A Special Offer to Optum Physical Health Network Providers

Electronic Health Records Search Made Simple

There are currently more than 400 Electronic Health Record (EHR) suppliers in the market. Starting your search may seem overwhelming. We have investigated three promising suppliers, all of which:

- Offer certified EHR solutions, allowing eligible users to apply for CMS[1] incentive funds
- Leverage the Web for cost-effective service delivery
- Include competitive discounts for Optum participating providers

Tips for Successful EHR Selection and Implementation

- Demo the program to make sure it fits with your practice and specialty.
- No system is perfect "out of the box" – almost every user will find the need to make some type of modification.
- Consider the company's customer service department. How do they support their users?
- If possible, find out what other customers have to say about the EHR solution.
- Consider quality and financial measurements. How will you compare your practice with EHR to your practice before EHR?
- Think about your office work flow. How will it be affected by EHR?
- Anticipate challenges. An incremental approach to implementation generally leads to greater long term success with minimal productivity losses.
- Clearly identified roles and responsibilities will save the day. Have a point person (the clinic EHR expert) whose responsibility it is to train and troubleshoot.

Sources:

[1] CMS: Centers for Medicare and Medicaid Services

[2] CCHIT: Certification Commission for Healthcare Information Technology

[3] ONC-ATCB: Approved by the Office of the National Coordinator for Health Information Technology (ONC) of the U.S. Department of Health and Human Services (HHS) as an Authorized Testing and Certification Body.

[4] The American Recovery and Reinvestment Act of 2009

OPTUM™ www.optum.com

OPTUM™

Electronic Health Records (EHR)
Search Made Simple

EHR options and special discounts for Optum Physical Health network providers.

Raintree SYSTEMS, INC.

Flexible, scalable and fully integrated, Raintree's CCHIT® Certified Electronic Health Records and Practice Management solutions are uniquely qualified to meet the needs of physical and occupational therapy practices. Raintree provides:

- **Configurable Solutions:** It's easy to create custom treatment templates which meet CMS[1] requirements and automate Correct Coding Initiative (CCI) compliant charge entry processes.
- **Superior Performance:** Fast, easy and secure utilization of integrated clinical and financial solutions anytime and anywhere you have Internet access.

Exclusive discount for Optum providers:

- 15% discount on professional services
- 25% discount on Software-as-a-Service licensing fees

To learn more about Raintree's special offer for Optum Network Providers, please call 951-252-9400, ext. 7013 or email Optum@raintreeinc.com. You may also visit Raintree's website at www.raintreeinc.com.

To obtain the discount, state that you are an Optum Physical Health network provider.

Raintree Systems Version 10.0

CCHIT CERTIFIED 2011 Ambulatory EHR

ONC-ATCB CERTIFIED Supporting Meaningful Use 2011-2012 Complete EHR

Raintree Systems Version 10.0
CC-1112-663800-1

INGENIX. CareTracker

Ingenix CareTracker™ EHR is a fully integrated, ONC-ATCB[3] and CCHIT®[2] Certified cloud-based solution that can help health care providers of all specialties meet meaningful use requirements.

CareTracker is:

- **Powerful:** Evaluation & Management (E/M) Evaluator and Clinical Decision Support are both included.
- **Cost-effective:** Low pay-as-you-go monthly subscription fee with minimal upfront commitment and always-current content.

Exclusive discount for Optum providers:

- First two months of subscription fees waived
- 10% discount on monthly subscription fees
- 3 year guaranteed price lock

To speak with a CareTracker representative, or to schedule a demonstration, visit www.ingenix.com/ehr (select "CONTACT" on the top navigation bar) or call 877-519-1906.

To obtain the discount, state that you are an Optum Physical Health network provider.

Ingenix CareTracker Version 7.0

CCHIT CERTIFIED 2011 Ambulatory EHR

ONC-ATCB CERTIFIED Supporting Meaningful Use 2011-2012 Complete EHR

Ingenix CareTracker Version 7.0
CC-1112-183916-2

Future Health eConnect

The fastest-growing EHR/Practice Management Software for chiropractors. Start with eConnect's free cloud-based software, including integrated scheduling; documentation; EHR; billing; and patient education. Then customize with affordable eConnect Apps and discounted App packages for things like efficiency, specialties, techniques and EHR/ARRA[4] certification.

- **Customizable:** Pay only for what you want, when you want it, with smartphone-like Apps.
- **Intuitive:** Easy, familiar Microsoft®-like look and feel.
- **Future Health® Software Learning System:** A proven system for implementation and ongoing training of EHR software in your clinic available 24/7, plus live support and training.

Exclusive discount for Optum providers:

- $100 off the most popular eConnect App package
- $400 off EHR/ARRA Certification App

For more information, call 1-888-919-9919, ext. 607, email Optum@FutureHealthSoftware.com or visit www.FHeConnect.com/1026. To sign up for free demonstration, visit www.FutureHealthSoftware.com/115.

To obtain the discount, state that you are an Optum Physical Health network provider.

ONC-ATCB CERTIFIED Supporting Meaningful Use 2011-2012 Complete EHR

Future Health Version 2.0 eConnect and CVOS CC-1112-888070-1

February 16, 2018

Zenaptic Chiropractic
Stuart Kelley Jr, MT
3021 NE 72nd Dr, Ste 15
Vancouver, WA 98661

RE: Participating Provider Approval

Dear Stuart Kelley Jr, MT:

OptumHealth Care Solutions, LLC (Optum) is pleased to inform you that your contract for participation as a Massage Therapist has been executed.

Optum® Provider ID: 061855
Tax Identification Number (TIN): XXXXX4396

Please note that at your office location address, 3021 NE 72nd Dr, Ste 15, Vancouver WA 98661, you have preferred access to only those patients of the following Optum clients as of the effective date(s) indicated. In addition, due to health plan requirements, effective dates for health plan participation may differ from the date you became effective with Optum.

