

# 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:

The image shows the final page of a contract. At the top, it reads "BY SIGNING HEREON, the Public Law of New York State and the Agreement reflects an effective date of the Effective Date." Below this is a section titled "PROVIDER:" with a red rectangular box around the contact information fields: Name, Title, Fax, Email, and Address. Further down, there is a "DAVIS VISION, INC." section with fields for Name, Title, Fax, and Email. The page number "22" is visible at the bottom right.

2. A completed Davis Vision Provider Add Form:

The image shows a "DAVIS VISION EYECARE REFRAMED" Provider Add Form. It includes a header with the company name and logo. Below the header is a section for "Provider Information" with fields for Name, Title, Fax, Email, and Address. There is also a section for "Physician Information" with fields for Name, Title, Fax, and Email. The form is designed for a provider to fill out their details for joining the network.

3. A copy of your W9 Form:

The image shows a "W-9" form titled "Request for Taxpayer Identification Number and Certification". It is a standard IRS form used for reporting payments to individuals. The form includes fields for Name, Address, and Taxpayer Identification Number (TIN). It also contains a section for "Signature" and "Date". The form is used to certify that the provider is not a tax-exempt entity and to provide their TIN for reporting purposes.

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

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

This **PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF TEXAS** (hereinafter “this Agreement” or “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, **Health Care Service Corporation, a Mutual Legal Reserve Company**, (hereinafter “**HCSC**”) having its principal place of business located at 300 East Randolph, Chicago, Illinois 60601 and **PARTICIPATING PROVIDER** (hereinafter “**PROVIDER**”) as defined herein below. **DAVIS**, **HCSC** and **PROVIDER** are herein referred to individually as “Party” and collectively as “Parties”.

**RECITALS**

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

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

**WHEREAS**, **HCSC** is a Party to this Agreement only with respect to the provision of vision care services by **PROVIDER** to Members in health maintenance organization Plans; and

**WHEREAS**, **DAVIS** is authorized to act as contracting agent for **HCSC** to contract with **PROVIDER** for the provision of Covered Services to Members in health maintenance organization 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 know as the Health Care Financing Administration (HFCA) or any successor agency thereto.

.2 “**Clean Claim**” means a claim for payment for Covered Services which contains the following information: (a) a valid confirmation of eligibility number, referencing a specific Member and Member’s information; (b) a valid, **DAVIS**-assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation was performed; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or Member. Claims from Participating Providers under investigation for fraud or abuse and claims submitted with a tax identification number not documented on a properly completed W-9 form are not Clean Claims. Further, submission of a properly completed CMS Form 1500 or any applicable Uniform Claim Form and any attachments approved or adopted for use in the applicable jurisdiction for payment of Covered Services and as promulgated by the rules and regulations of said jurisdiction shall be deemed a Clean Claim.

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

.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 ordering and when applicable, dispensing plan eyeglasses from a **DAVIS** laboratory.

.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 1396 *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 Medical Assistance Program (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 the convenience of the Member or the **PROVIDER**; and is not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the Member's illness, injury, or disease.

.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**” or “**Medicare Advantage Subscriber**” means an individual who is enrolled in and covered under a Medicare Advantage Program or any successor program(s) thereto regardless of the name(s) thereof. Dually eligible Medicare

Advantage Subscribers are those individuals who are (i) eligible for Medicaid; and (ii) for whom the state is responsible for paying Medicare Part A and B cost sharing..

.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 dependent(s) of such an individual who are enrolled in or who have entered into contract with or on whose behalf a contract has been entered into with Plan(s), and who is entitled to receive Covered Services.

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

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

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

.20 “**Plans**” means a health maintenance organization, corporation, trust fund, municipality, or other purchaser of vision care services that has entered into a Plan Contract with **DAVIS** or **HCSC**.

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

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

.23 “**State**” means the state in which **PROVIDER**’s practice is located or the state in which the **PROVIDER** renders services to a member and/or the State of Texas.

.24 “**Texas Administrative Code**” (hereinafter “**TAC**”) means Title 28 Insurance, Part 1 Texas Department of Insurance, Chapter 11 Health Maintenance Organizations and its subchapters.

