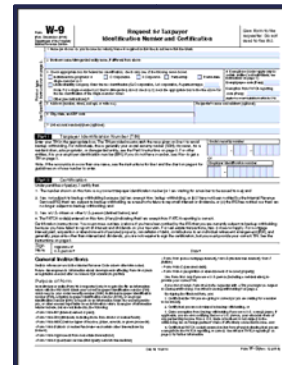
Welcome to Davis Vision!

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 COMMONWEALTH OF PENNSYLVANIA

This **PARTICIPATING PROVIDER AGREEMENT** for the **COMMONWEALTH OF PENNSYLVANIA,** and any Addenda, Amendments, Attachments or Exhibits attached hereto (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 referred to herein individually as "Party" and collectively as "Parties".

RECITALS

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

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

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

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

I
PREAMBLE AND RECITALS

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

II
DEFINITIONS

.1 "**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.

.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.

.3 "**Copayment**" or "**Deductible**" means those charges for vision care services 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 plan.

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

.5 "**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).

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

.7 "**Medical Assistance Program**" (hereinafter "MAP") means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States for Medical Assistance Programs, Section 1369 et seq, as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.8 "**Medical Necessity**" / "**Medically Necessary Services**" With respect to the Medicaid and/or Medical Assistance programs (MAP), "Medical Necessity" or "Medically Necessary

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

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

.9 "**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.

.10 "**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.

.11 "**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.

.12 "**Medicare Advantage Member**" means a Member who is enrolled in and covered under a Medicare Advantage Program.

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

.14 "**Member**" or "**Enrollee**" means an individual, and the eligible dependents of such 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) and, who is entitled to receive Covered Services.

.15 “**Negative Balance**” means receipt of Copayments, 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.

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

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

.18 “**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.

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

.20 “**Pennsylvania (PA) Medical Assistance MCO Program**” means the Commonwealth’s mandatory managed care program for Medical Assistance recipients residing in designated Pennsylvania counties which may include, but is not limited to, the “HealthChoices” program (and/or any successor program thereto).

.21 “**Plan(s)**” means a health maintenance organization, Medicare Advantage organization, corporation, trust fund, municipality, and/or other purchasers of vision care services that have entered into a Plan Contract with **DAVIS**.

.22 “**Plan Contract(s)**” means the agreements between **DAVIS** and Plans to provide for or to arrange for the provision of vision care services to individuals enrolled as Members of such Plans.

.23 “**Provider Manual**” means the **DAVIS** Vision Care Plan Provider Manual, as amended from time to time by **DAVIS**.

.24 “**State**” means the State in which **PROVIDER**’s practice is located or the State in which the **PROVIDER** renders services to a Member.

.25 "**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.

.26 "**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").

III
SERVICES TO BE PERFORMED BY THE PROVIDER

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

(a) **PROVIDER** agrees the frame collection will be shown to all Members receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees the frame collection shall be openly displayed in an area accessible to all Members.
(c) **PROVIDER** shall maintain the Plan frame collection in the exact condition in which it was delivered less any normal deterioration.
(d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.
(e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan and, with reasonable notice, at any other time. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted for frames.
(f) At any time, and upon reasonable notice, **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection.
(g) Should the display and/or frame collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume full cost of the display and/or frame collection and will be required to reimburse **DAVIS** its fair market value.

.2 **Open Clinical Dialogue**. Nothing contained herein shall be construed to limit, prohibit or otherwise preclude **PROVIDER** from engaging in open clinical dialogue with any Members, 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 plan designs; or (b) the process **DAVIS** uses on its own behalf or on behalf of Plan(s) to deny payment for a vision are services; or (c) the decision by **DAVIS** on its own behalf or on behalf of Plan(s) to deny payment for a vision care service. Throughout the Term of this Agreement, **DAVIS** and **PROVIDER** are prohibited from instituting gag clauses for their employees, subcontractors, or agents that would limit the ability of such person(s) to share information with Plan(s) and/or any or all regulatory agencies regarding the PA Medical Assistance MCO Program(s) and Medicare Program(s).

.3 **Services**. **PROVIDER** shall provide all Medically Appropriate Covered Services to Members within the scope of his/her/its license and shall manage, coordinate and monitor all such care rendered to each such Member to ensure that it is cost-effective and Medically Appropriate. **PROVIDER** agrees and acknowledges Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO and of the Plan(s). Throughout the entire Term(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.

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

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

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

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

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

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

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

.5 **Treatment Records**. **PROVIDER** shall (1) establish and maintain a treatment record consistent in form and content with generally accepted standards and the requirements of **DAVIS** and Plan(s); and (2) promptly provide **DAVIS** and Plan(s) with copies of treatment records when requested; and (3) keep treatment records confidential. Treatment records shall be kept confidential, but **DAVIS** and/or Plan(s) shall have a mutual right to a Member's treatment records, as well as timely and appropriate communication of Member information, so that both the **PROVIDER** and Plan(s) may perform their respective duties efficiently and effectively for the benefit of Member.

IV
COMPENSATION

.1 **Compensation**. **DAVIS** shall pay **PROVIDER** the compensation amounts communicated to **PROVIDER** from time to time by **DAVIS** and hereby incorporated by reference, as full compensation for the Covered Services provided by **PROVIDER** to Members under an applicable Plan pursuant to this Agreement.

.2 **Copayments, Deductibles and Discount**. **PROVIDER** shall bill and collect all Copayments and Deductibles from Member(s), which are specifically permitted and/or applicable to a Member's benefit plan. Under no circumstances shall the **PROVIDER** bill any Member for services authorized by **DAVIS** or Plans or covered under this Agreement, except for authorized Co-payments, Deductibles, or co-insurances. **PROVIDER** shall further bill and collect all charges from a Member for those Non-Covered Services provided to a Member. **PROVIDER** shall provide services to Medicaid consumers who have selected Plan, but whose coverage is not yet effective. Services for these Medicaid consumers should be invoiced to Pennsylvania (PA) Medical Assistance MCO Program on a fee-for-service basis. **PROVIDER** shall provide services to a Medicaid consumer even if the Medicaid consumer is unable to pay a required Co-payment at the time a service is requested. **PROVIDER** may only bill a Member when **DAVIS** has denied prior 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 a courtesy discount of twenty percent (20%) off of **PROVIDER'**s usual and customary fees to Members for the purchase of materials not covered by a Plan(s) and/or a discount of ten percent (10%) off of **PROVIDER**'s usual and customary fees for disposable contact lenses.

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

.4 **Member Billing/Hold Harmless**. Except as provided in Section IV.5 below, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation, remuneration or reimbursement from Members or persons acting on Member(s)' behalf, or from the MCO, the Plan, or the MAP for Covered Services, even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, either now existing or hereafter entered into between Member(s) or persons acting on Member(s)' behalf and **PROVIDER,** which relate to liability for payment; shall survive termination of this Agreement, regardless of the reason for termination; shall be construed to be for the benefit of the Member(s); and may not be changed without the approval of appropriate regulatory authorities.

.5 **Payment of Compensation**. Payment shall be made within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable state's prompt pay statute, whichever is least restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member, less any Copayment and Deductible collected or to be collected from the Member. For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within sixty (60) days following the provision of Covered Services, submit to **DAVIS** an invoice, 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 sixty (60) days of service delivery will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason including, but not limited to, Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

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

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

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

.8 **Overpayment**. 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 automatically, when possible, 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.