Optum Client	Effective Date
Health Allies	02/26/2018
EnhancedcareMD	02/26/2018
UnitedHealthcare SignatureValue	02/26/2018
UHC PREMA - Clark County WA (46601)	02/26/2018
UHC - Navigate	02/26/2018
UHC - Compass	02/26/2018
UHC - Charter	02/26/2018
NexusACO R	02/26/2018
NexusACO NR	02/26/2018

Enclosed is a fully executed copy of your participating Provider Agreement.

Please go to our Web Site to access your Operations Manual, Plan Summaries, Fee Schedules, Clinical Policies, information on claims submission and helpful program reference materials at: www.myoptumhealthphysicalhealth.com . When referring to the Plan Summary, you are considered a Tier 2 provider.

Please acquaint yourself with these materials as they will help you to effectively interact with us, our clients and their members. As additional Optum are implemented in your area, additional Plan Summaries will be distributed.

We look forward to working with you. Please contact our Provider Services department at (800) 873-4575.

Sincerely,

Physical Health Network Management

Enclosures

MN103-0700, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Fax (888) 626-1701
email: network_physicalhealth@optum.com

OPTUMHEALTH CARE SOLUTIONS, LLC
PROVIDER AGREEMENT

THIS AGREEMENT ("Agreement") is between OptumHealth Care Solutions, LLC, formerly ACN Group, Inc., ("Optum") and the undersigned person ("Individual") or entity ("Group"), (Individual and Group are also individually and collectively referred to as "Provider") and sets forth the terms and conditions under which Provider shall participate in one or more networks developed by Optum to render Covered Services to Members. This Agreement supersedes and replaces any existing provider agreements between the parties related to the provision of Covered Services.

SECTION 1
Definitions

Benefit Contract: A benefit plan that includes health care coverage, is sponsored, issued or administered by Plan and contains the terms and conditions of a Member's coverage, including applicable copayments, deductibles, and limits on coverage for services rendered outside specified networks.

Covered Services: The health care services covered by the Member's Benefit Contract.

Customary Charge: The fee for health care services charged by Provider that does not exceed the fee Provider would charge any other person regardless of whether the person is a Member.

Emergency Services: Services provided for a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Fee Schedule Amount: The maximum amount that Provider may receive as payment for provision of a Covered Service to a Member, including Member Expenses, as set forth in the Fee Schedule.

Member: An individual who is properly covered under a Benefit Contract.

Member Expenses: Any amounts that are the Member's responsibility to pay Provider in accordance with the Member's Benefit Contract, including copayments, coinsurance and deductibles.

Participating Provider: A health care professional, including Provider, who has a written participation agreement in effect with Optum, to provide Covered Services to Members.

Payor: The entity or person that has the financial responsibility for payment of Covered Services. Payor may be Optum, Plan or other entity as designated by Optum or Plan.

Plan: The entity or person that is authorized by Optum to access one or more networks of Participating Providers developed by Optum. Plan has the responsibility for issuance and administration of the Benefit Contract.

Plan Summary: A written summary that identifies the Plan, sets forth the Fee Schedule Amount, and specific unique requirements for the particular Plan.

SECTION 2
Networks of Participating Providers

2.1 Provider Participation. Provider shall participate in those networks of Participating Providers designated by Optum in Plan Summaries. When applicable, Provider will be listed in the provider directories for each network in which Provider is designated for participation.

Optum and Plan reserve the right to determine Provider's participation in one or more networks, even though Provider has a contract with Optum. The inclusion of Provider in a particular network will be communicated to Provider by distribution of the relevant Plan Summary.

2.2 Plan Summary. Upon execution of this Agreement, and within 30 calendar days of receiving a written request from Provider, Optum shall supply applicable Plan Summaries for Plans with which Provider is currently participating. During the term of the Agreement, Optum shall provide relevant Plan Summaries to Provider. Plan Summaries are incorporated into this Agreement by this reference. Provider shall notify Optum in writing within 15 days of receiving a Plan Summary if provider wishes not to participate in the program described in the Plan Summary.

In the event there are any significant changes to the content of a Plan Summary, provider will be notified in advance. Plan Summaries shall remain in effect for as long as Optum has a valid contract with Plan, or until Optum notifies Provider, 30 days in advance, of any changes in Provider's status under each Plan Summary.

SECTION 3
Duties of Provider

3.1 Member Eligibility. To determine whether an individual is a Member and, therefore, entitled to receive Covered Services, Provider shall ask the individual to present his or her identification card. Provider is responsible to further verify Member's eligibility by contacting Optum or the Plan, in accordance with instructions in the applicable Plan Summary. If Provider provides health care services to an individual, and it is later determined the individual was not a Member at the time the health care services were provided, those services shall not be eligible for payment under this Agreement. Provider may then directly bill the responsible party for such services. Plan retains the right of final verification of eligibility and this verification supersedes any previous approval of care, verification of eligibility, and/or claims payment review.

3.2 Provision of Covered Services. Provider shall provide Covered Services to Members only at credentialed locations. Provider shall accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, whether Member is enrolled through a private purchaser or a publicly funded program such as Medicare or Medicaid, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall, and shall require any employed or subcontracted health care professionals and facilities, to comply with the protocols and requirements of Optum and Plan and the requirements of all applicable regulatory authorities. Such requirements include, but are not

limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract.

Optum's utilization management, quality assurance and improvement standards, and procedures do not diminish Provider's obligation to provide services to Members in accordance with the applicable standard of care.

3.3 Operations Manual. Provider shall comply with the Optum Operations Manual, which is incorporated into this Agreement by reference. Optum shall provide one copy of the Operations Manual to Provider at no cost. The Operations Manual describes, among other things, Optum's administrative and operational procedures, such as claims submission, and clinical submission requirements. The Operations Manual may be amended, revised, supplemented or replaced from time to time by Optum will provide written notice of any material changes to the Operation Manual.

