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 OHIO

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF OHIO** (hereinafter the "Agreement") is entered into by and between **DAVIS VISION, INC.**, (hereinafter "**DAVIS**") having its principal place of business located at 159 Express Street, Plainview, New York 11803 and **PARTICIPATING PROVIDER** (hereinafter "**PROVIDER"**) as defined herein below. **DAVIS** and **PROVIDER** are individually referred to herein as "Party" and collectively referred to 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, employers, 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 the "Network") to provide, or to arrange for the provision of, or in order to grant access to the vision care services (hereinafter "Covered Services") of the Network to individuals or employees (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 Covered Services on behalf of **DAVIS** to Members of Plan(s) under Plan Contract 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 part of this Agreement.

II
DEFINITIONS

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

.2 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a confirmation of eligibility number assigned by **DAVIS**, referencing a specific Member, and Member's information; (b) a valid, **DAVIS-**assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation was performed; (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, as promulgated by the rules and regulations for payment of Covered Services of said jurisdiction, shall be deemed a Clean Claim.

.3 "**Copayment**", "**Coinsurance**" or "**Deductible**" means those charges for vision care services, which are the responsibility of the Member under a benefit Product 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 Product. Such charges are herein also referred to as "cost sharing" as pertains to charges for which a dually eligible Medicare Advantage Subscriber is responsible.

.4 "**Covered Families and Children Medicaid**" (hereinafter "CFC") (including Healthy Start, Healthy Families) means a Federal and State financed grant-in-aid program administered by the State providing medical coverage to low-income families, children and pregnant women who meet eligibility criteria of Chapter 5101:1-39 and 5101:1-40 of the Ohio Administrative Code (hereinafter "OAC").

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

.6 "**Edit**" means adjusting one or more procedure codes billed by **PROVIDER** on a claim for payment or a practice that results in any of the following: (1) payment for some but not all of the procedure codes originally billed by **PROVIDER**; (2) payment for a different procedure code than the procedure code originally billed by **PROVIDER**; or (3) a reduced payment as a result of services provided to a Member that are claimed under more than one procedure code on the same service date.

.7 "**Electronic Claims Transport**" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States Department of Health and Human Services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the Parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.

.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 "**Healthy Families**" is Ohio's name for the Covered Families and Children Medicaid eligibility program which provides Medicaid services for families who meet certain income limits.

.10 "**Healthy Start**" is the name for the Covered Families and Children Medicaid eligibility program which provides Medicaid services for pregnant women, infants, and children up to specified ages and income limits.

.11 "**Managed Care Organization**" ("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.

.12 "**Material Amendment**" means an amendment to this Agreement that decreases **PROVIDER**'s payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase **PROVIDER**'s administrative expenses, or adds a new product. A material amendment does not include any of the following: (1) a decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in this Agreement; (2) a decrease in payment or compensation that was anticipated under the terms of this Agreement, if the amount and date of applicability of the decrease is clearly identified in this Agreement; (3) an administrative change that may significantly increase the **PROVIDER**'s administrative expense, the specific applicability of which is clearly identified in this Agreement; (4) changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the **PROVIDER**'s administrative expense; (5) changes to an Edit program or to specific Edits if the **PROVIDER** is provided notice of the changes pursuant to §3963.04(A)(1) of the Ohio Revised Code ("ORC") and the notice includes information sufficient for **PROVIDER** to determine the effect of the change; (6) changes to this Agreement described in §3963.04(B) of the ORC.

.13 "**Medicaid**" means the joint Federal and State program providing medical assistance to low income persons pursuant to 42 U.S.C. §1369 et seq.

.14 "**Medical Assistance Program/Medicaid**" ("MAP") means the joint Federal and State program, administered by 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.

.15 "**Medical Necessity**" / "**Medically Necessary Services**" With respect to the Medicaid and/or Medical Assistance (MAP) programs, "Medical Necessity" or "Medically Necessary Services" are those services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an

illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee, and if applicable, meet the general principles regarding reimbursement for Medicaid Covered Services set forth in rule 5101:3-1-02 of the Ohio Administrative Code. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. A course of treatment may include mere observation or where appropriate no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not Medically Necessary Services for purposes of this Agreement.

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

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

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

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)

(i) be appropriate within generally accepted standards of practice;

(ii) be efficacious, as demonstrated by scientifically supported evidence;

(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and

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

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

(d) The Covered Service, or the specific use thereof, for which coverage is requested is not experimental or investigational. A service or the specific use of a service is investigational or

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

.17 "**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.

.18 "**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.

.19 "**Medicare Advantage Member**" or "**Medicare Advantage Subscriber**" means an individual who is enrolled in or who has entered into contract with or on whose behalf a contract has been entered into with Plan(s), for the provision of Covered Services 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.

.20 "**Medicare Advantage Program**" shall mean a benefit program/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.

.21 "**Member**" or "**Enrollee**" means an individual and the eligible dependent(s) of such an individual, or an employee, or a member of an organization sponsoring a multiple employer welfare arrangement, who is enrolled in or who has entered into contract with, or on whose behalf a contract has been entered into with Plan(s), and who is eligible to receive Covered Services.