V
OBLIGATIONS OF PROVIDER

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

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

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

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

Medicare Advantage Member satisfaction; and (d) to report health outcomes; and

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

.1.5 any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 CFR §§ 422.516 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 Obligation of PROVIDER**. **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) is responsible. **PROVIDER** shall report to **DAVIS** all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this paragraph when billing is submitted to **DAVIS** for payment.

.3 **Compliance with Laws, Regulations and Ethical Standards**. During the Term of this Agreement, **PROVIDER** and **DAVIS** shall at all times, comply with all applicable federal, state or municipal statutes or ordinances, including but not limited to, all applicable rules and regulations, all applicable federal and State tax laws, all applicable federal and State criminal laws, as well as the customary ethical standards of the appropriate professional society from which **PROVIDER** seeks advice and guidance or to which **PROVIDER** is subject to licensing and control. **PROVIDER** shall comply with all applicable laws and administrative requirements, including but not limited to, Medicaid laws and regulations, Medicare laws, CMS instructions and policies, **DAVIS**' and Plan(s)' credentialing policies, processes, utilization review, quality improvement, medical management, peer review, complaint and grievance resolution programs, systems and procedures. If at any time during the Term of this Agreement, **PROVIDER'**s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall **immediately notify DAVIS,** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as otherwise provided herein. **PROVIDER** agrees to cooperate with **DAVIS** in order that **DAVIS** may comply with any requirements imposed by State and federal law, as amended, and all regulations issued pursuant thereto.

.4 **Compliance with DAVIS Rules**. **PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS**, including without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes that from time to time, **DAVIS** may amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **DAVIS** shall maintain

the Provider Manual to comply with applicable laws and regulations. However, in instances when **DAVIS**' rules are not in compliance, applicable State and federal laws and regulations shall take precedence and govern. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

(a) To the extent that a requirement of the Medicare, Medicare Advantage, or Medicaid Program is found in a policy, manual, or other procedural guide of **DAVIS,** Plan(s), 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 Medicare and Medicaid laws and regulations, the CMS instructions and policies, Pennsylvania Medical Assistance MCO Program regulations, 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 Plans(s), peer review, complaint, grievance resolution and appeals processes, comparative performance analysis, and enforcement and monitoring by appropriate government agencies. Further, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the Pennsylvania Medical Assistance MCO Program and performance under this Agreement shall be monitored on an ongoing basis to ensure performance of the Parties is consistent with the Plan Contract(s) between **DAVIS** and the Medical Assistance MCO Program and consistent with the contract between the Medical Assistance MCO Program and the Pennsylvania Department of Public Welfare.

(c) In relation to the provision of Covered Services to Medicare Advantage Members and Plan(s) hereunder, **PROVIDER** acknowledges and agrees to the following: **PROVIDER** and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet and comply with all applicable Medicare Advantage credentialing and re-credentialing requirements and processes; all services delivered and performed by **PROVIDER** hereunder must be accomplished in accordance with the requirements of Plan agreements with the CMS and with Medicare laws and regulations; Plan(s) are ultimately responsible to the CMS for performance of services; services and processes shall be monitored and audited by the Plan(s) and/or by the CMS and/or its delegates on an ongoing basis; and the Plan(s) and the CMS retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s).

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

(a) **PROVIDER** shall safeguard all information about Members according to applicable State and Federal laws and regulations. All material and information, in particular information relating

to Members or potential Members, which is provided due to or is obtained by or through **PROVIDER**'s performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and Federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of **PROVIDER**'s obligations and for 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. **PROVIDER** and **DAVIS** agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. **PROVIDER** and **DAVIS** further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, **PROVIDER** and **DAVIS** shall conduct good faith negotiations to amend this Agreement.

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

.7 **Cooperation with Plan Medical Directors**. **PROVIDER** understands contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and Plans, in certain instances, 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 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of the CMS and 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, 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/or the CMS and Plan(s). Such documentation shall include, but shall not be limited to proof of: National Provider Identifier Number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS**' sole option, the right to deny any professional participation privileges in the Network or the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall **immediately notify DAVIS in writing** in the event **PROVIDER** suffers a suspension or a termination of license or of professional liability insurance coverage. **PROVIDER** shall; devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER's** duties hereunder to Member(s); use best efforts to ensure vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices; and abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, the DHHS, the MAP, or any 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 and 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), **PROVIDER** and Participating Provider(s) agree to be available to provide Covered Services for Medically Appropriate care, taking into account the urgency of the need for services and when necessary and appropriate, to provide Covered Services for Medically Appropriate emergency care. **PROVIDER** and Participating Provider(s) shall ensure Members will have access to either an answering service, a pager number, and/or an answering machine, twenty-four (24) hours per day, seven (7) days per week, in order that Members may ascertain **PROVIDER**'s office hours, have an opportunity to leave a message for the **PROVIDER** and/or Participating Provider(s) regarding a non-emergent concern and to receive pre-recorded instructions with respect to the handling of an emergency.

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

(b) **PROVIDER** agrees to provide **DAVIS** with thirty (30) calendar days notice if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/its office location, (c) change his/her/its place of employment (d) change his/her/its employer, or (e) reduce capacity at an office location. The thirty (30) calendar day notice shall, at a minimum, include the effective date of the change, the new tax identification number and a copy of the W-9 as applicable, the name of the new practice, the name of the contact person, the address, telephone and fax numbers and other such information as may materially differ from the most recently completed credentialing application submitted by **PROVIDER** and/or Participating Provider to **DAVIS**. Under no circumstance shall the 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, affiliates, subcontractors, or independent contractors.

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

.12 **Malpractice Insurance**. Unless otherwise agreed upon in a writing by and between the Parties hereto, **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, and **PROVIDER** shall provide proof of such insurance to **DAVIS** if so requested. In addition, and in the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall, following the effective termination date of the foregoing policy, maintain "tail coverage" with the same liability limits. The foregoing policies shall not limit **PROVIDER**'s ability to indemnify the State or enrollees of a Medical Assistance Program.

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

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such

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

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

.15 **<u>Participation Criteria</u>**. **PROVIDER** hereby warrants and represents that **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 the Medicare/Medicare Advantage program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of federal funds; federal laws designed to prevent fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq.) and the anti kick-back statute (42 U.S.C. §1320a-7b(b)), 42 CFR §§422.504(h)(1), 423.505(h)(1). **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.

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

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

.16 **Provider Roster**. **PROVIDER** agrees **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER's** name, address, phone number, type of practice, and willingness to accept new patients in the **DAVIS** or Plan roster of provider participants. The roster is 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, 423.505 or other applicable law, whichever is later. In the case of a minor Member, **PROVIDER** shall

retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. **PROVIDER** shall make available premises, physical facilities, equipment, records and any relevant information the CMS may require which pertains to Covered Services provided to Medicare Advantage Program Members. **PROVIDER** and Participating 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 practioner(s), employees, and involved parties available for interviews, as requested. Such records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission, or the submission by Participating Provider(s) of inaccurate or incomplete books and records.