3.4 Optum and Plan Programs. Provider shall cooperate and comply with all programs, policies and procedures of Optum and Plan, including credentialing and re-credentialing processes, utilization management, quality improvement, or other similar Optum or Plan programs. These are set forth in this Agreement, the Operations Manual, Plan Summaries, or other documents of Optum or Plan, as amended from time to time. Optum will provide written notice of any material changes to Optum's programs.

3.5 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of members to other providers at times as may be appropriate and consistent with standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or other participating health professionals in accordance with the terms and conditions of Member's Benefit Contract. A Member requiring Emergency Services shall also be referred to the "911" emergency response system.

3.6 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to Covered Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring them to another Participating Provider or their benefit plan. Provider shall arrange for an answering machine or service. Provider shall include office hours and emergency information on the answering machine or with the service and allow Members to leave a message 24 hours a day.

3.7 Employees and Contractors of Provider. Provider will ensure that its employees and contractors abide by the terms of this agreement when providing Covered Services to Members. Provider understands that the employees and contractors of Provider may be restricted by Optum from providing Covered Services to Members in the event such employee or contractor does not meet credentialing requirements, or for otherwise failing to abide by the terms of this Agreement as requested by Provider.

All payments for Covered Services provided to Members shall be paid to Provider. Provider will make its own financial arrangements with its employees and contractors who have provided such Covered Services. Employees and contractors of Provider must look solely to Provider for

reimbursement for Covered Services provided to Members. Payor will have no responsibility for payment beyond paying Provider the amounts required by this Agreement.

SECTION 4
Payment Provisions

4.1 Payment for Covered Services. Covered Services will be paid by Payor at the lesser of: (1) Provider's Customary Charge for such Covered Services, less any applicable Member Expenses; or (2) the Fee Schedule Amount for such Covered Services, less any applicable Member Expenses. Payment will be made for Covered Services, as determined by Optum, Plan or Payor, provided they have been rendered and billed in accordance with Optum, Plan and Payor policies and procedures.

The obligation for payment for Covered Services provided to a Member is solely that of Payor, although Optum may arrange for claims processing services. For any claim Optum is obligated to pay as the Payor, when Optum has received all information necessary to process and pay a claim, payment will be made within the timeframes indicated by applicable State law.

4.2 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. Provider shall not bill Members for charges not paid due to inappropriate or inaccurate billing, or Provider's failure to comply with policies or procedures of Optum, Plan or Payor. If Payor denies payment for services rendered by Provider on grounds that Provider did not follow (a) clinical submission requirements, (b) timely claim filing guidelines, or (c) other administrative requirements, Provider shall not collect payment from the Member for the services. Provider shall not bill or collect payment from the Member for non-covered services, as defined by Members' Benefit Contract, unless Provider first obtains the Member's written consent, prior to the services being rendered. Upon request, Provider will provide documentation of Member's written consent.

4.3 Submission of Claims. Provider shall submit claims as described in the applicable Plan Summary. All information necessary to process the claims must be received within the time frame stated in the Plan Summary. Provider agrees that claims received after the applicable time period may be rejected for payment, at Optum's or Payor's discretion.

A claim will be considered properly completed if Provider complies with the billing procedures set forth in this Agreement, the Plan Summary, the Operations Manual, or other applicable documents, or as otherwise prescribed by state law. If Provider fails to submit claims in accordance with these provisions, Provider shall not bill Member for those Covered Services.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

4.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

4.5 Member Protection Provision. This provision applies when Optum is the Payor, when required by a specific Payor other than Optum, or when required pursuant to applicable statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for Covered Services rendered to Members by Provider, due to insolvency of Payor, or breach by Optum of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Covered Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, Member Expenses or charges for services not covered under the Member's Benefit Contract.

The provisions of this section shall (1) apply to all Covered Services rendered while this Agreement is in force; (2) with respect to Covered Services rendered while this Agreement is in force, survive the termination of this Agreement regardless of the cause of termination; (3) be construed to be for the benefit of the Members; and (4) supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such Covered Services.

SECTION 5
Liability of Parties, Laws, Regulations and Licenses

5.1 Responsibility for Damages. Each party shall be responsible for any and all damages, claims, liabilities or judgments, which may arise as a result of its own, or its employees or subcontractors, negligence or intentional wrongdoing. Any costs for damages, claims, liabilities or judgments, other than defense costs, incurred at any time by one party as a result of the other party's negligence or intentional wrongdoing shall be paid for or reimbursed by the other party.

5.2 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, the following:

If Provider is an Individual: (1) comprehensive general and/or umbrella liability insurance in the amount of the industry standard per occurrence and aggregate, (2) medical malpractice or professional liability insurance in the amount of $100,000 per occurrence and $300,000 aggregate and or such greater limits as may be required in the Plan Summary.

If Provider is a Group: (1) comprehensive general and/or umbrella liability insurance in the amount of the industry standard per occurrence and aggregate, (2) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $ $3,000,000 aggregate and or such greater limits as may be required in the Plan Summary.

Provider shall also require that all health care professionals employed by or under contract with Provider to render Covered Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies. Provider's and other health care professionals' medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by Optum. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to Optum in writing evidence of insurance coverage.

5.3 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits, without sanction, revocations, suspension, censure,

probation or material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Covered Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render Covered Services to Members, including covering Providers, comply with this provision. If a Regulatory Addendum is attached to this Agreement, Provider shall comply with all requirements set forth therein. Optum shall at all times comply with all applicable federal and state laws and regulations.

