QZ, 02HA4QZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02RK0JZ, 02RL0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ), if part of the care management of a transplant patient, will be treated as Heart Transplant services and will not be payable under this Appendix. The implant of heart assist systems is payable under this Appendix only if the service is a Covered Service and is not part of the care management of a transplant patient. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to these services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer, the services may be payable under that agreement or appendix.

[@] This Section applies when billed in conjunction with a transplant claim. If part of the care management of a transplant patient, this service will be treated as a transplant service and will not be payable under this Appendix. This service is payable under this Appendix only if it is a Covered Service and is not part of the care management of a transplant patient. When this service is not part of the care management of a transplant patient, this service is considered priced according to the terms of this Appendix. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was

accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan.

3.7 This Section Intentionally Left Blank.

3.8 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

SECTION 4
Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

For the purpose of this Section 4, PPR applies to all forms of PPR payments under this Appendix, including without limitation PPR, PPR Per Case, and PPR Per Case to a fixed cap. With respect to a “PR Per Case to a fixed cap, the PPR will adjust, and the fixed cap does not adjust pursuant to this Section.

4.2 Duty to Give Notice. Facility will notify United at least 60 days prior to the implementation date of any increase (or cumulative increases within a contract year) made by Facility to its Customary Charges (Facility’s Chargemaster Notice) for particular Covered Services that, due to the amount of the increase, is likely to have a significant impact on Payers. For purposes of this notice requirement, a significant cost impact is an impact of 1% or more in the total amount to be paid by Payers for commercial business under this Appendix. Notification is required for Facility Customary Charge changes for any Covered Service reimbursed under this Appendix based on a Percentage Payment Rate methodology.

4.3 Content of Notice. The Facility's Chargemaster Notice will include the following:

(a) The effective date of the Facility's new Chargemaster.

(b) Facility's estimate of Chargemaster increase shall be calculated using Facility's aggregate weighted average charge increase where weights equal volume for specific charges.

4.4 Cooperation with United. Facility will cooperate with United in administration of this Section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates.

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates (excluding any Fee Schedule Default PPR rate), and thresholds determined by Eligible Charges using the estimates in the notice. United will create and implement a new version of this Appendix that is identical to this Appendix, other than the revised inpatient and outpatient PPR contract rates and thresholds determined by eligible charges set forth in the notice.

United may implement the revised appendix without Facility's consent, provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment that will include, along with the effective date of the revised appendix. Unless there are unavoidable circumstances (such as a natural disaster or office fire) that prohibit United from being able to implement the revised appendix in a timely manner, if United does not implement a revised appendix within the later of (i) 120 days of the Chargemaster increase effective date specified in Facility's Chargemaster Notice or (ii) 120 days of the date in which the Facility notified United in writing and confirmed receipt via electronic mail (E-Mail) with United of the Facility's Chargemaster Notice, no retroactive adjustment will be applied if United revises the appendix at a later date. For example, if Facility notifies and confirms with United via E-Mail on June 10th of a change to the Customary Charges effective July 1st, United shall implement a revised appendix no later than 120 days of June 10th. Any revisions made to the appendix after the applicable 120 day period will be made on a go-forward basis only. In addition, United will not, during this, or any subsequent term of the agreement, seek to recover any payments, resulting from United's failure to identify and/or implement any Chargemaster related rate adjustment(s), during the period of September 1, 2012, through June 30, 2021.

4.6 United's right to audit. In addition to any other audit rights that United may have under the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information. United may recover those overpayments. United will give Facility notice of, and United's intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates and thresholds determined by Eligible Charges to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement.

UHC OPG (Outpatient Procedure Grouper) Exhibit

Facility acknowledges receipt of an electronic version of the UHC OPG (Outpatient Procedure Grouper) Exhibit.

REVENUE CODE:

0360, 0361, 0369

0481

0490, 0499

0750

0790

WITH CPT / HCPCS CODES THAT ARE CONSIDERED "OPG ELIGIBLE" AS NOTED WITH A "Y" IN THE MOST CURRENT UHC OPG (OUTPATIENT PROCEDURE GROUPER) EXHIBIT

All Payer Appendix

Facility Name(s): Ventura County Medical Center and Santa Paula Hospital
Effective Date of this Appendix: 10/01/2023

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 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.

CMS: Centers for Medicare and Medicaid Services.

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 3.6 of this Appendix.

Institutional Claim: Any UB-04 or electronic version or successor form.

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.

Outpatient Encounter: Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Case: The Payment Method designated "Per Case" in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Per Diem: The Payment Method designated "Per Diem" in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

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

PPR Per Case (Percentage Payment Rate Per Case): The Payment Method designated "PPR Per Case" in this Appendix is the percentage applied to Facility's total Eligible Charge during one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the PPR Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel employed or subcontracted by Facility (regardless of whether those services are characterized as professional services), nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

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 contract rate will be the lesser of (1) Facility's aggregate Eligible Charges, or (2) the aggregate applicable contract rate 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.

2.1.1 Optum Health. This Appendix does not apply when Facility has an agreement with Optum Health and the services are provided pursuant to an authorization or notification from Optum Health.

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.

Table 1A**: Inpatient Service Category Table**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Medical/Surgical ^ (see note ^ below) Includes the following Revenue Codes. Revenue Codes: 0100-0101, 0110-0113, 0117, 0119-0123, 0127, 0129-0133, 0137, 0139-0143, 0147, 0149-0153, 0157, 0159-0160, 0164, 0169, 0170-0174, 0179,	**Per Diem**	
ICU-Intermediate/CCU-Intermediate ^ (see note ^ below) Includes the following Revenue Codes. Revenue Codes: 0206, 0214	**Per Diem**	
ICU/CCU/PICU ^ (see note ^ below) Includes the following Revenue Codes. Revenue Codes: 0200-0203, 0207-0212, 0219	**Per Diem**	
Hospice ~ ^ (see notes ~ and ^ below) Revenue Codes: 0115, 0125, 0135, 0145, 0155, 0655-0656	**Per Diem**	
Nursery* (see note * below) Normal Newborn: MS-DRG: 795 Lower Level Neonate: MS-DRGs: 789, 792, 794 Higher Level Neonate: MS-DRGs: 791, 793 Severe Level Neonate: MS-DRG: 790	 **Per Diem** **Per Diem** **Per Diem** **Per Diem**	

Obstetrics (Mother Only)* (see note * below) **Vaginal Delivery** MS-DRGs: 768, 796-798, 805-807 2 day stay case rate w/ Per Diem for additional days **Cesarean Section** MS-DRGs: 783-785, 786-788 4 day stay case rate w/ Per Diem for additional days	**Per Case up to 2 days.** **Per Diem beginning on day 3.** **Per Case up to 3 days.** **Per Diem beginning on day 4.**	
False Labor MS-DRGs: 817-819, 831-833 WITH PRINCIPAL ICD-10-CM DIAGNOSIS CODES O47.00-O47.03; O47.1; or O47.9	**Per Diem**	
Rehabilitation ~ ^ (see notes ~ and ^ below) Revenue Codes: 0118, 0128, 0138, 0148, 0158	**Per Diem**	
Hospital Sub-Acute Revenue Codes: 0190-0194, 0199 However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by Bill Types on this Inpatient Service Category Table or Section 3.6	**Per Diem**	
Inpatient Skilled Nursing Services~ (see note ~ below) Bill Types: 211-219	**Per Diem**	
Trauma Care Unit +Revenue Code: 0682	**Per Diem**	

Notes to Table 1A

*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

^ However, this service category does not apply where one of these revenue codes is billed in connection with Covered Services included in any Per Case Payment Method service category or any service category defined by MS-DRGs or any service category defined by Bill Types on this Inpatient Service Category Table or Section3.6 .