.25 “**Texas Health and Human Services Commission**” (hereinafter “**HHSC**”) means the entity with oversight responsibilities for designated Health and Human Services agencies, and which administers certain health and human services programs in the State of Texas, including the Texas Medicaid Program and the Children’s Health Insurance Program (CHIP).

.26 “**Texas Health Maintenance Organization Act** (hereinafter “**TX HMO Act**”)” means the Texas Insurance Code (hereinafter “**TIC**”) codified at Chapters 20A and 843.

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

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

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

### III SERVICES TO BE PERFORMED BY THE PROVIDER

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

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

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



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

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

.4 **Scope of Practice.** The Parties hereto agree and acknowledge they shall comply with the TX HMO Act §843.363(a)(b) and (c) and that nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** and/or Participating Providers from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current, prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to the following:

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

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

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

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

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

.4.6 The termination of **PROVIDER**'s agreement with the MCO or the fact that the **PROVIDER** will otherwise no longer provide vision care services under the **DAVIS** or **HCSC** 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 Plans shall have a mutual right to a Member's treatment records, as well as timely and appropriate communication of Member information, so that both the **PROVIDER** and Plans may perform their respective duties efficiently and effectively for the benefit of the Member.

#### IV COMPENSATION

.1 **Billing.** For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within ninety-five (95) days following the provision of Covered Services, submit to **DAVIS** a claim. Such claim may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**, and if applicable, shall be the standard claim form mandated by the State in which Covered Services were rendered. When applicable, and pursuant to Article 21.52Z of the TIC and §21.3701 of Subchapter CC of the TAC, **PROVIDER** shall comply with requirements pertaining to electronic claims filing and **DAVIS** shall comply with all requirements pertaining to the waiver thereof. Failure of **PROVIDER** to submit said claim within ninety-five (95) 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. Notwithstanding anything herein to the contrary, and pursuant to TX HMO Act §843.323, **DAVIS** shall not refuse to process or to pay an electronically submitted Clean Claim because **PROVIDER** submits the claim in or with a batch submission that includes a claim that does not satisfy the definition of a Clean Claim as defined herein.

.2 **Coding Guidelines and Fee Schedules.** Pursuant to the TX HMO Act §843.321; **DAVIS** shall ensure that **PROVIDER** has access, within thirty (30) days of a **PROVIDER's** request, to a description and copy of the coding guidelines including any underlying bundling, recoding, or other payment process and fee schedules applicable to **PROVIDER**. Further, **DAVIS** shall ensure that **PROVIDER** is given notice of changes in coding guidelines or fee schedules that are applicable to **PROVIDER**, at least ninety (90) days prior to the effective date of the change(s), unless such change(s) is required by statute or regulation within a shorter timeframe. **DAVIS** will not retroactively make changes to coding guidelines or fee schedules. **PROVIDER** may terminate his/her/its participation hereunder, on or before the thirtieth (30<sup>th</sup>) day after the **PROVIDER** receives information under this Section IV.1, and in accordance with the termination provisions contained herein, without penalty or discrimination in other vision care benefit Plans hereunder.

(a) A **PROVIDER** who receives information under Section IV.1 may only (i) use or disclose the information for the purpose of practice management, billing activities, and other business operations, or (ii) use or disclose the information to a governmental agency involved in the regulation of health care or insurance.

.3 **Compensation.** DAVIS shall pay PROVIDER the compensation amounts set forth in **Exhibit 1** attached hereto, less any Copayment, Coinsurance, and Deductible collected or to be collected from the Member by the PROVIDER. Such compensation amounts are and shall be deemed to be full compensation for the Covered Services provided by PROVIDER to Members under applicable Plan(s) pursuant to this Agreement. 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.

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

.4 **Copayments, Coinsurances, Deductibles and Discounts.** PROVIDER shall bill and collect, at the time Covered Services are rendered, all Copayments, Coinsurances, and Deductibles from Member(s) which are specifically permitted and/or applicable to Member(s)' benefit plan. PROVIDER shall bill and collect all charges from a Member for those Non-Covered Services provided to a Member. PROVIDER may only bill the Member when DAVIS has denied 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 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.