(b) All hard copy or electronic records, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, which are originated or are prepared in connection with and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicaid program hereunder, will be retained and safeguarded by the **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors, in accordance with applicable sections of the Federal and State regulations. Records stored electronically must be produced at the **PROVIDER**'s expense, upon request, in the format specified by State or Federal authorities. All such records must be maintained for a minimum of six (6) 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, all such records must be maintained until such time as the matter under audit or investigation has been resolved, whichever is later.

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

.18 **Subcontractors**. **PROVIDER** agrees that in no event shall **PROVIDER** or Participating Provider(s) enter into subcontracts or lease arrangements with any person or entity outside of the jurisdiction of the United States ("offshore subcontractor") for the purpose of rendering vision care services to Medicare/Medicare Advantage Members covered under this Agreement or the Addenda, without the prior, written approval of **DAVIS**, the Medicare Advantage Plan and 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) the dated signature of all parties to the subcontract.

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

.20 **Verification of Eligibility**. **PROVIDER** shall verify eligibility of Member(s) by calling the appropriate toll-free (800/888) number supplied by **DAVIS**, or by accessing the **DAVIS** website (www.davisvision.com), or by receiving from Member(s) a valid pre-certified voucher.

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 contained herein, this Agreement shall automatically renew for up to, but not more than two (2), successive twelve (12) month Terms on the same terms and conditions herein.

VII
TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause**. After the initial twelve (12) month Term has ended, this Agreement may be terminated by either Party, without cause, upon ninety (90) days prior written notice. If **DAVIS** elects to terminate this Agreement other than at the end of a Term hereof, or for a reason other than those set forth in Section VII.2 hereof, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**'s request or within such time as is required by applicable law or regulation.

.2 **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) a suspension or a history of suspension of **PROVIDER** from Medicare or Medicaid;

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

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

(e) a conviction of a felony;

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

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

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

(i) the death of **PROVIDER**; and/or

(j) the **PROVIDER** is reasonably suspected of committing fraud, abuse or waste.

"Cause" for the purposes of suspension shall mean:

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

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

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

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

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

Provided, however, that **PROVIDER** shall not be penalized nor shall this Agreement be terminated or suspended because **PROVIDER** acts as an advocate for a Member in seeking appropriate Covered Services, or files a complaint, grievance or appeal. **DAVIS** shall notify **PROVIDER**, in writing, of the reason for denial, suspension and/or termination.

.3 **Responsibility for Members at Termination**. In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **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 patient), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date of this Agreement) at the rates contemplated in this Agreement for Covered Services.

.4 **PROVIDER Rights Upon Termination**. **PROVIDER** agrees, except as otherwise required by law and subject to the appeal process set forth in the Provider Manual, any **DAVIS** decision to terminate this Agreement pursuant to Section VII herein shall be final.

(a) **PROVIDER** acknowledges and agrees Plan(s) have the authority to determine whether a **PROVIDER** shall be suspended or terminated from participation in a particular Plan without termination of this Agreement. However, Plan(s) shall not have the authority to terminate **PROVIDER** for (a) maintaining a practice that includes a substantial number of patients with expensive health conditions; (b) objecting to or refusing to provide a Covered Service on moral or religious grounds; (c) advocating for Medically Appropriate care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable standard of care; (d) filing a grievance on behalf of and with the written consent of a Member or helping a Member to file a grievance; and (e) protesting a Plan decision, policy or practice that **PROVIDER** reasonably believes interferes with the provision of Medically Appropriate care.

.5 **Return of Materials, Payments of Amounts Due and Settlement of Claims**. 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 **DAVIS** to **PROVIDER** if **PROVIDER** owes any monies to **DAVIS**. **DAVIS** retains the right to reclaim the frame samples, with reasonable notice, at any time during the Term of this Agreement. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims.

.6 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above, or should **PROVIDER** move office location, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to notify effected Member(s) a minimum of thirty (30) days prior to the effective date of such action or termination.

VIII
DOCUMENTATION AND AMENDMENT

.1 **Amendment**. This Agreement may be amended by **DAVIS** with thirty (30) days advance written notice to **PROVIDER**. Should **DAVIS** be required by applicable laws and/or regulations to amend this Agreement, thirty (30) days advance written notice to **PROVIDER** shall not be required.

.2 **Conformity of Laws, Rules and Regulations**. Any provision of this Agreement which conflicts with State or federal law is hereby amended to conform to the requirements of such law. Notwithstanding anything herein to the contrary, should any applicable federal or state law be amended and their implementing regulations, policy issuances and instructions be modified, no particular notice of amendment by **DAVIS** to **PROVIDER** shall be required. Such amended laws apply as of their respective effective dates and this Agreement shall automatically amend to conform to such changes without the necessity for executing written amendments. **DAVIS** shall however, employ its best efforts to notify **PROVIDER** of such occurrences within a practicable timeframe.

.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 and at no cost to the requesting entity.

(a) Upon termination of this Agreement for any reason, **PROVIDER** shall, in a useable form, make available to any Oversight Entities, all records, whether dental/medical or financial, related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement 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 to ensure that practice guidelines and utilization management guidelines:

(a) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
(b) consider the needs of the enrolled population;
(c) are developed in consultation with Participating Providers who are physicians; and are reviewed and updated periodically; and
(d) are communicated to Participating Providers of the Plan(s) and as appropriate to the Members.

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

.3 **Establishment of UR/QM Programs**. Utilization review and quality management

programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS**, 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 to treat a Member.

.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 Davis Rules" herein.

.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; and utilization and management review; care coordination activities including, but not limited to, medical record reviews, HEDIS reporting, disease management programs, case management, clinical practice guidelines, and other quality measurements to improve Members' care. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and Medical Assistance Program Members. **PROVIDER** shall implement a continuous quality improvement action plan if areas for improvement are identified.

X
GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof, will be settled by arbitration in accordance with the commercial arbitration

rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the Parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorneys' fees and costs to the prevailing Party.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the Parties to it and their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, neither Party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other Party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate, or to any successor to its business, by merger or by 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 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 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 to the addresses appearing herein. 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. 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 information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Member, including but not limited to, the Member's name, address and telephone number ("Member Information"), and all other "**DAVIS** trade secret information." For purposes of this Agreement, "**DAVIS** trade secret information" shall include but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS**. **PROVIDER** shall not disclose or use any Member Information or **DAVIS** trade secret information for his/her/its own benefit or gain either during the Term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Member if Medically Appropriate for the proper treatment of such Member or upon the express prior written permission of **DAVIS**, the Plan in which the Member is enrolled, and the Member.

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

.13 **Third Party Beneficiaries**.

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

(b) Other Persons. Other than the Plans and the Parties hereto and their respective successors or assigns, nothing in this Agreement whether express or implied, or by reason of any term, covenant, or condition hereof, is intended to or shall be construed to confer upon any person, firm, or corporation, any remedy or any claim as third party beneficiaries or otherwise; and all of the terms, covenants, and conditions hereof shall be for the sole and exclusive benefit of the Parties hereto and their successors and assigns.

