THIS AGREEMENT MAY BE SUBJECT TO
APPROVAL BY THE NEW YORK
STATE DEPARTMENT OF HEALTH

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

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

RECITALS

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

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

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

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

I
PREAMBLE AND RECITALS

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

II
DEFINITIONS

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

.2 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a confirmation of eligibility number assigned by **DAVIS**, referencing

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

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

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

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

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

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)
(i) be appropriate within generally accepted standards of practice;

(ii) be efficacious, as demonstrated by scientifically supported evidence;
(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and
(iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and

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

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

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

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

.12 "**Medicare Advantage Member/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/or the eligible dependents of such an individual who is enrolled in or who has entered into contract with, or on whose behalf a contract has been entered into with Plan(s), and who is entitled to receive Covered Services.

.15 "**Negative Balance**" means receipt of Copayment(s), Coinsurance(s) 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** and have satisfied Network participation criteria, and who will provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s). All obligations, terms, and conditions of this Agreement that are applicable to **PROVIDER** shall similarly be applicable to and binding upon Participating Provider(s) as defined herein.

.20 "**Plan(s)**" 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**.

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

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

.23 "**State**" means the State in which **PROVIDER**'s practice is located or the State in which the **PROVIDER** renders services to a Member.

.24 "**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.

.25 "**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).

.26 "**Urgently Needed Services**" means Covered Services that are not emergency services as defined in 42 C.F.R. §422.113 provided when a Member/Enrollee is temporarily absent from the Medicare Advantage Program Plan's service area (or if applicable, continuation area) or, under unusual and extraordinary circumstances, Covered Services provided when the Member 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 Members or any designated representative of a Member(s), regarding: (a) any Medically Necessary or Medically Appropriate care, within the scope of **PROVIDER**'s practice, including but not limited to, the discussion of all possible and/or applicable treatments, including information regarding the nature of treatment, risks of treatment, alternative treatments or the availability of alternative treatments or consultations and diagnostic tests, and regardless of benefit coverage limitations under the terms of the Plan(s)' documents or medical policy determinations and whether such treatments are Covered Services under the applicable **DAVIS** plan designs; or (b) the process **DAVIS** uses on its own behalf or on behalf of Plan(s) to deny payment for a vision care service; or (c) the decision by **DAVIS** on its own behalf or on behalf of Plan(s) to deny payment for a vision care service. In addition, **DAVIS** and **PROVIDER** are prohibited, throughout the Term(s) of this Agreement, from instituting gag clauses for their employees, contractors, subcontractors, or agents that would limit the ability of such person(s) to share information with Plan(s) and/or any regulatory agencies regarding the Medical Assistance MCO Program(s) and the Medicare Program(s).

.3 **Services**. **PROVIDER** shall provide all Medically Appropriate Covered Services to Members within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Member to ensure that it is cost-effective and Medically Appropriate. **PROVIDER** agrees and acknowledges that Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO 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 that nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** and/or Participating Providers from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current, prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to the following:

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

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

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

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

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

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

.5 **Treatment Records**. **PROVIDER** shall (1) establish and maintain a treatment record 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 **Compensation**. As full compensation for the Covered Services provided by **PROVIDER** to Members under an applicable Plan pursuant to this Agreement, **DAVIS** shall pay **PROVIDER** according to the schedule attached hereto as **Attachment 2**. From time to time and at **DAVIS**' sole discretion, **Attachment 2** may be amended with thirty (30) days advance written notice to **PROVIDER**.

(a) Notwithstanding the foregoing, **DAVIS** shall provide **PROVIDER** with ninety (90) days prior written notice for adverse reimbursement changes to **Attachment 2**. **PROVIDER** may contest adverse reimbursement changes within thirty (30) days of receipt of notice. Pursuant to New York Insurance Laws §3217-b, **DAVIS** shall reserve the right to terminate this Agreement for Cause, and in accordance with Section VII.2 herein, upon Parties' inability to agree upon such adverse reimbursement changes. **DAVIS** shall not be required to provide **PROVIDER** with ninety (90) days prior written notice of adverse reimbursement changes when **Attachment 2** is amended for reasons of regulatory imposition or governmental reduction in fee schedule.