.5 **Financial Incentives.** DAVIS shall not provide PROVIDER with any financial incentive to withhold Covered Services, which are Medically Appropriate. Further, the Parties hereto agree to comply with and to be bound by, to the same extent as if the sections were restated in their entirety herein, the provisions of 42 CFR §417.479 and 42 CFR §434.70, as amended by the final rule effective January 1, 1997, and as promulgated by the CMS (formerly the Health Care Financing Administration, DHHS). In part, these sections govern physician incentive plans operated by federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. As applicable and pursuant to 42

CFR §417.479 and 42 CFR §434.70, no specific payment will be made directly or indirectly, under Plans hereunder to a physician or physician group, as an inducement to reduce or limit medically necessary services furnished to a Member.

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

.7 **Payment of Compensation.** Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable state's prompt pay statute, whichever is most restrictive.** Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment and Deductible collected or to be collected from the Member. **DAVIS** shall pay **PROVIDER** eighteen percent (18%) interest per annum on Clean Claims which are not paid within thirty (30) days of receipt.

.8 **Negative Balance.** When a Negative Balance occurs, **DAVIS** shall have the right to offset future compensation owed to **PROVIDER** and/or Participating Provider(s) 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). **PROVIDER** shall be responsible to remit such Negative Balance(s) to **DAVIS** within fifteen days of receipt of invoice from **DAVIS**. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS'** Network in accordance with the suspension and termination provisions set forth in this Agreement. A Negative Balance shall not mean an Overpayment as defined herein.

.9 **Overpayment.** At **DAVIS'** sole discretion, **DAVIS** may bill **PROVIDER** and/or Participating Provider(s) for an Overpayment. **PROVIDER** shall be responsible to remit payment on such Overpayment invoice within forty-five (45) days from receipt of invoice. Should **DAVIS** not receive payment within the aforementioned timeframe, **DAVIS** will, when legally permissible, automatically apply the Overpayment to other outstanding payables on **PROVIDER's** account. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS'** Network in accordance with the suspension and termination provisions set forth in this Agreement. Notwithstanding the foregoing, should this provision conflict with any applicable rules and

regulations, said rules and regulations shall govern. Notwithstanding the foregoing, **DAVIS'** overpayment recovery efforts shall comply with any legislative or statutory timeframe(s) specified within the jurisdiction where services were provided.

.10 **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 each Plan, the federal government, the CMS, and the HHSC harmless from any obligation to compensate **PROVIDER** for Covered Services.

## V OBLIGATIONS OF PROVIDER

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

- .1.1 Any data necessary to characterize the context and purposes of each encounter with a Member, including without limitation, appropriate diagnosis codes applicable to a Member; and
- .1.2 Any information necessary for Plan(s) and/or MCOs to administer and evaluate program(s); and
- .1.3 As requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and
- .1.4 Any information and data necessary for **DAVIS** and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and the CMS instructions and policies under 42 CFR §422.210; and
- .1.5 Any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 CFR §§422.516 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 of Participating Provider(s) of inaccurate or incomplete books and records.

.2 **Coordination of Benefits.** **PROVIDER** shall cooperate with **DAVIS** with respect to Coordination of Benefits (COB) and will bill and collect from other payer(s) such charges for which the other payer(s) 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 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 regulations, Medicare laws, CMS instructions and policies, **DAVIS**' and Plan(s)' credentialing policies, processes, utilization review, quality improvement, medical management, peer review, complaint and grievance resolution programs, systems and procedures. If at any time during the Term of this Agreement, **PROVIDER**'s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall **immediately notify DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as provided herein. **PROVIDER** agrees to cooperate with **DAVIS** in order that **DAVIS** may comply with any requirements imposed by state and federal law, as amended, and all regulations issued pursuant thereto.

