OPTUMHealth™
Physical Health of California

4/15/2020

Michele Christine Linares
dba : Learning Grove Speech Language Pathology
18631 Sherman Way, Ste D
Reseda, CA 91335

RE: Participating Provider Approval

Dear Provider,

ACN Group of California, Inc. dba OptumHealth Physical Health of California (OptumHealth) is pleased to inform you that your contract for participation as a **Speech Language Pathologist** provider has been executed.

Group Name: Learning Grove Speech Language Pathology
Tax Identification Number (TIN):*****4169
OptumHealth Provider ID: 775338

Please note you are a participating provider group under the above TIN and associated office location(s) only for those patients under the following OptumHealth Clients, as of the effective date indicated below. The effective date for a specific client may differ from the date your application was approved by OptumHealth.

Specialty	OptumHealth Clients	Your Effective Date
SLP	NexusACO NR	05/10/2020
SLP	NexusACO R	05/10/2020
SLP	UHC - Charter	05/10/2020
SLP	UHC - Compass	05/10/2020
SLP	UHC - Navigate	05/10/2020
SLP	UHC In California	05/10/2020
SLP	UnitedHealthcare Dual Complete (CA)	05/10/2020
SLP	UnitedHealthcare Medicare Solutions (West)	05/10/2020
SLP	UnitedHealthcare SignatureValue	05/10/2020
SLP	Zelis	05/10/2020

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

Please log on to our Web Site to access your Operations Manual, Plan Summaries, Fee Schedules and information on claims submission and helpful program reference materials at: www.myoptumhealthphysicalhealth.com. Please contact Provider Services at 800-873-4575 to obtain password information.

As additional OptumHealth clients are implemented in your area, we will distribute additional Plan Summaries.

We look forward to working with you. Please feel free to contact Provider Services at 800-873-4575 if you have any questions or need assistance.

Sincerely,

Physical Health Network Management

PO Box 880009 | San Diego, CA 92168-0009 | Toll Free: (800) 428-6337 | Phone: (619) 641-7100 | Fax (619) 641-7185
email: network_physicalhealth@optum.com

ACN GROUP OF CALIFORNIA, INC.
PROVIDER PARTICIPATION AGREEMENT

THIS AGREEMENT (“Agreement”), effective on the date set forth in the acceptance letter ("Effective Date"), is between ACN Group of California, Inc. (“ACN”) 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 ACN 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. By signing this Agreement, Provider agrees to comply with applicable provisions of the documents identified in Section 2.2 (Plan Summaries), Section 3.3 (Provider Operations Manual), Section 8 (Provider Dispute Resolution Mechanism) and Section 9.2(6) (Credentialing Risk Management Plan) each of which (unless otherwise specified in this Agreement) is available to Provider upon request and/or available on the Plan’s provider website located at https://www.myoptumhealthphysicalhealth.com.

SECTION 1
Definitions

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

Covered Services: Those Noninstrumental Speech-Language Pathology/Speech Therapy services that are within Provider’s authorized scope of practice, as defined in California Business and Professions Code section 2530.2 and 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 (including a psychiatric 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:

(a) Placing the patient’s health in serious jeopardy;
(b) Serious impairment to bodily functions;
(c) Serious dysfunction of any bodily organ or part.

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

Medically Necessary: Necessary and appropriate for diagnosis or treatment of accidents, illnesses or conditions; established as safe and effective; and furnished in accordance with generally accepted practice and professional standards.

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 Speech-Language Pathology/Speech Therapy provider licensed under California law, including Provider, that has a written participation agreement in effect with ACN, to provide Covered Services to selected groups of Members.

Payor: ACN or the entity or person, including but not limited to, a health plan, workers' compensation insurer or automobile insurer, that is authorized by ACN to access one or more networks of Participating Providers developed by ACN and actively encourages its subscribers or enrollees to obtain Covered Services through one or more ACN networks.

Plan Summary: A written summary that sets forth the Fee Schedule Amount, withhold amounts, Members, and the relevant terms and conditions for rendering Covered Services under a Benefit Contract. ACN, in its sole discretion, reserves the right to distribute new or revised Plan Summaries to Provider at any time, except that any new or revised Plan Summary that includes a material change or that changes a material term of this Agreement shall be subject to Section 10.1.

