AMENDMENT

UnitedHealthcare Insurance Company, contracting on behalf of itself, UHC of California doing business as UnitedHealthcare of California and the other entities that are United's Affiliates (collectively referred to as "United") and **County of Monterey, a political subdivision of the State of California, on behalf of Natividad Medical Center** ("Facility") are parties to a facility participation agreement effective December 22, 2009 (the "Agreement") under which Facility participates in United's network of participating providers.

The purpose of this Amendment Number One (1) to this Agreement is to (i) clarify the correct contracting parties, (ii) to modify financial terms of the PPR All Payer Appendix by adding a payment rate for Trauma Services, (iii) to update Section 4 of the PPR All Payer Appendix, Charge Master Description, and (iv) to introduce new contract language to the Agreement.

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

This Amendment Number 1 is effective January 1, 2016.

1) Parties hereby agree that correct contracting party is County of Monterey, a political subdivision of the State of California, on behalf of Natividad Medical Center and that the introductory paragraph will be deleted in its entirety and replaced with the following:

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

2) The following sentence is added to the end of Section 9.9 of the Agreement in its entirety:

Notwithstanding the foregoing, the parties acknowledge that this Agreement is subject to disclosure pursuant to the California Public Records Act and any disclosure required thereunder will not require any notice to United.

3) Parties hereby agree that Section 2.2, Inpatient Covered Services and Table 1, Inpatient Services Category Table of the PPR All Payer Appendix is hereby deleted in its entirety and replaced with the following:

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 1: Inpatient Service Category Table

RATES REDACTED

Notes to Table 1

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

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

4) Parties hereby agree that Section 4 of the PPR All Payer Appendix, Charge Description Master ('CDM") Limitation/Audit Provision is here hereby deleted in its entirety and replaced with the new Section 4, Charge Description Master ('CDM") Limitation/Audit Provision.

SECTION 4

RATES REDACTED

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

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

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

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

Illustration of CDM indexing examples:

Example 1: Adjustment to Contracted Billed Charge Percentages

[A] Contracted Percentage of Billed Charges

[B] Target CDM Increase

[C] Actual CDM Increase

RATES

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

[E] Adjusted Contracted Billed Charges = (1-D) * A

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

Billed Charge for Service at next period at Target CDM Increase (

Billed Charge for Service at next period at Actual CDM Increase

Paid Amount for Service at next period@ Target CDM Increase (

REDACTED

Paid Amount for Service at next period@ Actual COM Increase (

Paid Amount for Service at next period @ Adjusted % of Billed C

5). The following sections of the Facility Participation Agreement are hereby amended as follows:

A) Section 3.3 Services not covered under a Benefit Plan and Section 6.5 Denial of claims for not following Protocols, not filing timely, or lack of medical necessity, are deleted in their entirety.

B) A new section 6.5, attached to this Amendment as Exhibit 2, is added to the Agreement.

6). To the extent any provision of the Agreement conflicts with the new provision attached as Exhibit 2, the new provision will prevail; however, this paragraph 4 does not apply to conflicts between the new provision and a regulatory appendix.

7). Facility will comply with United's Protocols regarding Medical Necessity established as of April 1, 2012. United will notify Facility any Protocol changes in accordance with the Agreement.

8). Exhibit 2 of this Amendment does not initially apply to the following Benefit Plans:

(1) Benefit Plans issued by United's Affiliates Golden Rule Insurance Company, All Savers Insurance Company, or UnitedHealthcare Life Insurance Company (formerly known as American Medical Security Life Insurance Company). However, effective April 1, 2014 this Amendment does apply to the Benefit Plans described in this paragraph 6(1), except for the Benefit Plans offered to individuals by All Savers Insurance Company outside of the exchange marketplace.

(2) Benefit Plans administered by United's Affiliate UMR, Inc.
(3) Benefit Plans described in the Agreement as being subject to an administrative guide other than the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the "Guide"), or Benefit Plans subject to a Supplement to the Guide.

If in the future United modifies the utilization management program applicable to certain of the Benefit Plans described above in this section 6, so as to make that program consistent with the utilization management program that applies to the other Benefit Plans subject to this Amendment, United may cause this Amendment to apply to those Benefit Plans by giving 90 days written notice to Facility.

9). The following is added to each state regulatory requirements appendix and applies to all benefit Plans subject to those Appendices:

"United and Facility, as applicable, shall comply with applicable law related to utilization management of health care services."

ALL OTHER PROVISIONS OF THE AGREEMENT REMAIN IN FULL FORCE AND EFFECT.

UnitedHealthcare Insurance Company, on behalf of itself, UHC of California doing business as UnitedHealthcare of California and its other affiliates	**County of Monterey, a political subdivision of the State of California, on behalf of Natividad Medical Center**
Signature:	Signature:
Print Name: Greg Siebert	Print Name: Gary Gray D.O.
Title: Vice President Network Management	Title: Chief Executive Officer
Date: _____	Date: _____

Exhibit 2

Denial of Claims for Not Following Protocols, for Not Filing Timely, for Services Not Covered under the Customer's Benefit Plan, or for Lack of Medical Necessity.

(a) Non-compliance with Protocol. Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under this Agreement.