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

(a) To the extent that a requirement of the Medicare, Medicare Advantage, or Medicaid Program is found in a policy 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, Medicare Advantage (and any successor program thereto), Medicaid and MAP laws and regulations, the CMS instructions and policies, agrees to audits and inspections by the CMS and/or its designees and shall cooperate, assist, and provide information as requested; and agrees to comply

with **DAVIS**' and Plan(s)' policies regarding credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, peer review, complaint, grievance resolution and appeals processes, comparative performance analysis, and enforcement and monitoring by appropriate government agencies, and activities necessary for the external accreditation of **DAVIS** and/or Plan(s) by the National Committee for Quality Assurance or any similar organization selected by **DAVIS** and/or Plan(s). Further, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the State MAP which shall, on an ongoing basis, monitor performance under this Agreement to ensure the performance of the Parties is consistent with the Plan Contract between **DAVIS** and the MCO and consistent with the contract between the State MAP and the MCO.

(c) In relation to the provision of Covered Services to Medicare and Medicare Advantage Members and Plan(s) hereunder, **PROVIDER**, and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare and Medicare Advantage credentialing and recredentialing requirements and processes and agree to all of the following: **DAVIS** and Plan(s) are ultimately accountable and responsible to the CMS for the services delivered and performed by **PROVIDER** hereunder; all services delivered and performed by **PROVIDER** hereunder must be delivered and performed in accordance with the requirements of Plan agreements with the CMS and with Medicare laws and regulations; such services shall, on an ongoing basis, be monitored by the Plan(s) and/or the CMS and their respective delegates; the Plan(s) and/or the CMS retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s); the Managed Care Organization (MCO) is accountable to the CMS for any functions and responsibilities described in the Medicare regulations pursuant to 42 CFR §422.504; and **PROVIDER** is required to comply with the MCO's policies and procedures.

.5 **Confidentiality of Member Information.** **PROVIDER** agrees to abide by all federal and State laws regarding confidentiality, including unauthorized uses 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 obtained by or through **PROVIDER**'s performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of **PROVIDER**'s obligations and the securement of **PROVIDER**'s rights under this Agreement.

(b) Neither **DAVIS** nor **HCSC** 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, DAVIS, and HCSC** acknowledge and agree the activities conducted to perform the obligations undertaken in this Agreement are subject to, or may be subject to HIPAA as well as to the regulations promulgated to implement HIPAA. **PROVIDER, HCSC, and DAVIS** agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. **PROVIDER, DAVIS, and HCSC** further agree, to the extent HIPAA or such implementing regulations require amendments(s) hereto, **PROVIDER, DAVIS, and HCSC** shall conduct good faith negotiations to amend this Agreement.

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

.7 **Cooperation with Plan Medical Directors.** **PROVIDER** understands contracting Plan(s) will place certain obligations upon **DAVIS** regarding the quality of care received by Members and in certain instances Plan(s) 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 any Plan contracting with **DAVIS**. **PROVIDER** agrees **PROVIDER** 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 require by State regulatory and licensing authorities. Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform credentialing and re-credentialing of **PROVIDER** as required by **DAVIS, Plan(s), or the CMS**. Such documentation shall include, but shall not be limited to, proof of: National Provider Identifier Number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS'** sole option, the right to deny any professional participation privileges in the Network, or the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall **immediately notify DAVIS in writing**, in the event **PROVIDER** suffers a suspension or termination of license or of professional liability insurance coverage. **PROVIDER** shall: (a) devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER's** duties hereunder to Member(s), (b) ensure vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices, and (c) abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services. Notwithstanding anything herein to the contrary, **DAVIS and HCSC** shall comply with the TX HMO Act §843.304



prohibiting the exclusion of a practitioner from Network participation based solely upon the type of license or authorization held by the practitioner.

.9 **Fraud/Abuse and Office Visits.** Upon the request of the CMS, the DHHS, the HHSC, the MAP, or other appropriate external review organization or regulatory agency (“Oversight Entities”) **PROVIDER** shall make available all administrative, financial, medical, and all other records that relate to the delivery of items or services under this Agreement. **PROVIDER** shall provide all such access to the aforementioned records at no cost to **DAVIS** and/or to the requesting Oversight Entity, and in the form and format requested. **PROVIDER** shall allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hours access. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity. **PROVIDER** shall permit and/or make available to the HHSC Office of the Inspector General and/or the Texas Medicaid Fraud Control Unit, its employees, agents, (sub)contractors, and patients, for private, in-person interviews, or for consultations, jury proceedings, pre-trial conferences, hearings, trials and such other processes as may be necessary to conduct such Oversight Entity’s investigation. **PROVIDER** understands and agrees the acceptance of funds under this Agreement acts as acceptance of the authority of the Texas State Auditor’s Office (“SAO”), or any successor agency, to conduct an investigation in connection with those funds. **PROVIDER** agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. **PROVIDER** further understands and agrees he/she/it is bound to report any suspected fraud or abuse, including any suspected fraud and abuse committed by the Plan or a Member, to the HHSC Office of the Inspector General. **PROVIDER**’s obligations contained herein shall survive termination of this Agreement.