.22 "**Multiple Employer Welfare Arrangement**" means an employee welfare benefit plan, trust or any other arrangement, whether such plan, or arrangement is subject to the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended, that is established or maintained for the purpose of offering or providing, through group insurance or group self-insurance programs, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident,

disability, or death, to the employees, and their dependents, of two or more employers, or to two or more self-employed individuals and their dependents.

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

.24 "**Network**" means the arrangement of Participating Providers established to provide services to eligible Members and Enrollees under Plan Contract(s).

.25 "**Non-Covered Services**" means those vision care services which are not Covered Services under Plan Contract(s).

.26 "**Ohio Administrative Code**" ("OAC") means the codification of the rules of the administrative agencies of the State of Ohio.

.27 "**Ohio Department of Job and Family Services**" (**"ODJFS**") refers to the agency responsible to administrate the Medicaid program(s) in the State of Ohio.

.28 "**Ohio Revised Code**" ("ORC") means all statutes of a permanent and general nature of the State of Ohio as revised and consolidated into general provisions, titles, chapters, and sections. Any terms that are defined terms in the ORC at §§1751, 3963, and 5111.17 and are used herein are to be understood to be used in a manner consistent with the ORC.

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

.30 "**Participating Provider**" means; a licensed health facility which or a licensed health professional who has entered into an agreement with a Plan(s) or with **DAVIS** to provide Medically Appropriate/Medically Necessary 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.

.31 "**Plan(s)**" means health maintenance organizations, Medicare Advantage organizations, Covered Families and Children Medicaid (CFC), 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**.

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

Plan(s).

.33 "**Procedure Codes**" includes the American Medical Association's current procedural terminology code (CPT) and the Centers for Medicare and Medicaid Service's health care common procedure coding system.

.34 "**Product**" means the vision care, benefit program services that shall be offered to Member(s) by the Plan(s) through Plan Contracts with **DAVIS** and for which **PROVIDER** may be obligated to provide vision care services pursuant to this Agreement. Such Product(s) may include a health maintenance organization or other product provided by a health insuring corporation; a preferred provider organization; Medicare; and/or Medicaid or the children's buy-in program established under §5101of the ORC.

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

.36 "**State**" means the State of Ohio, or the state in which **PROVIDER**'s practice is located or the state in which the **PROVIDER** renders services to a Member.

.37 "**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.

.38 "**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).

.39 "**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 **<u>CFC Medicaid and Medicaid Members</u>**. **PROVIDER** agrees to:

(i) identify Members who require sign language and oral interpretation and/or oral translation services;

(ii) consult with such identified Member(s) with regard to Member's preferred method of communication and arrangement for said services; and

(iii) provide such services at no cost to Member(s) and **DAVIS**.

.2 **CFC Medicaid and Medicaid Member's Medical Records**. **PROVIDER** agrees to make Member medical records available for transfer to new provider(s) at no cost to Member.

.3 **CFC Medicaid and Medicaid Member's Right to Hearing**. **PROVIDER** agrees to mail or to personally deliver notice of the Member(s)' right to request a State hearing whenever the **PROVIDER** bills a Member for a Non-Covered Service due to denial of payment by **DAVIS** or Plan(s), utilizing the procedures and forms as specified in OAC rule 5101:6-2-35, and as amended.

.4 **CFC Medicaid and Medicaid Member's Right to Anonymity**. **PROVIDER** agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting Member(s) by mail.

.5 **CFC Medicaid and Medicaid Missed Appointments**. **PROVIDER** agrees not to bill CFC Medicaid and Medicaid Members for missed appointments.

.6 **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 at any other time upon reasonable notice. **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.

.7 **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).

.8 **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 Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO and the Plan(s). Throughout the entire Term(s) of this Agreement, **PROVIDER** shall maintain in good working condition, all necessary diagnostic equipment in order to perform all Covered Services as defined in this Agreement.

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

.9 **Scope of Practice**. The Parties acknowledge and agree nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current, prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to any of the following:

(a) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
(b) Any information the Member needs in order to decide among all relevant treatment options;
(c) The risks, benefits, and consequences of treatment versus non-treatment;
(d) The Member's right to participate in decisions regarding his or her vision care, including the right to refuse treatment, and to express preferences about future treatment decisions;
(e) 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
(f) 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.

.10 **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) shall keep treatment records confidential. Treatment records shall be kept confidential, but **DAVIS** and/or Plans shall have a mutual right to a Member's treatment records, as well as timely and appropriate communication of Member information, so that both the **PROVIDER** and Plans may perform their respective duties efficiently and effectively for the benefit of the Member.

IV
COMPENSATION

.1 **Billing**. For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within one hundred and eighty (180) days following the provision of Covered Services, submit to **DAVIS** a Clean Claim which, may be written, electronic or verbal; 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 invoice within one hundred and eighty (180) days of service delivery will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered.

