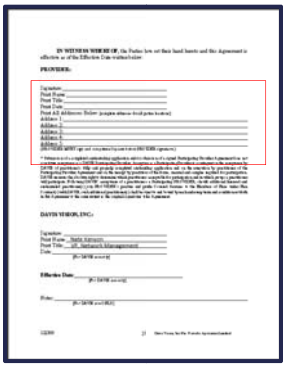
Welcome to Davis Vision!

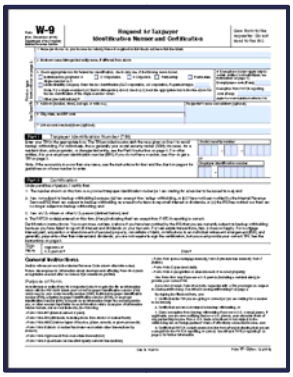
We're ready to start processing your application! Before we can begin, we'll need 3 simple documents submitted to us:

1. **A signed copy of the last page of the Davis Vision Contract:**



2. **A completed Davis Vision Provider Add Form:**

3. **A copy of your W9 Form:**



Fax your completed documents to 1.888.553.2847 or call 1.800.584.3140 for more information.

DAVIS VISION
EYECARE REFRAMED℠

DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR THE STATE OF NEW JERSEY

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NEW JERSEY** (hereinafter "Agreement") is entered into by and between **DAVIS VISION, INC.**, (hereinafter "**DAVIS**") having its principal place of business located at 159 Express Street, Plainview, New York 11803, and **PARTICIPATING PROVIDER** (hereinafter "**PROVIDER**") as defined herein below. **DAVIS** and **PROVIDER** are herein referred to individually as "Party" and collectively as "Parties".

RECITALS

WHEREAS, **DAVIS** has entered into or intends to enter into agreements (hereinafter "Plan Contract(s)") with health maintenance organizations, Medicare Advantage organizations, Medical Assistance organizations and other purchasers of vision care services ("hereinafter Plan(s)"); and

WHEREAS, **DAVIS** has established or shall establish a network of participating vision care providers (hereinafter "Network") to provide, or to arrange for the provision of, or to grant access to, the vision care services of the Network to individuals (hereinafter "Members") who are enrolled as Members of such Plans; and

WHEREAS, the Parties desire to enter into this Agreement whereby **PROVIDER** agrees (upon satisfying all Network participation criteria) to provide certain vision care services (hereinafter "Covered Services") on behalf of **DAVIS** to Members of such Plans under Plan Contract(s) with **DAVIS**.*

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, and intending to be bound hereby, the Parties agree as follows:

I
PREAMBLE AND RECITALS

.1 The preamble and recitals as set forth above are hereby incorporated into and made part of this Agreement.

II
DEFINITIONS

.1 "**Authorization**" means a determination required under a vision care services benefit program that is based upon information provided by the **PROVIDER,** and/or the Member and which satisfies the requirements for Medical Necessity/Medically Necessary Services/Medically Appropriate Services under the Member's vision care services benefit program.

.2 "**Centers for Medicare and Medicaid Services**" ("hereinafter CMS") means the division of the United States Department of Health and Human Services, formerly known as the Health Care Financing Administration (HCFA) or any successor agency.

.3 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a confirmation of eligibility number assigned by **DAVIS** referencing a specific Member and Member's information; (b) a valid **DAVIS**-assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation was performed, if an examination was provided; (f) a description of services provided (i.e. examination, materials, etc.); and (g) (if applicable) all necessary prescription eyewear order information. Any claim that does not have all of the information as set forth herein may be pended or denied until all information is received from the **PROVIDER**, the Participating Provider and/or the Member. All claims must be received by **DAVIS** within ninety (90) days from the date services were rendered in order for the claims to be adjudicated. If **PROVIDER** is filing a claim under an assignment of benefits from the Member, **PROVIDER** shall file the claim within one hundred eighty (180) days from the last date upon which services were rendered for a particular course of treatment. Claims from Participating Providers under investigation for fraud or abuse and claims submitted with a tax ID number not documented on a properly completed W-9 form are not Clean Claims. Further, submission of a properly completed CMS Form 1500 or any applicable Uniform Claim Form and any attachments approved or adopted for use in the applicable jurisdiction for payment of Covered Services and as promulgated by the rules and regulations of said jurisdiction shall be deemed a Clean Claim.

4 "**Copayment**", "**Coinsurance**", or "**Deductible**" means those charges for vision care services, which are the responsibility of the Member under a benefit program and which shall be collected directly by **PROVIDER** from Member as payment, in addition to the fees paid to **PROVIDER** by **DAVIS**, in accordance with the Member's benefit program. Such charges are herein also referred to as "cost sharing" as pertains to charges for which a dually eligible Medicare Advantage Subscriber is responsible.

.5 "**Covered Services**" means, except as otherwise provided in the Member's benefit plan, a complete and routine eye examination including, but not limited to, visual acuities, internal and external examination, including dilation where professionally indicated, refraction, binocular function testing, tonometry, neurological integrity, biomicroscopy, keratometry, diagnosis and treatment plan and, when authorized by state law and covered by a Plan, medical eye care, diagnosis, treatment and eye care management services, and <u>if applicable</u>, ordering and dispensing plan eyeglasses from the central **DAVIS** laboratory.

.6 "**Generally Accepted Standards of Medical Practice**" means standards that are based upon: credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas; and any other relevant factor as determined by statutes and/or the regulation(s) of the Commissioner. ["**Commissioner**" means the Commissioner of the New Jersey Department of Banking and Insurance.]

.7 "**Managed Care Organization**" (hereinafter "MCO") means an entity that has or is seeking to qualify for a comprehensive risk contract and that is: (1) a Federally qualified HMO that meets the advance directives requirements of 42 CFR 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are accessible to other recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR 438.116.

.8 "**Medical Assistance Program**" (hereinafter "MAP") means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or

assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States for Medical Assistance Programs, Section 1396 et seq, as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.9 "**Medical Necessity**" / "**Medically Necessary Services**." With respect to the Medicaid and/or Medical Assistance programs, "Medical Necessity" or "Medically Necessary Services" are those services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. A course of treatment may include mere observation or where appropriate no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not Medically Necessary Services for purposes of this Agreement.

Medically Necessary Services provided must be based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance. In the case of pediatric Members/enrollees, the definition herein shall apply with the additional criteria that the services, including those found to be needed by a pediatric Member as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily Covered Services for all other Medicaid Members are appropriate for the age and health status of the individual, and the service will aid the overall physical and mental growth and development of the individual, and the service will assist in achieving or maintaining functional capacity.

.10 **"Medical Necessity**" / "**Medically Necessary**" / "**Medically Appropriate**." With respect to the Medicare and/or Medicare Advantage program, in order for services provided to be deemed Medically Necessary or Medically Appropriate, Covered Services must: (1) be recommended by a **PROVIDER** who is treating the Member and practicing within the scope of her/his license and (2) satisfy each and every one of the following criteria:

(a) The Covered Service is required in order to diagnose or treat the Member's medical condition (the convenience of the Member, the Member's family or the Participating Provider is not a factor to be considered in this determination); and

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)
(i) be appropriate within generally accepted standards of practice;
(ii) be efficacious, as demonstrated by scientifically supported evidence;
(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and

(iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and

(c) The Covered Service is the least costly alternative course of diagnosis or treatment that is adequate for the Member's medical condition; factors to be considered include, but are not limited, to whether the Covered Service can be safely provided for the same or lesser cost in a medically appropriate alternative setting; and

(d) The Covered Service, or the specific use thereof, for which coverage is requested is not experimental or investigational. A service or the specific use of a service is investigational or experimental if there is not adequate, empirically-based, objective, clinical scientific evidence that it is safe and effective. This standard is not met by (i) a Participating Provider's subjective medical opinion as to the safety or efficacy of a service or specific use or (ii) a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating a different condition. Use of a drug or biological product that has not received FDA approval is experimental. Off-label use of a drug or biological product that has received FDA approval is experimental unless such off-label use is shown to be widespread and generally accepted in the medical community as an effective treatment in the setting and condition for which coverage is requested.

.11 "**Medically Appropriate**" With respect to Plans other than Medicare and Medicaid, the term "Medically Appropriate" means or describes a vision care service(s) or treatment(s)that a **PROVIDER** hereunder, exercising **PROVIDER**'s prudent, clinical judgment would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease, or its symptoms and that is in accordance with the "Generally Accepted Standards of Medical Practice"; and is clinically appropriate in terms of type, frequency, extent site and duration; and is considered effective for the Member's illness, injury or disease; and is not primarily for the convenience of the Member or the **PROVIDER**; and is not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the Member's illness, injury, or disease.

.12 "**Medicare**" means the Federal program providing medical assistance to aged and disabled persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 et seq, as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.13 "**Medicare Advantage Member**" or "**Medicare Advantage Subscriber**" means an individual who is enrolled in and covered under a Medicare Advantage Program or any successor program(s) thereto regardless of the name(s) thereof. Dually eligible Medicare Advantage Subscribers are those individuals who are (i) eligible for Medicaid; and (ii) for whom the state is responsible for paying Medicare Part A and B cost sharing.

.14 "**Medicare Advantage Program**" means a product established by Plan pursuant to a contract with CMS which complies with all applicable requirements of Part C of Title 42 of United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 et seq, as amended from time to time, and which is available to individuals entitled to and enrolled in Medicare or any successor program(s) thereto regardless of the name(s) thereof.

.15 "**Member**" or "**Enrollee**" means an individual and the eligible dependents of such an individual who are enrolled in or who have entered into contract with or on whose behalf a contract has been entered into with Plan(s), for the provision of Covered Services. Eligible dependents of Members typically include spouses, minor children, and adult children who are full-time students.

.16 "**Negative Balance**" means receipt of Copayments, Coinsurances, Deductibles or other compensation by **PROVIDER** or Participating Provider which are in excess of the amounts that are due to **PROVIDER** or Participating Provider for Covered Services under this Agreement.

.17 "**New Jersey Department of Banking and Insurance**" (hereinafter "DOBI") means the New Jersey State Division of Insurance which monitors and has regulatory responsibility over health maintenance organizations and insurance producers.

.18 "**New Jersey Department of Human Services**, (hereinafter "NJDHS") **Division of Medical Assistance and Health Services**" ("DMAHS") means the division of the NJDHS responsible for the administration of the State Medical Assistance Programs, NJ FamilyCare and NJ KidCare.

.19 **"Non-Covered Services**" means those vision care services which are not Covered Services and which are not covered benefits under the Plan Contracts between **DAVIS** and the Plan(s).

.20 "**Network**" means the arrangement of Participating Providers established to service eligible Members and/or eligible dependents who are enrolled in or who have entered into contract with, or on whose behalf a contract has been entered into with Plan(s).

.21 "**Overpayment**" means an incorrect claim payment made to a **PROVIDER** or Participating Provider via check or wire transfer due to one or more of the following reasons: (i) a **DAVIS** processing error (ii) an incorrect or fraudulent claim submission by **PROVIDER** or Participating Provider (iii) a retroactive claim adjustment due to a change, oversight or error in the implementation of a fee schedule.

.22 "**Participating Provider**" means a licensed health facility which has entered into or a licensed health professional who has entered into an agreement with **DAVIS** to provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s) and those employed and/or affiliated, independent, or subcontracted optometrists or ophthalmologists who have entered into agreements with **PROVIDER**, who have been identified to **DAVIS** and have satisfied Network participation criteria, and who will provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s). All obligations, terms and conditions of this Agreement that are applicable to **PROVIDER** shall similarly be deemed applicable to and binding upon Participating Provider(s) as defined herein.

.23 "**Plans**" means health maintenance organizations, preferred provider organizations, corporations, trust funds, municipalities, employers, employer groups, and/or other purchasers of vision care services that have entered into a Plan Contract with **DAVIS** to have a benefit plan administered by **DAVIS**

.24 "**Plan Contracts**" means the agreements between **DAVIS** and Plans to provide or to arrange for the provision of vision care services to individuals enrolled as Members of such Plans.

.25 "**Provider Manual**" means the **DAVIS** Vision Care Plan Provider Manual, as amended by **DAVIS** from time to time.

.26 "**State**" means the State of New Jersey or the state in which the **PROVIDER**'s practice is located or the state in which the **PROVIDER** renders services to a Member.

.27 "**United States Code of Federal Regulations**" (hereinafter "CFR") means the codification of the general and permanent rules and regulations published in the Federal Register by the executive department and agencies of the Federal government.

.28 "**United States Department of Health and Human Services**" (hereinafter "DHHS") means the executive department of the Federal government which provides oversight to the Centers for Medicare and Medicaid Services ("CMS").

.29 "**Urgently Needed Services**" means Covered Services that are not emergency services as defined in 42 CFR §422.113 provided when a Member is temporarily absent from the Medicare Advantage Program Plan's service area (or if applicable, continuation area) or, under unusual and extraordinary circumstances, Covered Services provided when the Member is in the service or continuation area but the Network is temporarily unavailable or inaccessible and when the Covered Services are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition; and it was not reasonable, given the circumstances, to obtain the Covered Services through the Medicare Advantage Plan Network. "**Stabilized Condition**" means a condition whereby the physician treating the Member must decide when the Member may be considered stabilized for transfer or discharge, and that decision is binding on the Plan.

.30 "**Utilization Management**" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a vision care service either given or proposed to be given to a Member shall be deemed to be a Covered Service hereunder. The system may include, but shall not be limited to: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

III
SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **Frame Collection**. As a bailment, **PROVIDER** shall maintain the selection of Plan approved frames, **if applicable**, in accordance with the Provider Manual and as set forth herein:

(a) **PROVIDER** agrees that the frame collection will be shown to all Members receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees that the frame collection shall be openly displayed in an area accessible to all Members.
(c) **PROVIDER** shall maintain the Plan frame collection in the exact condition as delivered less any normal deterioration.
(d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.

(e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan, and, with reasonable notice, at any other time. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted frames.

(f) Upon reasonable notice, **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection at any time.

(g) Should the display and/or frame collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume full cost of the display and/or frame collection and will be required to reimburse **DAVIS** its fair market value.