SECTION 6
Notices

Provider shall notify Optum within 10 days of knowledge of the following:

(1) Changes in liability insurance carriers, termination of, or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
(2) Action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government or agency under which Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
(3) Indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
(4) Claims or legal actions for professional negligence or bankruptcy;
(5) Provider's termination, for cause, from a provider network offered by any plan, including, without limitation, any health care service plan or health maintenance organization, any health insurer, any preferred provider organization, any employer, or any trust fund;
(6) Any occurrence or condition that might materially impair the ability of Provider to discharge its duties or obligations under this Agreement;
(7) Any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, and/or Members;
(8) A change in Provider's name, ownership or Federal Tax I.D. number;

Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. The parties shall provide each other with proper addresses of all designees that should receive certain notices or communication instead of that party.

SECTION 7
Records

7.1 Confidentiality of Records. Optum and Provider shall maintain the confidentiality of all Member records in accordance with any applicable statutes and regulations, including, but not limited to those promulgated under the Health Insurance Portability and Accountability Act ("HIPAA").

7.2 Maintenance of and Optum Access to Records. Provider shall maintain adequate medical, financial and administrative records related to Covered Services in a manner consistent with the standards in the community and in accordance with all applicable statutes and regulations. Such records shall include all medical records, documents, evidences of coverage and other relevant information in Provider's possession upon which Optum relied to reach a decision concerning a Member complaint or grievance. Any such records shall be maintained for a period of six years and shall be readily available to Optum and Plan at all reasonable times during the term of this Agreement or a period of six years, whichever is longer.

To perform its utilization management and quality improvement activities, Optum shall have access to such information and records, including claims records, at all reasonable times, and in any event, within 14 days from the date the request is made, except that, in the case of an audit by Optum, such access shall be given at the time of the audit. If requested by Optum, Provider shall provide copies of such records free of charge. Optum shall have access to and the right to audit information and records during the term of this Agreement and for 3 years following its termination, whether by rescission or otherwise. It is Provider's responsibility to provide Optum with requested information and records or copies of records and to allow Optum to release such information or records to Plans as necessary for the administration of the Benefit Contract or compliance with any state or federal laws applicable to the Plans. Such obligation survives the termination of this Agreement, whether by rescission or otherwise.

This section shall not be construed to grant Optum access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 7.3 of this Agreement.

7.3 Government and Accrediting Agency Access to Records. During the term of this Agreement and the three (3) year period following its termination (whether by rescission or otherwise), the federal, state and local government, or accrediting agencies including, but not limited to, the Department of Managed Health Care, the National Committee for Quality Assurance (the "NCQA") and the applicable professional licensing board, and any of their authorized representatives, shall have access to during normal business hours, and Optum and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of Optum or Provider, including, but not limited to records and information supplied by the other party, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Optum, Plan, Payor or Provider.

SECTION 8
Resolution of Disputes

Optum and Provider will work together in good faith to resolve any disputes about their business relationship. If the parties are unable to resolve the dispute within 30 days following the date one party sent written notice of the dispute to the other party, and if Optum or Provider wishes to pursue the dispute, it shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement or the Members' Benefit Contract, shall have no authority to

award any punitive or exemplary damages, and shall be bound by controlling law. If the dispute pertains to a matter which is generally administered by certain Optum procedures, such as claims payment, credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her right to arbitration under this section. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

SECTION 9
Term and Termination

9.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated as provided below.

9.2 Termination. This Agreement may be terminated as follows:

(1) By mutual agreement of Optum and Provider;
(2) by either party upon 90 days prior written notice to the other party;
(3) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(4) by Optum immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment or any other adverse action taken against any of Provider's licenses or certifications, or loss of insurance required under this Agreement;
(5) by Provider upon 60 days prior written notice to Optum due to an amendment made to this Agreement pursuant to Section 10.1 of this Agreement;
(6) by Optum immediately if Optum determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement.

During periods of notice of termination, Optum reserves the right to transfer Members to another Provider, and Provider agrees to cooperate and assist with such transfers.

9.3 Information to Members. Provider acknowledges the right of Optum to inform Members of Provider's termination and agrees to cooperate with Optum regarding the form of such notification. In the event of termination, Provider will notify Members of the impending non-participation status prior to the date of termination, and will clearly communicate to new patients the date upon which Provider will no longer be a Participating Provider.

9.4 Continuation of Services After Termination. Upon request of Optum, or pursuant to applicable State law, Provider shall continue to provide Covered Services authorized by Optum to Members, who are receiving such services from Provider, as of the date of termination of this Agreement, until arrangements are completed for such Members to be transferred to another Participating Provider. Payor shall pay Provider for such services at the Provider's contracted rate.

SECTION 10
Miscellaneous

10.1 Amendment. Optum may amend this Agreement by sending a copy of the amendment to Provider at least 30 days prior to its effective date. The signature of Provider shall not be required. Optum may also amend this Agreement to comply with the requirements of state and federal regulatory authorities, and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.

10.2 Assignment. Neither party may assign any of its rights and responsibilities under this Agreement to any person or entity, except that Optum may assign this Agreement to any entity controlling, controlled by or under common control with Optum without Provider's prior written consent.

10.3 Administrative Responsibilities. Optum may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

10.4 Relationship Between Optum and Provider. The relationship between Optum and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture. Optum and Provider agree that the relationship established through this Agreement is unique and specific to them. Consequently, any dispute that may arise between the parties relative to this Agreement shall be resolved exclusively between them pursuant to Section 8 of this Agreement.

10.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, Optum and Plan shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, Optum and Plan shall not otherwise use each other's name, symbol or service mark, or the name, symbol or service mark of Provider's, OptumHealth's, and Plan's parent corporations or affiliates, without prior written approval.

10.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that (1) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates, or Fee Schedule Amounts, and (2) Optum may disclose certain terms to Plans or designees that need the information to process claims or administer a Benefit Contract, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law.

10.7 Communication. Optum encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Contract. Provider will provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Provider will assure that individuals with disabilities are furnished with effective communications in making decisions regarding treatment options. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with Optum's ability to administer its quality improvement, utilization management and credentialing programs.