+The Trauma Care Unit Per Diem is applicable for the entire admission (and applies only to Ventura County Medical Center).

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 will 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.

2.2.1 Transfer of Customer. This Section applies only when a Per Case, Per Case plus Per Diem after Threshold or MS-DRG Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

2.2.1.1 Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by CMS except for MS-DRGs designated by CMS as "special pay" MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the "Imputed Per Diem Rate") as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.2 Transfer from Facility to post acute care for MS-DRGs designated by CMS as "special pay" MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an Imputed Per Diem Rate as described above in Section 2.2.1.1. The contract rate for the first day of the Admission is ____ of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is ____ of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

2.2.1.3 CMS Modifications. In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

2.2.2 Readmission within 30 Days. If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

(a) Based on CMS readmission guidelines; and

(b) To readmissions with a related diagnosis (as determined by United); and

(c) To the determination of the contract rate for the subsequent Admission.

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

2.2.4 Inpatient High Cost Implantable Pass Through

The contract rate for Inpatient High Cost Implantable (Revenue Code 0274, 0275, 0276, 0278) that are Covered Services and that have Eligible Charges greater than $____ ("Pass Through Threshold") cumulative total for all applicable revenue codes, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be a PPR of ____ of the Eligible Charge for that Inpatient High Cost Implantable Covered Service. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.2.

2.2.5 Inpatient High Cost Drug Pass Through

The contract rate for Inpatient High Cost Drugs (Revenue Codes 0343, 0344, 0636, and 0891) that are Covered Services and that have Eligible Charges greater than $____ ("Pass Through Threshold") per applicable revenue code, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be a PPR of ____ of the Eligible Charge for that Inpatient High Cost Drug Covered Service, not to exceed a contract rate of $____ ("Pass Through Fixed Cap") per applicable revenue code. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.2.

2.2.6 Inpatient Dialysis Pass Through

The Contract rate for Inpatient Dialysis (Revenue Codes 0800- 0804, 0809) that are Covered Services, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be $____ per diem.

2.3 Outpatient Covered Services. For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

2.3.1 Observation, Outpatient Therapeutic, Diagnostic, Emergency, Urgent Care Covered Services. For the provision of Observation, therapeutic, diagnostic, Emergency, and Urgent Care Covered Services rendered by Facility to a Customer on an outpatient basis (except for Outpatient Procedures addressed in Section 2.3.2 of this Appendix), the contract rate will be determined according to this Section 2.3.

If more than one type of Covered Service for which a Payment Method applies are provided to a Customer during one calendar day, each of the applicable Payment Methods will be considered in calculating the aggregate contract rate for those Covered Services; provided, however, if the Customer receives any Covered Service for which a Per Case or PPR Per Case to a fixed cap or a PPR Per Case Payment Method applies, all Covered Services which would otherwise be paid pursuant to a Per Visit, Per Unit via Facility Fee Schedule, or PPR Payment Method, will instead be included in the Per Case or PPR Per Case to a fixed cap or PPR Per Case contract rate and will not be separately reimbursed except for Covered Services eligible for reimbursement as a pass through under Section 2.3.5 or 2.3.6.

The contract rate for outpatient diagnostic and therapeutic Covered Services rendered by Facility to a Customer, for which a Payment Method is detailed on Table 2 below, will be determined according to the table.

Table 2: Outpatient Diagnostic and Therapeutic Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Observation (Revenue Code: 0762)	**Per Case**	
Emergency (Revenue Codes: 0450-0452, 0459) **(1)**	**PPR Per Case to a fixed cap**	
Trauma Care Unit **Revenue Code: 0682**	**Per Case**	
Urgent Care (Revenue Code: 0456)	**PPR Per Case to a fixed cap**	
Other Outpatient, Diagnostic and Therapeutic Services Revenue Codes: 0260, 0269, 0280, 0289, 0300-0307, 0309, 0310-0312, 0314, 0319, 0320-0324, 0329, 0330, 0331, 0332, 0333, 0335, 0339, 0340,-0342, 0349, 0350-0352, 0359, 0380-0389, 0390-0392, 0399, 0400, 0401, 0402,0403, 0404, 0409, 0410, 0412, 0413, 0419, 0420-0424, 0429, 0430-0434, 0439, 0440-0444, 0449, 0460, 0469, 0470-0472, 0479, 0480, 0482, 0483, 0489, 0540, 0542, 0543, 0545, 0546-0549, 0610-0612, 0614-0616, 0618-0619 0720-0722, 0724, 0729, 0730, 0731, 0732, 0739, 0740, 0820-0825, 0829, 0830-0835, 0839-0845, 0849-	**PPR Per Case to a fixed cap**	

0855, 0859, 0860-0861, 0900, 0917-0918, 0920, 0921, 0922, 0923, 0924, 0925, 0929, 0940, 0942, 0943, 0948, 0949		

Additional information regarding nondiagnostic services under this Appendix

The following applies to Outpatient nondiagnostic services under this Appendix:

If the rendering of Outpatient nondiagnostic services occurs during the three calendar days immediately preceding an Admission of a Customer and the services are related to the Admission as defined by CMS in connection with the fee for service Medicare program, charges for such services will not be billed by Facility separately and will not be paid by Payer or by the Customer but will be included in the contract rate for the Admission.

(1) Facility's Emergency department visits coding guidelines will be consistent with the coding principles described and updated by CMS, including without limitation the 11 principles listed by CMS in the *CY 2008 OPPS/ASC final rule with comment period (72 FR 66805)*. Within 14 days of a request from United, Facility will provide its Emergency department visits coding guidelines. In addition Facility will provide Customer medical records pursuant to Section 4.10 of the Agreement. In the event Facility changes its Emergency department visits coding guidelines, Facility will notify United at least 90 days prior to the implementation date of any change.