Urgent Care Services: Covered Services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Covered Person's health, alleviate severe pain, or treat an illness or injury with respect to which treatment can not reasonably be delayed.

SECTION 2
Networks of Participating Providers

2.1 Provider Participation. Provider shall participate in those networks of Participating Providers designated by ACN in Plan Summaries. When applicable, Provider will be listed in the provider directories for each network in which Provider is designated for participation. ACN reserves the right to change Provider's network assignment.

2.2 Plan Summary. Upon execution of this Agreement, and within 30 calendar days of receiving a written request from Provider, ACN shall disclose to Provider a summary of all Payors eligible to claim the rate for Covered Services set forth in Section 4.1.1 of this Agreement. During the term of the Agreement, ACN shall provide relevant Plan Summaries to Provider. Plan Summaries are incorporated into this Agreement by this reference and effective 45 business days from delivery to Provider. Provider shall notify ACN in writing within 15 days of ACN's delivery of a new or amended Plan Summary if Provider objects to or wishes not to participate in said Payor contract identified in the Plan Summary. Notwithstanding anything herein to the contrary, any new or modified Plan Summary that includes a material change or that changes a material term of this Agreement shall be subject to Section 10.1.

SECTION 3
Duties of Provider

3.1 Member Eligibility. Provider is responsible to verify Member eligibility in accordance with instructions in the applicable Plan Summary. ACN and/or Payors will have no responsibility for services provided to persons who are ineligible to receive Covered Services except in the case of services provided as a result of inaccurate or erroneous eligibility information provided by ACN and/or Payors. Provider shall be responsible to bill ineligible patients directly for professional services provided to ineligible patients. Each Payor retains the right of final verification of eligibility and this verification supersedes any authorization of care, verification of eligibility, and/or claims payment review made by ACN or Payor.

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 or discrimination based on race, religion,

gender, color, national origin, age or physical or mental health status, sexual orientation 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 requirements of ACN and Payor and the requirements of all applicable regulatory authorities. ACN, reserves the sole discretion to transfer some or all of a designated Payor's Members to another Provider if ACN determines that events constituting grounds for termination under Section 9.2(6) or 9.2(9) have occurred, and Provider agrees to cooperate and assist with such transfers.

3.3 Operations Manual. Provider shall comply with the ACN Provider Operations Manual ("Operations Manual"), which is incorporated by reference. ACN shall provide one copy of the Operations Manual to Provider at no cost. The Operations Manual describes, among other things, ACN's administrative and operational procedures, such as credentialing and risk management, claims submission and payment, utilization management and grievance policies and procedures. The Operations Manual may be amended, revised, supplemented or replaced from time to time by ACN in its sole discretion, in accordance with Section 10.1 of this Agreement.

3.4 Grievance Procedures. Provider shall cooperate with ACN and Payors in identifying, processing, and resolving all Member grievances and other complaints, in accordance with ACN's Grievance Resolution Policy and Procedure (as described in the Operations Manual) as well as in accordance with such time limits as required by state and/or federal law. Provider shall comply with ACN's resolution of any such complaints or grievances including specific findings, conclusions and orders of the Department of Managed Health Care and other governmental agencies, subject to its right to contest such resolutions under this Agreement or otherwise pursuant to applicable law.

3.5 Compliance with Performance Improvement Agreements Issued by ACN. ACN may require that Provider sign a Performance Improvement Agreement (PIA). A PIA communicates issues requiring corrective action, including, but not limited to:

a. Deficiencies in Provider performance;
b. Provider non-compliance with the requirements of this Agreement;
c. Other areas needing modification or improvement by Provider.

Failure to comply with, or agree to, a PIA issued by ACN may result in termination of this Agreement.

3.6 Quality Improvement Program. Provider shall participate in the components of ACN's Quality Management and Improvement Program as part of the "Clinical Support Program" set forth in the Operations Manual.

3.7 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 applicable provider 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 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.