.2 **Compensation**. **DAVIS** shall pay **PROVIDER** the compensation amounts indicated on **Exhibit A** and the "Summary Disclosure Form" appended hereto and made a part hereof, as full compensation for the Covered Services provided by **PROVIDER** to Members under an applicable Plan pursuant to this Agreement. Should a dispute arise between the terms and conditions of this Agreement and the contents of the Summary Disclosure Form, this Agreement shall control.

(a) In accordance with 42 CFR §422.504(g)(1)(iii), and to the extent applicable, **PROVIDER** agrees that dually eligible Medicare Advantage Subscribers 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, Coinsurances, Deductibles and Discount**. **PROVIDER** shall bill and collect all Copayments, Coinsurances and Deductibles from Member(s), which are specifically permitted and/or applicable to Member(s)' benefit plan. **PROVIDER** shall bill and collect all charges from a Member for those Non-Covered Services provided to a Member. **PROVIDER** may only bill the Member when **DAVIS** has denied confirmation of eligibility for the service(s) and when the following conditions are met:

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

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

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

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

.4 **Financial Incentives**. **DAVIS** shall not provide **PROVIDER** with any financial incentive to withhold Covered Services, which are Medically Appropriate. Further, the Parties 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**. **PROVIDER** agrees in no event, including but not limited to nonpayment by **DAVIS**, insolvency of **DAVIS**, or breach of this Agreement shall **PROVIDER** bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services pursuant to this Agreement. This does not prohibit **PROVIDER** from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the DAVIS or its successor. Further, and 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 from the MCO, the Plan, the MAP, or the ODJFS for Covered Services, even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, either now existing or hereinafter entered into between any Member(s) or person acting on Member(s)' behalf and **PROVIDER** which relate to liability for payment; and shall survive termination of this Agreement regardless of the reason for termination, including the insolvency of **DAVIS** or Plan(s); and 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 **Payment of Compensation**. Payment to **PROVIDER** shall be made within thirty (30) days of receipt of a Clean Claim by **DAVIS, or in accordance with the state's "prompt pay" or similar applicable statute, whichever is most restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member, less any Copayments, Coinsurances and Deductibles collected or to be collected from the Member. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

(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 **PROVDER** determines are Medically Necessary or Medically Appropriate within the scope of **PROVIDER**'s practice and in accordance with applicable laws and ethical standards.

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

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

.9 **Overpayment Recovery**. At **DAVIS**' sole discretion, **DAVIS** may bill **PROVIDER** or Participating Provider for an Overpayment. **PROVIDER** shall be responsible to remit payment on such an Overpayment invoice within forty-five (45) days from receipt of invoice. Should **DAVIS** not receive payment within the aforementioned timeframe, **DAVIS** will, when legally permissible, automatically apply the Overpayment to other outstanding 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, should this provision conflict with any applicable rules and regulations, said rules and regulations shall govern. Notwithstanding the foregoing, **DAVIS**' Overpayment recovery efforts shall comply with any legislative or statutory timeframe(s) specified within the jurisdiction where services were provided.

V
OBLIGATIONS OF PROVIDER

.1 **Access to Records**. To the extent applicable and necessary for **DAVIS** and/or Plan(s) to meet their respective data reporting and submission obligations to the CMS, to ODJFS, 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 CMS instructions and policies under 42 CFR §422.210; and

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

.1.6 **PROVIDER** shall certify (based upon best knowledge, information and belief) the accuracy, completeness and truthfulness of **PROVIDER**-generated encounter data that **DAVIS** and/or Plan(s) are obligated to submit to 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 Law 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, the instructions and policies of the CMS, and **DAVIS**' and Plan(s)' credentialing policies, processes, utilization review, quality improvement, medical management, peer review, complaint and grievance resolution programs, systems, and procedures. If at any time during the Term of this Agreement **PROVIDER's** license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall immediately notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect. **PROVIDER** agrees to cooperate with **DAVIS** in order that **DAVIS** may comply with any requirements imposed by state and federal law as amended, and all regulations issued pursuant thereto.

.4 **Compliance with Rules, Policies, Administrative Requirements & Procedural Guides**. **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 **DAVIS** Provider Manual. **PROVIDER** recognizes **DAVIS** may, from time to time, amend such provisions and 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 state and federal laws and regulations shall take precedence and govern. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

(a) To the extent that a requirement of the Medicare, Medicare Advantage, or Medicaid Program is found in a policy or other procedural guide of **DAVIS,** Plan(s), ODJFS, DHHS, 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 (i) Medicare, Medicare Advantage (and any successor program thereto), Medicaid and MAP laws and regulations, (ii) CMS instructions and policies, as well as cooperating and assisting with and providing information for audits and inspections by the CMS and/or its designees, and by maintaining records a minimum of ten (10) years, (iii) ODJFS regulations, (iv) and **DAVIS**' and Plan(s)' policies regarding credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, 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), peer review, complaint, grievance resolution and appeals processes, (including OAC Rule 5101:3-26-01) comparative performance analysis, and enforcement and monitoring by appropriate government agencies. Further, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the State MAP, the ODJFS and any other state agency responsible for the administration of Medicaid program(s) which, on an ongoing basis, shall monitor performance under this Agreement to ensure performance of the Parties is consistent with the Plan Contract(s) between **DAVIS** and the MCO and consistent with the contract(s) between the State MAP and the MCO.