2.3.2 Outpatient Procedures. This Section 2.3.2 applies to Covered Services rendered to a Customer that involve an Outpatient Procedure, as listed in the UHC OPG (Outpatient Procedure Grouper) Exhibit to this Appendix, performed in an outpatient unit of Facility ("Outpatient Procedure"). For Outpatient Procedures, the contract rate will be paid as a PPR Per Case to a fixed cap, as set forth below and as further described in this Section 2.3.2. Unless otherwise specified in this Appendix, payment under this contract rate, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to a Customer during an Outpatient Procedure. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. United may revise the information in the UHC OPG Exhibit based on updated Outpatient Procedure grouping information developed by CMS and newly published codes, which may be modified by United to include procedures that are not maintained by CMS, but are considered for payment under this Appendix. The codes indicated with a "Y" under the "OPG Eligible" column in the UHC OPG Exhibit that corresponds to the date of service, that are Covered Services, are considered eligible for payment under this Section 2.3.2. Updates to the information in the UHC OPG Exhibit can be accessed at www.UHCprovider.com or its successor website.

The UHC OPG Exhibit includes a comprehensive list of revenue codes and CPT/HCPCS codes for which the contract rate is determined according to the Outpatient Procedures table below. The "OPG Group Number" column in the UHC OPG Exhibit does not apply to this Appendix. In the event a revenue code from the table below is billed with a CPT/HCPCS code indicated with an "N" under the "OPG Eligible" column in the UHC OPG Exhibit that corresponds to the date of service, the detail line item that includes that revenue code and CPT/HCPCS code is not eligible for consideration for reimbursement. However, if that detail line item is the only detail line item that has a revenue code from the table below, then the parties will consult as needed, at an operational level, to review the circumstances of the claim and assign appropriate CPT/HCPCS coding. Facility may resubmit the claim with the corrected coding information for consideration for reimbursement pursuant to this Appendix.

Table 3: Outpatient Procedures

OUTPATIENT SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Outpatient Procedures CPT/HCPCS Codes: All appropriate outpatient procedure codes Revenue Codes: 0360-0361, 0369, 0481, 0490, 0499, 0750, 0790 See the UHC OPG Exhibit for Revenue Code and CPT or HCPCS code criteria	**PPR Per Case to a fixed cap**	

*The PPR Per Case contract rate listed above is subject to change under Section 4 as a result of changes to Facility's Customary Charges. Additionally, adjustments to the PPR Per Case contract rate pursuant to Section 4 of this Appendix will carry forward into subsequent years.

2.3.3 This Section Intentionally Left Blank.

2.3.4 Multiple Per Case Covered Services.

If the Customer receives any Covered Services for which a Per Case or PPR Per Case to a fixed cap or PPR Per Case Payment Method applies, all Covered Services during a single Outpatient Encounter that would otherwise have a contract rate pursuant to a Per Visit, Per Unit via Facility Fee Schedule, PPR to a fixed cap, PPR or Per Unit Payment Method will instead be included in the Per Case or PPR Per Case to a fixed cap or PPR Per Case contract rate except for Covered Services eligible for reimbursement as a pass through under Section 2.3.5 or 2.3.6.

If more than one Covered Service subject to a Per Case or PPR Per Case to a fixed cap or PPR Per Case Payment Method applies during a single Outpatient Encounter (as specified in Section 2.3), the contract rate will be the rate applicable to the Covered Service with the highest ranking, as indicated in the Case Rate Service Ranking table below. No additional payments for additional Covered Services provided during that same single Outpatient Encounter, for which a Per Case or PPR Per Case to a fixed cap or PPR Per Case Payment Method applies, will be made; instead, such additional Covered Services will be considered to have been included in the contract rate for the Covered Service with the highest ranking on the table below.

Services on the Case Rate Service Ranking table below are ranked from the highest ranking to the lowest ranking, with Outpatient Trauma Care Unit, as identified in Section 2.3.1, having the highest ranking.

Case Rate Service Ranking
Trauma Care Unit
Outpatient Procedures, as identified in Section 2.3.2
Observation
Emergency
Urgent Care
Other Outpatient, Diagnostic and Therapeutic Services

2.3.5 Outpatient High Cost Drugs Pass Through

The contract rate for Outpatient High Cost Drugs (Revenue Codes 0343, 0344, 0636, and 0891) that are Covered Services

and that have Eligible Charges greater than $____ ("Pass Through Threshold") per applicable revenue code, will be calculated in addition to the contract rates set forth elsewhere in this Appendix, at a PPR of ____ of the Eligible Charge for that Outpatient High Cost Drug Covered Service, not to exceed a contract rate of $____ ("Pass Through Fixed Cap") per applicable revenue code. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.3.

2.3.6 Outpatient High Cost Implantable Pass Through
The contract rate for Outpatient High Cost Implantables (Revenue Code 0274, 0275, 0276, 0278) that are Covered Services and that have Eligible Charges greater than $____ ("Pass Through Threshold") cumulative total for all applicable revenue codes, will be calculated in addition to the contract rates set forth elsewhere in this Appendix and will be at a PPR of ____ of the Eligible Charge for that Outpatient High Cost Implantable Covered Service. If the Pass Through Threshold is not met, the contract rate will be determined based on the applicable contract rate set forth in Section 2.3.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, 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. All items and non-Physician services provided to Customers at Facility must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for implantable prosthetic devices performed at Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Customer's Benefit Plan and billed for separately by Facility.

Notwithstanding the foregoing, Facility will only bill for inpatient and outpatient laboratory services provided by Facility. Facility will not bill, nor be reimbursed for laboratory/pathology services performed by another provider entity and not by Facility.

3.2 Payment Code Updates. United will update CPT codes, HCPCS codes, ICD-10-CM codes or successor version, 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 CMS, (c) the latest edition of the ICD-10-CM manual, or successor version, 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 reasonable efforts to assure that all Facility-based Physicians and other providers are participating providers as long as the Agreement is in effect.

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, including the calculation of 'lesser of' determinations under Section 2.1 of this Appendix. 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. In these cases the contract rate applicable to the Admission or Outpatient Encounter is considered payment in

full. 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 4: 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 that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment. Services or items listed in the table below and billed with indicated codes, when they are Covered Services billed with a Covered Service subject to a Per Case, Per Diem, , PPR to a fixed cap, Payment Method under this Appendix, are always considered included in other services. These Covered Services are therefore not subject to additional payment.

Services or items listed in the table below and billed with indicated codes, when they are Covered Services billed with a Covered Service subject to a PPR Per Case to a fixed cap or PPR Per Case Payment Method under this Appendix, are subject to that PPR Per Case to a fixed cap or PPR Per Case contract rate and will not be paid pursuant to this Section.

Services or items billed with listed codes in the table below, when they are Covered Services, but are not billed with a Covered Service subject to a Per Case, Per Diem, PPR Per Case to a fixed cap, PPR Per Case Payment Method under this Appendix, are subject to a PPR of _____ of Eligible Charges for the Covered Service, less any applicable Customer Expenses. However, this PPR is subject to change under Section 4 as a result of changes to Facility's Customary Charges. Additionally, adjustments to the PPR rate pursuant to Section 4 of this Appendix will carry forward into subsequent years.