3.8 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. Members must be able to access Covered Services within three business days from the time of the request for an appointment for routine care and within 24 hours for urgent appointments. If the Provider is unavailable, instructions must be provided for the Member referring them to another Participating Provider or their

benefit plan. If Provider is unavailable when Members call, Provider shall arrange for an answering service. Provider shall include office hours and emergency information with the answering service and allow Members to leave a message 24 hours a day.

3.9 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 ACN 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

4.1.1 Payment for Covered Services. Provider shall be paid for Covered Services authorized by ACN or Payor and provided by Provider to a Member 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. In the event a Member's Benefit Contract provides for a Member Expense that is stated as a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Contract.

4.1.2 Time for Claims Payment. ACN or Payor will pay each claim received from Provider within 30 working days after receipt of the claim. ACN or Payor shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt in the same manner as the claim was submitted. Identification and acknowledgment of the date of receipt shall occur either (a) in the case of an electronic claim, within two (2) working days of the date of receipt; (b) in the case of a paper claim, within fifteen (15) working days of the date of receipt of the claim, by the office designated to receive the claim. If the claim is submitted to a claims clearinghouse, ACN or Payor identification and acknowledgement to the clearinghouse within the above referenced timeframes shall constitute sufficient receipt and acknowledgement of such claim. If a complete claim, or portion thereof, is neither contested nor denied, and is not reimbursed by delivery to Provider within thirty (30) working days, interest accrual will automatically begin on the 1st calendar day after the thirty (30) working day period, at the rate of 15 % per annum, so long as the claim is not for emergency services or care, in which case interest will accrue at the greater of $15 for each 12-month period or portion thereof or at a rate of 15% per annum.

If ACN contests a claim or portion thereof, ACN will notify Provider in writing within 30 working days of receiving the claim that the claim is contested or denied. Such notice shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

For the purposes of this Section, a claim, or portion thereof, is reasonably contested where ACN has not received the completed claim and all information necessary to determine Payor liability for the claim, or has not been granted reasonable access to information concerning Provider's services. Information necessary to determine Payor liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for ACN to determine the medical necessity for the health care

services provided.

If a claim or portion thereof is contested on the basis that ACN has not received all information necessary to determine Payor liability for the claim or portion thereof and notice has been provided pursuant to this Section, then the ACN shall have 30 working days after receipt of this additional information to complete reconsideration of the claim. If ACN has received all of the information necessary to determine Payor liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, interest shall automatically accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30 working day period, so long as the claim is not for emergency services or care, in which case interest will accrue at the greater of $15 for each 12-month period or portion thereof or at a rate of 15% per annum.

4.1.3 Overpayments. In the event of an overpayment by Payor, Provider must promptly notify ACN, and Provider shall reimburse Payor within 30 working days of Provider's receipt of notice of an overpayment, unless the overpayment or portion thereof is contested by Provider. Provider shall notify Payor in writing within 30 working days if an overpayment or any portion thereof is contested by Provider, and such notice shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. If Provider fails to make reimbursement for an uncontested overpayment within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30 working day period.

4.1.4 Denied Claims. Denied claims and a clear written explanation of the reason for denial shall be listed on the provider's remittance advice form. Reasons for denial of a claim may include, but not be limited to:

- Claim does not meet the criteria for a clean, payable claim.
- Member is not eligible for services on the date services are rendered.
- Service is not a benefit under the Benefit Contract.
- Service requiring authorization was not authorized.
- Patient self-referral to a non-contracting provider.
- Service was not Medically Necessary.
- Coordination of benefits.
- Benefit is exhausted.

All appeals from providers must be submitted in accordance with ACN's Provider Dispute Resolution Mechanism, or as otherwise required under applicable 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, and shall not bill Members for non-covered charges which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges or Fee Schedule Amount 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 or collect payment from the Member for non-covered services, including but not limited to, maintenance/elective services, as determined by Provider or ACN, unless Provider has obtained the Member's signed written consent prior to the service being rendered.

4.3 Submission of Claims. Provider shall submit claims for Covered Services to ACN within 120 calendar days of the date of service and in a manner and format prescribed by ACN, which may be an electronic format. 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 as otherwise prescribed by state law.