(c) **PROVIDER** acknowledges and agrees 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 and Medicare Advantage credentialing and re-credentialing requirements and processes and agrees 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; all services delivered and performed by **PROVIDER** hereunder must be delivered and performed in accordance with all requirements of Plan(s) 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 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 and responsible 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 MCO's policies and procedures.

.5 **<u>Confidentiality of Member Information</u>**. **PROVIDER** shall be bound by the same standards of confidentiality which apply to the ODJFS and the State of Ohio as described in OAC rule 5101:1-1-03, including unauthorized uses of or disclosures of patient information and personal health information.

(a) **PROVIDER** shall safeguard all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members which is provided 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 state and federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of **PROVIDER**'s obligations and the securement of **PROVIDER**'s rights under this Agreement.

(b) Neither **DAVIS** nor **PROVIDER** shall share confidential information with any Member(s)' employer, absent the Member(s)' written consent for such disclosure. **PROVIDER** agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange and to the storage of Protected Health Information ("PHI"), as defined by Title 45 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.

(c) **PROVIDER** and **DAVIS** acknowledge and agree the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. The Parties agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. The Parties further agree they shall conduct good faith negotiations to amend this Agreement to the extent HIPAA or such implementing regulations require amendments(s) hereto. **PROVIDER** shall maintain adequate medical, financial and administrative records related to Covered Services rendered by **PROVIDER**, in accordance with Federal and State law.

.6 **<u>Consent to Release PROVIDER Information</u>**. 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 **<u>Cooperation with Plan Medical Directors</u>**. **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 Plan(s)' medical directors in the medical directors' review of the quality of care administered to Members.

.8 **<u>Credentialing, Licensing and Performance</u>**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees 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. **PROVIDER** agrees to provide services within the scope of **PROVIDER**'s license(s) and certification(s) and within the scope of the Plan(s) Product(s) as provided to **PROVIDER**, from time to time, by **DAVIS.** **PROVIDER** agrees he/she/it 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** and Plan(s) or the CMS. Such documentation shall include, but shall not be limited to, proof of: National Provider Identifier ("NPI") number, licensure, 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 Network participation privileges or to remove any professional from Network participation 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 a termination of license or of professional liability insurance coverage. **PROVIDER** shall; (a) devote the time, attention and energy necessary for the competent and effective performance of duties hereunder to Member(s); (b) ensure that vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices; and (c) abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

(a) In order for **PROVIDER** to provide services to CFC Medicaid and/or Medicaid Members, **PROVIDER** must have a current Medicaid provider number, must meet the qualifications specified in OAC Rule 5101:3-26-05(C), and must not have previously had a Medicaid provider number which was terminated, suspended, denied, or not renewed as a result of any action in accordance with the ORC, the OAC, the CMS, or the Medicaid fraud unit of the office of the Ohio Attorney General.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, DHHS, MAP, ODJFS 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. **PROVIDER** shall provide all such access to the aforementioned records in the form and format requested and at no cost to **DAVIS** and/or to the requesting Oversight Entity. Further, the **PROVIDER** shall cooperate with allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after-hours access. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity.

.10 **Hours and Availability of Services**. Pursuant to and in accordance with 42 CFR §438.206(c)(1), as amended, **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. Services not requiring emergency care shall be provided on a timely basis. **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** fail to comply with timely access standards and that Plan(s) have the right to approve **DAVIS**' scheduling and administration standards.

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

.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, subcontractor or independent contractors to comply with 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 of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER's** agents, servants or employees, affiliates, independent contractors, and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** when so requested. In addition, and in the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall maintain "tail coverage," with the same liability limits, following the effective termination date of the foregoing policy. The foregoing policies shall not limit **PROVIDER**'s ability to indemnify the Sate or Enrollees of a Medical Assistance Program. Should **PROVIDER**'s liability insurance coverage be cancelled or reduced, **PROVIDER** shall notify **DAVIS** no later than ten (10) days after **PROVIDER**'s receipt of notice of such cancellation or reduction of coverage.

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

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** shall

comply with the "General Prohibitions Against Discrimination," 28 CFR §35.130 and similar regulations or guidelines that apply to the agencies with which Plan(s) contract. In accordance with Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) (45 CFR 84) and the Age Discrimination Act of 1975, (42 U.S.C. §6101 et seq.) (45 CFR 91) and the Rehabilitation Act of 1973, (29 U.S.C. §701 et seq.), and the regulations implementing the Americans with Disabilities Act ("ADA"), (42 U.S.C. §12101 et seq.) (28 CFR §35.101 et seq.), **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence), claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and in conformity with all laws applicable to the receipt of federal funds, including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised DHHS LEP Guidance"); and **PROVIDER** agrees to promote, observe and protect the rights of Members as patients. Pursuant to and in accordance with 42 CFR §438.206(c)(2), **PROVIDER** and Participating Provider(s) agree Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and **PROVIDER** shall maintain written procedures as to interpretation and translation services for Members requiring such services. During the Term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee's or applicant's hire, tenure, terms, conditions, or privileges of employment due to such individual's race, color, religion, gender, disability, marital status or national origin.