.14 **<u>Use of Name</u>**. **DAVIS** reserves the right to the control and to the use of its name(s) and all copyrights, symbols, trademarks or service marks presently existing or later established. **PROVIDER** shall not use **DAVIS'** or any Plan's name(s), tradename(s), trademark(s), symbol(s), logo(s), or service mark(s) without the prior, written authorization of **DAVIS** or such Plan.

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

-SIGNATURE PAGE TO FOLLOW-

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

PROVIDER:

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

* Submission of a completed credentialing application and/or submission of a signed Participating Provider Agreement for the Commonwealth of Pennsylvania does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of a practitioner's fully and properly completed credentialing application and on the execution by practitioner of the Participating Provider Agreement for the Commonwealth of Pennsylvania and on the receipt by practitioner of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a **PROVIDER's** acceptance by **DAVIS,** should additional practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Members of Plans under Contract 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 COMMONWEALTH OF PENNSYLVANIA

ADDENDUM

FOR CONTRACTS COVERING
MEMBERS OF HEALTH MAINTENANCE ORGANIZATIONS
IN PENNSYLVANIA

The Participating Provider Agreement for the Commonwealth of Pennsylvania (heretofore and hereinafter referred to as the "Agreement") entered into by and between Davis Vision, Inc. (heretofore and hereinafter referred to as "**DAVIS")** and **PROVIDER** is hereby amended with respect to Members who are members of health maintenance organizations (collectively, "**HMOs**") in the Commonwealth of Pennsylvania by adding the following:

1. The contract(s) between **DAVIS** and the **HMO(s)** is/are incorporated into the Agreement as if fully set forth herein. **PROVIDER** may have a copy of such contract(s) on request.

2. Nothing in the Agreement is intended to limit:

   a. The authority of the **HMO** to ensure **PROVIDER**'s participation in and compliance with the **HMO**'s quality assurance, utilization management, member grievance and other systems and procedures;

   b. The authority of the Department of Health of the Commonwealth of Pennsylvania (the "Department") to monitor the effectiveness of the **HMO**'s systems and procedures or the extent to which the **HMO** adequately monitors any function delegated to **DAVIS**, or to require the **HMO** to take prompt corrective action regarding quality of care or consumer grievance or complaints; and

   c. The **HMO**'s authority to sanction or terminate a **PROVIDER** found to be providing inadequate or poor quality care or failing to comply with the **HMO**'s systems, standards or procedures.

3. **PROVIDER** shall participate in and abide by the decisions of the **HMO**'s quality assurance, utilization review/management, and member grievance programs and systems.

4. **PROVIDER** agrees to cooperate with and to provide the **HMO**, the Department, and any external quality review organization approved by the Department, with access to Member's medical records. **PROVIDER** also agrees to provide such information, including, but not limited to, encounter, utilization, referral and other data, as **DAVIS** may require.

5. **PROVIDER** acknowledges that participation under the program of any **HMO** is dependent on **PROVIDER** meeting the credentialing requirements of the **HMO**, and the **HMO** has sole authority to accept, reject or terminate a **PROVIDER** who fails to meet such requirements.

6. **PROVIDER** acknowledges that all/any activities delegated by the **HMO** to **DAVIS** are subject to oversight by the **HMO** and that if **DAVIS** shall fail to properly carry out its responsibilities, the **HMO** may terminate its contract with **DAVIS**, and as a result, **PROVIDER's** participation in the **HMO**.

7. **PROVIDER** acknowledges that, if in the judgment of the **HMO**, **PROVIDER** has failed to cooperate with the **HMO** in the provision of cost-effective, quality services to **HMO** members, or has failed to cooperate and abide by the provisions of the **HMO's** quality assurance, utilization management, or member grievance systems, or is found to be harming **HMO** patients, the **HMO** may terminate **PROVIDER's** participation in the **HMO**.

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

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DAVIS VISION, INC.
ADDENDUM TO THE PARTICIPATING PROVIDER AGREEMENT
FOR THE COMMONWEALTH OF PENNSYLVANIA

FOR COMPLIANCE WITH MEDICARE ADVANTAGE,
ADULTBASIC, CHIP, PENNSYLVANIA MEDICAL ASSISTANCE MCO PROGRAM,
and ACT 68

WHEREAS, Davis Vision, Inc. (hereinafter "Davis") has entered into agreements with certain managed care entities, Medicare Advantage organizations, Pennsylvania (PA) Medical Assistance MCO Program organizations, and insurers (collectively "Plan(s)") to provide and/or to arrange for the provision of certain vision care services (hereinafter "Covered Services") to their respective Enrollees, Members and/or Participants; and

WHEREAS, Davis and Provider entered into that certain Participating Provider Agreement for the Commonwealth of Pennsylvania (hereinafter the "Agreement"); and

WHEREAS, Davis may request that Provider provide Covered Services under the Agreement to Enrollees, Members, and/or Participants of a Medicare Advantage, adultBasic, CHIP, PA Medical Assistance MCO Program, and/or Act 68 Plan(s) and Provider recognizes that federal and state regulation(s) along with Plan contractual provisions, impose certain requirements on all providers who render such services to individuals enrolled in such Plans; and

THEREFORE, Davis and Provider agree to add the following provisions to the Agreement in order to be in compliance with federal and state rules, codes, and regulations, including CMS instructions and including any laws pertaining and applicable to the receipt of Federal funds:

1. RELATIONSHIP TO THE AGREEMENT.

This Addendum is a part of the Davis Vision, Inc. Participating Provider Agreement for the Commonwealth of Pennsylvania, and the terms of this Addendum are incorporated therein. Where there is a conflict between the provisions in the Agreement and the provisions of this Addendum, in relation to Participating Provider's participation in Medicare Advantage, adultBasic, CHIP, PA Medical Assistance MCO Program, and Act 68 Plans/Programs/Products (as hereinafter defined), as well as Participating Provider's provision of and Davis Vision's reimbursement of Covered Services rendered to Medicare Advantage, adultBasic, CHIP, PA Medical Assistance MCO Program, and Act 68 Members (as hereinafter defined), the provisions of this Addendum shall control.

2. DEFINITIONS.

Capitalized terms shall have the meaning assigned to such terms in this Addendum, or where not defined herein, such terms shall have the meaning assigned to them in the Agreement. The following terms shall have the meaning assigned to them below:

2.1 **"CMS"** shall mean the Centers for Medicare & Medicaid Services, a division of the United States Department of Health and Human Services, or any successor agency.

2.2 **"Medicare Advantage Member"** shall mean a Member who is enrolled in and covered under a Medicare Advantage Program.

2.3 **"Medicare Advantage Program"** shall mean a Network Product established by Plan pursuant to a contract with 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.

2.4 **"Evidence of Coverage"** shall mean the Plan document as applicable to a Medicare Advantage Member, that is approved by CMS and issued by Plan(s) to Medicare Advantage Members and that contains the rights and responsibilities of a Medicare beneficiary as a member of a Medicare Advantage Program.

2.5 **"Emergency Medical Condition"** shall mean a medical condition manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could expect the absence of immediate attention to result in (a) serious jeopardy to the health of the Enrollee, Member, and/or Participant (or an unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of a bodily organ or part.

2.6 **"Emergency Services"** shall mean Covered Services that are (a) furnished by a qualified and credentialed Provider and (b) needed to evaluate or stabilize an Emergency Medical Condition.