.2 **Open Clinical Dialogue**. Nothing contained herein shall be construed to limit, prohibit or otherwise preclude **PROVIDER** from engaging in open clinical dialogue with any Member(s) or any designated representative of a Member(s), regarding: (a) any Medically Necessary or Medically Appropriate care, within the scope of **PROVIDER**'s practice, including, but not limited to, the discussion of all possible and/or applicable treatments, including information regarding the nature of treatment, risks of treatment, alternative treatments or the availability of alternative treatments or consultations and diagnostic tests, and regardless of benefit coverage limitations under the terms of the Plan(s)' documents or medical policy determinations and whether such treatments are Covered Services under the applicable **DAVIS** benefit program designs; or (b) the process **DAVIS** uses on its own behalf or on behalf of Plan(s) to deny payment for a vision care service; or (c) the decision by **DAVIS** on its own behalf or on behalf of Plan(s) to deny payment for a vision care service. In addition, **DAVIS** and **PROVIDER** are prohibited, throughout the Term(s) of this Agreement, from instituting gag clauses for their employees, contractors, subcontractors, or agents that would limit the ability of such person(s) to share information with Plan(s) and/or any regulatory agencies regarding the Medical Assistance MCO Program(s) and the Medicare Program(s).

.3 **Services**. **PROVIDER** shall provide all Medically Appropriate Covered Services to Members within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Member to ensure that it is cost-effective and Medically Appropriate. **PROVIDER** agrees and acknowledges that Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations and contractual obligations of the MCO. Throughout the entire term of this Agreement, **PROVIDER** shall maintain in good working condition, all necessary diagnostic equipment in order to perform all Covered Services as defined in this Agreement.

(a) To the extent required by law, **DAVIS** and/or Plan(s) will provide coverage of Urgently Needed Services to Members of a Medicare Advantage Program and where applicable, **DAVIS** shall reimburse **PROVIDER** for Urgently Needed Services rendered to Member(s) in order to attain Stabilized Condition and in accordance with applicable laws, administrative requirements, CMS regulations (42 CFR §422.113) and without regard to prior authorization for such services. **PROVIDER** also agrees to notify **DAVIS** of Urgently Needed Services and any necessary follow-up services rendered to any Member(s).

.4 **Scope of Practice**. The Parties hereto agree and acknowledge that nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** and/or Participating Providers from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current,

prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to the following:

.4.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

.4.2 Any information the Member needs in order to decide among all relevant treatment options;

.4.3 The risks, benefits, and consequences of treatment versus non-treatment;

.4.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions;

.4.5 Information or opinions regarding the terms, requirements or services of the health care benefit plan as they relate to the medical needs of the patient; and

.4.6 The termination of **PROVIDER**'s agreement with the MCO or the fact that the **PROVIDER** will otherwise no longer provide vision care services under the **DAVIS** Plan Contract(s) with MCO.

.5 **Treatment Records**. **PROVIDER** shall (1) establish and maintain a treatment record in form and content consistent with generally accepted standards and the requirements of **DAVIS** and Plans; and (2) promptly provide **DAVIS** and Plans with copies of treatment records when requested. Treatment records shall be kept confidential, but **DAVIS** and/or Plans shall have a mutual right to a Member's treatment records, as well as timely and appropriate communication of Member information, so that both the **PROVIDER** and Plans may perform their respective duties efficiently and effectively for the benefit of the Member.

IV
COMPENSATION

.1 **Compensation**. **DAVIS** shall pay **PROVIDER** the compensation amounts indicated on **Exhibit B**. Such compensation amounts are and shall be deemed to be full compensation for the Covered Services provided by **PROVIDER** to Members under applicable Plan(s) pursuant to this Agreement.

(a) In accordance with 42 CFR §422.504(g)(1)(iii), and to the extent applicable, **PROVIDER** agrees that dually eligible Subscribers of Medicare Advantage plans shall not be held liable for Medicare Parts A and B cost sharing when the appropriate State Medicaid agency is liable for the cost sharing. **PROVIDER** further agrees that upon receiving payment from **DAVIS** for a Medicare Advantage Subscriber, **PROVIDER** will either: (i) Accept the Medicare Advantage payment as payment in full; or (ii) Bill the appropriate State source.

.2 **Copayments, Coinsurances, Deductibles and Discount**. **PROVIDER** shall bill and collect all Copayments, Coinsurances and Deductibles from Member(s), which are specifically permitted and/or applicable to Member(s)' benefit program. **PROVIDER** shall bill and collect all charges from a Member for those Non-Covered Services provided to a Member. **PROVIDER** may only bill the Member when **DAVIS** has denied confirmation of eligibility for the service(s) and when the following conditions are met:

(a) The Member has been notified by the **PROVIDER** of the financial liability in advance of the service delivery;

(b) The notification by the **PROVIDER** is in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement which is signed by all patients is not sufficient for this purpose;

(c) The notification is dated and signed by the Member; and

(d) To the extent permitted by law, **PROVIDER** shall provide to Members either a courtesy discount of twenty percent (20%) off of **PROVIDER**'s usual and customary fees for the purchase of materials not covered by a Plan(s), and/or a discount of ten percent (10%) off of **PROVIDER**'s usual and customary fees for disposable contact lenses.

.3 **Financial Incentives**. **DAVIS** shall not provide **PROVIDER** with any financial incentive to withhold Covered Services, which are Medically Appropriate. Further, the Parties hereto agree to comply with and to be bound by, to the same extent as if the sections were restated in their entirety herein, the provisions of 42 CFR §417.479 and 42 CFR §434.70, as amended by the final rule effective January 1, 1997, and as promulgated by the CMS (formerly the Health Care Financing Administration, DHHS). In part, these sections govern physician incentive plans operated by Federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. As applicable and pursuant to 42 CFR §417.479 and 42 CFR §434.70, no specific payment will be made directly or indirectly, under Plans hereunder to a physician or physician group, as an inducement to reduce or limit medically necessary services furnished to a Member.

.4 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees that **DAVIS**' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit program, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation, remuneration or reimbursement from Members, persons acting on Member(s)' behalf, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit program. This hold harmless provision supersedes any oral or written agreement to the contrary, either now existing or hereinafter entered into between Member(s) or persons acting on Member(s)' behalf and **PROVIDER,** which relate to liability for payment; shall survive termination of this Agreement regardless of the reason for termination; shall be construed to be for the benefit of the Member(s); and shall not be changed without the approval of appropriate regulatory authorities.

.5 **Payment of Compensation**. Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable prompt pay statute, whichever is most restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment, Coinsurance and Deductible collected or to be collected from the Member. For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within one hundred and eighty (180) days following the provision of Covered Services, submit to **DAVIS** an invoice using the standard claim form required by NJAC 11:22-3.3. Failure of

PROVIDER to submit said invoice within one hundred and eighty (180) days of service delivery will, at **DAVIS**' option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including but not limited to Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

Davis shall not collect or attempt to collect funds for reimbursement on or before the 45th calendar day following the submission of a reimbursement request to the health care provider. If the health care provider should dispute the request for reimbursement and initiates an appeal on or before the 45th calendar day following submission of a reimbursement request to the health care provider, Davis shall not collect or attempt to collect the funds for reimbursement until after the health care provider's rights to an appeal have been exhausted.

(a) **PROVIDER** acknowledges and agrees no specific payment made by **DAVIS** or Plan(s) for services provided under this Agreement is an inducement to reduce or to limit services or products **PROVIDER** determines are Medically Necessary or Medically Appropriate within the scope of **PROVIDER**'s practice and in accordance with applicable laws and ethical standards.

.6 **Plan Hold Harmless.**. **PROVIDER** agrees that **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold harmless each Plan, the Federal government, and the CMS from any obligation to compensate **PROVIDER** for Covered Services.

.7 **Negative Balance**. When a Negative Balance occurs, **DAVIS** has the right to offset future compensation owed to **PROVIDER** or Participating Provider with the amount owed to **DAVIS** and the right to bill **PROVIDER** or Participating Provider for such Negative Balance(s). **DAVIS** will automatically, when possible, apply the Negative Balance to other outstanding payables on **PROVIDER**'s account. In some instances it may be necessary for **DAVIS** to send an invoice to **PROVIDER** for outstanding Negative Balance(s). The **PROVIDER** is responsible to remit payment to **DAVIS** upon receipt of invoice. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS** network in accordance with the suspension and termination provisions set forth in this Agreement. A Negative Balance shall not mean an Overpayment as defined herein.

.8 **Overpayment Recovery**. At **DAVIS**' sole discretion, **DAVIS** may bill **PROVIDER** or Participating Provider for an Overpayment. **PROVIDER** shall be responsible to remit payment on such an Overpayment invoice within forty-five (45) days from receipt of invoice. Should **DAVIS** not receive payment within the aforementioned timeframe, **DAVIS** will, when legally permissible, automatically apply the Overpayment to other outstanding payable on **PROVIDER**'s account. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS**' network in accordance with the suspension and termination provisions set forth in this Agreement. *However, this forty-five (45) day timeframe is stayed during any internal payment appeal process or state sponsored binding payment arbitration proceedings*. Notwithstanding the foregoing, should this provision conflict with any applicable rules and regulations, said rules and regulations shall govern. Notwithstanding the foregoing, **DAVIS**' Overpayment recovery efforts shall comply with any legislative or statutory timeframe(s) specified within the jurisdiction where services were provided.

V
OBLIGATIONS OF PROVIDER

.1 **Access to Records**. To the extent applicable and necessary for **DAVIS** and/or Plan(s) to meet their respective data reporting and submission obligations to CMS, or other appropriate governmental agency; **PROVIDER** shall provide to **DAVIS** and/or Plan(s) all data and information in **PROVIDER**'s possession. Such information shall include, but shall not be limited to the following:

.1.1 any data necessary to characterize the context and purposes of each encounter with a Member, including without limitation, appropriate diagnosis codes applicable to a Member; and

.1.2 any information necessary for Plan(s) to administer and evaluate program(s); and

.1.3 as requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and

.1.4 any information and data necessary for **DAVIS** and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies under 42 CFR 422.210; and

.1.5 any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 CFR §§ 422.516 and 422.310, and all other sections of 42 CFR § 422 relevant to reporting obligations; and

.1.6 **PROVIDER** shall certify (based upon best knowledge, information and belief) the accuracy, completeness and truthfulness of **PROVIDER**-generated encounter data that **DAVIS** and/or Plan(s) are obligated to submit to CMS; and

.1.7 **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission, or the submission by Participating Provider(s) of inaccurate or incomplete books and records

.2 **Coordination Of Benefits**. **PROVIDER** shall cooperate with **DAVIS** with respect to Coordination of Benefits (COB) and will bill and collect from other payers such charges for which the other payer(s) is responsible. **PROVIDER** shall report to **DAVIS**, all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this paragraph when billing is submitted for payment.

.3 **Compliance with Laws, Regulations and Ethical Standards**. During the term of this Agreement, **PROVIDER** and **DAVIS** shall at all times comply with all applicable Federal, state or municipal statutes or ordinances, including but not limited to all applicable rules and regulations and all applicable federal and State tax laws, all applicable federal and state criminal laws, as well as the customary ethical standards of the appropriate professional society from which **PROVIDER** seeks advice and guidance or to which **PROVIDER** is subject to licensing and control. **PROVIDER** shall comply with all applicable laws and administrative requirements, including but not limited to Medicaid laws and regulations, Medicare laws, CMS instructions and policies, **DAVIS**' and Plan(s)' credentialing policies, processes, utilization review, quality

improvement, medical management, peer review, complaint and grievance resolution programs, systems and procedures. If at any time during the term of this Agreement, **PROVIDER'**s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall immediately notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as provided herein. **PROVIDER** agrees to cooperate with **DAVIS** in order that **DAVIS** may comply with any requirements imposed by state and Federal law, as amended, and all regulations issued pursuant thereto.

.4 **Compliance with DAVIS and Plan Rules**. **PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS** including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes that from time to time **DAVIS** may amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **DAVIS** shall maintain the Provider Manual to comply with applicable laws and regulations. However, in instances when **DAVIS**' rules are not in compliance, applicable State and federal laws and regulations shall take precedence and govern. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

(a) To the extent that a requirement of the Medicare, Medicare Advantage, or Medicaid Program is found in a policy, manual, or other procedural guide of **DAVIS,** Plan(s), NJDHS or other government agency, and is not otherwise specified in this Agreement, **PROVIDER** will comply and agrees to require its employees, agents, subcontractors and independent contractors to comply with such policies, manuals, and procedures with regard to the provision of Covered Services to Members of such Programs.

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements, including but not limited to, Medicare, Medicare Advantage (and any successor program thereto), Medicaid laws and regulations, CMS instructions and policies, MAP/DMAHS regulations, audits and inspections by CMS and/or its designees, and shall cooperate, assist, and provide information as requested, and agrees to comply with **DAVIS**' and Plan(s)' policies regarding credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, peer review, complaint, grievance resolution and appeals processes, comparative performance analysis, and enforcement monitoring by appropriate government agencies, and activities necessary for the external accreditation of **DAVIS** and/or Plan(s) by the National Committee for Quality Assurance or any other similar organization selected by **DAVIS** and/or Plan(s). Further, **PROVIDER** acknowledges and agrees that **DAVIS** is *accountable and responsible to the NJDHS and DMAHS (and any successor agency), and the NJDHS and DMAHS shall, on an ongoing basis, monitor performance under this Agreement, to ensure that performance of the Parties is consistent with the Plan Contract between **DAVIS** and the MCO and consistent with the contract between the NJDHS and the MCO*.

(c) In relation to the provision of Covered Services to Medicare and Medicare Advantage Members and Plan(s) hereunder, **PROVIDER** acknowledges and agrees to the following: **PROVIDER** and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet and comply with all applicable Medicare and Medicare Advantage credentialing and re-credentialing requirements and processes and agree to all of the following: **DAVIS** and *Plans are ultimately accountable and responsible to CMS for all services delivered and performed by **PROVIDER** hereunder*; all services delivered and performed by **PROVIDER** hereunder must be delivered and performed in accordance with the requirements of Plan agreements with CMS and with Medicare laws and regulations; such services shall, on an ongoing basis be

monitored and audited by the Plan(s) and/or CMS and their respective delegates; the Plan(s) and/or CMS retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s); the Managed Care Organization (MCO) is accountable to CMS for any functions and responsibilities described in the Medicare regulations pursuant to 42 CFR §422.504; and **PROVIDER** is required to comply with MCO's policies and procedures.

.5 **Confidentiality of Member Information**. **PROVIDER** agrees to abide by all Federal and State laws regarding confidentiality, including unauthorized uses of or disclosures of patient information and personal health information.

(a) **PROVIDER** shall safeguard all information about Members according to applicable State and Federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided due to, or is obtained by or through, **PROVIDER**'s performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and Federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of **PROVIDER**'s obligations and the securement of **PROVIDER**'s rights under this Agreement.