.14 **Notice of Non-Compliance and Malpractice Actions**. **PROVIDER** shall notify **DAVIS** immediately, in writing, should **PROVIDER** be in violation of any portion of this Section V. However, with respect to professional liability and malpractice insurance, **PROVIDER** shall notify **DAVIS** not more than ten (10) days after **PROVIDER** receives notification of any reduction or cancellation of coverage. 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** understands and agrees payments may be derived from federal and State funds, and **PROVIDER** shall be civilly and/or criminally liable to both Plan(s) and government agencies for non-performance, non-compliance, misrepresentation, and fraud or abuse of Covered Services rendered hereunder.

(a) **PROVIDER** hereby warrants and represents **PROVIDER**, and all of his/her/its employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services, currently meet, and throughout the Term of this Agreement shall continue to meet, any and all applicable conditions necessary to participate in Medicaid, Medical Assistance, Medicare/Medicare Advantage programs, 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 **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 Section 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 number, as applicable.

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

(c) **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 agrees 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 constitute overpayments.

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

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

(a) Pursuant to 42 CFR §§422.504 and 423.505 and in accordance with the CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to safeguard and maintain, in an accurate and timely manner, contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agrees to provide such information to **DAVIS,** 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, 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) Pursuant to OAC Rules 5101:3-26 and 5101:3-26-06(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 <u>Medicaid program</u> hereunder will, in an accurate and timely manner be retained, maintained and safeguarded by the **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors, in accordance with applicable sections of the federal regulations and the Ohio Administrative Code. 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 **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, then all records must be maintained until such time as the matter under audit or investigation has been resolved, whichever is later.

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

.18 **<u>Subcontractors</u>**. **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 contractor") for the purpose of rendering health/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/Medicare Advantage Plan and the CMS. Failure to obtain prior approval may result, at the discretion of **DAVIS** or Plan, in the immediate termination of **PROVIDER** and/or Participating Provider(s). **PROVIDER** agrees 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) dated signature of all parties to the subcontract.

19. **Training Regarding the Plan Contracts**. **PROVIDER** agrees to train his/her/its 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 rendered 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**. Unless this Agreement is terminated in accordance with the termination provisions herein, this Agreement shall automatically renew for up to, but not more than, three (3) successive twelve (12) month Terms on the same terms and conditions contained herein.

VII
TERMINATION OF THE AGREEMENT

.1 **MCO Non-Renewal or Termination**. Notwithstanding anything herein to the contrary, the MCO must give the **PROVIDER** at least sixty (60) days prior, written notice for non-renewal or termination of this Agreement except in cases where a successful prosecution of **PROVIDER** under CFC Medicaid or Medicaid laws/regulations has occurred, or where there is an adverse finding by a regulatory agency or where a quality of care concern dictate that the Agreement be sooner terminated. If the MCO issues a notice to non-renew and/or terminate the Agreement due to any of the foregoing, the MCO must so notify the ODJFS within one (1) working day of issuing such notice. MCO shall also make a good faith effort to give written notice of non-renewal and/or termination of a **PROVIDER**, within fifteen (15) calendar days after receipt of or issuance of such notice, to each Member who received his or her primary care from, or was seen on a regular basis by the terminated **PROVIDER**.

.2 **Provider Non-Renewal or Termination**. Notwithstanding anything herein to the contrary, the **PROVIDER** may non-renew and/or terminate this Agreement if:

(a) The **PROVIDER** provides the MCO with at least sixty (60) days prior, written notice for the non-renewal and/or the termination of this Agreement and the effective date for the non-renewal and/or termination must be the last day of the month; OR

(b) The ODJFS has proposed action, in accordance with OAC Rule 5101:3-26-10(G) regardless of whether the action is appealed or whether a quality of care concern dictates that the Agreement be terminated sooner than sixty (60) days. The **PROVIDER**'s non-renewal and/or termination notice must be received by the MCO within fifteen (15) working days prior to the end of the month in which the **PROVIDER** is proposing non-renewal and/or termination. If the notice is not received by this date, the **PROVIDER** must extend the non-renewal and/or termination date to the last day of the subsequent month.

(c) If the MCO receives the **PROVIDER**'s notice to non-renew and/or to terminate this Agreement due to an action proposed by the ODJFS and in accordance with OAC Rule 5101:3-26-10(G) or for a quality of care concern, the MCO agrees to notify the ODJFS within one (1) working day of the receipt of the **PROVIDER**'s written notice.

(d) **PROVIDER** agrees to serve Members through the last day this Agreement is in effect.