Regardless of which of the above paragraphs apply, the Eligible Charges for the services or items listed in the table below are considered in other calculations for payment, including the calculation of "lesser of" determinations under Section 2.1 of this Appendix. 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, as permitted under the Agreement.

Table 5: Services that may or may not be Separately Reimbursed but that are always Eligible for Consideration in Other Calculations for Payment

Revenue Code	Description	Revenue Code	Description
0230-0239	Nursing Increment	0541	Ambulance/Supply
0240-0249	All Inclusive Ancillary	0544	Ambulance/Oxygen
0250	Pharmacy	0621	Med-Surg Sup/Incident Radiology

0251	Drugs/Generic	0622	Med-Surg Supplies Incident ODX
0252	Drugs/ Non Generic	0623	Surgical Dressing
0254	Drugs/Incidental Other DX	0631	Single Source Drug
0255	Drugs/Incidental Radiology	0632	Multiple Source Drug
0257	Drugs/Nonprescription	0633	Restrictive Prescription
0258	IV Solutions	0634	EPO < 10,000 Units
0259	Drugs/Other	0635	EPO 10,000 or More Units
0261	IV Therapy/Infusion Pump	0636 *	Drugs Requiring Detailed Coding
0262	IV Therapy/RX Svs	0637	Self Administrable Drugs Not Requiring Detailed Coding
0263	IV Therapy/Drug/Supply Delv	0681	Trauma Level 1
0264	IV Therapy/Supplies		
0270	Medical Surgical Supplies	0683-0689	Trauma Response
0271	Non Sterile Supply	0690-0696, 0699	Pre-hospice/Palliative care services
0272	Sterile Supply	0700	Cast Room
0274 ~	Prosthetic/Orthotic Device	0710	Recovery Room
0275 ~	Pacemaker	0723	Circumcision
0276 ~	Intraocular Lens	0760-0761, 0769	Specialty Services/Treatment Room
0278 ~	Supply/Implants	0770	Preventive Care Svr/General
0279	Supply/Other	0780	Telemedicine
0343-0344 *	Nuclear Medicine Diagnostic/Therapeutic Radiopharmaceuticals		
0370-0379	Anesthesia	0810-0819 w/HCPCS Code V2785	Donor Bank/Corneal Tissue
0500	OP Service	0880-0881, 0889	Dialysis Miscellaneous
0509	OP/Other	0891 *	Special Processed Drugs FDA Approved Cell Therapy
0510-0511, 0514-0520, 0523, 0526, 0529	Clinic	0946	Complex Med Equip
0530-0539	Osteopathic Services	0947	Complex Med Equip/Ancillary
		0950-0952	Other Therapeutic Services
		2101	Acupuncture
		2103	Massage

~ If Eligible Charges are not given an additional contract rate as an Inpatient or Outpatient High Cost Implantable Pass Through under this Appendix, then the contract rate will be determined according to this Section 3.5.

* If Eligible Charges are not given an additional contract rate as an Inpatient or Outpatient High Cost Drug Pass Through under this Appendix, then the contract rate will be determined according to this Section 3.5.

3.6 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 6: 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/2 bed	0580-0589	Home Health - Other Visits
0126	Detox/2 bed	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	0650-0652, 0657-0659	Hospice Services
0146	Detox/Pvt/Deluxe	0660-0669	Respite Care
0154	Psych/Ward	0810-0819 w/o HCPCS Code V2785	Donor Bank/Bone, Organ, Skin, Bank *@ (see note @ below)*
0156	Detox/Ward	0870-0875	Cell/Gene Therapy *@ (see note @ below)*
0204	ICU/Psych	0882	Dialysis/Home Aid Visit
0213	CC/Transplant *@ (see note @ below)*	0901-0907	Psychiatric/Psychological Treatments
0290-0299	Durable Medical Equipment	0911-0916, 0919	Psychiatric/Psychological Services
0362	OR/Organ Transplant *@ (see note @ below)*	0941	Recreation/RX
0367	OR/Kidney Transplant *@ (see note @ below)*	0944	Drug Rehab
0512	Clinic - Dental Clinic	0945	Alcohol Rehab
0513	Clinic - Psychiatric Clinic	0953	Chemical Dependency (Drug and Alcohol)
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic (RHC)/ Federally Qualified Health Center (FQHC)	0960-0989	Professional Fees
0550-0559	Home Health - Skilled Nursing	1000-1006	Behavioral Health Accommodations
		3101-3109	Adult Care

MS-DRGs	Description	MS-DRGs	Description
001-002 w/o ICD-10-PCS Codes 02HA0QZ, 02HA0RZ, 02HA3QZ, 02HA4QZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02RK0JZ, 02RL0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ	Heart Transplant [+] *(see note + below)*	014	Allogeneic Bone Marrow Transplant
005-006	Liver Transplant	016-018	Autologous Bone Marrow Transplant with CC/MCC; Autologous Bone Marrow Transplant without CC/MCC; Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies, respectively
007	Lung Transplant	019	Pancreas/Kidney Transplant with Hemodialysis
008	Pancreas/Kidney Transplant	650-652	Kidney Transplant
010	Pancreas Transplant		

[+] Services related to implant of heart assist systems (MS-DRGs 001 & 002 with ICD-10-PCS Codes 02HA0QZ, 02HA0RZ, 02HA3QZ, 02HA4QZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02RK0JZ, 02RL0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ), if part of the care management of a transplant patient, will be treated as Heart Transplant services and will not be payable under this Appendix. The implant of heart assist systems is payable under this Appendix only if the service is a Covered Service and is not part of the care management of a transplant patient. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to these services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer, the services may be payable under that agreement or appendix.

[@] This Section applies when billed in conjunction with a transplant claim. If part of the care management of a transplant patient, this service will be treated as a transplant service and will not be payable under this Appendix. This service is payable under this Appendix only if it is a Covered Service and is not part of the care management of a transplant patient. When this service is not part of the care management of a transplant patient, this service is considered priced according to the terms of this Appendix. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was

accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan.

3.7 This Section Intentionally Left Blank.

3.8 Temporary Transfer. If a Customer is temporarily transferred by Facility, without being discharged from an inpatient Admission or Outpatient Encounter, for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid to Facility as one continuous Admission or Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Customer, without discharging Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Customer nor Payer will be billed separately.

If a Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Customer, and neither Customer nor Payer will be billed.

SECTION 4
Adjustment to Contract Rates Due to Changes in Facility's Customary Charges

4.1 Intent. The intent of this Section is to allow Facility to modify its Customary Charges when and how Facility chooses, while assuring that increases to Facility's Customary Charges do not have the impact of increasing the amount paid by Payers separately for inpatient or outpatient Covered Services under this Appendix.

