AMENDMENT TO MOLINA HEALTHCARE OF WASHINGTON, INC.

HOSPITAL SERVICES AGREEMENT

THIS AMENDMENT TO THE HOSPITAL SERVICES AGREEMENT ("Amendment") is made and entered by and between Molina Healthcare of Washington, Inc., ("Health Plan") and Kadlec Regional Medical Center, ("Provider").

A. Whereas, Health Plan and Provider entered into a Hospital Services Agreement, effective November 1, 2009 as amended from time to time ("Agreement"); and

B. Whereas, Provider agrees to contract with Health Plan for Health Plan's Health Benefit Exchange product(s);

Now therefore, in consideration of the rights and obligations contained herein, Health Plan and Provider agree to amend the Agreement as follows:

1. Section [2.9] **Claims Payment**, subsection [b], **Compensation**, is deleted and replaced with the following subsection [b]:

   [b]. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D and its applicable sub-attachments. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

2. Section [2.9] **Claims Payment,** subsection [c], **Co-payment and Deductibles**, is deleted and replaced with the following subsection [c]:

   [c]. **Co-payment, Deductibles and Co-Insurance**. Provider is responsible for collection of co-payments, deductibles and co-insurance, if any, provided for in the Member's Health Plan product.

3. Section [2.9] **Claims Payment** is amended by adding the following subsection [d], **Member Hold Harmless**:

   [d]. **Member Hold Harmless.** Provider agrees that in no event, including but not limited to nonpayment, insolvency, or breach of this Agreement by the Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or co-payments as specifically provided in the Member's evidence of coverage, or, subject to applicable law, fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor. This provision will survive the termination of Agreement regardless of the reason for the termination, including the insolvency of Health Plan.

4. Section [2.11] **Compliance with Applicable Law** is amended by adding the following subsection [c]:

   [c]. For Covered Services rendered to Members enrolled in a Molina Health Benefit Exchange Product, Medicaid statutes and regulations referenced in this Agreement are inapplicable, and Provider shall comply with all statutory and regulatory requirements of the Washington Health Benefit Exchange Act, including the 2012 regular session laws, chapter 87 Affordable Care Act Implementation and regulations adopted pursuant to RCW 43.71.

5. Section [5.3] **Entire Agreement** is deleted and replaced with the following:

   Entire Agreement. This Agreement, together with Attachments, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan and listed in Attachment C, the contract between the Washington Department of Social and Health Services and the Health Plan shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

6. Section [5.11] **Attachments** is amended to add the following to the list of Attachments which are part of the Agreement:

   "Attachment D-X – Compensation Schedule – Molina Health Benefit Exchange Program"

7. Section [5.12] is added as follows:

   Conflict with Health Plan Product. Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product shall govern.

8. All cross-references to Attachment D in the Agreement not specifically addressed by this Amendment are revised as follows:

   "Attachment D, and its applicable sub-attachments"

9. Attachment B, Definitions, is amended by adding the following defined terms:

   "**Health Benefit Exchange** means the Washington health benefit exchange established in RCW 43.71.020, et seq., the Health Benefit Exchange Act.

   "**Molina Health Benefit Exchange Product** means those health benefit programs offered and sold by Health Plan to individuals who obtain health coverage through the Washington Health Benefit Exchange.

10. Attachment C, Products/Programs, is amended by adding the following product:

    "Molina Health Benefit Exchange Product."

11. Attachment D-X, (Compensation Schedule-Molina Health Benefit Exchange Program), attached hereto, is added.

12. Attachment E, (Required Provisions (Health Care Service Plans)), is amended by adding the following section 19:

    19. Upon termination of this Agreement without cause, Provider will continue to render Covered Services to Members until the earliest of the following: (1) the date Covered Services being rendered to Member by Provider are completed or medically appropriate provisions have been made by Health Plan for another provider to assume responsibility for providing such Covered Services; or (2) sixty (60) days following notice to the Member of Provider's contract termination. The provision of such Covered Services and the reimbursement to Provider for such Covered Services shall be subject to all applicable terms of this Agreement on the same basis as Covered Services provided during the term of this Agreement.

13. There are no performance bonus or special compensation programs applicable to the Molina Health Benefit Exchange Program. Any such additional compensation requires a written amendment to this Agreement.

14. Health Plan and Provider recognize that this Amendment and/or the Agreement may require further amendments in the event that any federal, state or local agency, administration, board or other governing body requires changes to this Amendment or Agreement as a condition of approval. Health Plan shall be entitled to revise this Amendment and the Agreement without the written agreement of Provider upon thirty (30) days prior written notice to Provider, if an additional amendment is being effected by Health Plan to comply with any federal, state or local agency, administration, board or other governing body request and/or regulatory requirement regarding the Health Benefit Exchange, such amendment shall be effective as of the effective date set forth in the amendment. Notwithstanding the above, Health Plan shall be entitled to amend the Agreement upon less than thirty (30) days prior written notice if a shorter notice period is required in order to comply with such federal, state or local agency, administration, board or other governing body request or regulatory requirement.

15. Effective Date. This Amendment shall become effective on the date this Amendment is signed by Health Plan, and renew with and under the terms of the Agreement.

16. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.

17. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement shall remain the same, in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers thereunto duly authorized.

Kadlec Regional Medical Center		Molina Healthcare of Washington, Inc.	
By:	DocuSigned by: Shelly Handkins 5[illegible]4	By:	
	Shelly Handkins		Peter Adler
Its:	VP, Payor Contracting	Its:	President
Date:	5/25/2016	Date:	5/25/2016

ATTACHMENT D-X
Compensation Schedule
Effective through December 31, 2016

MOLINA HEALTH BENEFIT EXCHANGE PROGRAM

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with the Molina Health Benefit Exchange Product program, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

Molina Health Benefit Exchange Product:

Inpatient Services:
Covered Services shall be paid at an amount equivalent to one hundred forty-two percent (142%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:
Covered Services shall be paid at an amount equivalent to one hundred forty-two percent (142%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service fee schedule, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred six-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Professional Services:

Hospital and Clinic Based
Covered Services shall be paid at an amount equivalent to one hundred forty-two percent (142%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service fee schedule, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred six-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

ATTACHMENT D-X
Compensation Schedule
Effective January 1, 2017

MOLINA HEALTH BENEFIT EXCHANGE PROGRAM

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with the Molina Health Benefit Exchange Product program, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

Molina Health Benefit Exchange Product:

Inpatient Services:
Covered Services shall be paid at an amount equivalent to one hundred fifty percent (150%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:
Covered Services shall be paid at an amount equivalent to one hundred fifty percent (150%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service fee schedule, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred six-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Professional Services:

Hospital and Clinic Based
Covered Services shall be paid at an amount equivalent to one hundred fifty percent (150%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the prevailing local and geographically adjusted Medicare Fee-For-Service fee schedule, as of the date(s) of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred six-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date(s) of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.