(e) The procedures to be employed upon the ending, non-renewal, or termination of this Agreement apply to this Section VII.2, including the **PROVIDER**'s agreement to promptly supply all records necessary for the settlement of outstanding medical claims.

.3 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate this Agreement without cause, pursuant to this Agreement, 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.

.4 **Provider Rights Upon Termination**. Subject to the Provider Appeal Policy attached hereto, or as otherwise required by law, **PROVIDER** agrees any **DAVIS** decision to terminate this Agreement pursuant to this Section VII shall be final.

.5 **Responsibility for Members at Termination**. In the event this Agreement is terminated, including for reasons of **DAVIS**' insolvency or cessation of operations, (but not for reasons of **PROVIDER**'s loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall continue to provide Covered Services to a Member who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement 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) and including all Covered Services that constitute medically necessary follow-up care; unless **DAVIS** or a Plan(s) makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider.

(a) **PROVIDER** shall not be responsible to continue to provide Covered Services to a Member under this Agreement after the occurrence of any of the following: (a) the end of the thirty (30) day period following the entry of a liquidation order under Chapter 3903 of the ORC; (b) the end of the Member's period of coverage for a contractual prepayment or premium; (c) the Member obtains equivalent coverage with another health insuring corporation or insurer; (d) the Member or the Member's

employer terminates coverage under the Plan contract; (e) a liquidator effects a transfer of **DAVIS**' obligations under the contract under §3903.21(A)(8) of the ORC.

(b) **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this Section VII.5, prior to and following the effective termination date of this Agreement, at the rates for Covered Services attached hereto.

(c) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement for reasons other than for cause, **PROVIDER** shall comply with Medicare and ODJFS continuity of care provisions and regulations. The Parties agree any Member, at the Member's option, may continue an ongoing course of treatment with **PROVIDER** for a transitional period of up to sixty (60) days from the date the Member is notified of the termination or the pending termination.

(d) In consultation with Plan(s), 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.

(e) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement, **PROVIDER** shall comply with applicable **PROVIDER** obligations as set forth in Section VII of this Agreement.

(f) **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 **<u>Return of Materials, Payments of Amounts Due and Settlement of Claims</u>**. 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**. **DAVIS** may reclaim frame samples, with reasonable notice, at any time during the Term of this Agreement. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding claims.

.7 **<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:

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

.7.2 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 safety or welfare; or

.7.3 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

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

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

(a) a suspension, revocation or conditioning of **PROVIDER'**s license to operate or to practice his/her/its profession;
(b) 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 to be limited to fraud;
(e) conviction of a felony;
(f) loss or suspension of a Drug Enforcement Administration (DEA) identification number;
(g) 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;
(h) the bankruptcy of **PROVIDER**; and/or
(i) a successful prosecution of **PROVIDER** under the CFC Medicaid and/or Medicaid laws/regulations.

"Cause" for the purposes of suspension shall mean:

(j) a failure by **PROVIDER** to maintain malpractice insurance coverage as provided in Section V.12 hereof;
(k) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section V.3 hereof;
(l) a failure by **PROVIDER** to comply with policies, administrative requirements and procedural guides as required in Section V.4 hereof; or a failure to comply with participation criteria as required in Section V.15 hereof;
(m) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section IX hereof; and/or
(n) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section X.9 hereof.
(o) Provided, however, prior to termination of **PROVIDER** on the basis of failure to meet **DAVIS** standards for quality of care or utilization in the delivery of health care services, **PROVIDER** shall be afforded an opportunity to implement corrective action pursuant to a performance improvement plan developed in conjunction with **DAVIS** and **PROVIDER**.

(p) Further, **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.

.9 **Termination Without Cause**. After the initial twelve (12) month Term this Agreement may be terminated by either Party, without cause, upon ninety (90) days prior written notice. If **DAVIS** elects to terminate this Agreement other than at the end of a Term hereof, or for a reason other than those set forth in this Section VII, **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 written request or within such time as is required by law or regulation.

VIII
AMENDMENT AND DOCUMENTATION

.1 **Amendment**. If an amendment is not a Material Amendment **DAVIS** shall provide **PROVIDER** notice of amendment at least fifteen (15) days prior to the effective date of the amendment, and pursuant to the Notice provisions contained in this Agreement. All other notices, not affecting the terms and conditions of this Agreement shall timely be provided by **DAVIS** to **PROVIDER.**

.2 **Material Amendments**.

(a) A material amendment shall be effective only if **DAVIS** provides **PROVIDER** with the Material Amendment and with notice of the Material Amendment in writing, not later than ninety (90) days prior to the effective date of the Material Amendment. The notice shall be conspicuously entitled "Notice of Material Amendment to Participating Provider Agreement".

(b) If within fifteen (15) days after receiving the Material Amendment and Notice, described in this section, the **PROVIDER** objects in writing to the Material Amendment, and there is no resolution of the objection, either Party may terminate this Agreement upon written notice of termination provided to the other Party, not later than sixty (60) days prior to the effective date of the Material Amendment.