2.7 "**Urgently Needed Services**" means Covered Services that are not emergency services as defined in 42 CFR §422.113 provided when a Member/Enrollee 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/Enrollee 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.

2.8 "**Stabilized Condition**" means a condition whereby the physician treating the Member/Enrollee must decide when the Member/Enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the Plan.

2.9 **"adultBasic"** shall mean the adultBasic Insurance Coverage Program in accordance with the Health Investment Insurance Act (Chapter 13 of Act 77 of 2001) (35 P.S. 5701.1301 et seq.) as developed from time-to-time by the Plan(s) or affiliates.

2.10 **"CHIP"** shall mean the Children's Health Insurance Program in accordance with Title XXI of the Social Security Act, as amended to include the State Children's Health Insurance Act (42 U.S.C. §§1397aa et seq.) and the Children's Health Care Act, Article XXIII of the Act of 1998-68 (Quality Health Care Accountability and Protection Act, 40 P.S. §§991.2101 et seq., and the regulations promulgated thereunder) as developed from time-to-time by Plan(s) or Plan affiliate.

2.11 **"Acts"** shall collectively mean the Health Investment Insurance Act (Chapter 13 of Act 77 of 2001) (35 P.S. 5701.1301 et seq.); Title XXI of the Social Security Act, as amended to include the State Children's Health Insurance Act (42 U.S.C. §§1397aa et seq.); and the Children's Health Care Act, Article XXIII of the Act of 1998-68 (Quality Health Care Accountability and Protection Act, 40 P.S. §§991.2101 et seq., and the regulations promulgated thereunder).

2.12 **"Act 68"** shall mean the Pennsylvania Quality Health Care Accountability and Protection Act (40 P.S. § 991.2101, et. seq.) and its implementing regulations as promulgated by the Pennsylvania Department of Health and Pennsylvania Insurance Department.

2.13 **"Act 68 Grievance"** shall mean a written grievance as filed by an Act 68 Member, or a Provider with the applicable Act 68 Member's written consent, regarding decisions relating solely to the medical necessity and appropriateness of a health care service or product.

2.14 **"Act 68 Member"** shall mean any Member who is covered under an Act 68 program, plan, or product.

2.15 **"Act 68 Network Product"** shall mean any program, plan, or product that is a "managed care plan" as such term is defined in Act 68.

2.16 **"Members," "Enrollees," "Participants," and/or "Subscriber"** shall mean those persons who are enrolled (including enrolled dependents) in a Medicare Advantage Program, AdultBasic

Insurance Coverage Program, Children's Health Insurance Program, PA Medical Assistance MCO Program, and/or an Act 68, plan, program, or product.

2.17 **"Practitioner(s)"** shall mean those persons who provide vision care services or who provide Covered Services to a Member, Enrollee, and/or Participant hereunder.

2.18 **"DPW"** shall mean the Commonwealth of Pennsylvania Department of Public Welfare.

2.19 **"Medicaid"** shall mean the joint federal and state program providing medical assistance to low income persons pursuant to 42 U.S.C. § 1369 et seq.

2.20 **"Pennsylvania (PA) Medical Assistance MCO Program"** shall mean the Commonwealth's mandatory managed care program for Medical Assistance Recipients residing in designated Pennsylvania counties, which may include but is not limited to the "HealthChoices" program and any successor program.

3. INTERPRETATION OF AGREEMENT AND ADDENDUM.

3.1 Davis and Provider agree that the terms and conditions of this Addendum and the Agreement, as they relate to the provision of Covered Services by any Provider or by any of Provider's practitioner(s) under the Medicare Advantage Program(s) shall be interpreted in a manner consistent with applicable requirements under Medicare Laws and CMS instructions and policies.

3.2 Davis and Provider agree that the terms and conditions of this Addendum and the Agreement, as they relate to the provision of Covered Services by any Provider or by any of Provider's practitioner(s) under the adultBasic, CHIP Program(s), and/or PA Medical Assistance MCO Program, shall be interpreted in a manner consistent with applicable requirements under the Acts.

3.3 Davis and Provider agree that the terms and conditions of this Addendum and the Agreement, as they relate to the provision of Covered Services by any Provider or by any of Provider's practitioner(s) under Act 68 Program(s), shall be interpreted in a manner consistent with the applicable requirements under the Pennsylvania Quality Health Care Accountability and Protection Act and its implementing regulations as promulgated by the DOH and PID, and any applicable amendments thereto.

3.4 Davis and Provider acknowledge and agree that Davis contracts with providers to create a network of Participating Providers on its own behalf and on behalf of Plan(s) in order to provide adequate access to Covered Services for Members, Enrollees, and/or Participants in a Medicare Advantage Program(s), in adultBasic Insurance Coverage Program(s), in Children's Health Insurance

Program(s), in PA Medical Assistance MCO Program(s) and Act 68 Program(s).

4. PARTICIPATION CRITERIA FOR MEDICARE ADVANTAGE, ADULTBASIC, CHIP, PENNSYLVANIA (PA) MEDICAL ASSISTANCE MCO PROGRAM, AND ACT 68.

4.1 Provider hereby warrants and represents that Provider, and all of his/her/its employees, subcontractors and/or independent contractors who provide Covered Services under the Agreement, including without limitation health care, utilization review, and/or administrative services, currently meet, and throughout the Term of the Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare program. Provider hereby warrants and represents that Provider, and all of Provider's employees, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a federal health care program as described in Section 1128B(f) of the Social Security Act, and that all employees, subcontractors, and/or independent contractors of Provider are able to provide a current National Provider Identifier Number.

4.2 Provider understands and agrees that meeting the above Medicare Advantage participation criteria, as well as meeting the Medicare Participation Criteria is a condition precedent to Provider's participation, and a condition precedent to the participation by Provider's practitioner(s) hereunder and, is an ongoing condition to the provision of Covered Services to Medicare Advantage Members hereunder by both the Provider and the Provider's practitioner(s) and, a condition to Davis' reimbursement for such Covered Services rendered by a Provider and/or Provider's practitioners. Upon Provider's meeting all Medicare Advantage participation criteria set forth in the Agreement and Section 4 herein, Provider shall participate as a Participating Provider for Medicare Advantage Programs covered under the Agreement.

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

4.4 Provider shall promptly advise Davis of any change in Provider's and/or practitioner's compliance with the Medicare Advantage participation criteria, as applicable to Provider and/or practitioners, and as described in Section 4 herein. Provider understands and agrees that any change in

Provider's or practitioner's compliance with the Medicare participation criteria or the Medicare Advantage participation criteria may, in Davis' sole discretion, result in the termination of the Agreement by Davis. Further, any such change in compliance may result in the setoff of future amounts owed to Provider by Davis, or in the repayment by Provider to Davis of overpayments.

