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 NORTH CAROLINA

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NORTH CAROLINA** (hereinafter "the Agreement" or "this Agreement") is entered into by and between **DAVIS VISION, INC.,** (hereinafter "**DAVIS**") having its principal place of business located at 175 E. Houston Street San Antonio Texas, 78205 and **PARTICIPATING PROVIDER*** (hereinafter "**PROVIDER**") as defined herein below. **DAVIS** and **PROVIDER** are referred to individually herein 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 Program organizations, Medical Assistance Program 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 in order 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 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 set forth above are hereby incorporated into and made a part of this Agreement.

II
DEFINITIONS

.1 "**Amendment**" means any change to the terms of a contract, including terms incorporated by reference that modifies fee schedules. A change required by federal or state law, rule, regulation, administrative hearing, or court order is not an amendment.

.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 (HFCA) or any successor agency thereto.

.3 “**Clean Claim**” means a claim for payment for services which contains the following information: (a) a confirmation of eligibility number 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; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or Member. Claims from Participating Providers under investigation for fraud or abuse and claims submitted with a tax identification 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. “Compensation Schedule” means the fee schedule that is Exhibit “A”.

.5 “**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.

.6 “**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(s) Product, eye care diagnosis, treatment and eye care management services, and when applicable, ordering and dispensing plan eyeglasses from a **DAVIS** laboratory.

.7 “**Division of Medical Assistance**” (hereinafter “DMA”) means the North Carolina Division of Medical Assistance, a division of the North Carolina Department of Health and Human Services.

.8 “**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 statute(s) and/or regulation(s).

.9 “**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.

.10 "**Medical Assistance Program/Medicaid**" 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.

.11 "**Medical Necessity**" means those services or supplies which, pursuant to and in accordance with NCGS 58-3-200(b), are:

(1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
(2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
(3) Within generally accepted standards of medical care in the community; and
(4) Not solely for the convenience of the insured, the insured's family, or the **PROVIDER**.

For medically necessary services, nothing in this subsection precludes **DAVIS** and/or Plan(s) from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered. 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.

.12 "**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.

.13 "**Medically Appropriate/Medical Necessity**." With respect to programs **other than** Medicare, Medicare Advantage 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 anyone's convenience; 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.

.14 "**Medical-Record Information**" means personal information that:

(a) Relates to an individual's physical or mental condition, medical history, or medical treatment; and

(b) Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

.15 "**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.

.16 "**Medicare Advantage Member**" or "**Medicare Advantage** Subscriber" means an individual who is enrolled in and who is 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.

.17 "**Medicare Advantage Program**" shall mean a product established by Plan(s) pursuant to a contract with the CMS which complies with all applicable requirements of Part C of the Social Security Act, 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.

.18 "**Member**" or "**Enrollee**" means a person who is enrolled in a Plan (including enrolled dependents) and is entitled to receive Covered Services.

19. **"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 Materials and Supplies provided by DAVIS under this Agreement.

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

.21 "**Non-Covered Services**" means those vision care services which are not Covered Services under Plan Contracts.

.22"**North Carolina Department of Health and Human Services**" (hereinafter "NC DHHS") means an agency of the executive branch of the North Carolina State government, authorized by the North Carolina Administrative Code ("NCAC").

23 **"Over Payment/Off Set"** means the insurer may recover overpayments made to healthcare provider or healthcare facility due to one of the following reasons: (i) A DAVIS processing error, (ii) an incorrect or fraudulent clam 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.

.24 "**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 applicable to and binding upon Participating Provider(s) as defined herein.

.25 "**Personal Information**" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include privileged information.

26 "**Plan(s) or carrier**" means health maintenance organizations, Medicare Advantage organizations, Medicaid, 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 Plan Product administered by **DAVIS**.

.27 "**Plan Contract(s)**" means the agreement(s) between **DAVIS** and Plan(s) to provide or to arrange for the provision of vision care services to persons enrolled as Members of such Plan(s).

.28 "**Product**" means the vision care, benefit program services that shall be offered to Member(s) by the Plan(s) through Plan Contracts with **DAVIS**.