(b) Neither **DAVIS** nor **PROVIDER** shall share confidential information with any Member(s)' employer, absent the Member(s)' written consent for such disclosure. **PROVIDER** agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange and to the storage of Protected Health Information ("PHI"), as defined by Title 45 CFR 160.103, in whatever form or medium **PROVIDER** may obtain and maintain such PHI. **PROVIDER** shall cooperate with **DAVIS** in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

(c) **PROVIDER** and **DAVIS** acknowledge and agree the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. **PROVIDER** and **DAVIS** agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. **PROVIDER** and **DAVIS** further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, **PROVIDER** and **DAVIS** shall conduct good faith negotiations to amend this Agreement.

.6 **Consent to Release PROVIDER Information**. Upon request by **DAVIS**, **PROVIDER** shall provide **DAVIS** with authorizations, consents or releases, in connection with any inquiry by **DAVIS** of any hospital, educational institution, governmental or private agency or association (including without limitation the National Practitioner Data Bank) or any other entity or individual relative to **PROVIDER'**s professional qualifications, **PROVIDER'**s mental or physical fitness, or the quality of care rendered by **PROVIDER**.

.7 **Cooperation with Plan Medical Directors**. **PROVIDER** understands contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and in certain instances Plans will have the right to oversee and review the quality of care administered to Members. **PROVIDER** agrees to cooperate with Plan(s)' medical directors in the medical director's review of the quality of care administered to Members.

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees that he/she/it shall be duly licensed and certified under applicable State and federal statutes and regulations to provide the vision care services that are the subject of this Agreement, shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE), and shall participate in such programs of continuing education required by State regulatory and licensing authorities. Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform credentialing and re-credentialing of **PROVIDER** as required by **DAVIS**, Plan(s) or the CMS. Such documentation shall include, but shall not be limited to proof of: National Provider Identifier number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees that **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS**' sole option, the right to deny any professional participation in the Network or the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees that at all times, and to the extent of his/her/its knowledge, **PROVIDER shall immediately notify DAVIS in writing** in the event that **PROVIDER** suffers a suspension or termination of license or of professional liability insurance coverage. **PROVIDER** shall: (a) devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s) (b) ensure vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices and (c) abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, DHHS, MAP, DOH, LDSS or any appropriate external review organization or regulatory agency ("Oversight Entities") **PROVIDER** shall make available for audit, all administrative, financial, medical, and all other records that relate to the delivery of items or services under this Agreement. **PROVIDER** shall provide all such access to the aforementioned records at no cost to **DAVIS** and/or to the requesting Oversight Entity, and in the form and format requested. Further, the **PROVIDER** shall allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hours access. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity.

.10 **Hours, Availability of Services, and Equality of Access**. Pursuant to and in accordance with 42 CFR 438.206(c)(1), **PROVIDER** and Participating Provider(s) agree to be available to provide Covered Services for Medically Appropriate care, taking into account the urgency of the need for services and when necessary and appropriate, to provide Covered Services for Medically Appropriate emergency care. **PROVIDER** and Participating Provider(s) shall ensure that Members will have access to either an answering service, a pager number, and/or an answering machine, twenty-four (24) hours per day, seven (7) days per week, in order that Members may ascertain **PROVIDER**'s office hours, have an opportunity to leave a message for the **PROVIDER** and/or Participating Provider(s) regarding a non-emergent concern and to receive pre-recorded instructions with respect to the handling of an emergency.

(a) **PROVIDER** agrees that **PROVIDER** is subject to regular monitoring of his/her/its compliance with the appointment wait time (timely access) standards of 42 CFR 438.206(c)(1). As such **PROVIDER** agrees and understands that corrective action shall be implemented should **PROVIDER** and/or Participating Provider(s) fail to comply with timely access standards and that Plan(s) have the right to approve **DAVIS**' scheduling and administration standards.

(b) **PROVIDER** agrees to provide **DAVIS** with ninety (90) calendar days notice if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move office location, (c) change place of employment (d) change employer, or (e) reduce capacity at an office location. The ninety (90) calendar day notice shall, at a minimum, include the effective date of the change, the new tax identification number and a copy of the W-9 as applicable, the name of the new practice, the name of the contact person, the address, telephone and fax numbers and other such information as may materially differ from the most recently completed credentialing application submitted by **PROVIDER** and/or Participating Provider to **DAVIS**. Under no circumstance shall provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER** and **DAVIS**.

(c) Unless a higher standard is required by the MCO's contract with the State, **PROVIDER** shall provide the same level of medical care and health service to DMAHS enrollees as **PROVIDER** does to enrollees of private or group contracts.

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, the Plan(s) and the State and their respective agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which, in any manner may accrue against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees through **PROVIDER**'s intentional conduct, negligent acts or omissions, or the intentional conduct, negligent acts or omissions of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

(a) To the extent applicable, **PROVIDER** agrees to indemnify and hold harmless the State and CMS from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the State or CMS as a result of failure of **PROVIDER**, or **PROVIDER**'s agents, employees, subcontractors or independent contractors to comply with the Non-Discrimination provisions contained in Section V.13 herein.

.12 **Malpractice Insurance**. **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire term of this Agreement, maintain a policy (or policies) of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants, employees, affiliates, independent contractors and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall, following the effective termination date of the foregoing policy, maintain "tail coverage" with the same liability limits. *The foregoing policies shall not limit **PROVIDER**'s liability to indemnify the State or enrollees of a DMAHS program or successor agency or program thereto*.

(a) **PROVIDER** shall cause his/her/its employed, affiliated, independent or subcontracted Participating Provider(s) to substantially comply with Section V.12 above, and throughout the term of this Agreement and upon **DAVIS**' request, **PROVIDER** shall provide evidence of such compliance to **DAVIS**.

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** shall comply with the "General Prohibitions Against Discrimination," 28 CFR §35.130 and similar regulations or guidelines that apply to the agencies with which Plan(s) contract. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the regulations implementing the Americans with Disabilities Act ("ADA"), 28 CFR §35.101 et seq., **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status, (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence), claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and in conformity with all laws applicable to the receipt of Federal funds including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised DHHS LEP Guidance"); and **PROVIDER** agrees to promote, observe and protect the rights of Members.

Pursuant to and in accordance with 42 CFR §438.206(c)(2), **PROVIDER** and Participating Provider(s) agree that Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and **PROVIDER** shall maintain written procedures as to interpretation and translation services for Members requiring such services. During the term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee's or applicant's hire, tenure, terms, conditions, or privileges of employment due to such individual's race, color, religion, gender, disability, marital status or national origin.

.14 **Notice of Non-Compliance and Malpractice Actions**. **PROVIDER** shall notify **DAVIS** immediately, in writing, should **PROVIDER** be in violation of any portion of this Section V. Additionally, **PROVIDER** shall advise **DAVIS** of each malpractice claim filed against **PROVIDER** and each settlement or other disposition of a malpractice claim entered into by **PROVIDER** within fifteen (15) days following said filing, settlement or other disposition.

.15 **Participation Criteria**. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage Program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of federal funds; federal laws designed to prevent fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b)), 42 CFR §§422.504(h)(l), 423.505(h)(l)) and the HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a Federal health care program as described in Sections 1128B(b) and 1128B(f) of the Social Security Act, and that all employees,

affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier number, as applicable.

(a) **PROVIDER** understands and agrees that meeting the Participation Criteria is a condition precedent to **PROVIDER**'s participation, and a condition precedent to the participation by **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractor(s) hereunder and, is an ongoing condition to the provision of Covered Services hereunder by both the **PROVIDER** as well as a condition precedent to the reimbursement by **DAVIS** for such Covered Services rendered by **PROVIDER**. Upon **PROVIDER**'s meeting all of the Participation Criteria set forth in this Agreement **PROVIDER** shall participate as a Participating Provider for Plan(s)/Product programs covered under this Agreement.

(b) **PROVIDER** may not employ, contract with, or subcontract with an individual, or with an entity that employs, contracts with, or subcontracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a Federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. **PROVIDER** acknowledges that this Agreement shall automatically be terminated if **PROVIDER**, any practitioner, or any person with an ownership or control interest in **PROVIDER**, is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in any other Federal health care program. Any payments received by **PROVIDER** hereunder on or after the date of such exclusion shall constitute overpayments.

.16 **PROVIDER Directory**. **PROVIDER** understands and agrees **DAVIS** and Plan(s) reserve the right to use **PROVIDER'**s name, address, telephone number, type of practice, and willingness to accept new patients for the purposes printing and distributing provider directories to Member(s). Such directories are intended for and may be inspected and used by prospective patients and others.

.17 **Record Requirements and Retention**. **PROVIDER** shall maintain adequate, accurate, and legible medical, financial and administrative records related to Covered Services rendered by **PROVIDER**. Such records shall be written in English and in accordance with Federal and State law. **PROVIDER** shall have written policies and procedures for storing all records.

(a) Pursuant to 42 CFR §§422.504 and 423.505 and in accordance with CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to safeguard and maintain, in an accurate and timely manner, contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage Program hereunder, and agrees to provide such information to **DAVIS,** contracting Plans, to applicable state and federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a term of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. In the case of a minor Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. **PROVIDER** shall make available premises, physical facilities, equipment, records and any relevant information the CMS may require which pertains to Covered Services provided to Medicare Advantage Program Members. **PROVIDER** and Participating Providers shall cooperate with any

such review or audit by assisting in the identification and collection of any books, records, data, or clinical records, and shall make appropriate practitioner(s), employees, and involved parties available for interviews, as requested. Such records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. **PROVIDER** and Participating Providers shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission, or the submission by Participating Providers of inaccurate or incomplete books and records.

(b) All hard copy or electronic records, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, which are originated or are prepared in connection with and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicaid or Medical Assistance program hereunder, will be retained and safeguarded by the **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors, in accordance with applicable sections of the Federal and State regulations. Records stored electronically must be produced at the **PROVIDER**'s expense, upon request, in the format specified by State or Federal authorities. All such records must be maintained for a minimum of ten (10) years from the termination date of this Agreement or, in the event that the **PROVIDER** has been notified that State or Federal authorities have commenced an audit or investigation of this Agreement, or of the provision of services by the **PROVIDER**, or by **PROVIDER**'s subcontractor or independent contractor, all records must be maintained until such time as the matter under audit or investigation has been resolved, whichever is later.

(c) **PROVIDER**'s obligations contained in Section V.17 herein shall survive termination of this Agreement.

.18 **Subcontractors**. **PROVIDER** agrees that in no event shall **PROVIDER** or Participating Provider(s) enter into subcontracts or lease arrangements with any person or entity outside of the jurisdiction of the United States ("offshore subcontractor") for the purpose of rendering vision care services to Medicare/Medicare Advantage Members covered under this Agreement, any addenda, or attachment hereto, without the prior, written approval of **DAVIS**, the Medicare Advantage Plan, and the CMS. Failure to obtain prior approval may result, at the discretion of **DAVIS** or Plan, in the immediate termination of **PROVIDER** and/or Participating Provider(s). **PROVIDER** agrees that if **PROVIDER** enters into any permitted subcontracts or lease arrangements to render any health/vision care services that are permitted under the terms of this Agreement, **PROVIDER**'s subcontracts or lease arrangements shall include the following:

(a) an agreement by the subcontractor or leaseholder to comply with all of **PROVIDER**'s obligations in this Agreement; and

(b) a prompt payment provision as negotiated by **PROVIDER** and the subcontractor or leaseholder; and

(c) a provision setting forth the terms of payment, any incentive arrangements, and any additional payment arrangements; and

(d) a provision setting forth the term of the subcontract or lease (preferably a minimum of one [1] year); and

(e) the dated signature of all parties to the subcontract.

.19 **Training Regarding the Plan Contracts**. **PROVIDER** agrees to train Participating Providers and staff at all duly credentialed **PROVIDER** offices regarding the fees and benefit or plan designs for Plan Contracts.

.20 **Verification of Eligibility**. **DAVIS** shall make available to **PROVIDER** a system for determining eligibility of Members seeking services under benefit programs hereunder. **PROVIDER** agrees to comply with eligibility system requirements and to obtain a valid confirmation of eligibility number prior to rendering services to any Member. To verify eligibility of Member(s) **PROVIDER** shall call the appropriate toll-free (800/888) number supplied by **DAVIS,** or access the **DAVIS** website (www.davisvision.com), or receive from Member(s) a valid pre-certified voucher. In order for **PROVIDER** to receive reimbursement for services rendered to a Member, services must be rendered within the timeframe communicated to **PROVIDER** upon receipt of confirmation of eligibility number, or upon **PROVIDER**'s receipt of an extension of the original confirmation of eligibility number. Neither **DAVIS** nor Plan(s) shall have any obligation to reimburse **PROVIDER** for any services rendered without a valid confirmation of eligibility number. However, if **DAVIS** provides erroneous eligibility information to **PROVIDER** and if benefits under the program(s) are provided to a Member, **DAVIS** shall reimburse **PROVIDER** for any benefits provided to such Member.

VI
TERM OF THE AGREEMENT

.1 **Term**. This Agreement shall become effective on the Effective Date appearing on the signature page herein, and shall thereafter be effective for an initial term of twelve (12) months.

.2 **Renewals**. Unless this Agreement is terminated in accordance with the termination provisions herein, this Agreement shall automatically renew for up to, but not more than, three (3) successive twelve (12) month terms on the same terms and conditions contained herein.

VII
TERMINATION OF THE AGREEMENT AND SUSPENSION OF PROVIDER

.1 **Termination Without Cause**. After the initial twelve (12) month term has ended, this Agreement may be terminated by either party without cause, upon ninety (90) days prior, written notice. If **DAVIS** elects to terminate this Agreement other than at the end of a term hereof, **PROVIDER** has a right to request a hearing in writing within ten (10) days of receipt of written notice of termination before a panel appointed by **DAVIS**. No such notice or hearing will be given when termination is based on non-renewal of the Agreement, or for reasons as set forth in Section VII.2 hereof.

Such hearing will be held within thirty (30) days of the receipt of the written request or within such timeframe as is required by applicable law or regulation. **PROVIDER**'s participation in the aforementioned hearing process shall not be deemed to be an abrogation of **PROVIDER**'s legal rights. Upon **PROVIDER**'s written request, **DAVIS** shall set forth in writing the reasons for termination within fifteen (15) days of receipt of the request, unless the reason for termination has not otherwise been stated in the written notice of termination to **PROVIDER**. **PROVIDER** may not be terminated or penalized solely because of filing a complaint or an appeal.