4.5 Provider will comply with, and will ensure that Provider's practitioners comply with all applicable requirements set forth in Articles XXI and XXIII of Act 68. Provider represents that he/she/it has complied with, that each of Provider's practitioners have complied with, and that Provider will ensure his/her/its continued compliance and ensure the continued compliance of Provider's practitioners during the Term of this Addendum and the Agreement, with all federal, state, municipal, and local laws, rules and regulations applicable to its activities in rendering Covered Services to Members, Enrollees and/or Participants under this Addendum and Agreement; including without limitation, Act 68 and the regulations promulgated thereunder by the PID and the DOH for implementation of Act 68; Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Sections 2000d *et seq.*); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Sections 701 *et seq.*); the Age Discrimination Act of 1975 (42 U.S.C. Sections 6101 *et seq.);* the provisions of the Americans with Disabilities Act (42 U.S.C. Sections 12101 *et seq.*); the Pennsylvania Human Relations Act of 1955 (43 P.S. Sections 951 *et seq.*, as amended); general provisions relating to nondiscrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of Federal funds; Federal laws designed to prevent fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 *et seq*.), and the Anti-Kickback statute (42 U.S.C. §1320a-7b(b)), 42 CFR §§ 422.504(h)(1), 423.505(h)(1).

5. COMPLIANCE WITH LAWS, POLICIES, CONTRACTUAL OBLIGATIONS, AND ADMINISTRATIVE REQUIREMENTS.

5.1 To the extent that a requirement of the Medicare Advantage, adultBasic, CHIP, PA Medical Assistance MCO Program, or Act 68 Programs is found in a policy or other procedural guide of Davis or Plan(s) and is not otherwise specified in the Agreement or this Addendum, provider will comply and agrees to require its practitioners to comply with such policies, manuals, and procedures with regard to the provision of Covered Services to Member, Enrollees and Participants of such Programs.

5.2 In the provision of services to Members, Enrollees, and Participants, Provider agrees to comply, and agrees to require its practitioner(s), employees, permitted subcontractors, or leaseholders to comply with all applicable laws and administrative requirements, including but not limited to Medicaid laws and regulations, Medicare laws, CMS instruction and policies, Davis' and Plan(s)' credentialing policies, processes, utilization review, quality improvement, medical management, peer review, complaint and grievance resolution programs, systems and procedures.

6. RECORDS AND ACCESS TO RECORDS.

6.1 To the extent applicable and necessary for Davis and/or Plans to meet their respective data reporting and submission obligations to CMS, Provider shall provide to Davis and/or Plan(s) all data and information in Provider's possession and in the possession of each of Provider's practitioner(s), to the extent applicable and as necessary. Such information shall include, but shall not be limited to the following:

6.1.1 any data necessary to characterize the context and purposes of each encounter between a Medicare Advantage Member and each Practitioner, including, without limitation, appropriate diagnosis codes applicable to a Medicare Advantage Member; and

6.1.2 any information necessary for CMS to administer and evaluate the program; and

6.1.3 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 years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and

6.1.4 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 (42 CFR §422.210); and

6.1.5 any data necessary for Davis and/or Plan(s) to meet their respective reporting obligations under 42 CFR § 422.516 and 42 CFR § 422.257.

Further, Provider shall certify the accuracy, completeness and truthfulness of Provider generated encounter data that Davis and/or Plan(s) are obligated to submit to CMS.

6.2 With respect to Act 68 or PA Medical Assistance MCO Program Members, Enrollees or Participants, Provider and Provider's practitioners shall keep confidential all records relating to Act 68 and PA Medical Assistance MCO Program Members, Enrollees, or Participants in accordance with Section 2131 of Act 68 and with the requirements of the PA Medical Assistance MCO Programs, and

all other applicable laws. Provider shall also, to the extent required by Pennsylvania law, permit the DOH, PID, any other official body access to Provider's records and to the records of Provider's practitioner(s) for the purpose of quality assurance, investigation of complaints or Act 68 Grievances, and enforcement or other activities related to compliance with Pennsylvania law; provided however, that such records shall only be accessible to employees of those departments having direct responsibilities for the activities recited herein.

6.3 Records. Provider agrees to:

6.3.1 Maintain adequate and accurate medical, financial and administrative records related to covered services rendered by Provider in accordance with federal and state law.

6.3.2 Safeguard all information about Members, Enrollees or Participants according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members, Enrollees or Participants or potential Members, Enrollees or Participants, which is provided to or obtained by or through Provider's performance under this Addendum, 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 his/her obligations and securement of his/her rights under this Addendum. Neither Davis nor Provider shall share confidential information with any Members', Enrollees' or Participants' employer, absent the Members', Enrollees' or Participants' consent for such disclosure. Provider agrees to comply and agrees to require its practitioners to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with Davis in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws. Provider and Davis acknowledge that the activities conducted to perform the obligations undertaken in this Addendum are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. Provider and Davis agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. Provider and Davis further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, Provider and Davis shall conduct good faith negotiations to amend this Addendum. Provider shall

maintain, and shall require its practitioners to maintain, adequate medical, financial and administrative records related to covered services rendered by Provider, and by Provider's practitioners in accordance with federal and state law.

6.3.3 To cooperate and provide Plans, Davis, government agencies and any external review organizations ("Oversight Entities") with access to each Member's, Enrollee's or Participant's vision records for the purposes of quality assessment, service utilization and quality improvement, investigation of Members, Enrollees or Participants complaints or grievances or as otherwise is necessary or appropriate.

6.3.4 That all records shall be made 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.

6.3.5 Upon termination of this Agreement for any reason, to make available to any Oversight Entities, in a useable form, 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.

7. FAILURE TO COMPLY, HOLD HARMLESS, AND INDUCEMENT.

7.1 Should Davis deny payment to Provider or to Provider's practitioner(s) due to the failure of Provider or the failure of Provider's practitioner(s) to comply with any of the provisions of the Agreement, or this Addendum, Provider shall not bill or seek remuneration from the Member, Enrollees and Participants for the denied amounts. Davis and Provider acknowledge and agree that the hold harmless provisions contained in Section IV.4 of the Agreement are hereby specifically incorporated into this Addendum. Provider acknowledges and agrees that no specific payment that Davis or the applicable Plan(s) makes to Provider is an inducement to reduce or limit services or products that Provider and Provider's practitioners determine are medically necessary and appropriate within the scope of their practice and in accordance with applicable laws and ethical standards for those Members, Enrollees, and Participants for whom Provider provides Covered Services hereunder.

7.2 No provision of the Agreement or this Addendum shall be construed to limit or prohibit any Provider's right, or the right of any of Provider's practitioners, to discuss with any Member, Enrollee, or Participant, or to discuss with any representative of a Member, Enrollee, or Participant (a) the process that Davis uses on its own behalf or on behalf of the Plan(s) to deny payment for a vision care

service; (b) any medically necessary and appropriate care, within the scope of Provider's practice, available to a Member, Enrollee, or Participant; including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternative treatments, or consultations and tests regardless of benefit coverage limitations under the terms of the Plan(s)' documents or medical policy determinations; and (c) the decision of Davis on its own behalf or on the behalf of Plan(s) to deny payment for a vision care service.

8. MEMBER COMPLAINTS, GRIEVANCES AND APPEALS.

8.1 Where necessary, Davis or Plan(s) will provide or make available to Provider, any information regarding relevant administrative requirements to be used in connection with or applicable to Member complaint or grievance processes.