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

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

(b) **PROVIDER** agrees to provide **DAVIS** with thirty (30) calendar days notice if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/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, the telephone and fax numbers and such other information as may materially differ from the most recently completed credentialing application submitted by **PROVIDER** and/or Participating Providers to **DAVIS**. Under no circumstance shall provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER**, **DAVIS**, and **HCSC**.

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, **HCSC**, 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**, **HCSC**, 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 herein.

.12 **Malpractice Insurance**. **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire Term of this Agreement, maintain a policy (or policies) of professional malpractice liability insurance in a minimum amount of One Million Dollars (\$1,000,000.00) per occurrence and Three Million Dollars (\$3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER**'s agents, servants, employees, affiliates, independent contractors and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In 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), The Age Discrimination Act of 1975 (45 CFR 91), The Rehabilitation Act of 1973, The Americans with Disabilities Act of 1990 (“ADA”), 28 CFR §35.101, and Title 40 of the Texas Administrative Code, chapter 73; **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member’s race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence), claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and in conformity with all laws applicable to the receipt of Federal funds including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (“Revised DHHS LEP Guidance”); and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR §438.206(c)(2), **PROVIDER** and Participating Provider(s) agree Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and **PROVIDER** shall maintain written procedures as to interpretation and translation services for Members requiring such services. During the Term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee’s or applicant’s hire, tenure, terms, conditions, or privileges of employment due to such individual’s race, color, religion, gender, disability, marital status or national origin.

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

.15 **Participation Criteria.** **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**’s employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of federal funds; federal laws designed to prevent or ameliorate fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b)), 42 CFR §§422.504(h)(1), 423.505(h)(1) and the HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**’s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a federal health care program as described in Sections 1128B(b) and 1128B(f) of the Social Security Act, and all employees, affiliates, subcontractors, and/or

independent contractors of **PROVIDER** are able to provide a current National Provider Identifier Number as applicable.

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

(b) **PROVIDER** may not employ, contract with, or subcontract with an individual, or with an entity that employs, contracts with, or subcontracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a Federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. **PROVIDER** acknowledges 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 Directory.** **PROVIDER** understands and agrees **DAVIS** and each Plan(s) which contracts with **DAVIS** or **HCSC** reserves the right to use **PROVIDER**'s name, address, telephone number, type of practice, and willingness to accept new patients for the purposes of printing and distributing provider directories to Member(s). Such directories are intended for and may be inspected and used by prospective patients and others.

.17 **Record Requirements and Retention.** **PROVIDER** shall maintain adequate, accurate, and legible medical, financial and administrative records related to Covered Services rendered by **PROVIDER**. Such records shall be written in English and in accordance with federal and State law. **PROVIDER** shall have written policies and procedures for storing all records. Except as set forth below, **PROVIDER** shall retain all such records for a minimum of five (5) years from the date that the document ceases to be an active document.

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

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

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

.18 **Subcontractors**. **PROVIDER** agrees 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 health/vision care services to Medicare/Medicare Advantage Members covered under the terms of this Agreement or any addenda or attachment hereto, without the prior written approval of **DAVIS**, the Medicare Advantage Plan and the CMS. Failure to obtain prior approval may result, at the discretion of **DAVIS** or Plan(s), 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 health/vision care services permitted under the terms of this Agreement, **PROVIDER**'s subcontracts or lease arrangements shall include the following:

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

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

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

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

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

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

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

## VI TERM OF THE AGREEMENT

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

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

## VII TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause.** After the Initial Term has expired, this Agreement may be terminated by **DAVIS** or **PROVIDER** without cause, upon ninety (90) days prior, written notice. If **DAVIS** elects to terminate this Agreement other than at the end of the Initial Term hereof, or for a reason other than those set forth in Sections VII.1 and VII.2 hereof, **DAVIS** shall comply with all applicable provisions of the TX HMO Act §843.306, and **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 and/or in accordance with TX HMO Act §843.306.