(c) If the **PROVIDER** does not object to the Material Amendment in the manner described in this section, the Material Amendment shall be effective as specified in the notice of Material Amendment described in this section.

(d) Pursuant to ORC §3963.04, this section does not apply if the delay caused by compliance with paragraphs (a), (b) and (c) above could result in imminent harm to a Member, if the Material Amendment is required by state or federal law, rule or regulation, or if the **PROVIDER** affirmatively accepts the Material Amendment in writing and agrees to an earlier effective date than otherwise required by paragraph (a) of this section.

(e) Pursuant to ORC §3963.04, this section does not apply if the **PROVIDER**'s payment or compensation is based on the current Medicaid or Medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule.

(f) Pursuant to ORC §3963.04, this section does not apply if a routine change or update of this Agreement is made in response to any addition, deletion or revision of any service code, procedure code, or reporting code, or a pricing change is made by any third party source.

(g) For purposes of paragraphs (e) and (f) of this section, the following definitions apply:

"Service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).

"Third party source" means the American Medical Association, American Dental Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the Department of Health and Human Services Office of the Inspector General, the Ohio Department of Insurance or the Ohio Department of Job and Family Services (ODJFS).

(h) Notwithstanding any of the foregoing paragraphs of this section or any provision herein to the contrary, should any pertinent state or federal 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**. As respects CFC and Medicaid, ODJFS shall notify the MCO and/or the Plan(s), and **DAVIS** of any changes in applicable State or Federal laws, regulations, waiver, or contractual obligation of the MCO and/or the Plan(s) and **DAVIS**; and **DAVIS** shall notify **PROVIDER** of such changes. This Agreement shall automatically amend to conform to such changes without necessitating an execution of written amendments.

.3 **Upon Request of CMS**. Upon request of the CMS, this Agreement and any addenda may be amended to exclude any Medicare Advantage Program Plan or State-licensed entity specified by 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 at no cost to the requesting entity.

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

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

(a) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
(b) consider the needs of the enrolled population;
(c) are developed in consultation with Participating Providers who are physicians; and are reviewed and updated periodically; and
(d) are communicated to Participating Providers of the 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 decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment hereunder for those Covered Services provided to a Member which are determined to not be Medically Appropriate or of poor quality or to 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 with 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 **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 Rules, Policies, Administrative Requirements & Procedural Guides" herein.

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

.5 **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.

.6 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; 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 Provider Services for Medicare, Medicare Advantage, CFC Medicaid and Medicaid Program Members. Further, **PROVIDER** shall comply with the ODJFS external quality review as described in OAC rule 5101:3-26-07, and shall implement a continuous quality improvement action plan if areas for improvement are identified.

X
GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof, or to the selling, renting or giving of **DAVIS**' rights to **PROVIDER**'s services to a third party pursuant to this Agreement, 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 reasonable attorneys' fees and costs to the prevailing party.

(a) Neither Party shall maintain an arbitration proceeding and simultaneously pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the superintendent, the superintendent may choose to investigate the complaint, or after reviewing the complaint advise the complainant to proceed to arbitration to resolve the complaint.

(b) If the superintendent of insurance notifies **DAVIS** in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against **DAVIS**, the arbitration proceeding shall be stayed at the request of **DAVIS**, pending the outcome of the market conduct investigation.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the Parties to it and to their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, **PROVIDER** is prohibited from assigning or delegating any of **PROVIDER**'s rights, duties or obligations under this Agreement without receiving the prior, written consent of **DAVIS**. **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS**' assets.

.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 the state or federal law is hereby amended to conform to the requirements of such law.

.5 **Entire Agreement of the Parties**. This Agreement supersedes any and all agreements, either written or oral, between the Parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the Parties with respect to the rendering of Covered Services. Each Party to this Agreement acknowledges 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 that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing 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 mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Notices shall be delivered or mailed to the addresses appearing herein. Either Party may change its address by providing written notice in accordance with this paragraph.

.11 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all "**DAVIS** trade secret information" including, but not limited to, any Member's name, address and telephone number ("Member Information"), whether such "**DAVIS** trade secret information" is obtained by **PROVIDER** directly or indirectly through **PROVIDER**'s participation with **DAVIS**. 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.

-SIGNATURE PAGE TO FOLLOW-

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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:____
Print Date:____
Print All Addresses Below [complete addresses for all practice locations]:
Address 1:
Address 2:
Address 3:
Address 4:
Address 5:

(PROVIDER MUST sign and complete all spaces below PROVIDER signature.)

* Submission of a completed credentialing application and/or submission of a signed Participating Provider Agreement 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 credentialing application and on the execution by practitioner of the Participating Provider Agreement 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. Following a **PROVIDER's** acceptance by **DAVIS,** should additional licensed and credentialed practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Members of Plans under Plan Contracts 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.:

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

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

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

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

LIST OF ADDENDA TO THE AGREEMENT

1. Exhibit A, Compensation
2. Exhibit B, Provider Appeal Policy
3. Summary Disclosure Form

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 $35.00 - $50.00
(**Including dilated fundus examination; CPT codes: S0620, S0621)

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

Contact Lens Fitting Fee^ # Ranges from $30.00 - $60.00
(^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; #When covered as an itemized service.)