.2 **Termination With Cause**. **DAVIS** may terminate this Agreement immediately for cause. "Cause" shall mean:

(a) a suspension, revocation or conditioning of **PROVIDER'**s license to operate or to practice his/her/its profession;

(b) a suspension, or a history of suspension, of **PROVIDER** from Medicare or Medicaid;

(c) the bankruptcy of **PROVIDER**;

(d) conduct by **PROVIDER** which endangers the health, safety or welfare of Members;

(e) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement to include but not be limited to a determination of fraud, breach of contract by **PROVIDER** which represents an imminent danger to a patient or the public health, safety, and welfare in the opinion of **DAVIS**' medical director or its equivalent.

Provided, however, that **PROVIDER** shall not be penalized nor shall this Agreement be terminated because **PROVIDER** acts as an advocate for a Member in seeking appropriate Covered Services, or files a complaint or appeal.

.3 **Termination Related to Medicare Advantage**. At the sole discretion of the CMS, Plan(s) and/or **DAVIS**, this Agreement may be immediately terminated, as it relates to **PROVIDER**'s provision of Covered Services to Medicare Advantage Members hereunder for the following reasons:

.3.1 The termination is for breach of contract, or there is a determination of fraud; or

.3.2 In the opinion of **DAVIS'** medical director or its equivalent, the health care professional represents an imminent danger to an individual patient or the public health, safety or welfare; or

.3.3 A decision by the CMS, Plan(s), and/or **DAVIS** that: (i) **PROVIDER** has not performed satisfactorily, or (ii) **PROVIDER**'s reporting and disclosure obligations under this Agreement are not fully met or timely met; or

.3.4 The failure of **PROVIDER** to comply with the equal access and non-discrimination requirements set forth in this Agreement.

.4 **Responsibility for Members at Termination**. In the event this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall continue to provide Covered Services to a Member who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement for a transitional period of one hundred and twenty (120) days from the date the Member is notified of the termination or pending termination, or until the Covered Services being rendered to the Member by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a Member), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date of this Agreement) at the compensation rates for Covered Services attached to this Agreement.

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents and/or accrediting standards. **PROVIDER** shall continue to provide Covered

Services to such Member(s) and the Parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

(b) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement, **PROVIDER** acknowledges and agrees that **PROVIDER**'s obligations as set forth in this Section VII survive such termination.

.5 **PROVIDER Rights Upon Termination**. Upon **PROVIDER**'s request, **DAVIS** shall provide in writing the reason(s) for the termination within fifteen (15) days of the request, if such reason is not otherwise stated in the written notice of termination. Except as otherwise required by law, **PROVIDER** agrees that, subject to the appeal process set forth in the Provider Manual, any **DAVIS** decision to terminate this Agreement pursuant to this Section VII shall be final. The panel shall render a decision on the matter within thirty (30) days of the close of the hearing.

(a) **PROVIDER** acknowledges that Plan(s), the NJDHS and the DMAHS, have the authority to determine whether a **PROVIDER** shall be suspended or terminated from participation in a particular Plan without termination of this Agreement.

(b) **PROVIDER** understands and agrees that the State may order the termination of this Agreement if it is determined that the **PROVIDER**:

(i) Takes any action or fails to prevent an action that threatens the health, safety, or welfare of any enrollee, including significant marketing abuses;

(ii) Takes any action that threatens the fiscal integrity of the Medicaid program;

(iii) Has his/her/its certification suspended or revoked by DOBI, DHSS, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

(iv) Becomes insolvent or falls below minimum net worth requirements;

(v) Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

(vi) Materially breaches this Agreement;

(vii) Violates state or federal law.

(c) However, Plan(s), the NJDHS and the DMAHS shall not have the authority to terminate this Agreement for any of the following reasons:

(i) Because **PROVIDER** expresses disagreement with a decision to deny or limit benefits to a Member; or assists the Member to seek reconsideration of **DAVIS**' decision; or discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether such are Covered Services or not; or discusses **DAVIS**' policy provisions; or discusses **PROVIDER**'s personal recommendation regarding selection of a health plan based on the **PROVIDER**'s personal knowledge of Member's health needs.

(ii) Because **PROVIDER** engages in medical communications with a patient, either explicit or implied, about medically necessary treatment options; or practices his/her/its profession in providing the most appropriate treatment required by his/her/its patients and provides informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

(d) Further, Plan(s), the NJDHS and the DMAHS shall not have the authority to terminate **PROVIDER**: for (a) maintaining a practice that includes a substantial number of patients with expensive health conditions; (b) objecting to or refusing to provide a Covered Service on moral or religious grounds; (c) advocating for Medically Appropriate care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable standard of care; (d) filing a grievance on behalf of and with the written consent of a Member or helping a Member to file a grievance; and (e) protesting a Plan decision, policy or practice that **PROVIDER** reasonably believes interferes with the provision of Medically Appropriate care.

.6 **Suspension of Provider**. **DAVIS** may immediately suspend continued participation of **PROVIDER** for cause. **PROVIDER** shall have ninety (90) days from the date of suspension to cure the reason(s) for suspension. Should **PROVIDER** not cure, the suspension will revert to a termination effective on the ninety-first (91st) day from the date of suspension. "Cause", for the purposes of this section shall mean:

(a) a failure of **PROVIDER** to maintain malpractice insurance coverage as provided in Section V.12 hereof; and/or

(b) a failure by **PROVIDER** to comply with applicable law, rules, regulations, and ethical standards as provided in Section V.3 hereof; and/or

(c) a failure by **PROVIDER** to comply with **DAVIS** rules and regulations as required in Section V.4 hereof; and/or

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section IX.3 hereof; and/or

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section X.9 hereof.

.7 **Return of Materials, Payments of Amounts Due and Settlement of Claims**. On termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including, but not limited to, frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** retains the right to reclaim the frame samples, with reasonable notice, at any time during the term of this Agreement. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims. **DAVIS** may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by **PROVIDER** after the 45th calendar day following the submission of the reimbursement request to **PROVIDER** or after **PROVIDER**'s rights to appeal set forth in this agreement have been exhausted, if **DAVIS** submits an explanation in writing to **PROVIDER** in sufficient detail so that **PROVIDER** can reconcile each covered person's ***bill***. If **DAVIS** determines that the overpayment to **PROVIDER** is a result of fraud committed by **PROVIDER** and **DAVIS** has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, **DAVIS** may collect an overpayment by assessing it against payment of any future claim submitted by **PROVIDER**.

.8 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate the subject Agreement pursuant to Section VII.1 above, or should **PROVIDER** move office location, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Members under

this Agreement, it agrees to notify affected Members a minimum of thirty (30) days prior to the effective date of such action or termination.

VIII
DOCUMENTATION AND AMENDMENT

.1 **Amendment**. This Agreement may be amended by **DAVIS or PROVIDER** on thirty (30) days advance written notice to the other party. If either party does not agree with the amendment, the objecting party may so indicate, in writing, within ten (10) business days of receipt of the amendment. The party offering said amendment shall have the right to review such notice and may offer an alternative. Any amendment will not be effective with respect to a Provider who terminates within10 days of receiving the amendment.

.2 **Documentation**. **DAVIS** shall provide **PROVIDER** with a copy of any document required by a contracting Plan which has been approved by **DAVIS** and which requires **PROVIDER'**s signature. If **PROVIDER** does not execute and return said document within fifteen (15) calendar days of document receipt, **DAVIS** may execute said document as agent of **PROVIDER** and said document shall be deemed to be executed by **PROVIDER**.

.3 **Modification of Law, Rules, Regulations**. Notwithstanding anything herein to the contrary, should any pertinent Federal or State law(s), regulation(s), rule(s), directive(s), and/or policies be amended, repealed, or legislated, **DAVIS** shall reserve the right to amend this Agreement without prior notice to or consent from **PROVIDER**. Such amended laws and implementing regulations shall apply as of their respective effective dates and this Agreement shall automatically amend to conform to such changes without necessitatingan execution of written amendments. Nonetheless, **DAVIS** shall employ its best efforts to notify **PROVIDER** of such occurrences where necessary within a practicable timeframe.

.4 **Upon Request of CMS**. Upon request of the CMS, this Agreement and any addenda may be amended to exclude any Medicare Advantage Program Plan or State-licensed entity specified by CMS. When such a request is made, a separate contract for any such excluded Plan or entity will be deemed to be in place.

IX
UTILIZATION REVIEW, QUALITY MANAGEMENT, QUALITY IMPROVEMENT AND GRIEVANCE PROCEDURES

.1 **Access to Records**. **PROVIDER** shall make all records related to **PROVIDER**'s activities undertaken pursuant to this Agreement available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

(a) Upon termination of this Agreement for any reason, **PROVIDER** shall, in a useable form, make available to any Oversight Entities, all records, whether dental/medical or financial, related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement at no cost to the requesting entity.

.2 **Consultation with Provider**. **DAVIS** agrees to consult with **PROVIDER** regarding **DAVIS**' medical policies, quality improvement program and medical management programs and ensure

that practice guidelines and utilization management guidelines:

(a) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

(b) consider the needs of the enrolled population;

(c) are developed in consultation with Participating Providers who are physicians; and are reviewed and updated periodically; and

(d) are communicated to Participating Providers of the Plan(s) and as appropriate to the Members.

With respect to utilization management, Member education, coverage of health care services, and other areas in which guidelines apply, **DAVIS** shall ensure decisions are consistent with applicable guidelines.

.3 **Establishment of UR/QM Programs**. Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS** and will be in addition to any utilization review and quality management programs required by a Plan. **PROVIDER** shall comply with and, subject to **PROVIDER'**s rights of appeal, shall be bound by all such utilization review and quality management programs. If requested, **PROVIDER** may serve on the utilization review and/or quality management committee of such programs in accordance with the procedures established by **DAVIS** and Plans. Failure to comply with the requirements of this paragraph may be deemed by **DAVIS** to be a material breach of this Agreement and may, at **DAVIS'** option, be grounds for immediate termination by **DAVIS** of this Agreement. **PROVIDER** agrees that decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment hereunder for those Covered Services provided to a Member which are determined to not be Medically Appropriate or of poor quality or to deny up to fifty percent (50%) of payment for services for which **PROVIDER** failed to receive a confirmation of eligibility prior to rendering services.

.4 **Grievance Procedures**. The grievance procedure, as set forth herein as **Exhibit A** shall be followed for the processing of any **PROVIDER** complaint regarding Covered Services. From time to time, should the grievance procedure require modification whether by **DAVIS** or Plan(s), it shall be modified in accordance with applicable regulations and and subject to applicable provisions set forth herein.

.5 **Member Grievance Resolution**. **PROVIDER** shall cooperate with **DAVIS** in the investigation of any complaint regarding the materials or services provided by **PROVIDER**. The cost of providing replacement services or materials to satisfy any reasonable Member complaint shall be borne by **PROVIDER** if the grievance is determined to be the result of improper execution of services on the part of **PROVIDER** or if materials are not functioning in the manner prescribed by the Participating Provider(s) and/or the professional staff.

.6 **Provider Cooperation with External Review**. **PROVIDER** shall cooperate and provide Plans, **DAVIS**, government agencies and any external review organizations ("Oversight Entities") with access to each Member's vision records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member(s)' complaints or grievances or as otherwise is necessary or appropriate.

.7 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review; care coordination activities including, but not limited to, medical record reviews, HEDIS reporting, disease management programs, case management, clinical practice guidelines, and other quality measurements to improve Members' care. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and Medical Assistance Program Members. **PROVIDER** shall implement a continuous quality improvement action plan if areas for improvement are identified. Nothing in this paragraph should be construed as an abrogation of **PROVIDER**'s right to appeal **DAVIS**' decisions as set forth in **Exhibit A** of this Agreement.

X
GENERAL PROVISIONS

.1 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the Parties to it and to their respective heirs, legal representatives, successors, and permitted assigns. Notwithstanding the foregoing, neither party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS**' assets.

.2 **Confidentiality of Terms/Conditions**. The terms of this Agreement and in particular the provisions regarding compensation are proprietary and confidential and shall not be disclosed except as and only to the extent necessary to the performance of this Agreement or as required by law.

.3 **Conformity of Law**. Any provision of this Agreement which conflicts with state or federal law is hereby amended to conform to the requirements of such law.

.4 **Entire Agreement of the Parties**. This Agreement supersedes any and all agreements, either written or oral, between the Parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the Parties with respect to the rendering of Covered Services. Each party to this Agreement acknowledges that no representation(s,) inducement(s), promise(s), or agreement(s), oral or otherwise, have been made by either party, or anyone acting on behalf of either party, which is not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing signed by the party to be charged.

.5 **Governing Law**. This Agreement is governed by New Jersey law

.6 **Headings**. The subject headings of the sections and sub-sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of the provisions of this Agreement.

.7 **Independent Contractor**. At all times relevant to and pursuant to the terms and

conditions of this Agreement, **PROVIDER** is and shall be construed to be an independent contractor practicing **PROVIDER'**s profession and shall not be deemed to be or construed to be an agent, servant or employee of **DAVIS**.

.8 **Non-Solicitation of Members**. During the term of this Agreement and for a period of two (2) years after the effective date of termination of this Agreement, **PROVIDER** shall not directly or indirectly engage in the practice of solicitation of Members, Plans or any employer of said Members without **DAVIS'** prior written consent. For purposes of this Agreement, a solicitation shall mean any action by **PROVIDER** which **DAVIS** may reasonably interpret to be designed to persuade or encourage (i) a Member or Plan to discontinue his/her/its relationship with **DAVIS** or (ii) a Member or an employer of any Member to disenroll from a Plan contracting with **DAVIS**. A breach of this paragraph shall be grounds for immediate termination of this Agreement.

.9 **Notices**. Should either party be required or permitted to give notice to the other party hereunder, such notice shall be given in writing and shall be delivered personally or by first class mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Notices shall be delivered or mailed to the addresses appearing herein. Either party may change its address by providing written notice in accordance with this paragraph.

.10 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Member, including but not limited to, the Member's name, address and telephone number ("Member Information"), and all other "**DAVIS** trade secret information". For purposes of this Agreement, "**DAVIS** trade secret information" shall include but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS**. **PROVIDER** shall not disclose or use any Member Information or **DAVIS** trade secret information for his/her/its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Member if Medically Appropriate for the proper treatment of such Member or upon the express prior written permission of **DAVIS**, the Plan in which the Member is enrolled, and the Member.

.11 **Severability**. Should any provision of this Agreement be held to be invalid, void or unenforceable by a court of competent jurisdiction or by applicable state or Federal law and their implementing regulations, the remaining provisions of this Agreement will nevertheless continue in full force and effect.

.12 **Third Party Beneficiaries**.