Provider shall not bill the Member for Covered Services if Provider fails to submit claims in accordance

with the above provisions.

ACN shall not rescind or modify an authorization after Provider has rendered the authorized service in good faith and pursuant to the authorization. ACN shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that ACN 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. In no event, including, but not limited to, nonpayment by ACN for Covered Services rendered to Members by Provider, insolvency of Payor or ACN, or breach by ACN 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. Provider shall also not seek to impose any surcharge or similar amount on Members. Provider acknowledges that ACN will take appropriate action, which may include termination of this Agreement, upon receiving notice of Provider's attempt to impose any surcharge or similar amount on Members.

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.

4.6 Contracted Rate for Members. After obtaining a signed Patient Billing Acknowledgement Form-Non-Covered Services, Provider may bill the Member directly (at no more than the Fee Schedule Amount) for services for which there is no longer any coverage under the Benefit Contract.

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 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, (1) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate and (2) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and aggregate, 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 ACN. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to ACN 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. ACN shall at all times comply with all applicable federal and state laws and regulations, including, but not limited to the applicable sections in the California Health and Safety Code.

SECTION 6
Notices

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

(1) Changes in liability insurance carriers, termination of, renewal 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 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) A change in Provider's name, address, telephone number, ownership or Federal Tax I.D. number;
(4) Indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
(5) Claims or legal actions for professional negligence or bankruptcy;
(6) Provider’s termination, for cause, from a provider network offered by any Payor, 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;
(7) Any occurrence or condition which might materially impair the ability of Provider to discharge its duties or obligations under this Agreement;
(8) Any condition or circumstance that may pose a direct threat to the safety of Provider, Providers’ staff, and/or Members.

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. ACN 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 ACN 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 applicable provider community and in accordance with all applicable statutes and regulations. Such records shall include all medical records, documents, Plan Summaries and other relevant information in Provider's possession relating to the provision of Covered Services to Members. Any such records shall be maintained for a period of five years and shall be readily available to ACN at all reasonable times during the term of this Agreement or a period of five years, whichever is longer.

To perform its utilization management and quality improvement activities, ACN 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 ACN, such access shall be given at the time of the audit. If requested by ACN, Provider shall provide copies of such records free of charge. Unless a longer time period is required by applicable statutes or regulations or the Operations Manual, ACN 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 obtain any Member consent in order to provide ACN with requested information and records or copies of records and to allow ACN to release such information or records to Payors as necessary for the administration of the Benefit Contract or compliance with any state or federal laws applicable to the Payors. Such obligation is not terminated upon termination of this Agreement, whether by rescission or otherwise.

This section shall not be construed to grant ACN 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 ACN 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 ACN 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 ACN, Payor or Provider.

Provider shall maintain adequate medical, financial and administrative records related to Covered Services in a manner consistent with the standards in the applicable provider community and in accordance with all applicable statutes and regulations. Such records shall include all medical records, documents, Plan Summaries and other relevant information in Provider's possession relating to the provision of Covered Services to Members. Any such records shall be maintained for a period of five years and shall be readily available to the Department of Managed Health Care at reasonable times during the term of this Agreement or a period of five years, whichever is longer.

7.4 Provider Access to Records. Upon Provider's request, ACN will provide a copy of records regarding the economic costs or utilization of services associated with the Covered Services provided by Provider which is utilized by ACN in evaluating Provider's performance under this Agreement. Such information shall be available for a period of 60 days after termination of this Agreement.

SECTION 8
Resolution of Disputes

ACN and Provider will work together in good faith to resolve any disputes about their business relationship. All contractual disputes, whether related to a claims payment issue under Section 4 of this Agreement or otherwise, shall first be addressed in accordance with ACN's Provider Dispute Resolution Mechanism. If the parties are unable to resolve the dispute within 30 days following the date one party sent notice that the dispute was not resolved under the Provider Dispute Resolution Mechanism, and if ACN 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, 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 ACN procedures, such as a 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 ACN 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, including, but not Limited to the terms of Section 4.6, 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 ACN 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 30 days prior written notice to ACN due to a non-material amendment made to this Agreement pursuant to Section 10.1 of this Agreement;
(6) by ACN in accordance with its Credentialing Risk Management Plan;
(7) by ACN in accordance with a Performance Improvement Agreement;
(8) by ACN in accordance with the Operations Manual;
(9) by ACN immediately if ACN determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; (10) by ACN in the event Provider attempts to add a surcharge for Covered Services. (11) by

either party upon 45 days written notice pursuant to Section 10.8.