Contract rates in this Appendix are subject to change according to this Section as a result of changes to Facility's Customary Charges. Additionally, adjustments to the contract rates pursuant to this Section of this Appendix will carry forward into subsequent years.

For the purpose of this Section 4, PPR applies to all forms of PPR payments under this Appendix, including without limitation PPR, PPR Per Case, and PPR Per Case to a fixed cap. With respect to a "PR Per Case to a fixed cap, the PPR will adjust, and the fixed cap does not adjust pursuant to this Section.

4.2 Duty to Give Notice. Facility will notify United at least 60 days prior to the implementation date of any increase (or cumulative increases within a contract year) made by Facility to its Customary Charges (Facility's Chargemaster Notice) for particular Covered Services that, due to the amount of the increase, is likely to have a significant impact on Payers. For purposes of this notice requirement, a significant cost impact is an impact of 1% or more in the total amount to be paid by Payers for commercial business under this Appendix. Notification is required for Facility Customary Charge changes for any Covered Service reimbursed under this Appendix based on a Percentage Payment Rate methodology.

4.3 Content of Notice. The Facility's Chargemaster Notice will include the following:

(a) The effective date of the Facility's new Chargemaster.

(b) Facility's estimate of Chargemaster increase shall be calculated using Facility's aggregate weighted average charge increase where weights equal volume for specific charges.

4.4 Cooperation with United. Facility will cooperate with United in administration of this Section by timely meeting with United to discuss and explain the information provided in accordance with Section 4.3, including Facility's calculation of the new PPR contract rates.

4.5 Adjustment to Contract Rates. Upon receipt of the notice described in Section 4.3, United will adjust the inpatient and outpatient PPR contract rates (excluding any Fee Schedule Default PPR rate), and thresholds determined by Eligible Charges using the estimates in the notice. United will create and implement a new version of this Appendix that is identical to this Appendix, other than the revised inpatient and outpatient PPR contract rates and thresholds determined by eligible charges set forth in the notice.

United may implement the revised appendix without Facility's consent; provided that the revised appendix contains no other changes. United will provide Facility with a copy of the revised Amendment that will include, along with the effective date of the revised appendix. Unless there are unavoidable circumstances (such as a natural disaster or office fire) that prohibit United from being able to implement the revised appendix in a timely manner, if United does not implement a revised appendix within the later of (i) 120 days of the Chargemaster increase effective date specified in Facility's Chargemaster Notice or (ii) 120 days of the date in which the Facility notified United in writing and confirmed receipt via electronic mail (E-Mail) with United of the Facility's Chargemaster Notice, no retroactive adjustment will be applied if United revises the appendix at a later date. For example, if Facility notifies and confirms with United via E-Mail on June 10th of a change to the Customary Charges effective July 1st, United shall implement a revised appendix no later than 120 days of June 10th. Any revisions made to the appendix after the applicable 120 day period will be made on a go-forward basis only. In addition, United will not, during this, or any subsequent term of the agreement, seek to recover any payments, resulting from United's failure to identify and/or implement any Chargemaster related rate adjustment(s), during the period of September 1, 2012, through June 30, 2021.

4.6 United's right to audit. In addition to any other audit rights that United may have under the Agreement, United may conduct audits in connection with this Section 4. The purpose of the audit may be to identify any instance in which Facility did not give the required notice, or provided inaccurate information, or provided incorrect estimates of the necessary changes to the PPR contract rates or fixed contract rates (impacted by lesser of). Facility will cooperate with the audit process and will provide to United documentation that United reasonably requests in order to perform such audits.

4.7 Recovery of overpayments. In the event that United determines that an overpayment to Facility has resulted due to Facility's failure to give timely notice as required under this Section 4, or due to Facility providing inaccurate information. United may recover those overpayments. United will give Facility notice of, and United's intent to, recover the overpayment. The notice will identify United's basis for believing that an overpayment has occurred, how United will recover the overpayment and how United will prospectively adjust the PPR contract rates and thresholds determined by Eligible Charges to prevent additional overpayments from occurring. United's right to collect overpayments under this Section 4.7 is in addition to any other rights to adjust claims or collect overpayments United may have under the Agreement and is not subject to any time limitations otherwise set forth in the Agreement.

United will timely meet with Facility, upon Facility's request, to discuss and explain the information in United's notice, how United calculated that information, and why United believes this information to be correct.

In the event that Facility initiates dispute resolution as further described under Section 4.8, the recovery and adjustments described in this Section 4.7 will not take place until the conclusion of the dispute resolution process.

4.8 Dispute resolution. In the event Facility disagrees with United as to the existence of an overpayment or the amount of the overpayment or with the amount of the contract rate adjustment described in Section 4.7, the issue will be resolved through the dispute resolution process set forth in the Agreement.

UHC OPG (Outpatient Procedure Grouper) Exhibit

Facility acknowledges receipt of an electronic version of the UHC OPG (Outpatient Procedure Grouper) Exhibit.

REVENUE CODE:

0360, 0361, 0369

0481

0490, 0499

0750

0790

WITH CPT / HCPCS CODES THAT ARE CONSIDERED "OPG ELIGIBLE" AS NOTED WITH A "Y" IN THE MOST CURRENT UHC OPG (OUTPATIENT PROCEDURE GROUPER) EXHIBIT

Facility Medicare Advantage Payer Appendix

Facility Name(s): Ventura County Medical Center and Santa Paula Hospital

Effective Date of this Appendix: October 1, 2022

APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan that covers Medicare Customers, the provisions of this Appendix apply to Covered Services rendered by Facility to Medicare Customers enrolled in Medicare Advantage Benefit Plans.

SECTION 1
Definitions

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

Acute Care Hospital: A facility, other than a psychiatric, cancer, or critical access hospital, which (a) primarily provides diagnostic, therapeutic and Rehabilitation Services under the supervision of Physicians to patients admitted for a variety of medical conditions and who are medically unstable, and (b) is licensed and operated as required by applicable laws.

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

APC (Ambulatory Payment Classifications): A system of classification included under the OPPS (Outpatient Prospective Payment System), for outpatient hospital services based on, among other factors, CPT codes, HCPCS procedure codes, and payment status indicators.

CMG (Case Mix Group): A CMS reimbursement methodology for distinct part inpatient rehabilitation facilities (IRFs), either free -standing or hospital-based, that is geographically adjusted and based on resource utilization of the Medicare Customer for all Covered Services rendered during an entire Admission. Facility must be CMS certified as an IRF to receive payment under the CMG Payment Method. Payment under the CMG Payment Method, less any applicable Customer Expenses, is payment in full, for all Covered Services rendered to the Medicare Customer during the Admission. Facility will utilize information from the most recent version of the CMS Patient Assessment Instrument (PAI) to classify residents into the applicable Health Insurance Prospective Payment System (HIPPS) rate code(s).