(a) Plans. Plans are intended to be third party beneficiaries of this Agreement. Plans shall be deemed, by virtue of this Agreement to have privity of contract with **PROVIDER** and may enforce any of the terms hereof.

(b) Other Persons. Other than the Plans and the Parties hereto and their respective successors or assigns, nothing in this Agreement whether express or implied, or by reason of any term, covenant, or condition hereof, is intended to or shall be construed to confer upon any person, firm, or

corporation, any remedy or any claim as third party beneficiaries or otherwise; and all of the terms, covenants, and conditions hereof shall be for the sole and exclusive benefit of the Parties hereto and their successors and assigns.

.13 **Use of Name**. **DAVIS** reserves the right to the control and to the use of its name(s), and all copyright(s), symbol(s), logo(s), trademark(s), or service mark(s) presently existing or later established. **PROVIDER** shall not use **DAVIS'** or any Plan's name(s), trade name(s), trademark(s), symbol(s), logo(s), or service mark(s) without the prior, written authorization of **DAVIS** or such Plan.

.14 **Waiver**. The waiver of any provision or the waiver of any breach of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver shall not operate as or be deemed to be a waiver of any prior or any future breach of such provision or of any other provision contained herein.

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IN WITNESS WHEREOF, the Parties set their hand hereto and this Agreement is effective as of the Effective Date written below.

PROVIDER:

Signature: _____
Print Name: _____
Print Title: _____
Print Date: _____
Print All Addresses Below [complete addresses for all practice locations]:
Address 1: _____
Address 2: _____
Address 3: _____
Address 4: _____
Address 5: _____
(PROVIDER MUST sign and complete all spaces below PROVIDER signature.)

***** Submission of a completed credentialing application and/or the Participating Provider Agreement for the State of New Jersey does not constitute acceptance as a Davis Vision Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by Davis Vision of the practitioner's fully and properly completed credentialing application and on the execution by the practitioner of the Participating Provider Agreement for the State of New Jersey, and on the receipt by practitioner of the forms, manual and samples required for network participation. Davis Vision reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a Provider's acceptance by Davis Vision, should additional licensed and credentialed practitioner(s) join Provider's practice and provide Covered Services to the Members(s) of Plans under Plan Contract with Davis Vision, such additional licensed and credentialed practitioner(s) shall be subject to and bound by each and every term and condition set forth in this Agreement, to the same extent as the original signatories to the Agreement.

DAVIS VISION, INC.:

Signature: _____
Print Name: Nate Kenyon
Print Title: VP, Network Management
Print Date: _____

Effective Date: _____
[For DAVIS use ONLY]

Notes: _____
[**For DAVIS use ONLY**]

EXHIBIT A

GRIEVANCE PROCEDURE

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PROVIDER *is not required to obtain consent of the covered person in order for the appeal to be reviewed pursuant to the following grievance process .However, in the event that an appeal is instituted by* ***PROVIDER*** *on behalf of a covered person without the covered person's consent, such appeals will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained. Nothing in this Agreement limits the right of the* ***PROVIDER*** *to submit an appeal on behalf of the covered person to situations in which the covered person may be financially liable for the costs of the health care services*

PROVIDER APPEALS PROCEDURE – PAYMENT OF CLAIMS

To appeal a claims decision, a practitioner must notify Davis Vision in writing of their intention to seek modification or reversal. The practitioner must send a written request for an internal review to modify or reverse a decision to terminate to the address listed on the notice of action. The request must be sent by certified mail, return receipt requested and postmarked no later than 90 days following receipt of the notice of action by the practitioner. There is no fee associated with a request for an internal review.

Davis Vision shall conduct an internal review by employees of Davis Vision who are not responsible for claims payment on a day-to-day basis. Notice of the decision of this internal review will be communicated in writing to the practitioner with ten (10) business days of the receipt of the appeal.

Such written decision shall include, but not be limited to the following information: (i) the names, titles, and qualifying credentials of the persons participating in the internal review; (ii) a statement of the participating providers grievance; (iii) the decision of the reviewers, along with a detailed explanation of the contractual and/or medical basis for such decision; (iv) a description of the evidence or documentation which supports the decision; and (v) shall include written instructions for referring the dispute to arbitration pursuant to N.J. St 17B:27-44.2.e(2)-(7).

If the practitioner does not receive a decision within thirty (30) days of the receipt of Davis Vision's receipt of the appeal, the practitioner may refer the dispute to arbitration pursuant to N.J. St 17B:27-44.2.e(2)-(7).

If the determination is in favor of the practitioner, Davis Vision shall pay the amount of money in dispute, if applicable, with accrued interest at the rate of 12% per annum, on or before the 30th calendar day following the notification of the determination on the appeal. Interest shall begin to accrue on the day the appeal was received by the Davis Vision.

Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that a health care provider may aggregate his own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals program shall be the subject of arbitration.

PROVIDER APPEALS PROCEDURE - TERMINATION

To challenge a termination decision, a practitioner must notify Davis Vision in writing of their intention to seek modification or reversal. The practitioner must send a written request for a hearing to modify or reverse a decision to terminate to the address listed on the notice of action. The request must be sent by certified mail,

return receipt requested and postmarked no later than ninety (90) days following receipt of the notice of action by the practitioner.

Within thirty (30) days of receipt of a request for a hearing to modify or reverse the decision to terminate, a three-member Appeals Committee composed of at least one Regional Quality Assurance Representative, all of whom are licensed optometrists, not involved in the initial determination shall convene to review the merits and circumstances presented. Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date. Failure to appear at the hearing will be deemed a waiver of the practitioner's right to appeal.

If the practitioner requires additional time or wishes to reschedule the hearing, the request for additional time or to reschedule must be made in writing, sent by certified mail (return receipt requested), and be received at Davis Vision at least ten (10) days before the scheduled hearing before the Appeal Committee.

Any documentation to be submitted by the practitioner at the hearing before the Appeals Committee, including the names, addresses and credentials of any witnesses, if applicable, must be mailed to the address listed in the notice of action by certified mail, return receipt requested and be received at least ten (10) days before the scheduled hearing date. The Appeals Committee at its discretion may accept documentation or testimony of witnesses received after this date.

At the hearing, the practitioner will present his/her explanation as to why the decision for termination should be modified or reversed. The Director of Professional Services or Vice President of Professional Affairs will present Davis Vision's position regarding the termination.

The Appeals Committee will prepare a report containing its findings and recommendation with respect to the appeal and forward the report to the overall Quality Support, within thirty (30) days of the hearing. The overall Quality Support, then considers the Appeals Committee's findings and recommendations and either accepts or rejects them within fifteen (15) days. If the findings and recommendations are accepted, the overall Quality Support will advise the practitioner in writing of the decision to accept the Appeals Committee's report as submitted, a copy of which will be enclosed. If the overall Quality Support rejects any of the Appeals Committee's findings or its recommendations, the overall Quality Support will issue a decision stating the reasons for rejecting the particular finding or the recommendation, a copy of which will be sent to the practitioner. Where the decision of the overall Quality Support results in the termination of a practitioner, Davis Vision will notify the practitioner in writing of his or her effective termination date. The termination date is effective upon the practitioner's receipt of the notice. The decision of the overall Quality Support constitutes Davis Vision's final decision with respect to the practitioner's network participation status.

If the decision of the overall Quality Support results in the termination of a practitioner's participation in accordance with the above policy, Davis Vision will notify, when appropriate, the National Practitioner Data Bank (NPDB) and the appropriate state licensing board(s) of its actions.

EXHIBIT B

COMPENSATION

PROFESSIONAL FEES*

*Fees listed below are sample fees for illustrative purposes only and do not reflect fees for all plans. All plan fees are considered reimbursement in full, whether fees are reimbursed entirely by Davis Vision or reimbursed in part by Davis Vision and in part by Member Co-payment.

Eye Examination** Ranges from $40.00 - $52.00
(**Including dilated fundus examination; CPT codes: S0620, S0621)

Eyeglass Frame Dispensing Fee+ Ranges from $15.00 - $30.00
(+Frames are supplied from the Davis Vision Tower Collection. Frames supplied by a Provider are sent to a Davis Vision laboratory for lenses.)

Contact Lens Fitting Fee^ (*when covered as an itemized service)* Ranges from $20.00 - $85.00
(^When contact lenses are supplied by Davis Vision – i.e. plan contact lenses are daily wear soft & disposable/planned replacement. Non-plan contact lenses are supplied by the Provider's usual source.)

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DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT

ADDENDUM
FOR CONTRACTS COVERING INDIVIDUALS WHO ARE MEMBERS OF HEALTH MAINTENANCE ORGANIZATIONS IN NEW JERSEY

The Participating Provider Agreement (the "Agreement") entered into by and between **DAVIS** and **PROVIDER** is hereby amended with respect to individuals who are Members of health maintenance organizations (collectively, "**HMOs**") in the State of New Jersey by adding the following

1. Incorporation by Reference. The contract(s) between **DAVIS** and the **HMO(s)** is/are incorporated into the Agreement as more fully set forth herein. **PROVIDER** may obtain a copy of such contract(s) from **DAVIS** upon request.

2. Periodic Accounting. When any compensation formula provides any payment to Provider which may be contingent on the occurrence of particular events or on the meeting of specified utilization targets, **PROVIDER** shall be entitled to receive an annual report with respect to such contingencies and the compensation derived therefrom. Such compensation formula, if any, is intended solely to encourage the cost effective delivery of Medically Appropriate Covered Services and not to provide a financial incentive to **PROVIDER** to deny Medically Appropriate Covered Services. Any dispute regarding such periodic accounting shall be resolved in accordance with Section X.1 of the Agreement.

3. Grievance and Appeal Procedure. A grievance and appeal procedure shall be established for the processing of any patient or provider complaint. Such procedure will be established by **DAVIS** and contracting Plans in their sole and absolute discretion. **PROVIDER** shall cooperate with and, subject to **PROVIDER'**s rights of appeal thereunder, shall be bound by such grievance procedure.

4. Responsibility for Members at Termination. In the event the Agreement is terminated for any reason except the failure to comply with legal requirements or the loss of licensure (as set forth in Section V of the Agreement), where medically necessary for the Member to continue treatment with **PROVIDER**, **PROVIDER** shall be continue to provide Covered Services as provided in Section VII.4 of the Agreement for up to one hundred twenty (120) days after such termination of the Agreement.

5. Malpractice Insurance. Except as may otherwise be required or permitted by the laws of the state in which services are provided, **PROVIDER** shall provide, at **PROVIDER**'s sole cost and expense, throughout the entire term of this Agreement, a policy of professional malpractice liability in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER**'s agents, servants or employees, and shall provide proof of such insurance to **DAVIS** if so requested.

6. Termination Without Cause. After the first twelve (12) months, the Agreement may be terminated without cause by either party on ninety (90) days' prior written notice. If **DAVIS** elects to terminate the Agreement other than at the end of the term hereof, or for a reason other than those set forth in Section VII.2 and VII.3 hereof, the notice of termination shall inform the **PROVIDER** that the **PROVIDER** may appeal the termination by requesting a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of the request.

7. Coordination of Benefits Obligation of Davis. **DAVIS** will conduct COB in accordance with the laws of New Jersey.

8. Independent Contractor. It is the intent of the Parties that at all times relevant to and pursuant to the terms and conditions of this Agreement, as permitted by statute, regulation and common law, **PROVIDER** is and shall be an independent contractor practicing **PROVIDER'S** profession and shall not be deemed or construed to be an agent, servant or employee of **DAVIS**.

Except as otherwise provided in this Addendum, all capitalized terms shall have the meanings set forth in the Agreement.

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DAVIS VISION, INC.
PARTICPATING PROVIDER AGREEMENT FOR THE STATE OF NEW JERSEY
MEDICAID ADDENDUM

PROVIDER acknowledges and agrees that **PROVIDER** and/or Participating Providers are bound by the terms of this Medicaid Addendum only to the extent applicable to the services rendered by **PROVIDER** and/or Participating Providers to the enrollees of the State Medical Assistance Programs, NJ FamilyCare and NJ KidCare, and any successor Programs**.**

For the purposes of this Medicaid Addendum the following are defined terms. Those terms not defined below, but previously defined in this Agreement retain the meaning given them in the Agreement.

1. "Contractor" means the Managed Care Organization (MCO)
2. "Contract/Subcontract" means this Davis Vision Participating Provider Agreement for the State of New Jersey.
3. "Provider/Subcontractor" means the **PROVIDER** as defined in this Agreement and the Participating Provider as defined in this Agreement.
4. For purposes of this Medicaid Addendum, the "New Jersey Department of Human Services" (NJDHS) is also referred to as the "Department".

The **PROVIDER** agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the contractor**.**

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The provider/subcontract agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the contractor's agreement with the State takes effect.

E.NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT

The provider/subcontractor understands that the contractor shall notify DMAHS at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the provider/subcontractor from participation in the contractor's network. If the termination was "for cause," the contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the provider's/subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractors shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in this section F.1 shall be construed:

a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between provider/subcontractors and their patients; or
b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontract or to otherwise require the contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT BY CONTRACTOR

The contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the contractor's decision; or because the provider/subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the contractor or not, policy provisions of the contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.
2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the provider/subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, including significant marketing abuses;
2. Takes any action that threatens the fiscal integrity of the Medicaid program
3. Has certification suspended or revoked by the DOBI, DHSS, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;
4. Becomes insolvent or falls below minimum net worth requirements;
5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;
6. Materially breaches the provider contract/subcontract; or
7. Violates state or federal law.

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations

promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. The contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

   A "qualified individual with a disability" as defined pursuant to 42 U.S.C. §12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

   The provider/subcontractor shall submit to MCO a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of provider/subcontractor's knowledge. The provider/subcontractor warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of the provider/subcontractor to be in compliance with the ADA. Where applicable, the provider/subcontractor must abide by the provisions of section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.
3. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental history, health or mental status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.
4. The provider/subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq.. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on the grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, martial status, genetic information, source of payment, sex, color, creed, religion, or national original or ancestry. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, martial status, religion, disability or sexual or affectional orientation or preference.
5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in PL 1975,

Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to MCO copies of all grievances alleging discrimination against enrollees because of race color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap, for review and appropriate action within three (3) business days or receipt by the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.
2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the contractor or the state, insolvency of the contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.
3. The providers/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the contractor, and shall be construed to be for the benefit of the contractor or enrollees.
4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereinafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.
5. The provider/subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.
6. The provider/subcontractor shall comply with the prohibition against balance billing as described within the payment in-full provision of N.J.S.A. 30:4D-6(c).