.29 "**Provider Manual**" means the **DAVIS,** Vision Care Plan Provider Manual, as amended from time to time by **DAVIS**, incorporated by reference and available to **PROVIDER** on **DAVIS**' website.

.30 "**State**" means the State of North Carolina or the state in which **PROVIDER**'s practice is located or the state in which the **PROVIDER** renders services to a Member.

.31 "**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.

.32 "**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).

.33 "**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.

III
SERVICES TO BE PERFORMED BY THE PROVIDER

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

(a) **PROVIDER** agrees the frame collection will be shown to all Members receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees the frame collection shall be openly displayed in an area accessible to all Members.
(c) **PROVIDER** shall maintain the frame collection in the exact condition in which it was 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 for frames.
(f) At any time and upon reasonable notice, **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection.
(g) Should the display and/or frame(s) contained in the collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume the 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 test, 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 Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO and of the Plan(s). 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, the 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 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/it's 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; and

.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 consistent, in form and content, with generally accepted standards and the requirements of **DAVIS** and Plan(s); and (2) promptly provide **DAVIS** and Plan(s) with copies of treatment records when requested; and (3) keep treatment records confidential. Treatment records shall be kept confidential, but **DAVIS** and/or Plan(s) 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 Plan(s) may perform their respective duties efficiently and effectively for the benefit of the Member.

IV
COMPENSATION

.1 **Billing and Claim Submission**. **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member, less any Copayment 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 of service delivery or such other time frame permitted under article IV .2 and IV .8 below, following the provision of Covered Services, submit to **DAVIS** a claim. Such claim may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**, and if applicable, shall be the standard claim form mandated by the State in which Covered Services were rendered. Failure of **PROVIDER** to submit said claim 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 Negative Balance, occurs for materials and supplies, Davis may offset such indebtedness against any compensation due to Provider pursuant to this agreement. In instances when Davis is not the primary payor, Provider will submit a claim to Davis no later than one hundred and eighty (180) days after receipt of payment from the primary payor, or in accordance with applicable State statute(s).

.2 **Compensation**. Pursuant to this Agreement, as full compensation for the Covered Services provided by **PROVIDER** to Members under applicable Plan(s), **DAVIS** shall pay **PROVIDER** the compensation amounts set forth in **Exhibit A** attached hereto, less any Copayment and Deductible collected or to be collected from the Member by the **PROVIDER**. Provider shall submit to Davis Vision all claims within 180 days after the date of the provision of care to the member by the Provider. Failure to submit the claim within 180 days after the date of the provision of service to the member does not necessarily invalidate or reduce the claim if it was not reasonably possible to submit the claim within the 180 day time frame, provided that the claim is submitted as soon as is reasonably possible and in no-event, except in the absence of legal capacity of the member, later than one year from the time submittal of the claim is otherwise required.

(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.

(b) 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.

.3 **Copayments, Deductibles**. **PROVIDER** shall bill and collect all Copayments 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

.4 **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.

.5 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees **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 Member(s), persons acting on Member(s)' behalf, from the MCO, the Plan, the NC DHHS, or the DMA, even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER.** However, this provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in

advance that the carrier may not cover or continue to cover specific services and the member chooses to receive the service. 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.

6. Negative Balance For Materials and Supplies. 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). When possible, **DAVIS** will automatically 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** within forty-five (45) days from 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.

7. Over Payment/ Off Set For Claims. At **DAVIS**' sole discretion, **DAVIS** may bill **PROVIDER** or Participating Provider for an Overpayment of claims. **DAVIS** will notify PROVIDER via written notice within thirty (30) days of over payment. 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 payables 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. Notwithstanding the foregoing, **DAVIS'** Overpayment recovery efforts shall comply with any legislative or statutory timeframe(s) specified within the jurisdiction where services were provided. Notwithstanding the foregoing **DAVIS** may not recover over payment(s) greater than two (2) years.