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

If Provider is terminated through the ACN credentialing process by virtue of Provider's failure to abide by or agree to the terms of a PIA, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant thereto.

9.3 Information to Members. Provider acknowledges the right of ACN to inform Members of Provider's termination and agrees to cooperate with ACN regarding the form of such notification.

9.4 Continuation of Services After Termination. Upon request of ACN or a Member, Provider shall continue to provide Covered Services authorized by ACN to any Member receiving care from such Provider for pregnancy, terminal illness, an acute condition or a serious chronic condition as of the date of termination of this Agreement, a surgery or other procedure which has been recommended and documented by the Provider to occur within 180 days of the date of termination of this Agreement, and the care of a newborn child between birth and age 36 months as of the date of termination of this Agreement.

In cases involving an acute condition or pregnancy, Provider shall provide Covered Services to the Member for the duration of the acute condition or pregnancy. In cases involving a terminal illness, Provider shall provide Covered Services for the duration of the terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee. In cases involving a serious chronic condition, Provider shall provide Covered Services to the Member for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Participating Provider as determined by ACN in consultation with Provider, consistent with good professional practice. In cases involving a surgery or other procedure, Provider shall provide Covered Services to the Member which ACN authorizes as part of a documented course of treatment and which has been recommended and documented by the Provider to occur within 180 days of the termination of this Agreement. In cases involving the care of a newborn child between birth and age 36 months, completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.

ACN shall pay Provider for such services at Provider's contracted rate pursuant to the policies, procedures and rates in effect at the time of termination.

SECTION 10
Miscellaneous

10.1 Amendment. ACN may amend this Agreement, or any manual, policy, or procedure document referenced herein, whether for regulatory compliance or other reasons, by sending a copy of the amendment to Provider at least 45 business days prior to its effective date, unless any state or federal law or regulation or any accreditation requirement of a private sector accreditation organization requires a shorter timeframe. For non-material amendments, the signature of Provider shall not be required and the amendment shall be deemed accepted by Provider unless, within 45 business days following ACN's delivery of the amendment, Provider delivers its written notice of termination pursuant to Section 9.2(5), in which case the Amendment shall be of no force or effect during the notice of termination period or otherwise. A proposed amendment that changes any material term of this Agreement shall not be deemed accepted absent Provider's signature. Nothing herein shall limit the Provider's ability to propose alternatives to the Amendment, nor limit the parties' ability to mutually agree to waive the 45 business day

notice and agree to a proposed amendment at any time after notice of the proposed amendment has been delivered to Provider.

10.2 Assignment. ACN may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with ACN. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of ACN, which consent shall not be unreasonably withheld.

10.3 Administrative Responsibilities. ACN 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 ACN and Provider. The relationship between ACN 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.

10.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, ACN and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, ACN and Payor shall not otherwise use each other's name, symbol or service mark 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) ACN may disclose certain terms to Payors 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. ACN 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. Nothing in this Agreement is intended to

interfere with Provider’s relationship with Members as patients of Provider, or with ACN’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 ACN's business model or arrangements with Payors. 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 45 business days of delivery of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement pursuant to Section 9.2(11). Any such notice of termination must be given within 10 days of the end of the 45-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 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 California law. This Agreement is subject to the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code (the Knox-Keene Act) and of Chapter 1 of Title 28 of the California Code of Regulations and applicable provisions of the California Labor Code pertaining to Workers' Compensation. Any provision required to be included in this Agreement by the above shall bind the parties whether or not provided in this Agreement.

10.12 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 Advantage Addendum. Provider also understands that ACN's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services ("CMS").

10.13 Language Assistance Program. ACN shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Members have appropriate access to language assistance while accessing health care services as required by the Language Assistance Program Regulations. ACN shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the language assistance program for Members.