K. INSPECTION

The provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the provider/subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the provider/subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by NJDHS or DHHS) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontract shall furnish any such record, or copy thereof to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

L. RECORD MAINTENANCE

The provider/subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. Records must be retained for the later of:

1. Five (5) years from the date of service, or
2. Three (3) years after final payment is made under the provider contract/subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the enrollee's confidentiality.

If an enrollee disenrolls from the contractor, the provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the contractor's agreement with the State.
2. The provider/subcontractor shall comply with the financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.
3. The provider/subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare Plan D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such

data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of the provider/subcontractor, its officers, agents and employees arising out of the alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the contractor's plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor; it; (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all request for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD AND ABUSE

1. The provide/subcontractor agrees to assist the contractor as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.
2. If the State has withheld payment and or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 456.23 and NJAC 10:49-9.10(a), the contractor shall have the right to withhold payments from the provider/subcontractor

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.
2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the contractor.
3. In the following situations, the provider/subcontractor may bill the contractor first and then coordinate with the liable third party, unless the contractor has received prior approval from the State to take other action.
   (a) The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.
   (b) The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
   (c) The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.
   (d) The claim is for a child who is in a DYFS supported out of home placement.

(e) The claim involves coverage or services mentioned in 3.a, 3.b, 3.c., or 3.d, above in combination with another service.

4. If the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the contractor without having received a written denial from the third party.

5. Sharing of Third Party Liability (TPL) Information by the Provider/Subcontractor.
   a. The provider/subcontractor shall notify the contractor within the thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the contractor, or casualty insurance coverage, or of any change in an enrollees' health insurance coverage.
   b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollees' diagnosis and the nature of the service provided to the enrollee.
   c. The provider/subcontractor shall notify the contractor within thirty (30) days of the date it becomes aware of the death of one of its Medicaid enrollees age 55 or older, giving the enrollee's full name, Social Security Number, Medicaid information number, and date of death.
   d. The provider/subcontractor agrees to cooperate with the contractor's and the State's efforts to maximize the collection of third party payments by providing to the contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third party liability, is the contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

   a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i) , 42 CFR 438.114 and/or NJAC 10:74-9.1; and

d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and

e. The protections afforded to enrollees under 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

f. The provider has received no program payments from either DMAHS or the contractor for the service; or

g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the contractor's network; or

b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

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COST SHARING REQUIREMENTS FOR NJ FAMILYCARE
PLAN C BENEFICIARIES

PERSONAL CONTRIBUTION TO CARE (PCC) FOR NJ FamilyCare – PLAN C

For beneficiaries solely eligible through NJ FamilyCare-Plan C, PCCs will be required for certain services provided to individuals whose family income is above !50% and up to and including 200% of the federal poverty level. Exception – Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, shall not be required to pay a personal contribution to care.

The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

Below are listed the services requiring PCCs and the amount of each PCC.

SERVICE	**AMOUNT OF PCC**
Optometrist Services	$5 PCC for each visit.
Physician Services	$5 PCC for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment age appropriate immunizations; prenatal care; and pap smears, when appropriate.

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COST SHARING REQUIREMENTS FOR NJ FAMILYCARE
PLAN D BENEFICIARIES

COPAYMENTS FOR NJ FamilyCare – PLAN D

Copayments will be required of parents/caretakers solely eligible through NJ FamilyCare Plan D whose family income is between 151% and up to including 200% of the federal poverty level. The same copayments will be required of children solely eligible through NJ FamilyCare Plan D whose family income is between 201% and up to and including 350% of the federal poverty level. Exception – Both Eskimos and Native American Indians under the age of 19 are not required to pay copayments.

The total family limit (regardless of family size) on all cost-sharing may not exceed 5% of the annual family income.

Below are listed the services requiring copayments and the amount of each copayment.

SERVICE	AMOUNT OF COPAYMENT
Optometrist Services	$5 copayment for each visit, except for newborns covered under fee-for-service.
Physician specialist office visits during normal office hours	$5 copayment per visit.
Physician specialist office visits during non-office hours or home visits	$10 copayment per visit.

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COST SHARING REQUIREMENTS FOR NJ FAMILYCARE PLAN H BENEFICIARIES

Copayments will be required of individuals eligible through NJ FamilyCare Plan H whose family income is between 151% and up to and including 250% of the federal poverty level. The total family limit (regardless of family size) on all cost-sharing may not exceed 5% of the annual family income.

Below are listed the services requiring copayments and the amount of each copayment.

SERVICE	**AMOUNT OF COPAYMENT**
Physician specialist office visits during normal office hours	$5 copayment per visit.
Physician specialist office visits during non-office hours or home visits	$10 copayment per visit.

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DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT

ADDENDEM
INCORPORATION OF PPO PAYOR AND THIRD PARTY ADMINISTRATOR AGREEMENTS

Purpose

The purpose of this Addendum is to incorporate by reference the approved PPO Payor and TPA agreements executed by Davis Vision and HM Life Insurance Company on April 1, 2008.

All terms and conditions of said Agreements shall become a part of this Participating Provider Agreement as if set fully set forth within.

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DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR THE STATE OF NEW JERSEY

ADDENDUM
UTILIZATION REVIEW PROCEDURES

Purpose

The purpose of the Utilization Management Program is to evaluate the medical necessity of care in connection with determining benefit eligibility to control health care costs. Benefits are subject to the patient's eligibility at the time charges are actually incurred and to all other terms, conditions and exclusions of the applicable plan. By reviewing services and procedures to determine appropriateness, frequency, duration and care setting, Davis Vision's Utilization Management Program helps reduce unnecessary claims.

The program promotes competent, efficacious, and appropriate rendering of medically necessary treatments and services to members that are consistent with Davis Vision's guidelines. The program ensures the treatment or procedure is appropriate to the member's vision condition and clinical needs given the current state of knowledge. In addition, the program utilizes peer reviews and audits to ensure that services are rendered only as and when medically necessary, as determined by professionals.

Davis Vision does not offer reimbursement, bonuses or incentives to staff or health care providers based directly on consumer utilization of health care services.

Scope of the Utilization Management Program

The Utilization Management Program includes the following components:

- Prior Approval (prospective) Review
- Concurrent Review
- Retrospective Review

Utilization Review Committee

The Utilization Review Committee is comprised of clinicians and representatives from Quality Assurance. The Utilization Review Committee reviews and determines whether treatment, procedures and services are medically necessary. The Committee conducts prior approval, concurrent and retrospective reviews and issues determinations in accordance with regulatory and accreditation standards and timeframes. The Utilization Review Committee establishes criteria for monitoring utilization and tracks and trends utilization. (Refer to Section I, Quality Committee Structure for detailed information about the Utilization Review Committee.)

Staff Qualifications and Training

Administrative personnel conduct intake screening, data collection and non-clinical review functions. Those licensed health care professionals, medical record technologists, or administrative personnel who have received appropriate training collect clinical information from the health care provider for use in the utilization review process. All cases that do not meet clinical criteria for medical necessity are referred to a licensed clinical peer for review and determination.

Davis Vision's licensed clinical peers are trained in utilization review. Their competency is validated through a comprehensive Certified Professional Utilization Review (CPUR) exam at the conclusion of training. CPUR status is valid for two (2) years and can be renewed by either repeating the exam or through documentation of completed continuing education in the area of utilization review.

Clinical Criteria

Davis Vision uses nationally recognized clinical criteria as guidelines for all utilization review determinations. The clinical criteria are reviewed and updated annually. Optometric providers are required to follow the clinical practice guidelines of the American Optometric Association (AOA). Ophthalmologists are required to follow the clinical practice guidelines of the American Academy of Ophthalmology (AAO).

Based on clinical practice guidelines of the American Optometric Association (AOA), contact lenses may be determined to be medically necessary and appropriate in the treatment of the following nine (9) conditions:

- Keratoconus
- Aphakia
- Anisometropia
- Aniseikonia
- Pathological Myopia
- Aniridia
- Corneal Disorders
- Post-Traumatic Disorders
- Irregular Astigmatism

All cases that do not meet clinical criteria for medical necessity are referred to a clinical peer for review and determination.

Member Protection

Only information that is necessary for prospective, concurrent or retrospective determination review may be collected. Routine requests of all patient records are not made. Only relevant sections of medical records needed to verify that services are medically necessary may be requested.

Utilization Review Process

Utilization review to determine medical necessity is based on clinical criteria specific to the condition

or service under review. Consideration is given to the individual's needs including, but not limited to, status, co-morbidities, psychosocial, environmental, special needs, response to treatment, and prior use of diagnostic services, if applicable.

Davis Vision's written agreements with participating providers define "medically appropriate/medical necessity" as a vision care service or treatment that:

- is appropriate to evaluate, diagnose or treat an illness, injury, disease, or its symptoms and
- is in accordance with the "Generally Accepted Standards of Medical Practice" and
- is clinically appropriate considered effective for the member's illness, injury or disease and
- is not primarily for the convenience of the member or the provider and
- is not more costly than an alternative service that are likely to produce equivalent results.

Utilization review professionals may not accept anything of value given to their employees, agents or contractors based on: (i) either a percentage of the amount by which a claim is reduced for payment, or the number of claims or the costs of services for which the person has denied authorization or payment; or (ii) any other method encouraging the rendering of an adverse determination.

Utilization management staff availability

For routine utilization-related inquiries, the HMO shall provide all members and providers with a toll free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis.

Prior Approval

Prior approval or prospective review involves services that have not yet been rendered. All pre-service reviews are for non-urgent care as services and materials for urgent/emergency care are not covered under Davis Vision plans. Prior Approval Representatives are available during normal business hours, Monday through Friday, from 8:00 a.m. until 4:30 p.m. EST. Practitioners requesting prior approval of services complete a Prior Approval Form including, but not limited to, the following information:

- Member and/or patient's identification number
- Patient's name
- Diagnosis
- Requested service or procedure
- Justification

The practitioner faxes the completed form to Davis Vision's Prior Approval Department at (800) 584-2329. A Prior Approval Representative reviews the request for completeness and for medical necessity based on utilization review clinical criteria. The Prior Approval Representative refers all cases that do not meet clinical criteria for medical necessity to a clinical peer for review and determination. As part of the review, the practitioner may be contacted to discuss the case. Individuals that conduct peer clinical review are available to discuss review determinations with the attending physician or ordering provider. If the original peer reviewer is not available, another clinical peer is available within one business day.

All determinations are rendered within three (3) business days of receipt of a complete request, both

verbally and in writing to both the member and the practitioner. If the request is incomplete, Davis Vision will request additional information within the initial three-business-day time frame. Davis Vision will allow the member, member's designee and/or provider 45 calendar days to submit the requested additional information. If the requested information is not received within 45 calendar days, Davis Vision will issue a decision within 15 calendar days of the expiration of the 45-day time frame. Written denials based on medical necessity include, but are not limited to, the following information:

- Criteria utilized, including clinical rationale, if any, and documentation supporting the decision.
- Statement that the decision will be final and binding unless the member appeals in writing to the Quality Assurance/Patient Advocate Department within 45 days of the date of the notice of the decision.
- Name, position, phone number and department of person(s) responsible for the outcome.
- Appeal and Grievance Procedures

In cases where a client, plan or regulatory agency mandates a specific appeal process, Davis Vision will abide by that appeal process. In all other cases, Davis Vision's Member Appeals or Member Grievance Process will apply.

Concurrent Review

Concurrent review involves services that are currently being rendered. The practitioner is requesting that services continue or extend beyond what has already been approved or for additional services. In rare cases, Davis Vision may review certain services on a concurrent basis during the course of ongoing treatment. Practitioners complete the Prior Approval Form and fax it to the Prior Approval Department at (800) 584-2329.

All determinations are rendered within one (1) business day of receipt of necessary information but no later than 15 calendar days following the request, both verbally and in writing to both the member and the practitioner. The written determination contains the following information:

- Number of extended services approved
- New total of approved services
- Date of onset
- Next review date
- Appeal and Grievance Procedures

Retrospective Review

Retrospective review involves services that have previously been rendered. Davis Vision does not conduct retrospective reviews for services covered under its plans. In rare instances, a retrospective review may be conducted:

- to determine medical necessity when a member or practitioner fails to obtain approval for services that require prior approval before services are rendered
- to determine medical necessity when a practitioner fails to obtain approval for services that require concurrent review before services continue beyond the approved timeframe

- to identify and refer potential quality of care/utilization issues

NOTE: A review initiated as the result of a notification or claim denial is considered an appeal.

If a service has been pre-authorized or approved by a Utilization Review Agent, the Utilization Review Agent shall not, pursuant to retrospective review, revise or modify the specific standards, criteria or procedures used for the utilization or review or procedures, treatments and services delivered to the insured during the same course of treatment.

A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the carrier for those services, unless the approval was based upon fraudulent information submitted by the covered person or the participating provider.

A provider may appeal a decision, with the consent of the covered person, any utilization management decision resulting in a denial, termination or limitation of services of the payment of benefits.

Out of Area (Emergency) Care

Davis Vision provides routine vision and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. Davis Vision does not provide or manufacture life-saving equipment, nor does Davis Vision authorize or provide medical treatment (emergency or routine).

When a member is out of the area and an emergency arises, if the member believes that an emergency medical condition exists or that a delay in services might compromise their health, they are permitted to seek emergency care from a licensed health care practitioner or provider without obtaining prior approval from Davis Vision. Because Davis Vision provides routine vision and eye care services, reimbursement for emergency services will be solely dependent upon whether the member is eligible for the benefit.

Utilization Review Appeals Process

A. Informal internal utilization management appeal process (Stage 1)
The Carrier shall establish and maintain an informal internal appeal process (stage 1 appeal) whereby any covered person, or any provider acting on behalf of a covered person, with the covered person's consent, who is dissatisfied with the Carrier's utilization management determination, shall have the opportunity to speak to and appeal that determination with the Carrier's medical director and/or physician designee who rendered the determination. All such stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergency care (including all situations in which the member is confined as an inpatient), and five business days in the case of all other appeals. If the appeal is not resolved to the satisfaction of the covered person at this level, the Carrier shall provide the covered person and/or the provider with a written explanation of his or her right to proceed to a stage 2 appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

B. Formal internal utilization management appeal process (Stage 2)

1. The Carrier shall establish and maintain a formal internal appeal process (stage 2 appeal) whereby any covered person or any provider acting on behalf of the covered person with the covered person's consent, who is dissatisfied with the results of the stage 1 appeal, shall have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the Carrier and who have not been involved in the utilization management determination at issue.

2. The formal internal utilization management appeal panel shall have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional shall participate in the panel's review of the case, if requested by the covered person and/or provider.