.8 **Payment of Claims**. **DAVIS** shall, within thirty (30) calendar days after receipt of a Claim, send by electronic or paper mail to the **PROVIDER**:

(1) Payment of the claim;
(2) Notice of denial of the claim;
(3) Notice that the claim is inadequate or incomplete;
(4) Notice that the claim is not submitted on the form required by **DAVIS**, by the contract between **DAVIS** and the Plan, or by applicable law;
(5) Notice that coordination of benefits information is needed in order to pay the claim; or
(6) (If applicable) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, **DAVIS** is presumed to have received a written claim five (5) business days after the claim has been placed first-class postage prepaid in the United States mail addressed to **DAVIS** or an electronic claim transmitted to **DAVIS** or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

(a) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by **DAVIS** to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through **DAVIS** which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, **DAVIS** shall pay the undisputed portion of the claim within thirty (30) calendar days after receipt of the claim and send the notice of the denial or contested status within thirty (30) days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the **PROVIDER**, **DAVIS** shall continue processing the claim and pay or deny the claim within thirty (30) days after receiving the additional information.

(b) If **DAVIS** requests additional information under subsection (a) of this section and **DAVIS** does not receive the additional information within ninety (90) days after the request was made, **DAVIS** shall deny the claim and send the notice of denial to the **PROVIDER** in accordance with subsection (a) of this section. **DAVIS** shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. **DAVIS** shall inform the **PROVIDER** in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one (1) year after the date of the denial notice closing the claim.

(c) Claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by **DAVIS** under subsection (a) of this section, interest on health benefit claim payments shall begin to accrue on the thirty-first (31st) day after **DAVIS** received the additional

information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the Plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which **DAVIS** is not liable.

(d) Insurers may require that claims be submitted within one hundred eighty (180) days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

(e) If a claim for which the claimant is a health care provider or health care facility has not been paid or denied within sixty (60) days after receipt of the initial claim, the insurer shall send a claim status report to the insured. Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under subsection (c) of this section. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured with a copy to the provider thirty (30) days after the previous report was sent.

(f) Subject to the timelines required under this section, **DAVIS** may recover overpayments made to the **PROVIDER** by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before **DAVIS** seeks overpayment recovery or offsets future payments, **DAVIS** shall give written notice to **PROVIDER,** which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two (2) years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by **PROVIDER** or **PROVIDER's** agents, or the claim involves **PROVIDER** receiving payment for the same service from a government payor. **PROVIDER** may recover underpayments or non-payments by **DAVIS** by making demands for refunds. Any such recoveries by **PROVIDER** of underpayments or nonpayment by **DAVIS** may include applicable interest under this section. The recovery of underpayments or non-payments shall be made within the two years after the date of the original claim adjudication, unless the claim involves **PROVIDER** receiving payment for the same service from a government payor.

(g) **DAVIS** shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pended, and the

insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(h) A violation of this section by **DAVIS** subjects **DAVIS** to the sanctions in G.S. 58-2-70. The authority of the Commissioner (NC Commissioner of Insurance) under this subsection does not impair the right of a **PROVIDER** to pursue any other action or remedy available under law. With respect to a specific claim, should **DAVIS** be paying statutory interest in good faith under this section, then **DAVIS** is not subject to sanctions for that claim under this subsection.

(i) **DAVIS** is not in violation of this section nor subject to interest payments under this section if **DAVIS**' failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond **DAVIS**' reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, **DAVIS** is not in violation of this section or subject to interest payments to the **PROVIDER** under this section if **DAVIS** has a reasonable basis to believe that the claim was submitted fraudulently and notifies the **PROVIDER** of the alleged fraud.

(j) Nothing in this section limits or impairs a Member's liability under existing law for payment of medical expenses.

.9 **Plan Hold Harmless**. **PROVIDER** agrees he/she/it 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.

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 the CMS, or other appropriate governmental agency; **PROVIDER** shall provide to **DAVIS** and/or Plan(s) all data and information in **PROVIDER**'s possession pertaining to Covered Services hereunder. 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) and/or MCOs 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 the 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, 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 the 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 payer(s) such charges for which the other payer(s) are 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 to **DAVIS** for payment.

.3 **Compliance with Laws 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, 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/it's 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 on **DAVIS** by State and federal law, as amended, and all regulations issued pursuant thereto.