10.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in Optum's business model or arrangements with Plans. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days written notice to the other party. Any such notice of termination must be given within 10 days of the end of the 30-day re-negotiation period.

10.9 Appendices. Additional and/or alternative provisions, if any, related to certain Covered Services rendered by Provider to Members covered by certain Benefit Contracts that are not contained in the Plan Summaries are set forth in the Appendices.

10.10 Entire Agreement. This Agreement, with its attachments, addenda and amendments, constitutes the entire agreement between the parties in regard to its subject matter. If any applicable statutes or regulations, or if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed or replaced, or that additional provisions be incorporated, such provisions shall be deemed to be removed or replaced or additional provisions incorporated into this Agreement as of the effective date of such statute or regulation or Payor requirement for all Covered Services provided which are subject to such statutes or regulations or Payor requirements.

10.11 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state law and ERISA.

10.12 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide Covered Services to Members enrolled in a Benefit Contract for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

10.13 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide Covered Services under this Agreement, to Members who are enrolled in a Benefit Contract for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare + Choice Addendum. Provider also understands that Optum's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

10.14 Effective Date. The Effective Date of this Agreement is 02/26/2018

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES, UNLESS CERTAIN STATE REGULATIONS OPPOSE THIS PROVISION – SEE STATE SPECIFIC REGULATORY REQUIREMENTS ADDENDUM.

INDIVIDUAL PROVIDER

Address: _____

_____

_____

Signature of Individual Provider:

_____

Print Name: _____

Title: _____

Date: _____

OR

GROUP PROVIDER

Clinic Name: ZENAPTIC CHIROPRACTIC

Address: 3021 NE 72ND AVE, #15

VANCOUVER, WA 98661

Signature of Owner/Program Director:

DocuSigned by:
STUART KELLEY
522FD0AF0BBF4FA...

Print Name: STUART KELLEY

Title: MASSAGE THERAPIST

Date: 11/28/2017

OptumHealth Care Solutions, LLC
Mail Route: MN103-0700
11000 Optum Circle
Eden Prairie, MN 55344
Telephone: (8

Signature: _____

Print Name: John DeSmet

Title: Chief Operating Officer

Date: 02/16/2018

Washington Regulatory Requirements Addendum

This Washington State Regulatory Requirements Addendum (this "Addendum") is made part of the Provider Agreement ("Agreement") entered into between OptumHealth Care Solutions, LLC ("Optum") and the health care professional or entity named in the Agreement ("Provider").

This Addendum applies to Benefit Contracts sponsored, issued or administered by or accessed through Optum, or Optum authorized Plan, to the extent such products are subject to regulation under Washington laws and for which Washington laws control. The requirements in this Addendum, however, do not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

Optum, Plan, Payor, and Provider, as applicable, all agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency with any term or condition between this Addendum and any term or condition contained in the Agreement , this Addendum shall control, except with regard to Benefit Contracts outside the scope of this Addendum.

Optum and Provider each acknowledge that Plans and Payors are obligated to comply with all state laws, statutes, and regulations that are applicable to entities such as Plan and Payor. Optum and Provider further acknowledge that certain Plans and Payors may not be parties to the Agreement and that any references to any obligations of Plan and Payor are an attempt by the parties to identify the Plan's and Payor's obligations under applicable state law.

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

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

1. **Section 1, "Definitions," "Emergency Services," of the Agreement shall be deleted in its entirety and replaced with the following:**

   Emergency Services: Services provided for an emergency medical condition manifesting itself by the acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health is serious jeopardy. Emergency Services are otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

2. **Section 2.2, "Plan Summary," of the Agreement shall be deleted in its entirety and replaced with the following:**

   Section 2.2 Plan Summary. Upon execution of the Agreement, and within 30 calendar days of receiving a written request from Provider, Optum shall supply applicable Plan Summaries for Plans with which Provider is currently participating. During the term of the Agreement, relevant Plan Summaries will be made available to Provider, by Optum, online or otherwise. Provider shall notify Optum in writing within 15 days of receiving a Plan Summary if provider wishes not to participate in the program described in the Plan Summary; otherwise, Provider shall comply with the relevant Plan Summary as per Section 3.4 of the Agreement.

In the event there are any material changes to the content of a Plan Summary, Provider will be notified in advance as per Section 3.4 of the Agreement. Providers will be given not less than 60 days notice of changes that affect Provider compensation or health care service delivery in accordance with Washington law. Plan Summaries shall remain in effect for as long as Optum has a valid contract with Plan or until Optum notifies Provider, 60 days in advance, of any changes in Provider's status under each Plan Summary.

3. **Section 3.3, "Operations Manual," of the Agreement is deleted in its entirety and replaced with the following:**

3.3 Operations Manual. Provider shall comply with the Optum Operations Manual as per Section 3.4 of the Agreement. The Operations Manual shall be available to Provider online or Optum shall provide one copy of the Operations Manual to Provider at no cost. The Operations Manual describes, among other things, Optum's administrative and operational procedures, such as claims submission and clinical submission requirements. The Operations Manual may be amended, revised, supplemented or replaced from time to time by Optum will provide written notice of any material changes to the Operation Manual as per Section 3.4 of the Agreement.

4. **Section 3.4, "Optum and Plan Programs," of the Agreement is deleted in its entirety and replaced with the following:**

3.4 Optum and Plan Programs. Pursuant to Washington law, Optum shall notify Providers of their responsibilities with respect to the applicable administrative policies and programs of Optum and Plan, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements.

Applicable documents, procedures, and other administrative policies and programs referenced in the Agreement must be available for review by the Provider prior to contracting. These policies and programs will be made available, by Optum, to Provider online or upon request. Provider must be given reasonable notice of not less than 60 days of changes to policies and programs that affect Provider compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, a Provider may terminate the Agreement without penalty if the Provider does not agree with the changes. No change to the contract may be made retroactive without the express consent of the Provider.