3. All such stage 2 appeals shall be acknowledged by the Carrier, in writing, to the covered person or provider filing the appeal within 10 business days of receipt.

4. All such stage 2 appeals shall be concluded as soon as possible after receipt by the Carrier in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care (including all situations in which the covered person is confined as an inpatient) and, except as set forth in (e) below, 20 business days in the case of all other appeals.

5. The Carrier may extend the review for up to an additional 20 business days where it can demonstrate reasonable cause for the delay beyond its control and where it provides a written progress report and explanation for the delay to the satisfaction of the Department, with notice to the covered person and/or provider within the original 20 business day review period.

6. If the stage 2 appeal is denied, the Carrier shall provide the covered person and/or provider with written notification of the denial and the reasons therefore together with a written notification of his or her right to proceed to an external (stage 3) appeal. This notification shall include specific instructions as to how the covered person and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

7. In the event that the Carrier fails to comply with any of the deadlines for completion of the internal utilization management determination appeals set forth in above, or in the event that the Carrier for any reason expressly waives its rights to an internal review of any appeal, then the covered person and/or provider shall be relieved of his or her obligation to complete the Carrier’s internal review process and may, at his or her option, proceed directly to the external appeals process set forth in C below.

C. External appeals process

1. Any covered person of the carrier, and any provider acting on behalf of a covered person, with the covered person’s consent, who is dissatisfied with the results of the internal appeal process set forth above, shall have the right to pursue his or her appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below (stage 3 appeal). Except as set forth above, the right to an external appeal under this section shall be contingent upon the covered person’s full compliance with both stages of the Carrier’s internal appeal process set forth above.

2. To initiate an external appeal, a covered person and/or provider shall, within 60 days from receipt of the written determination of the stage 2 internal appeal panel under b.6, file a written request with the Department. The request shall be filed on the forms automatically provided to the covered person in accordance with B.6, and shall include both the fee specified in (c) below and a general release executed by the covered person for all medical records pertinent to the appeal. The request shall be mailed to the following address:

New Jersey Department of Banking and Insurance
Office of Managed Care
Division of Health Care Systems Analysis
PO Box 360
Trenton, New Jersey 08625-0360

3. The fee for filing an appeal shall be $25.00, payable by check or money order to the "New Jersey Department of Banking and Insurance." Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by the member through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ KidCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

4. Upon receipt of the appeal, together with the executed release and the appropriate fee, the Department shall immediately assign the appeal to an IURO for review.

5. Upon receipt of the request for appeal from the Department, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

a. The individual was or is a covered person of the Carrier;

b. The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the covered person;

c. Except as set forth at B.7, the covered person has fully complied with both the stage 1 and stage 2 appeals available above; and

d. The covered person has provided all information required by the IURO and Department to make the preliminary determination including the appeal form and a copy of any information provided by the Carrier regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the Carrier and any other relevant health care provider.

6. Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefore.

7. Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the Carrier's utilization management determination, the member was deprived of medically necessary covered services. In reaching this determination the IURO shall take into

consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the Carrier pursuant to the Clinical Criteria as defined above.

8. The full review referenced in 7 above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.

9. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control, except that in no event shall it render its determination later than 90 days following receipt of a completed application. In the event the IURO needs to extend its review period, it shall, prior to the conclusion of the 30 business day review, provide written notice to the member and/or provider, to the Department, and to the Carrier setting forth the status of its review and the specific reasons for the delay.

a. Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

10. If the IURO determines that the covered person was deprived of medically necessary covered services, the IURO shall recommend to the member and/or provider who filed the appeal, the Carrier and the Department, the appropriate covered health care services the covered person should receive.

11. The decision of the external UM appeal process is binding on the parties.

Definitions

Appeal	A formal request by a practitioner or member for reconsideration of a decision with the goal of finding a mutually acceptable solution.
Clinical Practice Guidelines	Systematically developed tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Such guidelines are usually evidence-based.
Denial	The non-authorization of care or service based on either medical appropriateness or benefit coverage. Partial approvals and care terminations when the practitioner does not agree are also considered denials.
Medical Necessity	Determinations on decisions that are or that could be considered covered benefits.
Peer Review	Evaluation or review of colleague performance by professionals with similar types and degrees of expertise; the evaluation of one physician's credentials and practice by another physician.
Post Service	Assessing the appropriateness of medical services on a case-by-case or

	aggregate basis, after services have been provided.
Pre-service Review	Any case or service that the organization must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and precertification are pre-service claims.
Prior Review, Prior Authorization, Prior Certification	Prior assessment that proposed services are appropriate for a particular patient and will be covered by an organization. Payment for services depends on whether the patient and the category of service are covered by the member's benefit plan.
Utilization Management	The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Review	A formal evaluation (pre-service, concurrent or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

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DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR THE STATE OF NEW JERSEY

ADDENDUM
UTILIZATION REVIEW PROCEDURES
FOR HMOs

Purpose

The purpose of the Utilization Management Program is to evaluate the medical necessity of care in connection with determining benefit eligibility to control health care costs. Benefits are subject to the patient's eligibility at the time charges are actually incurred and to all other terms, conditions and exclusions of the applicable plan. By reviewing services and procedures to determine appropriateness, frequency, duration and care setting, Davis Vision's Utilization Management Program helps reduce unnecessary claims.

The program promotes competent, efficacious, and appropriate rendering of medically necessary treatments and services to members that are consistent with Davis Vision's guidelines. The program ensures the treatment or procedure is appropriate to the member's vision condition and clinical needs given the current state of knowledge. In addition, the program utilizes peer reviews and audits to ensure that services are rendered only as and when medically necessary, as determined by professionals.

Davis Vision does not offer reimbursement, bonuses or incentives to staff or health care providers based directly on consumer utilization of health care services.

Scope of the Utilization Management Program

The Utilization Management Program includes the following components:

Prior Approval (prospective) Review
Concurrent Review
Retrospective Review

Utilization Review Committee

The Utilization Review Committee is comprised of clinicians and representatives from Quality Assurance. The Utilization Review Committee reviews and determines whether treatment, procedures and services are medically necessary. The Committee conducts prior approval, concurrent and retrospective reviews and issues determinations in accordance with regulatory and accreditation standards and timeframes. The Utilization Review Committee establishes criteria for monitoring utilization and tracks and trends utilization. (Refer to Section I, Quality Committee Structure for detailed information about the Utilization Review Committee.)

Staff Qualifications and Training

Administrative personnel conduct intake screening, data collection and non-clinical review functions. Those licensed health care professionals, medical record technologists, or administrative personnel who have received appropriate training, collect clinical information from the health care provider for use in the utilization review process. All cases that do not meet clinical criteria for medical necessity are referred to a licensed clinical peer for review and determination.

Davis Vision's licensed clinical peers are trained in utilization review. Their competency is validated through a comprehensive Certified Professional Utilization Review (CPUR) exam at the conclusion of training. CPUR status is valid for two (2) years and can be renewed by either repeating the exam or through documentation of completed continuing education in the area of utilization review.

Member Protection

Only information that is necessary for prospective, concurrent or retrospective determination review may be collected. Routine requests of all patient records are not made. Only relevant sections of medical records needed to verify that services are medically necessary may be requested.

Utilization Review Process

1. All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The determination shall be directly communicated by the physician to the provider or, if this is not possible, the provider shall be supplied with the physician's name, telephone number, and where he or she can be reached. The physician shall be available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the HMO's New Jersey members. Such determinations shall be made in accordance with clinical and medical necessity criteria developed pursuant to N.J.A.C. 11:24-8.1(b) and the evidence of coverage.

Utilization management determinations shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers within the network and based upon generally accepted medical standards. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to members and participating providers in the relevant practice areas.

2. ***Clinical Criteria***

Davis Vision uses nationally recognized clinical criteria as guidelines for all utilization review determinations. The clinical criteria are reviewed and updated annually. Optometric providers are required to follow the clinical practice guidelines of the American Optometric Association (AOA). Ophthalmologists are required to follow the clinical practice guidelines of the American Academy of Ophthalmology (AAO).

Based on clinical practice guidelines of the American Optometric Association (AOA), contact lenses may be determined to be medically necessary and appropriate in the treatment of the following nine

(9) conditions:

Keratoconus
Aphakia
Anisometropia
Aniseikonia
Pathological Myopia
Aniridia
Corneal Disorders
Post-Traumatic Disorders
Irregular Astigmatism

All cases that do not meet clinical criteria for medical necessity are referred to a clinical peer for review and determination.

3. All determinations shall be made on a timely basis, as required by the exigencies of the situation.

4. An HMO shall not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

5. A member or provider acting on behalf of a member shall receive a written notice of any determination to deny coverage or authorization for services required in this subchapter or in the evidence of coverage, which shall be subject to appeal in accordance with the appeals procedures set forth below. The written notice of determination shall include an explanation of the appeal process.

6. **Utilization management staff availability**

(a) A registered professional nurse or physician shall be immediately available by phone seven days a week, 24 hours a day, to render utilization management determinations for providers.

(b) For routine utilization-related inquiries, the HMO shall provide all members and providers with a toll free telephone number by which to contact utilization management staff on at least a five-day, 40 hours a week basis.

(c) All members must have immediate phone access seven days a week, 24 hours a day, to their primary care provider or his or her authorized on-call back-up provider. When these providers are unavailable, a registered nurse or physician on the utilization management staff must be available to respond to inquiries concerning emergency or urgent care.

7. **Utilization Review Appeals Process**

A. Informal internal utilization management appeal process (Stage 1)

The HMO shall establish and maintain an informal internal appeal process (stage 1 appeal) whereby any member, or any provider acting on behalf of a member, with the member's consent, who is dissatisfied with the HMO utilization management determination, shall have the opportunity to speak

to and appeal that determination with the HMO medical director and/or physician designee who rendered the determination. All such stage 1 appeals shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergency care (including all situations in which the member is confined as an inpatient), and five business days in the case of all other appeals. If the appeal is not resolved to the satisfaction of the member at this level, the HMO shall provide the member and/or the provider with a written explanation of his or her right to proceed to a stage 2 appeal, including the applicable time limits, if any, for making the appeal, and to whom the appeal should be addressed.

B. Formal internal utilization management appeal process (Stage 2)

1. The HMO shall establish and maintain a formal internal appeal process (stage 2 appeal) whereby any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the stage 1 appeal, shall have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the HMO who have not been involved in the utilization management determination at issue.

2. The formal internal utilization management appeal panel shall have available consultant practitioners who are trained or who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. In no event, however, shall the consulting practitioner or professional have been involved in the utilization management determination at issue. The consulting practitioner or professional shall participate in the panel's review of the case, if requested by the member and/or provider.

3. All such stage 2 appeals shall be acknowledged by the HMO, in writing, to the member or provider filing the appeal within 10 business days of receipt.

4. All such stage 2 appeals shall be concluded as soon as possible after receipt by the HMO in accordance with the medical exigencies of the case, which in no event shall exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care (including all situations in which the member is confined as an inpatient) and, except as set forth in (e) below, 20 business days in the case of all other appeals.

5. The HMO may extend the review for up to an additional 20 business days where it can demonstrate reasonable cause for the delay beyond its control and where it provides a written progress report and explanation for the delay to the satisfaction of the Department, with notice to the member and/or provider within the original 20 business day review period.

6. If the stage 2 appeal is denied, the HMO shall provide the member and/or provider with written notification of the denial and the reasons therefore together with a written notification of his or her right to proceed to an external (stage 3) appeal. This notification shall include specific instructions as to how the member and/or provider may arrange for an external appeal and shall also include any forms required to initiate such an appeal.

7. In the event that the HMO fails to comply with any of the deadlines for completion of the internal utilization management determination appeals set forth in above, or in the event that the HMO for any reason expressly waives its rights to an internal review of any appeal, then the member and/or provider

shall be relieved of his or her obligation to complete the HMO internal review process and may, at his or her option, proceed directly to the external appeals process set forth in C below.

C. External appeals process

1. Any HMO member, and any provider acting on behalf of a member, with the member's consent, who is dissatisfied with the results of the internal appeal process set forth above, shall have the right to pursue his or her appeal to an independent utilization review organization (IURO) in accordance with the procedures set forth below (stage 3 appeal). Except as set forth in B.7 above the right to an external appeal under this section shall be contingent upon the member's full compliance with both stages of the HMO internal appeal process set forth at above.

2. To initiate an external appeal, a member and/or provider shall, within 60 days from receipt of the written determination of the stage 2 internal appeal panel under b.6, file a written request with the Department. The request shall be filed on the forms automatically provided to the member in accordance with B.6, and shall include both the fee specified in (c) below and a general release executed by the member for all medical records pertinent to the appeal. The request shall be mailed to the following address:

New Jersey Department of Banking and Insurance
Office of Managed Care
Division of Health Care Systems Analysis
PO Box 360
Trenton, New Jersey 08625-0360

3. The fee for filing an appeal shall be $25.00, payable by check or money order to the "New Jersey Department of Banking and Insurance." Upon a determination of financial hardship, the fee may be reduced to $2.00. Financial hardship may be demonstrated by the member through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ KidCare, General Assistance, SSI, or New Jersey Unemployment Assistance.

4. Upon receipt of the appeal, together with the executed release and the appropriate fee, the Department shall immediately assign the appeal to an IURO for review.

5. Upon receipt of the request for appeal from the Department, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:

a. The individual was or is a member of the HMO;

b. The service which is the subject of the complaint or appeal reasonably appears to be a covered service under the benefits provided by contract to the member;

c. Except as set forth at B.7, the member has fully complied with both the stage 1 and stage 2 appeals available above; and

d. The member has provided all information required by the IURO and Department to make the preliminary determination including the appeal form and a copy of any information provided by the

HMO regarding its decision to deny, reduce or terminate the covered service, and a fully executed release to obtain any necessary medical records from the HMO and any other relevant health care provider.

6. Upon completion of the preliminary review, the IURO shall immediately notify the member and/or provider in writing as to whether the appeal has been accepted for processing and if not so accepted, the reasons therefore.

7. Upon acceptance of the appeal for processing, the IURO shall conduct a full review to determine whether, as a result of the HMO's utilization management determination, the member was deprived of medically necessary covered services. In reaching this determination the IURO shall take into consideration all pertinent medical records, consulting physician reports and other documents submitted by the parties, any applicable, generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations, and any applicable clinical protocols and/or practice guidelines developed by the HMO pursuant to the Clinical Criteria as defined above.

8. The full review referenced in 7 above shall initially be conducted by a registered professional nurse or a physician licensed to practice in New Jersey. When necessary, the IURO shall refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO shall be approved by the medical director of the IURO.