.4 **Compliance with DAVIS 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 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 the instances when **DAVIS**' rules are not in compliance, applicable federal and State 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), NC DHHS, DMA 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, and Medicare Advantage (and any successor program thereto), Medicaid and MAP laws and regulations, the CMS instructions and policies, and DMA regulations; agrees to audits and inspections by the 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 and 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 **DAVIS** is accountable and responsible to the State MAP which shall, on an ongoing basis, monitor performance under this Agreement to ensure the performance of the Parties is consistent with the Plan Contract between **DAVIS** and the MCO and consistent with the contract between the State MAP and the MCO.

(c) In relation to the provision of Covered Services to Medicare and Medicare Advantage Members and Plan(s) hereunder, **PROVIDER**, and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare Advantage credentialing and re-credentialing requirements and processes and agree to all of the following: **DAVIS** and Plan(s) are ultimately accountable and responsible to the CMS for services delivered

and performed by **PROVIDER** hereunder; and all such services must be delivered and performed in accordance with the requirements of Plan agreements with the CMS and with Medicare laws and regulations; such services shall, on an ongoing basis, be monitored by the Plan(s) and/or the CMS and/or their respective delegates; the Plan(s) and/or the CMS retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s); the Managed Care Organization (MCO) is accountable to the CMS for any functions and responsibilities described in the Medicare regulations pursuant to 42 CFR §422.504; and **PROVIDER** is required to comply with the MCO's policies and procedures.

.5 **Confidentiality of Member Information**. **PROVIDER** shall be bound by the same standards of confidentiality which apply to the NC DHHS, the DMA and the State of North Carolina including but not limited to unauthorized uses of or disclosures of Personal Information, and the standards of confidentiality pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

(a) **PROVIDER** shall safeguard all Personal Information about Members according to applicable Federal and State laws and regulations, including the North Carolina General Statutes, Chapter 58, Article 39. All material and information, in particular information relating to Members which is provided to or 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 Federal and State laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of his/her/its obligations and securement of his/her/its rights under this Agreement. 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 or the storage of Protected Health Information ("PHI"), as defined by Title 45 of the CFR, Part 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. **PROVIDER** and **DAVIS** acknowledge 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, to the extent HIPAA or such implementing regulations require amendments(s) hereto, **PROVIDER** and **DAVIS** shall conduct good faith negotiations to amend this Addendum. **PROVIDER** shall maintain adequate medical, financial and administrative records related to covered services rendered by **PROVIDER**, in accordance with federal and State law.

.6 **Consent to Release 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, contracting Plans will have the right to oversee and review the quality of care administered to Members. **PROVIDER** agrees to cooperate with contracting Plan(s)' medical directors in the medical directors' 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 the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS** and the requirements of the North Carolina Administrative Code, Title 11, Insurance, Chapters 20.0404 and 20.0202(6). **PROVIDER** agrees 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) and the CMS. Such documentation shall include, but is not limited to, proof of: National Provider Identifier number, licensure, accreditation, credentials, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees **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 privileges 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 at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall immediately notify **DAVIS in writing**, in the event **PROVIDER** suffers a suspension or termination of license or professional liability insurance coverage. *Should **PROVIDER** experience any change(s) to the information provided to **DAVIS** on his/her/its last credentialing application **PROVIDER** shall notify **DAVIS,** in writing and within thirty (30) calendar days of such an occurrence*. **PROVIDER** shall ensure that vision care services provided under this Agreement are of a quality consistent with accepted professional practices. **PROVIDER** agrees to 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 DHHS, the NC DHHS, the DMA, or other 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.

Further, the **PROVIDER** shall cooperate with and allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hours admissions. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity.

.10 **Hours and Availability of Services**. 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 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 **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 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 thirty (30) calendar days' notice if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/it's office location, (c) change his/her/its place of employment (d) change his/her/it's employer, or (e) reduce capacity at an office location. The thirty (30) 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**.

.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, subcontractors, or independent contractors.

(a) To the extent applicable, **PROVIDER** agrees to indemnify and hold harmless the State and the CMS from all losses, damages, expenses, claims, demands, suits and actions

brought by any party against the State or the CMS as a result of a failure of **PROVIDER** or **PROVIDER**'s agents, employees, subcontractors or independent contractors to comply with the Non-Discrimination provisions contained 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 an amount acceptable to the Carrier and no less than 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 or affiliates, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In addition, and 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. **PROVIDER** shall notify the Carrier and **DAVIS**, of any change, reduction, restriction, or loss of his/her/it's professional, malpractice liability insurance on a timely basis and within ten (10) days of such occurrence(s). The foregoing policies shall not limit **PROVIDER**'s ability to indemnify the State or Enrollees of a Medical Assistance Program.