Covered Service: A health care service or product for which Medicare Customer is entitled to receive coverage from a Payer pursuant to the terms of the Medicare 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(n) Medicare Customer.

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

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

Institutional Claim: Any UB04 or electronic version or successor form.

IRF (Inpatient Rehabilitation Facility): A facility or distinct part unit which is certified by CMS as an Inpatient Rehabilitation Facility and which (a) provides comprehensive inpatient Rehabilitation Services under the supervision of Physicians to patients with physical disabilities who require one or more of the following therapies or services: physical therapy, occupational therapy, speech pathology, social or psychological services and orthotics and prosthetics services, and (b) is licensed and operated as required by applicable laws.

Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage organization as part of the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act (as that program name may change from time to time) but does not include Medicare Advantage Private Fee-For-Service plans and Medicare Advantage Medical Savings Account plans.

Medicare Customers: Medicare beneficiaries who are enrolled in Medicare Advantage Benefit Plans.

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. For purposes of determining the contract rate under this Appendix, the MS-DRG at discharge, as that term is defined in the Final Rule, as published by CMS and most recently made effective under this Appendix, controls.

The Payment Method designated "MS-DRG" in this Appendix and applicable to Covered Services rendered to Medicare Customer for an entire Admission. The contract rate is determined by applying the CMS MS-DRG relative weight to the contracted percentage of the CMS base rate as further described in this Appendix. Unless otherwise specified in this Appendix, payment under the MS-DRG Payment Method is payment in full, less any applicable Customer Expenses, for all Covered Services rendered to the Medicare Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including but not limited to diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

Observation: Services furnished by Facility on 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.

OPPS (Outpatient Prospective Payment System): A prospective payment system implemented by CMS for hospital outpatient services. APCs are a component of the OPPS. Fee schedules are another component of this payment system.

Outpatient Encounter: Covered Services rendered to Medicare Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

Payment Method: A methodology for determining contract rates under this Appendix.

Per Visit: The flat rate Payment Method designated "Per Visit" in this Appendix and applicable to Covered Services rendered to Medicare Customer on one-calendar day period, for each Service Category within Section 2 for which a Per Visit Payment Method is indicated in this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Medicare Customer including, but not limited to, Physician and other professional fees billed by the Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and facility and ancillary services. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

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

Rehabilitation Services: Rehabilitation services that meet CMS coverage guidelines, including all of the following criteria: (a) are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; (b) are ordered by a Physician; and (c) are necessary for the treatment of the sickness or injury.

RUG (Resource Utilization Group): A CMS reimbursement methodology under the SNF PPS (Skilled Nursing Facility Prospective Payment System) that is geographically adjusted and based on resource utilization requirements of the Medicare Customer for all Covered Services rendered during each day of a SNF or swing bed Facility Admission. Facility must be CMS certified as a SNF to receive payment under the RUG Payment Method. Payment under the RUG Payment Method, less any applicable Customer Expenses, is payment in full, for all Covered Services rendered to the Medicare Customer during each day of the Admission (except services considered to be outside the SNF consolidated billing requirement by CMS and therefore separately reimbursable). Facility will utilize information from the most recent version of the CMS Resident Assessment Instrument (RAI), to classify Medicare Customers into the applicable Health Insurance Prospective Payment System (HIPPS) Rate code(s). For billing purposes, there is a payment code associated with each of the RUG groups.

SNF (Skilled Nursing Facility): A facility or distinct part unit which is certified by CMS as a Skilled Nursing Facility and which (a) primarily provides inpatient Skilled Nursing Services to patients who require medical, nursing or Rehabilitation Services, and (b) is licensed and operated as required by applicable laws.

Skilled Nursing Services: Skilled nursing services that meet CMS coverage guidelines, including all of the following criteria. Skilled Nursing Services (a) must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; (b) are ordered by a Physician; and (c) are necessary for the treatment of the sickness or injury. A determination of coverage for Skilled Nursing Services is based on both the skilled nature of the service and the need for Physician-directed medical management. Skilled Nursing Services are not determined by the availability of caregivers to perform them; the absence of a person to perform an unskilled service does not cause the service to become "skilled."

SECTION 2
Contract Rate for Covered Services

2.1 Contract Rate. For Covered Services rendered by Facility to Medicare Customer, the contract rates will be the lesser of (1) Facility's Eligible Charges, or (2) the applicable contract rates determined in accordance with Sections 2.2, 2.3 or 3 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. All coding and billing guidelines issued by CMS will be followed by Facility in submitting claims unless otherwise specified below.

2.2 Inpatient Covered Services. For the provision of Covered Services to Medicare Customer during an Admission, the contract rate is determined as described in this Section 2.2.

Table1: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
All MS-DRGs (except those listed in Section 3.5, and those service categories defined below)	**MS-DRG**	

2.2.1 Determination of Contract Rates using an MS-DRG Payment Method other than for transfers. The contract rates for inpatient services using an MS-DRG Payment Method will be determined in accordance with CMS' methodology for calculating MS-DRG payments applicable to services provided by Facility to Medicare beneficiaries covered under original Medicare (that is Part A and Part B), as it applies to Medicare Advantage Benefit Plans. The contract rate, therefore, will not include the following items:

(a) Direct graduate medical education (DGME)
(b) Operating IME
(c) Bad Debt
(d) Annual cost report settlements

2.2.2 Determination of Contract Rates using CMG Payment Method other than for transfers. The contract rates for inpatient services using the CMG Payment Method will be determined in accordance with CMS' methodology for calculating these payments applicable to services provided by Facility to Medicare beneficiaries covered under original Medicare (that is Part A and Part B), as it applies to Medicare Advantage Benefit Plans.

2.2.3 Determination of Contract Rates for Transfers. If Medicare Customer is admitted to Facility for a particular service or for treatment of a particular condition and the Medicare Customer is subsequently transferred, the applicable contract rates will be determined in accordance with CMS rules. All items and nonphysician services provided to inpatients must be directly furnished by Facility or billed by Facility when services are provided "under arrangements" by another facility when the Medicare Customer has not been discharged from Facility.

2.2.4 Determination of Contract Rate for Subsequent Admissions. If Medicare Customer after discharge from Facility (the "Initial Admission"), is admitted to Facility or another Acute Care Hospital within the same system as Facility with a related diagnosis (as determined by United) less than 31 days after the discharge date of the Initial Admission (a "Subsequent Admission"), United may, prior to processing Facility's claim for Covered Services provided to Medicare Customer as part of the Subsequent Admission, perform a review to determine whether the Subsequent Admission was preventable. No later than 30 days from receipt of United's request, or within such later time frame as set forth in the request, Facility will provide to United all medical records and supporting documentation related to the Initial and Subsequent Admissions. United will review the entire medical record and supporting documentation submitted by Facility. During the review, United will examine the Initial Admission, up to and including discharge, as well as the Subsequent Admission, to determine whether the Subsequent Admission could reasonably have been prevented by steps taken during the Initial Admission (including, but not limited to, discharge at the appropriate time, proper discharge planning, and discharge to the appropriate destination).