In the event payment is denied under this subsection (a) for Facility's failure to comply with a Protocol, regarding notification, untimely filing, or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection (a) will be reversed, if Facility can show:

(i) the denial was incorrect because Facility complied with the Protocol; or
(ii) Facility's services were medically necessary (as "medically necessary" is defined in subsection (g)); or
(iii) at the time the Protocols required notification or prior authorization or at the time the claim was due, Facility did not know and was unable to reasonably determine that the patient was a Customer, Facility took reasonable steps to learn that the patient was a Customer, and Facility promptly submitted a claim after learning the patient was a Customer; or
(iv) United previously authorized the provision of services by the Facility; or
(v) Facility did not receive notice of a change in the applicable Protocols at least 30 days in advance of the date of service.

The grounds stated in clause (ii) (iii) (iv) and (v) above are also a basis for reconsideration of a denial under subsection (c), (d) or (e) of this section.

The grounds stated in clause (iii) above are also a basis for reconsideration of a denial for lack of timely claim filing as referenced in Article VI, 6.3 under this Agreement.

A claim denied under this subsection (a) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (a) does not preclude United from upholding a denial for one of these other reasons.

(b) Non-Covered Services. Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that the Facility obtained the Customer's written or verbal consent, which consent may be included in the Facility's standard admissions or registration forms or, if provided verbally, documented in the medical record, and obtained prior to the rendering of services), except as provided below in subsections (d), (e) and (f).

If a service is not a Covered Service because a discharge order has been written by a physician treating the Customer but the Customer has elected to remain an inpatient, Facility may seek and collect payment from the Customer for those non-Covered Services, but only if, prior to

receiving the service, the Customer had knowledge of the discharge order and the lack of coverage for additional inpatient service and specifically agreed in writing to be responsible for payment of those charges.

United will not deny payment and will continue to be liable to Facility for additional inpatient services under this subsection (b) if the reason Facility rendered services that were not medically necessary was because appropriate post-discharge care, or care in a setting that was an appropriate alternative to inpatient care, could not be arranged from a participating provider despite reasonable efforts by Facility to arrange for such care.

(c) Denials for Lack of Medical Necessity through the Prior Authorization Process. If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or similar concept in the Benefit Plan, such as not consistent with nationally recognized scientific evidence as available, and not consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing or verbally, provided that such verbal consent is documented in the Customer's medical record, to be responsible for payment of those charges.

(d) Clinical Review of Inpatient Bed Days. If a determination is made after a Customer becomes an inpatient that certain services are not medically necessary (including cases in which a part of an admission is determined to be medically necessary and part of the same admission is determined not to be medically necessary), except in the event such services were preauthorized by United, the claim with regard to services that are not medically necessary (including room, board, and other services for a given day) may be denied and Facility must not seek or collect payment from the Customer. Payment will be made in accordance with the applicable payment appendix for the part of the admission that is determined to be medically necessary, and Facility may collect from the Customer the applicable copayment, deductible or coinsurance for that part of the admission. A claim may also be denied in whole or in part under this subsection (d) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

United will not reduce payment under this subsection (d) when the contract rate for the claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

United will not deny payment under this subsection (d) if the reason Facility rendered services that were not medically necessary was because appropriate post-discharge care, or care in a setting that was an appropriate alternative to inpatient care, could not be arranged from a participating provider despite reasonable efforts by Facility to arrange for such care.

(e) Level of Care Determinations. United may determine that the level of care provided for a given service was not medically necessary, because the service could more appropriately have been rendered at a lower level of care (for instance, observation or ambulatory surgery rather than inpatient, or medical/surgical rather than ICU or CCU). If Facility submits a claim for the level of care deemed not medically necessary, and Facility will not seek or collect payment from the Customer. A claim may also be denied in whole or in part under this subsection (e) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

(f) Delay in Service. If United determines that Facility did not execute a physician's written order in a timely manner and that, as a result, the Customer's inpatient stay was lengthened, United may deny the claims with regard to the bed day(s) at the end of the stay that would not have been needed were it not for the delay in service (including room, board and other services for the given day), and process the claim based on the contract rate that would apply without that day(s); Facility will not seek or collect payment from Customer in excess of the coinsurance, copayment or deductible associated with the claim as processed.

United will not reduce payment under this subsection (f) when the contract rate for a claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

(g) Definition. As used in subsection (c), "medical necessity" or "medically necessary" will be defined in accordance with the applicable Benefit Plan.

As used in subsections (a), (d) and (e), "medical necessity" or "medically necessary" is defined as health care services or products that are provided to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is a) in accordance with Generally Accepted Standards of Medical Practice; b) most appropriate in terms of type, frequency, extent, site, and duration; and c) not primarily for the convenience of the patient, physician, or other health care provider.

> If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. United reserves the right to consult expert opinion in determining whether health care services are Medically Necessary.

(h) Collaboration between the parties on utilization management. The parties will work together to engage in timely discussion and exchange of information to facilitate the processes described in this Exhibit 2.

Prior to the deadline under this Agreement for Facility to submit a claim for a given service, United will make its staff reasonably available to discuss with Facility staff whether given inpatient days should be approved or denied.