.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 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 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 HHS 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) as applicable, **PROVIDER** and Participating Provider(s) agree Covered Services and information regarding treatment options 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 he/she/it be in violation of any portion of this Article 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, 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 or ameliorate 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 all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier, as applicable.

(a) **PROVIDER** understands and agrees meeting the Participation Criteria is a condition precedent to **PROVIDER**'s participation, and a condition precedent to the participation by **PROVIDER**'s employees, 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 and understands this Agreement shall automatically be terminated if **PROVIDER**, or 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 be improper.

.16 **Provider Directory**. **PROVIDER** understands and agrees that, pursuant to N.C. Administrative Code Title 11 Section .0202, **DAVIS** and Plan(s) are obligated to maintain and update provider directories that include listings of network providers available to Members. Such directories shall include **PROVIDER's** name, address, telephone number, type of practice, and willingness to accept new patients and shall be available for distribution via printed or electronic means. 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 the CMS regulations, **PROVIDER** agrees 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,** to 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 minimum of 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 and 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 and 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 Provider(s) 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 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.

(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 program hereunder, will be retained and safeguarded by the **PROVIDER** and **PROVIDER**'s 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) In accordance with NCAC 20.020(11) **PROVIDER** shall:

(i) Maintain confidentiality of Member medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.

(ii) Maintain adequate medical and other health records according to industry, carrier, and Plan standards.

(iii) Make copies of such records available to the carrier, and to the NC Department of Insurance in conjunction with its regulation of the carrier.

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

.18 **Subcontractors**. **PROVIDER** agrees 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 or any addenda or attachment hereto without the prior, written approval of **DAVIS**, the Medicare Advantage Plan and the CMS. Failure to obtain prior, written approval may result, at the discretion of **DAVIS** or Plan, in the immediate termination of **PROVIDER** and/or Participating Provider(s). **PROVIDER** agrees if **PROVIDER** enters into any permitted subcontracts or lease arrangements to render any health/vision care services 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 his/her/it's 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 the 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 provided within the timeframe communicated to **PROVIDER** upon receipt of a 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 a 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.** This agreement shall continue in effect until termination by either party upon ninety (90) days written notice of intent to terminate sent by certified mail. Such termination shall have no effect upon the rights and obligations of the parties arising out of transactions occurring prior to the effective date of termination. In event of termination of this agreement, Provider shall complete all Covered Services initiated prior to termination.

VII
TERMINATION OF THE AGREEMENT

.1 **<u>Termination Without Cause</u>**. 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 an initial Term hereof, or for a reason other than those set forth in Sections VII.1 and VII.2 hereof, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**'s request or within such time as is required by applicable law or regulation.

.2 **<u>Termination With Cause</u>**. **DAVIS** may terminate this Agreement immediately for cause or may suspend continued participation as set forth below. <u>"Cause" shall mean:</u>

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

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

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

(d) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement, to include but not be limited to fraud;

(e) a conviction of a felony;

(f) a loss or suspension of a Drug Enforcement Administration (DEA) identification number;

(g) a voluntary surrender of **PROVIDER**'s license to practice in any state in which the **PROVIDER** serves as a **DAVIS** provider while an investigation into the **PROVIDER**'s competency to practice is taking place by the state's licensing authority; and/or

(h) the bankruptcy of **PROVIDER.**

<u>"Cause" for the purposes of suspension shall mean:</u>

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

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

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

(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.

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

.3 **<u>Termination Related to Medicare Advantage</u>**. 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 **<u>Responsibility for Members at Termination</u>**. Pursuant to Title 11 NCAC 20.0202(5), in the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), or in the event that **DAVIS** and/or Plan(s) become insolvent, **PROVIDER** shall cooperate with **DAVIS** in the transition of administrative duties and records and 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 minimum transitional period of sixty (60) 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 rates contemplated for Covered Services in this Agreement.