9. The IURO shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case which, except as provided for in this subsection, in no event shall exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control, except that in no event shall it render its determination later than 90 days following receipt of a completed application. In the event the IURO needs to extend its review period, it shall, prior to the conclusion of the 30 business day review, provide written notice to the member and/or provider, to the Department, and to the HMO setting forth the status of its review and the specific reasons for the delay.

a. Notwithstanding (i) above, if the appeal involves care for an urgent or emergency case, the IURO shall complete its review within no more than 48 hours following its receipt of the appeal.

10. If the IURO determines that the member was deprived of medically necessary covered services, the IURO shall recommend to the member and/or provider who filed the appeal, the HMO and the Department, the appropriate covered health care services the member should receive.

11. The decision of the external UM appeal process is binding on the parties.

12. Nothing in this section shall limit the authority of the Division of Medical Assistance and Health Services (DMAHS) or the Department of Human Services (DHS) to adopt in any contract to provide HMO services to Medicaid recipients, its own process for appeals of utilization management determinations. At the request of the Commissioner of Human Services, the Commissioner shall adopt, in accordance with N.J.S.A. 52:14B-1 et seq. and N.J.A.C. 1:30, any such appeals process proposed by DMAHS or DHS as the exclusive appeals process for all Medicaid HMO members, if he

or she find that it meets or exceeds the standards set forth in this chapter.

Definitions

Appeal	A formal request by a practitioner or member for reconsideration of a decision with the goal of finding a mutually acceptable solution.
Clinical Practice Guidelines	Systematically developed tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Such guidelines are usually evidence-based.
Denial	The non-authorization of care or service based on either medical appropriateness or benefit coverage. Partial approvals and care terminations when the practitioner does not agree are also considered denials.
Medical Necessity	Determinations on decisions that are or that could be considered covered benefits.
Peer Review	Evaluation or review of colleague performance by professionals with similar types and degrees of expertise; the evaluation of one physician's credentials and practice by another physician.
Post Service	Assessing the appropriateness of medical services on a case-by-case or on an aggregate basis after services have been provided.
Pre-service Review	Any case or service that the organization must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and precertification are pre-service claims.
Prior Review, Prior Authorization, Prior Certification	Prior assessment that proposed services are appropriate for a particular patient and will be covered by an organization. Payment for services depends on whether the patient and the category of service are covered by the member's benefit plan.
Utilization Management	The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Review	A formal evaluation (pre-service, concurrent or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

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DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR THE STATE OF NEW JERSEY

ADDENDUM
DAVIS VISION QUALITY IMPROVEMENT PROCEDURES

Policy

Davis Vision's Quality Improvement Program achieves and sustains significant and meaningful improvements in the care, services and support processes offered by Davis Vision. The program is structured to allow for a collaborative effort among leaders, associates, independent practitioners, components and members to quantify and qualify Davis Vision's performance to determine that what is done is done well. Davis Vision continuously monitors performance indicators, utilization trends, and advances in the field of vision care so that Davis Vision will meet industry standards or establish new industry benchmarks.

Administration

- The Senior Vice President of Professional Affairs and Quality Management maintains overall responsibility and accountability for the Quality Management Program.
- Quality Improvement and/or Business and Commerce Services may periodically update this policy and procedure. At a minimum, this policy and procedure will be reviewed annually to determine if any updates or changes are needed.
- This policy and procedure requires the approval of the Senior Vice President or above of the area designated as the Policy Owner. The Senior Vice President may delegate approval authority.
- Prior to any changes to this policy or procedure, Quality Improvement and/or Business and Commerce Services must review and approve to ensure consistency with required client, accreditation and regulatory requirements.

Procedures

- Monitor annual updates to accreditation standards and ensure compliance.
- Monitor Davis Vision's continued ongoing compliance with accreditation standards.
- Coordinate submission of evidentiary documentation and participation in onsite survey for accrediting bodies.
- Coordinate assembly and submission of documentation required for delegation oversight audits.
- Facilitate onsite delegation oversight audits and develop corrective action plans, as needed.
- Communicate outcome of all audits to corporate leadership.
- Identify key business issues supporting corporate goals through data analysis that represent potential improvement projects.
- Coordinate, integrate, and implement organization-wide performance improvement activities.
- Examine internal processes to eliminate unnecessary steps and increase accuracy.
- Develop internal auditing program to ensure compliance, including appropriate audit tools.
- Conduct internal audits of credentialing, UM, and recruiting files to ensure compliance with group/client, state and accreditation agency requirements.

- Collect, tabulate, and analyze audit results to identify trends and recommend actions for process improvement to increase group/client/customer satisfaction, and report audit results to management and/or client/group as needed.
- Collaborate with other operational areas to develop reporting mechanisms for key performance indicators as a measure of ongoing performance.
- Track and trend results of key performance indicators.
- Collaborate with parties responsible for key performance indicators to develop action plans to enhance performance.
- Coordinate and facilitate QIP including updating and distributing work plans.

Accreditation

Consumers, purchasers and regulators use accreditation status to assess and compare the caliber of health care organizations. Accreditation is a process by which an impartial organization will review a company's operations to ensure that the company is conducting business in a manner consistent with national industry standards. Typically the accreditation process consists of a review of policies and procedures (the "desktop review") and an onsite visit to the applicant organization to determine that it is, in fact, operating according to its stated policies.

Accreditation standards in such areas as member rights and responsibilities, quality management and improvement, utilization management and the credentialing process demonstrate organizational excellence. Davis Vision received certification for Credentialing by NCQA in June 2006 and will undergo recertification in June 2008. Davis Vision is actively pursuing URAC Accreditation.

Quality Improvement staff is responsible for providing oversight and guidance to those areas of the company involved in accreditation activities. Because accreditation standards are updated annually, they require ongoing monitoring.

Delegation Oversight Review

Davis Vision provides routine vision and eye care to more than 35 million beneficiaries nationally through managed care organizations (HMOs and PPOs), insurance companies, governmental groups, corporations, union trust funds and third party administrators. Because these organizations delegate responsibility to Davis Vision for certain functions for which they are ultimately responsible, the organizations conduct periodic delegation oversight reviews and/or audits.

Upon notification of an impending review, Davis Vision collects documentation requested by the client including, but not limited to, policies and procedures, program descriptions, copies of letters, and supporting statistical data. Documentation for offsite reviews is sent to the client. Documentation for onsite reviews may be sent to the client in advance, or may be given to the reviewer upon arrival. Credentialing files are typically audited during onsite reviews. Post-review feedback identifies potential areas for performance improvement efforts.

Delegation oversight reviews provide an opportunity for Davis Vision to maintain an open dialogue with our clients, to evaluate their satisfaction with our services, and to proactively enhance our products and services.

Quality Improvement Projects

Because Davis Vision embraces the principles of Total Quality Management and the belief that quality improvement is not a technique, but a way of life for the entire organization, an interdepartmental

leadership group assesses corporate performance and identifies corporate goals annually. These goals provide a framework within which specific, measurable projects are selected for targeted interventions to improve performance. At least one project focuses on error reduction and/or consumer safety.

For each project, Davis Vision's baseline performance is calculated, measurable goals are established, and projected time frames for meeting goals are assigned. Depending on the type of project involved, either a barrier analysis or cause and effect study is conducted. Performance is re-measured quarterly and results are reported quarterly to the Quality Improvement Committee.

Quality Improvement Projects undertaken in 2007 include the following:

- Implementation of auto-adjudication of claims utilizing MACESS
- Renovation of the member Web site
- Develop basic direct on-line enrollment for members to be used where possible
- Develop process to e-mail members when glasses are shipped to the provider
- Implementation of new system for processing ancillary medical claims
- Survey sample of members with access to participating providers who used non-participating providers
- Implement the National Practitioner Identifier (NPI) in accordance with HIPAA regulations
- Integrate CAQH Universal Credentialing DataSource® into credentialing process
- URAC Accreditation
- Relocate Las Vegas Laboratory
- Increase participation by ophthalmologists in provider network
- Revise group implementation process
- Track non-plan frame usage through CompuVision™ Order Entry System

Corporate Policies and Procedures

To ensure consistency across the organization, responsibility for maintaining corporate policies is centralized within Quality Improvement. The corporate Policy Committee, comprised of key staff from departments involved in developing corporate processes, approves all new and revised policies. All policies are reviewed annually, and revised as needed. All staff is advised when new or revised policies have been approved, and copies are posted on the Intranet for reference.

Internal Auditing

Davis Vision audits its internal processes to ensure they are being conducted in accordance with documented procedures. In addition, files critical to the operation of the company are audited to identify inconsistencies and to ensure they are in compliance with group/client, regulatory and accreditation requirements.

When auditing a process, Quality Improvement observes the process as it is performed by key personnel and compares it to the documented procedures. When auditing files, Quality Improvement develops an audit tool using the appropriate requirements and examines a sample of files. Variation in the process is documented and discussed with management. Follow up actions may include, but are not limited to, re-educating the staff, revising the process, and/or revising the documented procedures.

Quality Improvement evaluates audit results to identify trends and to recommend actions for process

improvement and to improve client and member satisfaction. Audit results are reported to the Quality Improvement Committee.

Key Performance Indicators

Davis Vision continually seeks opportunities for improvement yet recognizes the importance of ongoing real-time assessment of service being offered to our members. Davis Vision monitors the following activities:

- Availability and access to care and services – GeoAccess™ reports (quarterly at a minimum).
- Entry, assessment and treatment processes – time frame from authorization date to utilization date.
- Preventive services

- Health Fair participation
- New contracts and renewals to include or expand upon benefit for preventive services such as:

    - VDT or safety eyewear
    - Dilated Fundus Examination for Diabetics

Practitioner integrity – monthly reports identify practitioners newly credentialed, practitioners scheduled for recredentialing (within the three-year cycle), and practitioners outside of the three-year recredentialing cycle.

Member Satisfaction

The purpose of Davis Vision's comprehensive member satisfaction program is to:

- Determine overall member perception of the vision care plan.
- Identify aspects of the program in which members would recommend a change.
- Identify practitioners on the panel who are not providing courteous and high quality services to members.
- Identify elements of the system which may be causing delays in the provision of care.
- Provide members with the opportunity to offer both positive and critical feedback
- Offer members the opportunity to ask questions regarding the program.
- Provide feedback to the practitioners on their patients' opinions about their care.
- Provide feedback to the laboratory on the patients' opinions about their services and materials.
- Provide feedback to the program's sponsor group on the assessment of the benefit by their constituents.

Patients' attitudes and perceptions are the fundamental component of quality improvement that is why Davis Vision members have the right to access and express their opinions and concerns. Patients obtaining services have the opportunity to complete a patient satisfaction survey to express their views concerning the quality of services rendered. This survey instrument is designed to elicit the patient's opinion on access to care, treatment by the professional staff and satisfaction with the examination and prescriptive eyewear.

Survey responses are evaluated and, if necessary, follow-up action is taken promptly. Davis Vision consistently achieves satisfaction rates of over 98%. Those who are surveyed and who indicate less than total satisfaction are contacted individually to ensure 100% satisfaction. If appropriate, participating providers are asked to respond to concerns raised by their patients.

Davis Vision conducts statistical analysis on aggregate results. Semiannually, the RQARs provide comparative statistics to provider offices whose patients completed and returned at least ten (10) surveys. Survey results are shared with the Director of Professional Services, the Quality Improvement Committee and are used during the re-credentialing process.

Practitioner Satisfaction

The Provider Satisfaction Survey establishes a platform for open communication and creates a better partnership between Davis Vision and its participating providers. The opinions, ideas and suggestions of Davis Vision's participating providers are as important as those of Davis Vision's members. At least annually, Davis Vision sends participating providers a Provider Satisfaction Survey that addresses topics such as laboratory services, administrative processes and reimbursement. Responses are scanned and evaluated. Aggregate results are presented to the Quality Improvement Committee. The Committee discusses issues and concerns expressed by the providers, focusing on challenging trends or dissatisfaction.

As a result of comments in the Provider Satisfaction Survey, Davis Vision may take action including, but not limited to:

- Referring a topic to the Opportunities Committee, or other appropriate committee
- Referring a survey to a Professional Field Consultant or Regional Quality Assurance Representative for a site visit

Violations

There are no exceptions allowed to these procedures. Davis Vision is subject to various regulatory and contractual penalties for non-compliance with these standards. Additionally, individual violations of these standards may result in disciplinary action up to, and including, termination of employment, if warranted.

Approval Authority

All processes and procedures are subject to approval by the Senior Vice President, Professional Affairs and Quality Management.

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DAVIS VISION
EYECARE REFRAMED℠

Provider Add Form

☐ **New Office Location** ☐ **Adding Doctor to Existing Location** **DV Provider#_____**

Provider Information			
Last Name:		First Name:	
Title (Circle one):	MD DO OD	SSN:	
DOB:		Sex (Circle one):	M F
Individual NPI #:		CAQH #:	
Medicaid # (Individual):		*Please note: CAQH attestation must be signed and dated within the past 30 days*	
Group/Office Name:		Group NP I#:	
Office Address:		Office city, State, Zip:	
Office Phone #:		Office Fax #:	
Office E-Mail address:		Medicaid # (Group):	

Please attach W-9 for billing address (Name/Address to send Check Payments)

Materials shipping street address: _____

City: _____ State: _____ Zip: _____ Country: _____

Please select below the services provided by your office:

____ Full Service (Exam, Eyeglasses & CLs)	
____ Exam Only	____ Eyeglasses & Contact Lenses
____ Exam & Contact Lenses	____ Eyeglasses Only
____ Exam & Glasses	____ Contact Lenses
____ Laser Surgery	

Languages Spoken:
☐ English ☐ American Sign ☐ Spanish ☐ Other_____

Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Attestation:
I understand and acknowledge that neither the submission of a completed Davis Vision, Vision Care Provider Application nor the execution of the Davis Vision Participating Provider Agreement constitutes acceptance as a Davis Vision Participating Provider. Acceptance as a Davis Vision Participating Provider is contingent on the acceptance by Davis Vision, Inc. of an applicant's completed Application, and on the execution by the applicant of the Davis Vision Participating Provider Agreement, and on the receipt by the applicant of the forms, manual and samples required for participation. Davis Vision, Inc. reserves the absolute right to determine which applicant is acceptable for participation and in which groups an applicant will participate.

***Signature:** _____**Date:** _____

***Print Name:** _____*(Must sign and print name in full.)

Submit completed requests to Network Development by fax to 1-888-553-2847

WCR

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.

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

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.)

Requester's name and address (optional)

6 City, state, and ZIP code

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.

Social security number

			–			–				

or

Employer identification number

		–							

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** ▶ | **Date** ▶

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.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.