If Facility fails to provide the requested medical records and supporting documentation to United within the requested time frame, United may deny claims for Covered Services provided to Medicare Customer as part of the Subsequent Admission, and Facility will not bill the Medicare Customer for those Covered Services.

If United determines that the Subsequent Admission was unpreventable, United will determine the contract rate for the Covered Services provided to Medicare Customer as part of the Subsequent Admission in accordance with this Appendix. As allowed for by CMS, if United determines that the Subsequent Admission was preventable (regardless of whether that Subsequent Admission, at the time it occurred, was medically necessary), United may deny payment for the Covered Services provided to Medicare Customer as part of the Subsequent Admission. Facility will not bill the Medicare Customer for those Covered Services.

As further explained in CMS coding and billing requirements, United may combine the Initial and Subsequent Admissions where appropriate (for example, scheduled readmission or leaves of absence), to determine the contract rate for the Covered Services provided to Medicare Customer as part of the Initial and Subsequent Admissions.

2.2.4.1 Reconsideration. Facility may request reconsideration of United's determination regarding the Subsequent Admission by submitting a written request to United in accordance with the provisions in the Agreement and in the Protocols for correction of underpayments. Facility may submit, with that request, any additional information Facility believes may be relevant to United's determination. If Facility submits a timely request for reconsideration, United will review the entire medical record and any additional information submitted by Facility. If United determines that the Subsequent Admission was unpreventable, United will determine the contract rate for Covered Services provided to Medicare Customer as part of the Subsequent Admission in accordance with this Appendix. If United determines that the Subsequent Admission was preventable, United will uphold the denial of payment.

2.2.4.2 Appeal. If Facility disagrees with United's reconsideration decision, the standard claims appeal process, as set forth in the Agreement and the Protocols, applies.

2.2.5 Groupings, Contract Rates and Updates. United will follow the grouping and update procedures set forth below in connection with the MS-DRG, CMG or RUG Payment Methods:

(a) MS-DRG Grouping and Contract Rates: United will group each claim to the applicable MS-DRG based on the applicable and correct coding information provided on the claim, subject to updates as described in subsections 2.2.5 (c) and (d) below, and subject to the review of the medical records by United in accordance with the Agreement. The contract rate under the MS-DRG Payment Method is determined by (i) applying the base rate as determined by CMS in effect on the date of discharge, (ii) identifying the applicable MS-DRG from the coding information provided on the claim, subject to updates as described in subsection 2.2.5 (c) and (d) below to determine the applicable relative weight, (iii) multiplying the base rate by the relative weight for the MS-DRG in effect under this Appendix as of the date of discharge, and (iv) applying the percentage of CMS listed in Table 1 to the resulting value.

(b) CMG and/or RUG Grouping and Contract Rates (if applicable): United will group to the applicable CMG or RUG based on the coding information provided on the claim, subject to updates as described in subsection 2.2.5 (c) and (d) below. The contract rate under the CMG or RUG Payment Method is determined by the RUG or CMG contained within the applicable HIPPS rate code, multiplied by the percentage of CMS listed in Table 1.

c) Updates: If CMS modifies the methodology used to calculate MS-DRG, CMG or RUG payments under original Medicare (that is Medicare Part A and Part B) or the Medicare Advantage Program, United will update its methodology used to calculate Facility's contract rate for services provided by Facility to Medicare Customers to be consistent with CMS' methodology. This update will occur as close to the CMS effective date as is reasonably possible, but in no case later than 45 days after the effective date of CMS' modification. Except, if the effective date is earlier than the date on which CMS places information regarding a modification in the public domain (for example, a retroactive modification or a change to a previously announced modification), United will update its methodology within 45 days after the date on which CMS places that information in the public domain.

d) When Updates are Effective: United's update to its methodology will be effective on the effective date of CMS' modification. United will not adjust claims for which payment has correctly been made in accordance with the applicable CMS Payment Method in effect prior to United's update.

2.3 Outpatient Covered Services. For the provision of Covered Services to Medicare Customer, the contract rate is determined according to CMS rules governing the hospital Outpatient Prospective Payment System (except as otherwise set forth in this Appendix) and according to this Section 2.3.

Table 2: Outpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
All Other Facility Outpatient Covered Services (1)	**As determined by CMS**	

(1) The contract rate for the OPPS Status Indicator A services (excluding ESRD and EPO for ESRD services) is determined by the applicable CMS fee schedule.

2.3.1 Determination of Outpatient Covered Services Contract Rates other than for preadmission diagnostic and nondiagnostic services rendered prior to an inpatient Admission. The above contract rates for outpatient Covered Services other than preadmission diagnostic and nondiagnostic services will be determined in accordance with CMS' methodology for calculating OPPS payments applicable to services provided by Facility to Medicare beneficiaries covered under original Medicare (that is Part A and Part B) as it applies to Medicare Advantage Benefit Plans. The contract rate will not include the following items:

(a) Bad Debt
(b) Annual cost report settlements

2.3.2 Determination of Outpatient Covered Services Contract Rates for preadmission diagnostic and nondiagnostic services rendered prior to an inpatient Admission. The contract rates for pre-admission diagnostic and nondiagnostic services (as defined by CMS), rendered prior to an inpatient Admission, will be determined in accordance with CMS rules governing the hospital prospective payment system.

2.3.3 Groupings and Updates. United will follow the grouping and update procedures set forth in (a) and (b) below in connection with the Outpatient Covered Services:

(a) Grouping: United will group each service on the claim consistent with the OPPS Payment Method, subject to updating as described below in 2.3.3(b), 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.

(b) Updates: If CMS modifies the methodology used to calculate OPPS payments under original Medicare (that is Medicare Part A and Part B) or the Medicare Advantage Program, United will update its methodology used to calculate Facility's contract rate for services provided by Facility to Medicare Customers to be consistent with CMS' methodology. This update will occur as close to the CMS effective date as is reasonably possible, but in no case later than 45 days after the effective date of CMS' modification. Except, if the effective date is earlier than the date on which CMS places information regarding a modification in the public domain (for example, a retroactive modification or a change to a previously announced modification), United will update its methodology within 45 days after the date on which CMS places that information in the public domain.

(c) When Updates are Effective: United's update to its methodology will be effective on the effective date of CMS' modification. United will not adjust claims for which payment has correctly been made in accordance with the applicable CMS Payment Method in effect prior to United's update.