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

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

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

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

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

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

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

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

.4 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees **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, person(s) acting on Member(s)' behalf, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit plan. 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, *it being understood that this hold harmless provision is in addition to the protections afforded to Members under Insurance Law Section 4307(d).*

.5 **Payment of Compensation**. Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable 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 Coinsurance collected or to be collected from the Member.

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

.6 **Submission of Claim for Covered Services**. **PROVIDER** shall submit to **DAVIS** a claim for all Covered Services rendered by **PROVIDER** to a Member pursuant to the applicable terms below:

(a) Covered Services in General. For all Covered Services rendered by **PROVIDER** to a Member hereunder, ***PROVIDER*** *shall, within one hundred and twenty (120) days following the provision of Covered Services, submit to* ***DAVIS*** *a claim* which may be written, electronic or verbal, shall be approved as to form and content by **DAVIS,** and if applicable, shall be the standard claim form mandated by the State in which Covered Services were rendered. Failure of **PROVIDER** to submit a claim within one hundred and twenty (120) days following the provision of Covered Services will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER**. 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.

(i) For some Covered Services rendered by **PROVIDER** to a Member enrolled in a Medicaid Managed Care Program, Family Health Plus, and Child Health Plus Program(s) (hereinafter collectively referred to as New York State Medical Assistance Programs) and as administered by **DAVIS**, the Plan(s) or **DAVIS** may direct **PROVIDER** to, and **PROVIDER** shall, in pursuance to such directive submit all such claims *within ninety (90) days following the provision of Covered Services*.

(b) Where applicable, and in compliance with New York Insurance Law §3224-a, as amended and effective April 1, 2010, **PROVIDER** may be permitted to request reconsideration of a Clean Claim that is denied exclusively because it was untimely. **DAVIS** shall advise **PROVIDER** of any reconsideration right granted pursuant to the aforementioned regulation, including but not limited to the applicable timeframe and method of contest and the production of necessary documentation for successful payment. **DAVIS** may reduce payment for reconsidered Clean Claims by up to twenty-five percent (25%).

(c) Disputes. Disputes pertaining to any compensation due to **PROVIDER** and indebtedness to **DAVIS** including, but not limited to Overpayments, Negative Balances or other payments due for materials and supplies under this contract shall be governed by the Provider Appeal Policy annexed hereto as **Attachment 1**.

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

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

.9 **Overpayment Recovery**. In accordance with §3224-b of the New York State Insurance Laws, **DAVIS** may bill **PROVIDER** or Participating Provider for an Overpayment. **PROVIDER** shall be responsible to remit payment on such an Overpayment invoice within forty-five (45) days from receipt of invoice. Should **DAVIS** not receive payment within the aforementioned timeframe, **DAVIS** will, when legally permissible, automatically apply the Overpayment to other outstanding payables on **PROVIDER**'s account. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate

PROVIDER from further participation in **DAVIS**' network in accordance with the suspension and termination provisions set forth in this Agreement.

V
OBLIGATIONS OF PROVIDER

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

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

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

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

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

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

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

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

.2 **Coordination of Benefits**. **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 for payment.

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

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

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements, including but not limited to: Medicare, Medicare Advantage (and any successor program thereto), Medicaid, and MAP laws and regulations, 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 maintain records a minimum of ten (10) years; and agrees to comply with **DAVIS**' and Plan(s)' policies regarding provisional credentialing, credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, peer review, complaint, grievance resolution and appeals processes, comparative performance analysis, and enforcement and monitoring by appropriate government agencies, and activities necessary for the external accreditation of **DAVIS** and/or Plan(s), by the National Committee for Quality Assurance or any other similar organization selected by **DAVIS** and/or Plan(s).