.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) a conviction of a felony (to include but not to be limited to fraud);

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

(f) 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;

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

“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.3 hereof;

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section X.8 hereof;

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

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

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

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

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

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

**.4 Responsibility for Members at Termination.** In the event 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 for a minimum transitional period of ninety (90) days, or until the Covered Services being rendered to the Member by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a Member), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Medically Appropriate, Covered Services provided to a Member pursuant to this Section VII.4 (prior to and following the effective termination date of this Agreement) at the rates for Covered Services indicated in **Exhibit 1** of this Agreement. Any dispute arising from this paragraph shall be resolved in accordance with the then current **DAVIS** Vision Care Plan Provider Manual.

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents, with accrediting standards, or with TX HMO Act §843.362 regarding Member(s) who have a "special circumstance" and in accordance with the dictates of medical prudence. For the purposes of this Section VII.4, "special circumstance" means a condition regarding which a **PROVIDER** reasonably believes that discontinuing care would



cause harm to a Member/patient. Examples of a Member who has a “special circumstance” include, but are not limited to, a Member with a disability, acute condition, life-threatening illness, or who is past the twenty-fourth (24<sup>th</sup>) week of pregnancy. **PROVIDER** shall continue to provide Covered Services to such Member(s) and the Parties agree all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

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

**.5 PROVIDER Rights Upon Termination.** Except as otherwise required by law, **PROVIDER** agrees, subject to the appeal process set forth below, any **DAVIS** decision to terminate this Agreement pursuant to this Section VII shall be final.

(a) **Review of Termination.** (i) In the event **DAVIS** terminates this Agreement, **DAVIS** must notify **PROVIDER** of such termination via a written notice to the **PROVIDER**, which shall explain the reason(s) for the termination. (ii) Except in cases involving imminent harm to Member(s)’ health, actions by a state licensing board or government agency which impair ability of **PROVIDER** to practice his/her/its profession, or fraud or malfeasance, **PROVIDER** may request, before the effective date of the termination and within a period not to exceed thirty (30) days following **PROVIDER**’s receipt of the written notification of termination, that **DAVIS**’ advisory review panel conduct a review of the termination. Such review will be in accordance with applicable HMO laws. The advisory panel shall consist of physicians and providers who are appointed to serve on **DAVIS**’ standing quality assurance committee or utilization review committee and shall include, when available, at least one representative of the **PROVIDER**’s specialty or a similar specialty. (iii) The panel shall make its formal recommendation within sixty (60) days following receipt of **PROVIDER**’s request for review. **DAVIS** must consider but shall not be bound by the recommendation(s) of the advisory review panel. (iv) **PROVIDER** may request a copy of the advisory review panel’s recommendation and of **DAVIS**’ determination. (v) In cases where **PROVIDER** has not requested an appeal **DAVIS** will provide Members with reasonable advance notice of the termination of this Agreement. **DAVIS** will make every effort to notify Member(s) immediately should this Agreement be terminated due to imminent harm to Member(s).

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

.6 **Return of Materials, Payments of Amounts Due and Settlement of Claims.** If applicable and upon reasonable notice, **DAVIS** may reclaim frame samples at any time during the Term of this Agreement. Upon termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including, but not limited to frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** may setoff any monies due from **PROVIDER** to **DAVIS**. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims.

.7 **Notification to Members upon Termination.** Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above **DAVIS** agrees to make a good faith effort to provide written notice to effected Member(s) within fifteen (15) days of receipt of or issuance of the termination notice. For the purposes of this section, "effected Member(s)" shall mean those Members who have had two or more visits with **PROVIDER** in the past twelve (12) months. Further, **PROVIDER** shall notify **DAVIS** at least thirty (30) days in advance 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.