Provider shall cooperate and comply with all applicable Optum and Plan policies and program. These policies and programs are set forth in the Agreement, the Optum Operations Manual, applicable Plan Summaries, and/or other documents of Optum or Plan, as amended from time to time. Optum will provide written notice of any material changes to Optum's or Plan's policies and programs in accordance with Washington law.

5. **Section 3.7, "Employees and Contractors of Provider," of the Agreement is deleted in its entirety and replaced with the following:**

3.7 Employees and Contractors of Provider. Provider will ensure that its employees and contractors abide by the terms of this Agreement and in accordance with Washington law when providing Covered Services to Members. Provider understands that the employees and contractors of Provider may be restricted by Optum from providing Covered Services to Members in the

event such employee or contractor does not meet credentialing requirements, or for otherwise failing to abide by the terms of this Agreement as requested by Provider.

All payments for Covered Services provided to Members shall be paid to Provider. Provider will make its own financial arrangements with its employees and contractors who have provided such Covered Services. Employees and contractors of Provider must look solely to Provider for reimbursement for Covered Services provided to Members. Payor will have no responsibility for payment beyond paying Provider the amounts required by this Agreement.

6. Section 4.1, "Payment for Covered Services," of the Agreement is deleted in its entirety and replaced with the following:

4.1 Payment for Covered Services. Covered Services will be paid by Payor at the lesser of: (1) Provider's Customary Charge for such Covered Services, less any applicable Member Expenses; or (2) the Fee Schedule Amount for such Covered Services, less any applicable Member Expenses. Payment will be made for Covered Services, in accordance with the claims payment standards contained in Washington state law, as set forth below in Section 4.1(a) – (h), provided they have been rendered and billed in accordance with Optum and Plan policies and procedures.

The obligation for payment for Covered Services provided to a Member is solely that of Payor, although Optum may arrange for claims processing services. For any claim Optum is obligated to pay as the Payor, when Optum has received all information necessary to process and pay a claim, payment will be made within the timeframes indicated by applicable Washington law.

a. Payment shall be made to Provider as soon as practical but subject to the following minimum standards: (1) 95% of the monthly volume of clean claims shall be paid within thirty 30 days of receipt by Optum or the Payor, as applicable; and (2) 95% of the monthly volume of all claims shall be paid or denied within 60 days of receipt by Optum or the Payor, as applicable, except as agreed to in writing by the parties on a claim-by-claim basis.

b. The receipt date of a claim is the date Optum or the Payor, as applicable, receives either written or electronic notice of the claim. Optum or Payor, as applicable, shall establish a reasonable method for confirming receipt of claims and responding to Provider inquiries about claims.

c. If Payor fails to pay claims within the standard established above, Payor shall pay interest on undenied and unpaid clean claims more than 61 days old until Payor meets the standard above. Interest shall be assessed at the rate of 1% per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Payor shall add the interest payable to the amount of the unpaid claim without the necessity of the Provider submitting an additional claim. Any interest paid under this section shall not be applied by Payor to a Member's deductible, copayment, coinsurance or any similar obligation of the Member.

d. Payor shall not unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision. The time limit after which payment should be made by reason of the application of a coordination of benefits provision is established as 6 months. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage will be conducted concurrently so as to create no further delay in the ultimate payment of benefits. If Payor is required by the time limit to make payment as the primary plan because it then has insufficient information to make it a secondary plan, it reserves all rights to recover any excess payments made thereby.

e. When Payor issues payment in the Provider and Member names, Payor shall make claim

checks payable in the name of the Provider first and the Member second.

f. For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

g. These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or Members, or instances where Optum or the Payor, as applicable, has not been granted reasonable access to information under the Provider's control.

h. Provider and Optum or Payor, as applicable, are not required to comply with the contract provisions contained in this section if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout or other labor dispute.

7. Section 4.5, "Member Protection Provision," of the Agreement is deleted in its entirety and replaced with the following:

4.5 Member Protection Provision.

a. Provider hereby agrees that in no event, including, but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person acting on the Member's behalf, other than Payor, for services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments, Co-insurance or Deductibles, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's Benefit Contract.

b. Provider agrees, in the event of the Payor's insolvency, to continue to provide the services promised in this Agreement to Members for the duration of the period for which premiums on behalf of the Member were paid or until the Member's discharge from inpatient facilities, whichever time is greater.

c. Notwithstanding any other provision of the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Member's Benefit Contract.

d. Provider may not bill the Member for Covered Services (except for Copayments, Coinsurance and Deductibles) where Optum or Payor, as applicable, denies payments because Provider has failed to comply with the terms or conditions of this Agreement.

e. Provider further agrees: (i) that the provisions of (a), (b), (c), and (d) of this Section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members; and (ii) that this Section supersedes any oral or written or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on the Members' behalf.

f. If Provider contracts with other health care providers who agree to provide Covered Services to Members with the expectation of receiving payment directly or indirectly from Payor, such providers must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this section.

g. Collection of Amounts from Members. Provider is hereby notified that willfully collecting or attempting to collect an amount from a Member knowing that collection to be in violation of this Agreement constitutes a class C felony under the Revised Code of Washington.

8. Section 7.2, "Maintenance of and Optum Access to Records," of the Agreement is deleted in its entirety and replaced with the following:

7.2 Maintenance of and Optum Access to Records. Provider shall maintain adequate medical, financial and administrative records related to the ability of the Provider to deliver Covered Services to Member in a manner consistent with the accepted standards of medical care prevalent in the community and in accordance with all applicable statutes and regulations. Such records shall include all medical records, documents, evidences of coverage and other relevant information in Provider's possession upon which Optum relied to reach a decision concerning a Member complaint or grievance. Any such records shall be maintained for a period of six years and shall be readily available to Optum and Plan at all reasonable times during the term of this Agreement or a period of six years, whichever is longer.