Provider shall cooperate and comply, as applicable, with ACN's language assistance program developed pursuant to Title 28 of the California Code of Regulations, Section 1367.04, including providing any information necessary to assess compliance.

REGULATORY AMENDMENT TO
ACN GROUP OF CALIFORNIA, INC.
PROVIDER PARTICIPATION AGREEMENT

This Amendment ("Amendment") is made a part of the ACN Group of California, Inc., doing business as Optum Physical Health of California ("Optum") Provider Participation Agreement ("Agreement").

WHEREAS, Optum and Provider entered into the Agreement under which Provider shall participate in one or more networks developed by Optum to render Covered Services to individuals covered by a Benefit Contract ("Member").

WHEREAS, California Senate Bill 137, Section 1367.27 of California Health and Safety Code ("Provider Directory Regulations"), commencing July 1, 2016, requires a health care service plan, that contracts with providers for alternative rates of payment, to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, and would require the plan to make an online provider directory or directories available on the plan or health insurer's Internet Web site, as specified.

WHEREAS, Section 1367.27(j)(1) of the Provider Directory Regulations requires the Agreement to be amended to require Provider to meet compliance with such regulations.

WHEREAS, the purpose of this Amendment is to satisfy the contractual requirements of the Provider Directory Regulations. This Amendment does not include or infer delegation of any Optum obligations under the Provider Directory Regulations.

WHEREAS, pursuant to Section 10.1 of the Agreement, Optum may amend the Agreement to comply with requirements of state and federal regulatory authorities by giving Provider written notice of such amendment and its effective date. The signature of Provider is not required for such amendment.

NOW, THEREFORE, in consideration of the mutual covenants, promises and agreements herein contained, and other good and valuable consideration, the sufficiency of which is hereby acknowledged, Optum amends the Agreement as follows:

1) **Definitions.** Unless otherwise provided in this Amendment, capitalized terms have the same meaning as set forth in the Agreement or in the Provider Directory Regulations.

2) **Compliance with Provider Directory Regulations.** Optum shall establish Provider obligations in order to ensure and maintain compliance with

Provider Directory Regulations, referenced in California Health and Safety Code Section 1367.27. Optum shall maintain ongoing administrative and financial responsibility for implementing and operating a provider directory on an ongoing basis for compliance with such regulations.

a) **Notification of Acceptance/Non-Acceptance of New Patients**. Provider shall cooperate and comply, as applicable, including providing any information necessary to assess compliance. Such requirements are as follows, as referenced in Section 1367.27(j)(1):

i) Provider shall inform Optum within **five business days** when either of the following occurs:

(1) Provider is not accepting new patients.

(2) If Provider had previously not accepted new patients, the Provider is currently accepting new patients.

ii) If Provider is not accepting new patients and is contacted by an Optum enrollee or potential enrollee seeking to become a new patient, Provider shall direct the Optum enrollee or potential enrollee to BOTH Optum for additional assistance in finding a provider and to the Department of Managed Health Care to report any inaccuracy with Optum' s directory or directories.

iii) If an Optum enrollee or potential enrollee informs Optum of a possible inaccuracy in its provider directory or directories, Optum shall promptly investigate, and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of Optum' s directory or directories.

b) **Accuracy of Provider Information**. Provider shall cooperate and comply, as applicable, to ensure the accuracy of information concerning Provider as listed in Optum's provider directory or directories for each product offered. Such requirements are as follows, as referenced in Section 1367.27(l)(1):

i) Each calendar year, Optum shall notify individual Provider(s) at least once every six months; or for Provider group(s) at least once annually. Such notification shall include the following:
(1) The information Optum has in its directory or directories regarding Provider, including a list of networks and products that Provider participates in.