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EXHIBIT B

PROVIDER APPEAL POLICY

Davis Vision affords Participating Providers who have signed Davis Vision's Participating Provider Agreement the opportunity to a written appeal process for contractual disputes, other than those based on utilization review and/or utilization management determinations.

The appeal process requires direct communication between any Participating Provider and Davis Vision and does not require any action by a member/enrollee. A written appeal from a Participating Provider is considered a formal request for review.

The appeal process is intended to:

- Provide a mechanism for all providers to dispute contractual concerns
- Be easily accessible to providers
- Provide a prompt, fair and full examination and resolution of an appeal
- Comply with requirements and criteria set forth by regulatory and accrediting bodies

Participating Providers who have signed a Participating Provider Agreement have the right to file an appeal at any time so long as the appeal is in writing, is signed and dated by the Participating Provider and is mailed via certified, return receipt mail or is delivered via insured, overnight carrier.

The request for appeal must include all of the following information in order for Davis Vision to examine and consider the appeal:

- Name, office address and telephone number of the Participating Provider
- The National Provider Identifier Number of the Participating Provider
- A letter or other writing, clearly denoted as a Participating Provider Request for Appeal Determination which includes a description of the issue to be examined and considered
- The specific basis or rationale for the Request for Appeal Determination
- Copies of all relevant documentation in support of the Request for Appeal Determination
- The specific remedy or relief sought

A Participating Provider must forward a Request for Appeal via certified, return receipt mail or insured overnight delivery to the address below:

Davis Vision, Inc.
Provider Appeals
Professional Affairs and Quality Management
159 Express Street
Plainview, NY 11803

For Appeal(s) upon Termination for Failure to Meet Davis Vision Standards for Quality of Care or Utilization in Delivery of Covered Services:

A Participating Provider may file a "Request for Appeal Determination" under this section upon termination for failure to adhere to the performance improvement plan developed in conjunction with the Participating Provider and Davis Vision for concerns over quality of care and utilization in the delivery of

covered services.

Davis Vision will contact the Participating Provider within fifteen (15) calendar days of receipt of a properly filed “Request for Appeal Determination” to provide for an opportunity to discuss the reason(s) for termination. Upon conclusion of said discussion, Davis Vision will render a determination within fifteen (15) calendar days and forward its determination of the appeal to the Participating Provider via a written notification.

Participating Provider may further appeal Davis Vision’s determination upon dissatisfactory resolution of its Initial Appeal. Davis Vision will convene a hearing within (30) calendar days of a receipt of a properly filed “Request for Appeal Determination”. Davis Vision will provide the Participating Provider with a forum to appeal its case to a panel of Participating Providers, which shall render its recommendation within thirty (30) days. Davis Vision will forward its determination and the panel’s recommendation of the appeal to the Participating Provider via a written notification and within thirty (30) calendar days of the completion of the appeal hearing date.

For General Appeal of Termination

Appeal determinations, including written notification, shall be completed within thirty (30) calendar days from receipt of the request. Davis Vision will forward its determination of the appeal to the Participating Provider via a written notification and within thirty (30) calendar days of the completion of the appeal hearing date.

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SUMMARY DISCLOSURE FORM

(1) Compensation terms
(a) Manner of payment
[X] Fee for service
[ ] Capitation
[ ] Risk
[ ] Other

(b) Fee schedule available at "Exhibit A".

(c) Fee calculation schedule available at (not applicable).

(d) Identity of internal processing edits available at (not applicable).

(e) Information in (c) and (d) is not required if information in (b) is provided.

(2) List of products or networks covered by this contract
Exclusive Provider Organization (EPO) Network

(3) Term of this contract available at Section VI "Term of the Agreement".

(4) Contracting entity or payer responsible for processing payment available at "Recitals", Section II.3 "Copayments and Deductibles", and Section IV.6 "Payment of Compensation".

(5) Internal mechanism for resolving disputes regarding contract terms available at "Exhibit B".

(6) Addenda to Participating Provider Agreement:

Title	Subject
(a) Exhibit A – Compensation	Sample professional fee ranges
(b) Exhibit B – Provider Appeal Policy	Appeal process for contractual disputes
(c) Summary Disclosure Form	Compliance with Ohio Revised Code §3963.03 as effective on June 25, 2008, regarding information sufficient for the participating provider to determine the compensation or payment terms for health care services rendered under the Agreement.

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer: 1-800-584-3140 and Website address: www.davisvision.com.

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(H) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the Parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after the execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either Party.

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DAVIS VISION
EYECARE REFRAMED℠

Provider Add Form

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

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

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

Materials shipping street address: ____

City: ____________________________ State: _______ Zip: ___________ Country: __________

Please select below the services provided by your office:

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

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

Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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

*__Signature:__ ____**Date:** ____________

__Print Name:__ ____(Must sign and print name in full.)

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

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.