To perform its utilization management and quality improvement activities, Optum shall have access to such information and records, including claims records, at all reasonable times, and in any event, within 14 days from the date the request is made, except that, in the case of an audit by Optum, such access shall be given at the time of the audit. Provider granting Optum access to medical records for audit purposes must be limited to only that necessary to perform the audit. If requested by Optum, Provider shall provide copies of such records free of charge. Optum shall have access to and the right to audit information and records during the term of this Agreement and for three years following its termination, whether by rescission or otherwise. It is Provider's responsibility to provide Optum with requested information and records or copies of records and to allow Optum to release such information or records to Plans as necessary for the administration of the Benefit Contract or compliance with any state or federal laws applicable to the Plans. In accordance with Washington law, Provider shall make medical records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members subject to applicable state and federal laws related to confidentiality of medical or health records. Such obligation survives the termination of his Agreement, whether by rescission or otherwise.

To the extent the Agreement allows Optum the right to audit Provider's billing records, Provider shall have the right to audit Optum's denial of Provider's claims under the same terms and conditions the Agreement sets forth for Optum's audit of Provider's billing records.

This section shall not be construed to grant Optum access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 7.3 of the Agreement.

9. Section 8, "Resolution of Disputes," of the Agreement is deleted in its entirety and replaced with the following:

Section 8
Resolution of Disputes

Optum and Provider will work together in good faith to resolve any disputes about their business relationship. Provider may submit a written request for review by Optum of a complaint or grievance relating to this Agreement. If Optum fails to grant or reject such request within 30 days after it is made, Provider may proceed as if the complaint or grievance had been rejected. A complaint or grievance that has been rejected by Optum may be submitted to non-binding mediation. Pursuant to Washington law, mediation shall be conducted under chapter 7.07 RCW or any other rules of mediation agreed to by the parties. If the parties are unable to resolve their dispute through mediation, the parties shall be free to pursue all legal and equitable remedies

available under applicable law. In the case of a billing dispute that has been timely-made by Provider as required under Section 11, "Overpayment Recovery," of the Agreement, Optum shall render a decision within 60 days of receipt of Provider's complaint.

10. **Section 9.3, "Information to Members," of the Agreement is deleted in its entirety and replaced with the following:**

    9.3 Information to Members. Provider acknowledges the right of Optum to inform Members of Provider's termination and agrees to cooperate with Optum regarding the form of such notification. In the event of termination, Optum or Provider, as applicable, shall make a good faith effort to give written notice of such impending termination to Members who are seen by Provider on a regular basis, within 15 working days of receipt or issuance of a notice of termination.

11. **Section 9.4, "Continuation of Services after Termination," of the Agreement is deleted in its entirety and replaced with the following:**

    9.4 Continuation of Covered Services after Termination. Upon request of Optum, or pursuant to applicable Washington law, Provider shall continue to provide Covered Services authorized by Optum to Members, who are receiving such services from Provider, as of the date of termination of the Agreement, until arrangements are completed for such Members to be transferred to another Participating Provider. Payor shall pay Provider for such services at the Provider's contracted rate. In the event Provider is a primary care physician and this Agreement is terminated without cause by Optum, Provider agrees to continue providing Covered Services to Members currently receiving such Covered Services, for at least 60 days following termination as specified by Optum at the time of termination, or in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Provider's relationship with Optum will be continued on the same terms and conditions as those of the Agreement, except for any provision requiring that the Optum or Plan assign new enrollees to the terminated provider.

12. **Section 10.1, "Amendment," of the Agreement is deleted in its entirety and replaced with the following:**

    10.1 Amendment. Optum shall provide no less than sixty days' notice to the Provider of a regulatory amendment, including without limitation any regulatory amendment that affects compensation and that affects health care service delivery, unless changes to federal or state laws or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required. Subject to any termination and continuity of care provisions of this Agreement, Provider may terminate the Agreement without penalty if Provider does not agree with such regulatory amendment.

    Optum shall provide at least sixty days' notice of any other amendment, unless a shorter notice is necessary in order to accomplish compliance. No change to the Agreement may be made retroactive without the express consent of Provider. The signature of Provider shall not be required. Provider has the option of terminating the Agreement, pursuant to Section 7 of the Agreement, should Provider decide that the terms of any amendment are unacceptable.

    Additionally, Optum shall provide no less than sixty days' notice to Provider of any proposed material amendment, as that term is defined by Washington law, which would result in requiring Provider to participate in Plan's product(s) with a lower fee schedule in order to continue to participate in a Plan's product(s) with a higher fee schedule. Provider shall advise Optum within sixty days of receipt should Provider reject participation in Plan's product(s) with a lower fee

schedule. Provider's rejection of such material amendment does not affect the terms of Provider's existing Agreement.

13. A new provision, "Overpayment Recovery," shall be added as Section 11 to the Agreement and shall be set forth as follows:

11. Overpayment Recovery.

a. Recovery by Provider.

(1) Except in the case of fraud, or as provided in subsection (2) of this section "**a**," Provider may not: (a) Request additional payment from Optum or Payor, as applicable, to satisfy a claim unless he or she does so in writing to Optum within 24 months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than 6 months after receipt of the request. Any such request must specify why Provider believes Payor owes the additional payment.

(2) Provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request additional payment from Optum or Payor, as applicable, to satisfy a claim unless he or she does so in writing to Optum within 30 months after the date the claim was denied or payment intended to satisfy the claim was made; or (b) request that the additional payment be made any sooner than 6 months after receipt of the request. Any such request must specify why Provider believes the Payor owes the additional payment, and include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim.

(3) If any provision of this Agreement conflicts with this section, this section shall prevail. However, nothing in this section prohibits Optum or Payor, as applicable, from choosing at any time to make additional payments to Provider to satisfy a claim.