(2) Instructions on how Provider can update the information in the provider directory or directories using Optum's online interface.

ii) Optum shall require an affirmative response from Provider acknowledging that the notification was received. Provider shall confirm that the information contained in Optum's provider directory or directories is current and accurate or update the information required to be in the directory or directories, including whether or not Provider is accepting new patients for each Optum product.

iii) If Optum does not receive an affirmative response and confirmation from Provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories, within 30 business days, Optum shall take no more than 15 business days to verify whether Provider's information is correct or requires updates. Optum shall document the receipt and outcome of each attempt to verify the information. If Optum is unable to verify whether Provider's information is correct or requires updates, Optum shall notify Provider ten (10) business days in advance of removal that Provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the ten (10) business day notice period. Provider shall not be removed from the provider directory or directories if he or she responds before the end of the ten (10) business day notice period

c) **Verification**. Provider shall cooperate and comply, as applicable, and shall confirm that Provider information is correct or requires updates. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates.

3) **Controlling Language.** Except as specifically amended by this Amendment, the Agreement shall continue in full force and effect. Whenever the terms of the Agreement and this Amendment are in conflict, the terms of this Amendment shall control.

Medicare Advantage Regulatory Appendix

The provisions contained in this Appendix supplement the Agreement between Provider and ACN (the "Agreement"). Because Provider has agreed to provide Covered Services to Medicare Members who receive their coverage under Medicare Advantage contracts between the Centers for Medicare and Medicaid Services ("CMS") and Payors (collectively "Medicare Advantage Plans"), applicable Medicare Advantage regulations and CMS guidelines require that the provisions contained in this Appendix be part of the Agreement. For Medicare Advantage Plans, this Appendix supersedes any inconsistent provisions that may be found elsewhere in the Agreement.

- **Data.** Provider shall cooperate with ACN and Payor in its efforts to report to CMS all statistics and other information related to its business, as may be requested by CMS. Provider shall send to ACN all encounter data and other Medicare program-related information as may be requested by ACN, within the timeframes specified and in a form that meets Medicare program requirements. By submitting encounter data to ACN, Provider represents to ACN, and upon ACN's request Provider shall certify in writing, that the data is accurate and complete, based on Provider's best knowledge, information and belief. If any of this data turns out to be inaccurate or incomplete, according to Medicare Advantage rules, payment may be withheld.

- **Policies.** Provider shall cooperate and comply with all of ACN's and Payor's policies and procedures, credentialing plan and provider administrative manual.

- **Payment.** Payor shall promptly process and pay Provider's claim no later than 60 days after it receives all appropriate information as described in applicable administrative procedures. If Provider is responsible for making payment to subcontracted providers, Provider shall pay them within this same timeframe.

- **Member Protection.** Provider agrees that in no event, including but not limited to, non-payment by Payor or an intermediary, insolvency of Payor or an intermediary, or breach by ACN 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 person (other than Payor or an intermediary) acting on behalf of the Member for Covered Services provided pursuant to the Agreement. This provision does not prohibit Provider from collecting copayments, coinsurance, or fees for services not covered under the Member's Benefit Plan and delivered on a fee-for-service basis to the Member. This provision does not prohibit Provider and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that the Benefit Plan may not cover or continue to cover a specific service or services.
- In the event of Payor's or an intermediary's insolvency or other cessation of operations or termination of Payor's contract with CMS, Provider shall continue to provide Covered Services to Members through the later of the period for which premium has been paid on behalf of the Member, or, in the case of Members who are Providerized as of such period or date, until the Member's discharge. Covered Services for a Member confined in an inpatient facility on the date of insolvency or other cessation of operations shall continue until the Member's continued confinement in an inpatient facility is no longer necessary.
- This provision shall be construed in favor of the Member, shall survive the termination of the Agreement regardless of the reason for termination, including ACN's or Payor's insolvency, and shall supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member 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.

- **Eligibility.** Provider agrees to immediately notify ACN in the event Provider is or becomes disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in federal health care programs. Provider shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in federal health care programs.

- **Laws.** The parties shall comply with all applicable Medicare laws, regulations and CMS instructions and shall cooperate with the other's efforts to comply. Provider shall also cooperate with ACN and Payor in its efforts to comply with its contract with CMS.