## **VIII DOCUMENTATION AND AMENDMENT**

.1 **Amendment.** This Agreement may be amended by **DAVIS** with thirty (30) days advance, written notice to **PROVIDER**. Notwithstanding the foregoing, this Agreement may also be amended by written consent of the Parties hereto.

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

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

.4 **Modification of Claims Payment Procedures.** Notwithstanding the foregoing, and pursuant to the TIC Chapters 843 and 20A, **DAVIS** shall provide **PROVIDER** with a ninety (90) calendar day written, notice should any claims payment procedures, or addenda, schedules, or policies submitted by or on behalf of **PROVIDER** and used by **DAVIS** in carrying out payment of

claims hereunder, be amended, revised or substituted. Such ninety (90) day notice period may be shortened when required by statute or regulation.

.5 **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 which are related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement, available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

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

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

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

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

.3 **Establishment of UR/QM Programs.** Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS**, in its sole and absolute discretion, and will be in addition to any utilization review and quality management programs required by a Plan. **PROVIDER** shall comply with and, subject to **PROVIDER**'s rights of appeal, shall be bound by all such utilization review and quality management programs. If requested, **PROVIDER** may serve on the utilization review and/or quality management committee of such programs in accordance with the procedures established by **DAVIS** and Plans. Failure to comply with the requirements of this paragraph may be deemed by **DAVIS** to be a material breach of this

Agreement and may, at **DAVIS'** option, be grounds for immediate termination by **DAVIS** of this Agreement. **PROVIDER** agrees decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment for services rendered to a Member which are determined to not be Medically Appropriate or of poor quality or to be services for which **PROVIDER** failed to receive a confirmation of eligibility prior to rendering services.

.4 **Grievance Procedures**. Subject to **PROVIDER's** rights of appeal, **PROVIDER** shall comply and be bound by the grievance procedure which, in the sole discretion of **DAVIS** and Plan(s) shall be established in accordance with applicable statutes and their implementing regulations for the processing of any **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** and Plan Rules" herein.

(a) In compliance with TX HMO Act §843.283, **PROVIDER** acknowledges and agrees **PROVIDER** is required, in all **PROVIDER** locations which participate in the **DAVIS** Network, to post information giving notice to Member(s) of the process for resolving complaints against the MCO. Such notice shall include the Texas Department of Insurance's toll-free telephone number for filing a complaint.

(b) In compliance with the TX HMO Act §843.281, **DAVIS** shall not engage in any retaliatory action, including the refusal to renew or the termination of **PROVIDER's** Participating Provider Agreement, because **PROVIDER** reasonably files a grievance or a complaint against **DAVIS** or MCO, or appeals a decision of **DAVIS** or MCO on behalf of a Member.

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

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

.7 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS'**, MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; 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 Member(s)' 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 to their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, the Parties may not assign any of their rights or delegate any of their duties hereunder without receiving the prior, written consent of the other Parties, except that **DAVIS** may assign this Agreement to a controlled subsidiary or to an affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS'** assets.

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

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

.5 **Entire Agreement of the Parties.** This Agreement 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, which are not embodied herein, have been made by either Party, or anyone acting on behalf of either Party and no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as is otherwise provided herein any effective modification must be in writing 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** or **HCSC**.

.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 **HCSC** or (ii) a Member or an employer of any Member to disenroll from a Plan contracting with **DAVIS** or **HCSC**. A breach of this paragraph shall be grounds for termination of this Agreement in accordance with the termination provisions contained herein.

.10 **Notices.** Should the Parties be required or permitted to give notice to one another, such notice shall be given in writing and shall be delivered personally or by first class mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Notices shall be delivered or mailed to the addresses appearing herein. The Parties may change their respective 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** or **HCSC** 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** or **HCSC** Plan agreements and the information contained therein regarding **DAVIS**, **HCSC**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or **HCSC** or any Plan and **DAVIS** or **HCSC**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS** or **HCSC**. **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**, **HCSC**, the Plan in which the Member is enrolled, and the Member.