8.2 As applicable and with the written consent of a Member, Enrollee or Participant, Plan(s) shall maintain a two-level internal grievance process by which an Act 68 or PA Medical Assistance MCO Program Member, Enrollee or Participant or by which a Provider may file a grievance. In addition and as applicable, Plan(s) shall establish and maintain an external grievance process by which an Act 68 or PA Medical Assistance MCO Program Member, Enrollee or Participant may or by which a Provider may, with the written consent of an Act 68 or PA Medical Assistance MCO Program Member, appeal the denial of a grievance following completion of the internal grievance process. Provider agrees to participate in any Act 68 or PA Medical Assistance MCO Program grievance and complaint process when necessary and to comply with and abide by any final decision resulting from a grievance or complaint process.

8.3 For Medicare Advantage Members, Provider agrees to, and shall ensure that Provider's practitioners, as applicable, shall comply with Medicare requirements regarding Medicare Advantage Member appeals and grievances and to cooperate with Davis and/or Plan(s) in meeting their respective obligations regarding Medicare Advantage Member appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner as well as compliance with appeals decisions.

9. QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT, AUDITS, REVIEWS, AND EVALUATIONS.

9.1 As applicable, Provider agrees, and shall ensure that Provider's practitioner(s) agree to participate in, cooperate with, comply with, and abide by decisions of Davis and/or Plan(s) with respect to Davis' and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization

and management review. Provider further agrees, and shall ensure that Practitioners as applicable, shall comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider Services for Medicare Advantage, adultBasic, CHIP, PA Medical Assistance MCO Program, and Act 68 Members, Enrollees, and Participants.

Davis agrees to consult with Participating Providers regarding its medical policies, quality improvement program and medical management programs and to ensure that practice guidelines and utilization management guidelines:

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

9.1.2 consider the needs of the enrolled population; and

9.1.3 are developed in consultation with participating Practitioners that are physicians; and

9.1.4 are reviewed and updated periodically; and

9.1.5 are communicated to Participating Providers of the Programs, and as appropriate, to the Members, Enrollees, and Participants.

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.

9.2 Provider and Provider's practitioner(s) shall, at his/her/its expense, make all books, records, documents and other evidence relating to Covered Services rendered under this Addendum available for audit, review, and evaluation by Davis, by Plan(s) and/or by the official bodies of the Commonwealth of Pennsylvania, including but not limited to the DOH, PID, the DHHS, the Comptroller General of the United States or their designees, and the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), its successors and assigns. Provider and Provider's practitioner(s) shall retain such books and records and shall make such books and records available for a period of no less than ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. Further, Provider and Provider's practitioner(s) shall make such books and records available onsite during normal business hours or, as requested by Davis, the Plans, the official bodies of the Commonwealth of Pennsylvania, the DOH, PID, DHHS, the Comptroller General of the United States, or the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), its successors and assigns, within the specified timeframes. Such books and records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. Provider and Provider's practitioner(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. Provider and provider's practitioner(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 Provider's practitioner(s) of inaccurate or incomplete books and records.

10. PROVISION OF AND AVAILABILITY OF PROVIDER SERVICES.

10.1 Provider agrees to render Covered Services through its practitioner(s) in a manner consistent with professionally recognized standards of health care that govern Provider, and Provider's Practitioner(s) and are consistent with Davis' and/or Plan(s)' (a) standards for timely access to care and; (b) administrative requirements that allow for individual medical necessity and appropriateness determinations and (c) administrative requirements for Provider's consideration, and the consideration of Provider's practitioner(s) of the input of Members, Enrollees, or Participants in the establishment of treatment plans.

10.2 As applicable, Provider will maintain weekly appointment hours that are sufficient and convenient to serve Members, Enrollees, and Participants. Provider agrees that scheduling of appointments shall be done in a timely manner. As applicable and consistent with administrative requirements, Provider shall make necessary and appropriate covering arrangements to assure the availability of Provider services for Members, Enrollees, and Participants on a 24 hour per day, 7 days per week basis. This includes covering arrangements to assure Provider Services can be rendered to Members, Enrollees, and Participants after-hours or when Provider or practitioner(s) is/are otherwise absent. All such covering arrangements shall comply with and be made in accordance with administrative requirements.

10.3 Provider and Davis acknowledge and agree that equal access and non-discrimination provisions contained in Section V.10 and V.13 of the Agreement are hereby specifically incorporated in this Addendum. Provider understands and acknowledges that Davis and Plan(s) must ensure that Covered Services are provided in a culturally competent manner to all Members, Enrollees, and Participants, including those with limited English language proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities. As requested by Davis or Plan(s), Provider and Provider's practitioners agree(s) to cooperate with and assist Davis and Plan(s) in meeting these obligations.

10.4 To the extent required by law, Davis and/or Plan(s) provide coverage of Emergency Services and Urgently Needed Services for Members, Enrollees, and Participants. Where applicable, Davis and/or Plan(s) shall reimburse Provider for Emergency and Urgently Needed Services rendered to Member, Enrollee, or Participant in order to attain Stabilized Condition and in accordance with applicable laws, administrative requirements, and CMS regulations (42 CFR §422.113) and without regard to prior authorization for such services. Provider also agrees to notify Davis of Emergency

Services or Urgently Needed Services and any necessary follow-up services rendered to any Member(s).

10.5 The Medicare Advantage Program Plan shall be financially responsible for Emergency and Urgently Needed Services (i) regardless of whether the services are obtained within or outside of the Medicare Program Plan area; (ii) regardless of whether prior authorization is obtained for the services (iii) in accordance with the prudent layperson definition of Emergency Medical Condition regardless of final diagnosis; (iv) for which a provider or other Medicare Advantage Program organization representative instructs a Member/Enrollee to seek Emergency Services within or outside of the Plan; (v) with a limit on charges to Member/Enrollee for emergency department services of $50 or what the Plan would charge the Member/Enrollee if the services were obtained through the Plan, whichever is less.

11. MEDICARE ADVANTAGE MEMBER TREATMENT PLANS, HEALTH ASSESSMENTS, FOLLOW-UP CARE AND SELF-CARE.

11.1 Provider and Provider's practitioners acknowledge that Davis and Plan(s) have procedures approved by CMS to (a) identify Medicare Advantage Members with complex or serious medical conditions; (b) assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and (c) establish and implement a treatment plan appropriate to those conditions with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees and shall ensure that Provider's practitioners agree to assist in the development and implementation of treatment plans. In addition, and to the extent applicable, Provider agrees and shall ensure Provider's practitioners agree to cooperate with conducting a health assessment of all new Medicare Advantage Members within ninety (90) days of the effective date of their enrollment**.** Further and in accordance with administrative requirements, Provider and Provider's practitioners will, to the extent applicable, inform Medicare Advantage Members of follow-up care and/or provide Medicare Advantage Members with training in self-care.

12. SUBCONTRACTORS.

12.1 Provider agrees that if Provider enters into subcontracts or lease arrangements to render any vision care services to Medicare Advantage Members that are permitted under the terms of the Agreement and this Addendum, Provider's subcontracts or lease arrangements shall include the following:

12.1.1 an agreement by the subcontractor or leaseholder to comply with all of Provider's and, where applicable, practitioner's obligations in this Addendum and in the Agreement;

and

12.1.2 a prompt payment provision as negotiated by Provider and the subcontractor or leaseholder; and

12.1.3 a provision setting forth the terms of payment, any incentive arrangements, and any additional payment arrangements; and

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

12.1.5 dated signature of all parties to the subcontract.