- **Records.** The Secretary of Health and Human Services, the Comptroller General and Payor and ACN shall have the right to audit, evaluate and inspect any books, contracts, medical records, patient care documentation and other records belonging to Provider that pertain to the Agreement and other program-related matters deemed necessary by the person conducting the audit, evaluation, or inspection. This right shall extend through 10 years from the later of the last day of a CMS contract period or completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. Provider shall make its premises, facilities and equipment available for these activities. Provider shall maintain medical records in an accurate and timely manner. Provider shall ensure that Members have timely access to medical records and information that pertain to them. The parties shall safeguard the privacy of any health information that identifies a Member and abide by all federal and state laws regarding privacy, confidentiality and disclosure of medical records and other health and Member information.

- **Accountability.** Provider agrees that Payor and ACN oversees and is accountable to CMS for any responsibilities that are contained in Payor's contract with CMS, including those may be delegated to Provider or others. Any responsibilities that are delegated must be specified in a written arrangement with the other party. The arrangement must include any reporting requirements, a right of revocation, performance monitoring by Payor and ACN, ongoing review, approval and auditing of credentialing processes, if applicable, and compliance with all applicable Medicare laws, regulations and CMS instructions.

- **Subcontracts.** If Provider has subcontract arrangements with other providers to deliver Covered Services to Members, Provider shall ensure that its contracts with those subcontracted providers contain all of the provisions in this Appendix and shall provide proof of such to ACN upon request.

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
OPTUM HEALTH CARE SOLUTIONS, LLC
PROVIDER

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the provider agreement ("Agreement") between OptumHealth Care Solutions, LLC, it subsidiaries, affiliated and its companies (collectively, "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. Benefit Plan may also be referred to as benefit contract, benefit document, plan, or other similar term under the Agreement.

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. Cost Sharing may also be referred to as patient expenses or other similar term under the Agreement.

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. A Covered Service may also be referred to as a health service or other similar term under the Agreement.

2.5 Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services. A Customer may also be referred to as an enrollee, member, patient, covered person, or other similar term under the Agreement.

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 by United to access Provider's services under the Agreement. A Payer may also be referred to as a payor, participating entity, or other similar term 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 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. 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. In the event of MA Organization's, Company's, 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 an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

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 the 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.

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.

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 health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. 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 health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. MA Customers shall not have any financial liability for services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of Federal Regulations.

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 and compliant with MA Organization's contractual obligations under the CMS Contract.

3.9 Records.

(a) Privacy and Confidentiality; Customer Access. 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) Retention. 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 other 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.

(c) Government Access to Records. Provider acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Provider related to the CMS Contract. Provider shall make available to its premises, physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 3.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, collection and inspection rights identified in subsection 3.9(c)

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, collection, or inspection, and will conduct such audit, evaluation, collection, 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 (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

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. All services provided pursuant to the Agreement that are subject to this Appendix and that involve MA Customer's protected health information ("PHI") must be performed within the United States, the District of Columbia, or the United States territories, unless Provider previously notifies MA Organization in writing and submits required offshoring information to, and received approval from, MA Organization.

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 promptly process and pay or deny 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.

4.3 Survivability. The terms of this Appendix shall survive the termination of the Agreement regardless of the reason for termination.

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

INDIVIDUAL PROVIDER **OR**

Address: _____

_____

_____

Signature: _____

Print Name: _____

Title: _____

Date: _____

GROUP PROVIDER

Address: 18631 Sherman Way, Suite D

Reseda, CA 91335 - 4162

Signature of Owner/Program Director: DocuSigned by: MICHELE LINARES 1C9B555BE5904A0...

Print Name: Michele Linares

Title: Owner

Clinic Name: The Learning Grove - Speech Language Pathology, Inc

Date: 11/14/2019

ACN GROUP OF CALIFORNIA, INC.
3111 Camino Del Rio N.
Suite 800
San Diego, CA 92108
Telephone: 1-800-428-6337

Signature: _____

Print Name: Stephen P Castro

Title: _____

Date: 04/15/2020

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.
Michele Christine Linares

2 Business name/disregarded entity name, if different from above
Learning Grove : Speech Language Pathology , Inc,

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.)
18631 Sherman Way, Suite D

Requester's name and address (optional)

6 City, state, and ZIP code
Reseda, CA 91335 - 4162

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
47 - 1124169

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: MICHELE LINARES 1C9B555BE5904A0... **Date** ▶ 11/14/2019

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.