2.3.4 Temporary Transfer. If Medicare Customer is temporarily transferred, without being discharged from an Outpatient Encounter for services arranged by Facility, facility services (including the services provided at the facility that receives the temporary transfer) will be paid as one continuous Outpatient Encounter. In such case, Facility is responsible for reimbursing the facility that receives the temporary transfer.

If Facility temporarily transfers Medicare Customer, without discharging Medicare Customer from Facility, via ambulance for services arranged by Facility, charges for the ambulance services are included in Facility's contract rate as determined in this Appendix and neither Medicare Customer nor Payer will be billed separately.

If Medicare Customer is temporarily transferred to Facility, without being discharged from the transferring facility, for services arranged by the transferring facility, Facility will bill the transferring facility for those services provided to such Medicare Customer, and neither Medicare Customer nor Payer will be billed.

SECTION 3
Miscellaneous Provisions

3.1 Inclusive Rates. The contract rates established by this Appendix are all-inclusive, including without limitation applicable taxes, for the provision of all Covered Services to the Medicare 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. All items and nonphysician services provided to Medicare Customers must be directly furnished by Facility or billed by Facility when services are provided by another entity. For example, surgical procedures for implantable DME or for prosthetic devices, performed in an inpatient or outpatient setting at the Facility include the cost of the device in the contract rates listed in Section 2, as applicable. No additional payments will be made for any services or items covered under the Medicare 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 or successor version 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, or successor version, 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.

All charges for professional services provided to Medicare Customer by Facility-based Physicians and provider groups and billed separately by Facility on a CMS 1500 or successor form are paid separate from the contract rates set forth in this Appendix, subject to the terms of United's agreements with such Facility-based Physicians or provider groups.

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, including the calculation of "lesser of" determinations under Section 2.1 of this Appendix. When these services are Covered Services, per the Medicare Customer's Benefit Plan, Facility will not bill and collect from the Medicare Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Medicare Customer's Benefit Plan,

Facility may bill and collect from the Medicare Customer for the services, to the extent permitted under the Agreement.

Table 3: 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	0624	FDA Invest Device
0180-0189	Leave of Absence	0670-0679	Outpatient Special Residence
0220-0229	Special Charges	0931-0932	Med Rehab Day Program
0253	Drugs/Take Home	0990-0999	Patient Convenience
0256	Drugs/Experimental	2100, 2102, 2104-2109	Alternative Therapy Services
0273	Supply/Take Home		
0277	Oxygen/Take Home		

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 Medicare Customer, or if another appendix to the Agreement applies to these services rendered to Medicare Customer, the services below may be payable under that appendix or agreement. When these services are Covered Services, per the Medicare Customer's Benefit Plan, Facility will not bill and collect from the Medicare Customer for the services, as prohibited under the Agreement. However, when these services are not Covered Services, per the Medicare Customer's Benefit Plan, Facility may bill and collect from the Medicare Customer for the services, to the extent permitted under the Agreement.

If Covered Services with the listed codes in the table below are not subject to payment under another appendix to the Agreement or under another agreement, reimbursement will be determined in accordance with CMS rules for providers that are not participating with a Medicare Advantage Plan.

Table 4: 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	0570-0579	Home Health Home Health Aide
0116	Detox/Private	0580-0589	Home Health Other Visits
0124	Psych/2 bed	0590	Home Health Units of Service
0126	Detox/2 bed	0600-0609	Home Health Oxygen
0134	Psych/3&4 bed	0640-0649	Home IV Therapy Services
0136	Detox/3&4 bed	0650-0652, 0657-0659	Hospice Services
0144	Psych/Room & Board Pvt/Deluxe	0660-0669	Respite Care

0146	Detox/Pvt/Deluxe	0810-0819 w/o HCPCS Code V2785	Donor Bank/ Bone, Organ, Skin, Bank *@ (see note @ below)*
0154	Psych/Ward	0870-0875	Cell/Gene Therapy *@ (see note @ below)*
0156	Detox/Ward	0882	Dialysis/Home Aid Visit
0204	ICU/Psych	0901-0907	Psychiatric/Psychological Treatments
0213	CC/Transplant *@ (see note @ below)*	0911-0916, 0919	Psychiatric/Psychological Services
0290-0299	Durable Medical Equipment	0941	Recreation/RX
0362	OR/Organ Transplant *@ (see note @ below)*	0944	Drug Rehab
0367	OR/Kidney Transplant *@ (see note @ below)*	0945	Alcohol Rehab
0512	Clinic Dental Clinic	0953	Chemical Dependency (Drug and Alcohol)
0513	Clinic Psychiatric Clinic	0960-0989	Professional Fees
0521-0522, 0524-0525, 0527-0528	Rural Health Clinic (RHC)/ Federally Qualified Health Centers (FQHC)	1000-1006	Behavioral Health Accommodations
0550-0559	Home Health - Skilled Nursing	3101-3109	Adult Care
0560-0569	Home Health Medical Social Services		
MS-DRGs	**Description**	**MS-DRGs**	**Description**
001-002 w/o ICD-10-PCS Codes 02HA0QZ, 02HA0RZ, 02HA3QZ, 02HA4QZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02RK0JZ, 02RL0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ	Heart Transplant *+ (see note + below)*	014	Allogeneic Bone Marrow Transplant
005-006	Liver Transplant	016-018	Autologous Bone Marrow Transplant with CC/MCC; Autologous Bone Marrow Transplant without CC/MCC; Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies, respectively

007	Lung Transplant	019	Pancreas/Kidney Transplant with Hemodialysis
008	Pancreas/Kidney Transplant	650-652	Kidney Transplant
010	Pancreas Transplant		

[+] Services related to implant of heart assist systems (MS-DRGs 001 & 002 with ICD-10-PCS Codes 02HA0QZ, 02HA0RZ, 02HA3QZ, 02HA4QZ, 02PA0RZ, 02PA3RZ, 02PA4RZ, 02RK0JZ, 02RL0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ), if part of the care management of a transplant patient, will be treated as Heart Transplant services and will not be payable under this Appendix. The implant of heart assist systems is payable under this Appendix only if the service is a Covered Service and is not part of the care management of a transplant patient. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan. In the event Facility is a party to another agreement with United or an affiliate of United that is applicable to these services rendered to a Customer, or another appendix to the Agreement applies to these services rendered to a Customer, the services may be payable under that agreement or appendix.

[@] This Section applies when billed in conjunction with a transplant claim. If part of the care management of a transplant patient, this service will be treated as a transplant service and will not be payable under this Appendix. This service is payable under this Appendix only if it is a Covered Service and is not part of the care management of a transplant patient. When this service is not part of the care management of a transplant patient, this service is considered priced according to the terms of this Appendix. These services are part of the care management of a transplant patient, even if a Customer ultimately does not receive a transplant, if the services were part of the progression for a transplant, the patient was accepted for evaluation as a transplant patient, or if the service was covered pursuant to the Customer's transplant benefits under the applicable Benefit Plan.