.12 **Relationship of the Parties.** **PROVIDER** hereby expressly acknowledges **PROVIDER**'s understanding that this Agreement constitutes a contract solely among **PROVIDER** and **DAVIS** and **HCSC**, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting **HCSC** to use the Blue Cross and Blue Shield Service Marks

in the state of Texas, and that **HCSC** is not contracting as the agent of the Association. **PROVIDER** further acknowledges and agrees **PROVIDER** has not entered into this Agreement based upon representations by any person other than **HCSC** and **DAVIS** on **HCSC's** behalf and that no person, entity, or organization other than **DAVIS** and **HCSC** shall be held accountable or liable to **PROVIDER** for any of their obligations to **PROVIDER** created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of **DAVIS** or **HCSC** other than those obligations created under other provisions of this Agreement.

.13 **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.

.14 **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.

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

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

*-SIGNATURE PAGE TO FOLLOW-*

**REMAINDER OF PAGE INTENTIONALLY LEFT BLANK**

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

**PROVIDER:**

Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Print Title: \_\_\_\_\_  
Print Date: \_\_\_\_\_

Print All Addresses Below (complete addresses for all practice locations):

Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
Address 3: \_\_\_\_\_  
Address 4: \_\_\_\_\_  
Address 5: \_\_\_\_\_

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

\* Submission of a completed Texas Standardized Credentialing Application and/or submission of a signed Participating Provider Agreement for the State of Texas does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's completed Texas Standardized Credentialing Application and on the execution by practitioner of the Participating Provider Agreement for the State of Texas 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 **DAVIS'** acceptance of a practitioner as a Participating **PROVIDER**, should additional licensed and credentialed practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Members of Plans under Plan Contract(s) with **DAVIS**, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in this Agreement to the same extent as the original signatories to this Agreement.

**DAVIS VISION, INC.:**

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

[For DAVIS use only]

**HEALTH CARE SERVICE CORPORATION,  
A MUTUAL LEGAL RESERVE COMPANY:**

By: Davis Vision, Inc. as Contracting Agent for  
HCSC in connection with the provision of  
Covered Services by PROVIDER to participate  
in health maintenance organization Plans

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

[For DAVIS use only]

**Effective Date:** \_\_\_\_\_

[For DAVIS use only]

Notes: \_\_\_\_\_

[For DAVIS use ONLY]



## **EXHIBIT 1**

### **COMPENSATION**

#### **PROFESSIONAL FEES\***

\*Fees listed below are sample fees for illustrative purposes only and do not reflect fees for all plans. Most plans currently reimburse at \$45.00, net of Co-payment, for routine eye exam. All plan fees are considered reimbursement in full, whether fees are reimbursed entirely by Davis Vision or reimbursed in part by Davis Vision and in part by Member Co-payment.

#### **Eye Examination\*\***

Ranges from \$35.00 - \$50.00

(\*\*Including dilated fundus examination when professionally indicated; CPT codes: S0620, S0621.)

#### **Eyeglass Dispensing Fee+**

Ranges from \$15.00 - \$30.00

(+For a complete pair of eyeglasses selected from the Davis Vision Tower Collection and fabricated through a Davis Vision laboratory.)

#### **Contact Lens Fitting Fee^**

Ranges from \$50.00 - \$85.00

(^When contact lenses are supplied by Davis Vision – i.e. plan contact lenses are daily wear soft & disposable/planned replacement. Non-plan contact lenses are supplied by the Provider's usual source.)

# DAVIS VISION

EYECARE REFRAMED<sup>SM</sup>

## 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):		<i>Please note: CAQH attestation must be signed and dated within the past 30 days</i>	
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**

## Request for Taxpayer Identification Number and Certification

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

<b>Print or type See Specific Instructions on page 2.</b>	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: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> 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. <input type="checkbox"/> 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												
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### 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.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### 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](http://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 <sup>1</sup>	Generally, exempt payees 1 through 5 <sup>2</sup>
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> 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](http://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](http://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](http://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 <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee <sup>1</sup>  The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>1</sup>
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor <sup>1</sup>
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 <sup>1</sup>
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

<sup>1</sup> 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.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> 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.

<sup>4</sup> 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](mailto: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](mailto:spam@uce.gov) or contact them at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 1-877-IDTHEFT (1-877-438-4338).

Visit [IRS.gov](http://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.