(c) In relation to the provision of Covered Services to Medicaid and the MAP Members and programs hereunder, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the New York State Department of Health ("NYSDOH") and the NYSDOH shall, on an ongoing basis, monitor performance of the Parties 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 NYSDOH and the MCO. Further, **PROVIDER** acknowledges and agrees **DAVIS** is accountable and responsible to the State MAP which shall, on an ongoing basis, monitor performance of the Parties 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.

(d) In relation to the provision of Covered Services to Medicare and Medicare Advantage Members and programs hereunder, **PROVIDER** acknowledges and agrees to all of the following: **PROVIDER** and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare and Medicare Advantage credentialing and re-

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

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

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

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

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

and maintain such PHI. **PROVIDER** shall cooperate with **DAVIS** in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

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

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

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** provisional credentialing, credentialing and re-credentialing policies and procedures and the provisional credentialing, 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 required by State regulatory and licensing authorities. Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform provisional credentialing, 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 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 **PROVIDER**'s license or professional liability insurance coverage. **PROVIDER** shall: (a) devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s); (b) ensure vision care

services provided under this Agreement are of a quality that is consistent with accepted professional practices; and (c) abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

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

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

(a) **PROVIDER** agrees **PROVIDER** is subject to regular monitoring of his/her/its compliance with the appointment wait time (timely access) standards of 42 CFR §438.206(c)(1). As such, **PROVIDER** agrees and understands corrective action shall be implemented should **PROVIDER** and/or Participating Provider(s) fail to comply with timely access standards and Plan(s) have the right to approve **DAVIS**' scheduling and administration standards. (b) **PROVIDER** agrees to provide **DAVIS** with ninety (90) calendar days notice if **PROVIDER** and/or Participating Provider shall (i) be unavailable to provide Covered Services to Members, (ii) move office location, (iii) change place of employment (iv) change employer, or (v) reduce capacity at an office location. The ninety (90) calendar day notice shall, at a minimum, include the effective date of the change, the new tax identification number and a copy of the W-9 as applicable, the name of the new practice, the name of the contact person, the address, telephone and fax numbers and other such information as may materially differ from the most recently completed credentialing application submitted by **PROVIDER** and/or Participating Provider to **DAVIS**. Under no circumstance shall the provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER** and **DAVIS**.

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, the Plan(s) and the State and their respective agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which, in any manner may accrue against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees

through **PROVIDER**'s intentional conduct, negligent acts or omissions, or the intentional conduct, negligent acts or omissions of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

(a) To the extent applicable, **PROVIDER** agrees to indemnify and hold harmless the State and the CMS from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the State or the CMS as a result of a failure of **PROVIDER**, or **PROVIDER**'s agents, employees, subcontractors or independent contractors to comply with the Non-Discrimination provision(s) 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 liability to indemnify the State or Enrollees of a Medical Assistance Program.

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

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** shall comply with the "General Prohibitions Against Discrimination," 28 CFR §35.130 and similar regulations or guidelines that apply to the agencies with which Plan(s) contract. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the regulations implementing the Americans with Disabilities Act ("ADA"), 28 CFR §35.101 et seq., **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence), claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and 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 **PROVIDER** be in violation of any portion of this Section V. Additionally, **PROVIDER** shall advise **DAVIS** of each malpractice claim filed against **PROVIDER** and each settlement or other disposition of a malpractice claim entered into by **PROVIDER** within fifteen (15) days following said filing, settlement or other disposition.

.15 **Participation Criteria**. **PROVIDER** hereby warrants and represents **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 law designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et. seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b), 42 CFR. §§422.504(h)(l), 423.505(h)(l)) and the HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **PROVIDER** hereby warrants and represents **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a federal health care program as described in 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 that meeting the Participation Criteria is a condition precedent to **PROVIDER**'s participation, and a condition precedent to the participation by **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractor(s) hereunder and, is an ongoing condition to the provision of Covered Services hereunder by both the **PROVIDER** as well as a condition precedent to the reimbursement by **DAVIS** for such Covered Services rendered by **PROVIDER**. Upon **PROVIDER**'s meeting all of the Participation Criteria set forth in this Agreement **PROVIDER** shall participate as a Participating Provider for Plan(s)/programs covered under this Agreement.