(a) Pursuant to 11 NCAC 20.0202(5), in the case of insolvency with health maintenance organization or of DAVIS, PROVIDER's continuing obligations after termination of this Agreement shall, after the health maintenance organization or DAVIS' insolvency, include the transition of administrative duties and records and the continuation of the provision of Covered Services to Enrollee(s) for the duration of the period for which premium payment has been made and, if applicable, until the Enrollee's discharge from inpatient facilities.

(b) 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 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.

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

(d) Notwithstanding the foregoing, should this Agreement be terminated "for Cause", as defined in this Agreement, **PROVIDER** shall cooperate with **DAVIS** and/or Plan to ensure the orderly transition of (a) any Member(s) receiving Covered Services from **PROVIDER** to the care of any Provider designated by **DAVIS** and/or Plan, and (b) **PROVIDER**'s administrative duties and records.

(e) **PROVIDER** consents to make reasonable accommodations should **DAVIS** and/or Plan request **PROVIDER** assume the provision of Covered Services for Member(s) transitioned from another Provider.

.5 **Provider Rights Upon Termination**. Except as otherwise required by law, **PROVIDER** agrees, 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.

(a) **PROVIDER** acknowledges and agrees Plan(s) have the authority to determine whether a **PROVIDER** shall be suspended or terminated from participation in a particular Plan without termination of this Agreement However, Plan(s) 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 **Return of Materials, Payments of Amounts Due and Settlement of Claims**. If applicable and upon reasonable notice, **DAVIS** may reclaim frame samples at any time during the Term of this Agreement. Upon 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** may setoff any monies due from **PROVIDER** to **DAVIS**. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims.

.7 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above, or should **PROVIDER** move his/her/its office location, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to notify effected Member(s) 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** with thirty (30) days advance written notice to **PROVIDER**. Notwithstanding the foregoing, this Agreement may also be amended by written consent of the Parties hereto.

2. **Modification of Compensation Schedule**. **DAVIS** shall provide **PROVIDER** with sixty (60) days advance written notice for amendments to the terms of this Agreement, either explicit herein or incorporated by reference, which modify the Compensation Schedule (Exhibit A). Such notice will be dated and labeled as "Amendment" and shall be signed by **DAVIS** and include an effective date for the proposed Amendment. Changes to the Compensation Schedule due to a change required by federal or State law, rule, regulation, administrative hearing or court order, shall not be deemed an amendment for this purpose.

(a) **Provider's Right To Objection**. **PROVIDER** receiving a proposed Amendment is given sixty (60) days from the date of receipt to object to the proposed amendment. Failure to object in writing, within sixty (60) days, shall result in the adoption of the proposed amendment. Should a **PROVIDER** object to the proposed Amendment and should the

Parties be unable to reach agreement, the proposed Amendment shall not be effective, and **DAVIS** shall be entitled to terminate this Agreement upon sixty (60) days written notice to **PROVIDER**.

.3 **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, or if **PROVIDER** does not provide **DAVIS** with a written notice of termination in accordance with the termination provision(s) contained herein, **DAVIS** may execute said document as agent of **PROVIDER** and said document shall be deemed to be executed by **PROVIDER**.

.4 **Modification of Law, Rules, and 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 necessitating an execution of written amendments. Nonetheless, **DAVIS** shall employ its best efforts to notify **PROVIDER** of such occurrences, where necessary, within a practicable timeframe.

.5 **Upon Request of the 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 the 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 the terms of this Agreement available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities and 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 and 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 to 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 Programs 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**, in its sole and absolute discretion, 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 the decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment for those services rendered to a Member which are determined to not be Medically Appropriate or of poor quality or to be services for which **PROVIDER** failed to receive a confirmation of eligibility prior to rendering services.

.4 **Grievance Procedures**. Subject to **PROVIDER**'s rights of appeal, **PROVIDER** shall comply and be bound by the grievance procedure which, in the sole discretion of **DAVIS** and Plan(s) shall be established in accordance with applicable statutes and their implementing regulations for the processing of any patient or **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 Section V.4 "Compliance with **DAVIS** Rules" herein. Further, **PROVIDER** agrees under NCAC 20.0202(12), **PROVIDER** is obligated to cooperate with Member(s) in Member grievance procedures.