(4) This section does not apply to claims for health care services provided through dental-only health carriers, health care services provided under Title XVIII (Medicare) of the social security act, or Medicare supplemental plans regulated under chapter 48.66 RCW.

b. Recovery by Optum or Payor, as Applicable.

(1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section "**b**," Optum or Payor, as applicable, may not: (a) Request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to the Provider within 24 months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than 6 months after receipt of the request. Any such request must specify why Optum or Payor, as applicable, believes Provider owes the refund. If Provider fails to contest the request in writing to Optum or Payor, as applicable, within 30 days of its receipt, the request is deemed accepted and the refund must be paid.

(2) Optum or Payor, as applicable, may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to Provider within 30 months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than 6 months after receipt of the request. Any such request must specify why Optum or Payor, as applicable, believes Provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If Provider fails to contest the request in writing to the Optum or Payor, as applicable, within 30 days of its receipt, the request is deemed accepted and the refund must be paid.

(3) Optum or Payor, as applicable, may at any time request a refund from Provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) Optum or Payor, as applicable, is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

(4) If any other provision of this Agreement conflicts with this section, this section shall prevail. However, nothing in this section prohibits Provider from choosing at any time to refund to Optum or Payor, as applicable, any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes Optum or Payor, as applicable, from recovering from a Member or beneficiary any amounts paid to a Provider for benefits to which the Member or beneficiary was not entitled under the terms and conditions of the Benefit Contract.

(7) This section does not apply to claims for health care services provided through dental-only health carriers, health care services provided under Title XVIII (Medicare) of the social security act, or Medicare supplemental plans regulated under chapter 48.66 RCW.

14. A new provision, "Retrospective Denial," shall be added as Section 12 to the Agreement and shall be set forth as follows:

12. Retrospective Denial. In the event Plan offers a Benefit Contract that is governed by Washington law, Optum will comply with the applicable retrospective claim denial requirements, as set forth in such Washington law, which prohibits retrospective denial of coverage for emergency and nonemergency care that had prior authorization under such Plan's written policies at the time the care was rendered.

15. A new provision, "Authority to Review," shall be added as Section 13 to the Agreement and shall be set forth as follows:

13. Authority to Review. Provider acknowledges his or her understanding of the following:

a. The Agreement shall be filed, by Plan, with Washington Insurance Commissioner prior to use. If the commissioner takes no action within 15 working days after submission of the Agreement, the Agreement is deemed approved except that the commissioner may extend the approval period an additional 15 working days upon giving notice to Plan before the expiration of the initial 15 day period.

b. The Plan shall ensure that the Agreement shall be available for review upon request by the Washington Insurance Commissioner.

c. Optum and Plan shall maintain the Agreement at its principal place of business and Plan shall have access to the Agreement and provide copies to facilitate regulatory review upon 20 days prior written notice from the Washington Insurance Commissioner.

d. Plan shall submit material changes to the Agreement to the Washington Insurance Commissioner within 30 working days prior to use. If the commissioner takes no action within 15 working days after submission, the change is deemed approved except that the commissioner may extend the approval period an additional 15 working days upon giving notice to Plan before the expiration of the initial 15 day period.

e. Optum and Provider are primarily responsible for performing the terms and conditions of the Agreement in compliance with all Washington Insurance Code provider contracting provisions applicable to Plan. However, execution of this contract shall not relieve Plan of its responsibility for compliance with applicable statutes or regulations.

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
OptumHealth Care Solutions, LLC
PROVIDER

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between OptumHealth Care Solutions, LLC, its subsidiaries, and its affiliated companies (collectiely, "Company") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

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

2.2 **CMS Contract:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 **Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 **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.

2.5 **Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 **Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 **Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

2.9 **Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with Company, either directly or indirectly, under which Company provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

2.10 **Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized to access Provider's services under the Agreement.

SECTION 3
PROVIDER REQUIREMENTS

3.1 **Data.** Provider shall submit to Company or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to Company or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.2 **Policies.** Provider shall cooperate and comply with MA Organization's policies and procedures.

3.3 **Customer Protection.** Provider agrees that in no event, including but not limited to, non-payment by Company, MA Organization or an intermediary, insolvency of Company, MA Organization or an intermediary, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the

MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's, Company, or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including Company or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

3.4 **Dual Eligible Customers.** Provider agrees that in no event, including but not limited to, non-payment by a State Medicaid Agency or other applicable regulatory authority, other state source, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, Company or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

3.5 **Eligibility.** Provider agrees to immediately notify Company and MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

3.6 **Laws.** Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions

of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

3.7 **Federal Funds.** Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

3.8 **CMS Contract**. Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

3.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.

(b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other electronic systems (including medical records), patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for

example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations.

For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

3.10 **MA Organization Accountability; Delegated Activities.** Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that Company may sub-delegate to Provider. If Company has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:

(a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.

(b) If Company has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.

(c) If Company has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA

Organization retains the right to approve, suspend or terminate the participation status of such health care providers.

(d) Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and Company regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

3.11 **Subcontracts.** If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Provider shall provide proof of such to Company or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization or Company, to meet any additional CMS requirements that may apply to the services.

3.12 **Offshoring.** Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4
OTHER

4.1 **Payment.** MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

4.2 **Regulatory Amendment.** Upon the request of MA Organization, Company may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. Company or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
ATLASRHINO, INC, PS

2 Business name/disregarded entity name, if different from above
ZENAPTIC CHIROPRACTIC

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☒ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
3021 NE 72ND AVE, #15

Requester's name and address (optional)

6 City, state, and ZIP code
VANCOUVER, WA 98661

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

TIN

Social security number
___ – ___ – ____

or

Employer identification number
46 - 2744396

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** DocuSigned by: STUART KELLEY 522FD0AF0BBF4FA... | **Date ▶** 11/28/2017

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.