(b) **PROVIDER** may not employ, contract with, or subcontract with an individual, or with an entity that employs, contracts with, or subcontracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from

participation in a federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. **PROVIDER** acknowledges and understands this Agreement shall automatically be terminated if **PROVIDER** or any practitioner, or any person with an ownership or control interest in **PROVIDER**, is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in any other federal health care program. Any payments received by **PROVIDER** hereunder on or after the date of such exclusion shall constitute overpayments.

.16 **PROVIDER Directory**. **PROVIDER** understands and agrees **DAVIS** and each Plan which contracts with **DAVIS** reserve 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.

(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 agree to provide such information to **DAVIS,** to contracting Plans, applicable state and federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a minimum of ten (10) years from the final date of the contract period or from the date of completion of any audit, or for such longer period of time provided for in 42 CFR §§422.504 and 423.505, or other applicable law, whichever is later. In the case of a minor Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, or for such longer period of time provided for in 42 CFR §§422.504, 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 **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 **PROVIDER**, or by **PROVIDER**'s subcontractor or independent contractor, all records must be maintained until such time as the matter under audit or investigation has been resolved, whichever is later.

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

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

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

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

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

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

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

.19 **Training Regarding the Plan Contracts**. **PROVIDER** agrees to train his/her/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 an initial Term of twelve (12**)** months.

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

VII
TERMINATION OF THE AGREEMENT

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

.2 **Termination With Cause and Suspension of Participation**. **DAVIS** may terminate this Agreement for cause as set forth below.

(a) "**Cause**" warranting ***immediate*** termination of this Agreement by **DAVIS** shall be**:**

(1) a final disciplinary action by a state licensing board or other governmental agency that impairs the **PROVIDER**'s ability to practice his/her/its profession, including but not limited to:

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

(ii) a suspension of **PROVIDER** from Medicare or Medicaid;

(iii) a loss or suspension of a Drug Enforcement Administration (DEA) identification number impairing **PROVIDER**'s ability to practice;

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

(v) a determination of fraud; and/or

(vi) 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.

(b) "**Cause**" warranting issuance of a notice of proposed contract termination by **DAVIS** pursuant to §4803(b) of New York Insurance Laws shall be:

(i) any material breach of any obligation of **PROVIDER** under the terms of this Agreement;

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

(iii) a conviction of a felony;

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

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

(vi) the failure of the Parties to mutually agree upon an adverse reimbursement modification to **Attachment 2** and pursuant to New York §3217-b.

(c) "**Cause**" warranting suspension of **PROVIDER** from network participation shall be:

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

(ii) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section V.4 hereof;

(iii) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section V.3 hereof;

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

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

Provided, however, that **PROVIDER** shall not be penalized nor shall this Agreement be terminated or suspended because **PROVIDER** acts as an advocate for a Member in seeking appropriate Covered Services, files a complaint or an appeal, or provides information or files a report with an appropriate government body regarding **DAVIS'** action. Further, no provision contained herein shall supersede or impair the **PROVIDER'S** right to a notice of reasons for the termination and an opportunity for hearing where applicable.

.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 if for breach of contract, or there is a determination of fraud; or

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

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

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

.4 **Responsibility for Members at Termination**. In the event this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall continue to provide Covered Services to a Member who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement for a minimum transitional period of ninety (90) days from the date the Member is notified of the termination or pending termination, or until the Covered Services being rendered to the Member by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a Member), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date of this Agreement) at the rates for Covered Services attached hereto.

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

Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

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

.5 **PROVIDER Rights Upon Termination**. Except as otherwise required by law, **PROVIDER** agrees, subject to the appeal process set forth in the Provider Appeal Policy, attached hereto as **Attachment 1** and the Provider Manual, any **DAVIS** decision to terminate this Agreement pursuant to this Section VII shall be final.