.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 **<u>Provider Participation/Cooperation with UR/QM Programs</u>**. 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 MA Program Members. Notwithstanding the foregoing, **PROVIDER**'s obligations to comply with **DAVIS**' utilization management program, credential verification program, quality management program and provider sanction program shall not negate **PROVIDER**'s professional or ethical responsibility or impede **PROVIDER** from providing information or assistance to Members. Notwithstanding the foregoing, **DAVIS** on behalf of carrier, may provide data and information to **PROVIDER** such as:

(a) Performance feedback reports or information to the **PROVIDER**, if compensation is related to efficiency criteria.

(b) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. Notification of changes in these requirements shall also be provided by the carrier, allowing **PROVIDER** time to comply with such changes.

X
GENERAL PROVISIONS

.1 **<u>Arbitration</u>**. Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof, will be settled by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the Parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorneys' fees and costs to the prevailing Party.

.2 **<u>Assignment</u>**. 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, the PROVIDER shall not assign, delegate or transfer any of his/her/its rights duties and obligations hereunder without receiving the prior, written consent of the Carrier. Carrier shall notify PROVIDER in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer. Further, **DAVIS** may, with **PROVIDER**'s prior written consent, assign, delegate or transfer its duties and obligations under 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.

.3 **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.

.4 **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.

.5 **Entire Agreement of the Parties**. This Agreement and the **DAVIS** Provider Manual, supersede 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 no representations, inducements, promises, or agreements, oral or otherwise, have been made by either Party, or anyone acting on behalf of either Party which are not embodied herein, and 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 and signed by the Party to be charged.

.6 **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the state in which **PROVIDER** maintains his, her, or its principal office or, if a dispute concerns a particular Member, in the state in which **PROVIDER** rendered services to that Member.

.7 **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.

.8 **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**.

.9 **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.

.10 **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 postage prepaid mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of five (5) business days after mailing. Notice may also be made by certified or registered mail and

are deemed received as of the date on the return receipt or for commercial carriers on the day of delivery. Notices shall be delivered or mailed to the persons and addresses of the respective Parties appearing herein. Either Party hereunder may change its address by providing written notice in accordance with this paragraph. Notices may be sent to Davis Vision - 175 E. Houston St. | San Antonio, TX 78205

.11 **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.

.12 **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.

.13 **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.

.14 **Use of Name**. **DAVIS** reserves the right to the control and to the use of its name(s) and all copyright(s), symbol(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.

.15 **Waiver**. The waiver of any provision or of the breach of any provision of this

Agreement must be set forth specifically in writing and signed by the waiving Party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision herein.

.16 **Terms of Agreement**. The terms of this Agreement are controlling. The Policies & Procedures of Davis Vision shall not conflict with or override any term of the Agreement, including contract fee schedules. In the event of a conflict between a Policy or Procedure of Davis Vision and the language in this Agreement, the language of this Agreement will prevail.

SIGNATURE PAGE TO FOLLOW-

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

PROVIDER:
Signature:____
Print Name:____
Print Title:____
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 Uniform Application to Participate as a Health Care Practitioner and/or submission of a signed Participating Provider Agreement for the State of North Carolina does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's fully and properly completed Application to participate as a Health Care Practitioner and on the execution by practitioner of the Participating Provider Agreement for the State of North Carolina, and on the receipt by practitioner of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a practitioner's acceptance by **DAVIS** as a **PROVIDER**, should additional practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Members of Plans under Plan Contract(s) with **DAVIS**, such additional 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 this Agreement.

DAVIS VISION, INC.:
175 E. Houston St. | San Antonio, TX 78205

Signature: ____
Print Name:____
Print Title:____
Print Date:____
[**For DAVIS use ONLY**]

Effective Date:____
[**For DAVIS use ONLY**]

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

EXHIBIT A

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 $45.00 - $60.00
(**Including dilated fundus examination)

Eyeglass Frame Dispensing Fee+ Ranges from $20.00 - $40.00
(+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^ Ranges from $30.00 - $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.)

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)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	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.