12.2 Provider agrees that in no event shall Provider or Provider's practitioners enter into subcontracts or lease arrangements with any person or entity outside of the jurisdiction of the United States ("offshore subcontractor") for the purpose of rendering vision care services to Medicare/Medicare Advantage Members covered under the Agreement and this Addendum, without the prior, written approval of Davis, the Medicare Advantage Plan and CMS. Failure to obtain such prior, written approval may result, at the discretion of Davis or Plan, in the immediate termination of Provider and/or Provider's practitioner.

13. REIMBURSEMENT.

13.1 Provider will be reimbursed for Covered Services provided to Medicare Advantage, Act 68, adultBasic, CHIP or PA Medical Assistance MCO Program Members, Enrollees, and/or Participants in accordance with Section IV of the Agreement.

13.2 In accordance with Title 42 of the Code of Federal Regulations, section 422.504(g)(1)(iii), and <u>to the extent applicable</u>, Provider agrees that dually eligible Subscribers of Medicare Advantage plans shall not be held liable for Medicare Parts A and B cost-sharing when the appropriate state Medicaid agency is liable for the cost-sharing. Provider further agrees that upon receiving payment from Davis for a Medicare Advantage Subscriber, Provider will either: (i) Accept the Medicare Advantage payment as payment in full; or (ii) Bill the appropriate State source.

14. AMENDMENT.

14.1 This Addendum may be amended in accordance with Section VIII of the Agreement, unless the amendment is required by applicable laws and/or regulations in which case, thirty (30) days advance written notice shall not be required. Further the Parties acknowledge and understand CMS may require additional contract terms and conditions as it may deem necessary and appropriate to implement requirements of this Addendum. The Parties hereby agree to such terms and conditions without the need for a specific, advance written notice.

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

15. TERM/TERMINATION.

15.1 This Addendum will have the same Term as the Agreement and shall immediately terminate upon termination of the Agreement, provided:

15.1.1 (a) any without cause termination requires at least sixty (60) days prior written notice; and

15.1.2 (b) any termination must comply with the requirements of Sections 2113, 2121 and 2171 of Act 68 (40 P.S. §§ 991.2113, 991.2121 and 991.2171); and

15.1.3 at the sole discretion of Davis and/or Plan(s), Provider's participation or the participation of a Provider's practitioner in adultBasic, CHIP or PA Medical Assistance MCO Program as the case may be, may be terminated in the event of a successful prosecution of Provider or Provider's practitioner(s) related to adultBasic, CHIP or PA Medical Assistance MCO Program; and

15.1.4 such termination from participation in adultBasic, CHIP, and/or PA Medical Assistance MCO Program alone shall not affect the remaining provisions of the Agreement or addenda thereto as it relates to Members covered under other Programs.

15.2 At the sole discretion of CMS, Plan(s) and/or Davis, this Addendum may be immediately terminated, as it relates to the provision of Covered Services to Medicare Advantage Members by the Provider or the Provider's practitioner(s) hereunder for the following reasons:

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

15.2.2 In the opinion of Davis' medical director or equivalent, the health care professional represents an imminent danger to an individual patient or the public health, safety or welfare; or

15.2.3 A decision by CMS, Plan(s), and/or Davis that: (i) Provider has not performed satisfactorily, or (ii) Provider's reporting and disclosure obligations under the Agreement or the addenda thereto are not fully met or timely met; or

15.2.4 The failure of Provider or Provider's practitioner(s) to comply with the equal access and non-discrimination requirements set forth in the Agreement and addenda thereto.

16. PROVIDER OBLIGATIONS UPON TERMINATION.

16.1 Should Davis and/or Plan(s) initiate termination of the Agreement or this Addendum for reasons other than for cause, Provider shall and Provider's practitioner(s) shall comply with the continuity of care provisions of Act 68, of Medicare regulations, and of the PA Medical Assistance MCO Program agreement. The Parties agree that any Member, at the Member's option, may continue an ongoing course of treatment with Provider and/or Provider's practitioner(s) for a transitional period of up to sixty (60) days from the date the Member is notified of the termination or the pending termination.

16.2 In consultation with Plan(s), the Act 68 or PA Medical Assistance MCO Program Member and/or the Provider and the Provider's practitioner(s) 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 and Provider's practitioner(s) shall continue to provide Covered Services to such Act 68 Member(s) and the Parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Addendum and the Agreement (including reimbursement rates) that are effective as of the date of termination.

16.3 Should Davis and/or Plan(s) initiate termination of the Agreement and/or addenda thereto, Provider and Provider's practitioner(s) shall comply with Provider obligations as set forth in Sections VII.3, VII.4, VII.5, VII.6, and X.8 of the Agreement

17. NOTICE AND APPEAL RIGHT.

17.1 To the extent notice is required under any applicable laws, rules, or regulations, Davis and/or Plan(s) shall give Provider and/or Provider's practitioner(s) written notice of termination of this Addendum and such notice shall include the reasons for the action, and if applicable, the Provider's right and/or the Provider's practitioner(s)' right to appeal the action, as well as the process and timing to request a hearing.

18. SURVIVAL.

18.1 The provisions in Sections 6, 7, 8.2, 8.3, 9.2 and 16 of this Addendum shall survive the termination of the Agreement and/or this Addendum regardless of the cause giving rise to such termination. In addition, any of the other terms and covenants contained in this Addendum which requires the performance or inaction of either party after the termination shall survive said termination. Termination of this Addendum does not constitute termination of the Agreement and of the HMO Addendum. The terms and covenants contained in the Agreement and the HMO Addendum shall survive termination of this Addendum. However, should the Agreement, the HMO Addendum, and this Addendum be terminated concurrently, the provisions in Sections III, IV, V, VII.3, VII.4, VII.5, VII.6, and X.8 of the Agreement shall survive termination.

DAVIS VISION
EYECARE REFRAMED℠

Provider Add Form

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

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

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

Materials shipping street address: ____

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

Please select below the services provided by your office:

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

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

Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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

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

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

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

WCR

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

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

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

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

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

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

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
☐☐☐ - ☐☐ - ☐☐☐☐

or

Employer identification number
☐☐ - ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

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

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

Purpose of Form

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

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

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

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

By signing the filled-out form, you:

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

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

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

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

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

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

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

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

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

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

Backup Withholding

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

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

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

Also see *Special rules for partnerships* above.

What is FATCA reporting?

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

Updating Your Information

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

Penalties

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

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

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

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

Specific Instructions

Line 1

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

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

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

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

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

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

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

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

Line 2

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

Line 3

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

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

Line 4, Exemptions

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

Exempt payee code.

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

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

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

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

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

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

5—A corporation

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

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

8—A real estate investment trust

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

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

11—A financial institution

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

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

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

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

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

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

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

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

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

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

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

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

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

G—A real estate investment trust

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

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

J—A bank as defined in section 581

K—A broker

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

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

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

Line 5

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

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

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

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

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

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

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

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

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

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

Part II. Certification

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

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

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

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

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

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

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

Secure Your Tax Records from Identity Theft

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

To reduce your risk:

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

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

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

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

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

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

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

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

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

Privacy Act Notice

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