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

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

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

.8 **Termination by the New York State Department of Insurance**. Should **DAVIS**' financial risk transfer agreement be terminated by the Superintendent of the New York State Department of Insurance (hereinafter referred to as the "Superintendent"), pursuant to the provisions set forth in 11NYCRR 101 Regulation 164 §101.4(a)(3), this Agreement shall be assignable on a prospective basis (without any obligation to pay any amounts owed to **PROVIDER** by **DAVIS**) to each insurer that entered into the financial risk transfer agreement with **DAVIS** for a period of time which is determined by the Commissioner of the New York State Department of

Health, as respects entities certified pursuant to Article 44 of the New York State Public Health Law, or by the Superintendent as respects all other insurers, to be necessary in order to provide the services that the insurer is legally obligated to deliver to its subscribers. No such assignment shall exceed twelve (12) months from the date the financial risk transfer agreement is terminated by the Superintendent.

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

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

.1 **Access to Records**. **PROVIDER** shall make all records related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities 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 to ensure practice guidelines and utilization management guidelines:

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

(b) consider the needs of the enrolled population;

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

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

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

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

.4 **Grievance Procedures**. The grievance procedure set forth herein as **Attachment 1** shall be followed for the processing of any **PROVIDER** complaint regarding Covered Services. **PROVIDER** shall comply with and subject to **PROVIDER'**s rights of appeal be bound by such grievance procedure. 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.3 "Compliance with Davis and Plan Rules" herein.

.5 **Member Grievance Resolution**. **PROVIDER** shall cooperate with **DAVIS** in the investigation of any complaint regarding the materials or services provided by **PROVIDER**. The cost of providing replacement services or materials to satisfy any reasonable Member complaint shall be borne by **PROVIDER** if the grievance is determined to be the result of improper

execution of services on the part of **PROVIDER** or if materials are not functioning in the manner prescribed by the Participating Provider(s) and/or the professional staff.

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

.7 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review, care coordination activities including, but not limited to, medical record reviews, HEDIS reporting, disease management programs, case management, clinical practice guidelines, and other quality measurements to improve Members' care. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and Medical Assistance Program Members. **PROVIDER** shall implement a continuous quality improvement action plan if areas for improvement are identified.

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 attorney fees and costs to the prevailing Party. Either Party may seek arbitration under Article 75 of the Civil Practice Laws and Rules for disputes regarding payment terms hereunder.

.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, neither Party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other Party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS**' assets.

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

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

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

.8 **Independent Contractor**. At all times relevant to and pursuant to the terms and conditions of this Agreement, **PROVIDER** is and shall be construed to be an independent contractor practicing **PROVIDER'**s profession and shall not be deemed to be or construed to be an agent, servant or employee of **DAVIS**.

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

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

.11 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a

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

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

.13 **Third Party Beneficiaries**.

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

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

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

.15 **Waiver**. The waiver of any provision or 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 credentialing application and/or submission of a signed Participating Provider Agreement for the State of New York does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's fully and properly completed, credentialing application and on the execution by practitioner of the Participating Provider Agreement for the State of New York 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:_____
Print Title:_____
Print Date:_____
[**For DAVIS use only**]

Effective Date:_____
[**For DAVIS use only**]

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

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 Address 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 credentaling application and/or submission of a signed Participating Provider Agreement for the State of New York does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's fully and properly completed, credentialing application and on the execution by practitioner of the Participating Provider Agreement for the State of New York 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 IPA, INC.:

Signature:_____
Print Name:_____
Print Title:_____
Print Date:_____
[**For DAVIS use only**]

Effective Date:_____
[**For DAVIS use only**]

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

Appendix A

New York State Department Of Health
Standard Clauses
For Managed Care Provider/IPA Contracts
(Revised 3/1/11)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions For Purposes Of This Appendix

"Managed Care Organization " or "MCO " shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association " or "IPA " shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider " shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least

thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:
    - quality improvement/management
    - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data
    - member grievances; and
    - provider credentialing
5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.
9. To the extent the MCO enrolls individuals covered by the Medical Assistance, and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

a. the MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

b. the Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and

c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

g. The Provider or IPA agrees , pursuant to 31 U.S.C.§1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying", Appendix ____ attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit

Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs)

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law§33.13.

C. Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from

collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.
4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.
5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law §4903.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.
3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.
4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to

DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.
4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if this Agreement is between the MCO and an IPA.** This provision shall survive termination of this Agreement.
5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.
6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-Specific Provisions

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

APPENDIX B

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Contractor for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Contractor shall complete and submit Standard Form - LLL "Disclosure Form to Report Lobbying", in accordance with its instructions.

3. The Contractor shall include the provisions of this section in all provider Agreements under this Agreement and require all Participating providers whose Provider Agreements exceed $100,000 to certify and disclose accordingly to the Contractor.

This certification is a material representation of fact upon which reliance was place when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

ATTACHMENT 1

PROVIDER APPEAL POLICY

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

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

The appeal process is intended to:

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

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

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

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

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

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

Davis Vision will convene a hearing within thirty (30) calendar days of receipt of a properly filed "Request for Appeal Determination". Davis Vision will forward its determination of the appeal to the Participating Provider via a written notification and within thirty (30) calendar days of the completion of the appeal hearing date.

ATTACHMENT 2

DAVIS VISION PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NEW YORK

COMPENSATION

PROFESSIONAL FEES*

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

Eye Examination** Ranges from $35.00 - $65.00
(**Including dilated fundus examination; CPT codes: S0620, S0621)

Eyeglass Frame Dispensing Fee+ Ranges from $14.00 - $40.00
(+Frames are supplied from the Davis Vision Tower Collection. Frames supplied by a Provider are sent to a Davis Vision laboratory for lenses.)

Contact Lens Fitting Fee^ (*when covered as an itemized service*) Ranges from $30.00 - $85.00
(^When contact lenses are supplied by Davis Vision – i.e. plan contact lenses are daily wear soft & disposable/planned replacement. Non-plan contact lenses are supplied by the Provider's usual source.)

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NOTICE OF AMENDMENT

For

DAVIS VISION, INC. AND DAVIS VISION IPA, INC.
PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NEW YORK

In conformity with the inclusion of the most recent CMS Clauses, please find Appendix C (New York State Department of Health Standard Clauses for Managed Care Provider / IPA Contract) enclosed herein.

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Appendix C

CMS CLAUSES

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173,117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Provider not inconsistent herein shall remain in full force and effect. The provisions of this Appendix shall supersede and replace any inconsistent provisions to the Agreement, to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

A. Definitions For Purposes Of This Appendix

"**Centers for Medicare and Medicaid Services ("CMS"):** The Agency with the Department of Health and Human Services that administers the Medicare program.

"**Completion of Audit**": Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

"**Downstream Entity**": Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

"**Final Contract Period**": The final term of the contract between CMS and the Medicare Advantage Organization.

"**First Tier Entity**" Any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for Medicare eligible individual under the MA program.

"**Medicare Advantage ("MA")**: An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

"**Medicare Advantage Organization (" MA Organization ")**": A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

"Member **or Enrollee**": A Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

"**Provider**" (1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State: and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

"**Related Entity**": Any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. Required Provisions:

First Tier or Downstream Entity ("Provider") agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit , evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation for the first tier, downstream, and entities related to CMS' contract with DAVIS, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504 (i)(2)(i) and (ii)]

2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R.§§422.504 (i)(3)(i) AND 422.504 (g)(1)(i)].

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source [42C.F.R.§§ 422.504 (i)(3)(i) and 422.504 (g)g(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42. C.F.R. §422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the DAVIS and the provider. {42 C.F.R. §§ 422.520 (b)b(1) and (2)

7. DAVIS and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions [42 C.F.R. §§ 422.504 (i) (4) (v)] The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:
   (i) The delegated activities and reporting responsibilities are specified as follows:

   NA

   (ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

   (iii) The MA organization will monitor the performance of the parties on an ongoing basis.

   (iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

   (v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

   [42 C.F.R. §§ 422.504(i) (4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of related agreement, the terms above control.