DAVIS VISION
PROVIDER DOCUMENT REQUIREMENTS FOR
THE COMMONWEALTH OF PENNSYLVANIA

Davis Vision's provider credentialing policy requires all applicants/practitioners in the Commonwealth of Pennsylvania to **complete and/or forward the following documents** for completion of the credentialing process prior to requesting authorization of services to a Davis Vision plan member.

_____ **APPLICATION**

Davis Vision's Provider Application: "Office Information," "Practitioner Information," and "Payee Information."

_____ **PARTICIPATING PROVIDER AGREEMENT FOR THE COMMONWEALTH OF PENNSYLVANIA**

Both the first page and the signature page of the Participating Provider Agreement must be completed & signed by the applicant/practitioner, and a complete copy of the signed Agreement must be returned to Davis Vision.

_____ **W-9 FORM** (Request for Taxpayer Identification Number and Certification)

_____ **COPY OF ALL CURRENT STATE REGISTRATIONS**

_____ **COPY OF DEA CERTIFICATE, IF APPLICABLE**

_____ **COPY OF CSR CERTIFICATE, IF APPLICABLE**

_____ **COPY OF BOARD CERTIFICATION, IF APPLICABLE**

_____ **COPY OF CURRICULUM VITAE OR RESUMÉ**

_____ **COPY OF CURRENT CERTIFICATE OF MALPRACTICE INSURANCE** (The insurance certificate must indicate coverage in the name of the applicant/practitioner, current dates of coverage, and be in a minimum amount of $1 million per occurrence; $3 million in the annual aggregate.)

_____ **COPY OF BLANK PATIENT EXAM FORM**

_____ **PROFESSIONAL LETTER OF REFERENCE** (A signed letter of reference from a licensed peer.)

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

1. IDENTIFICATION

Last Name:_____ First Name:_____ MI: ____
Degree(s): _____
Gender: ___ Date of Birth: ___/___/____ Maiden Name: _____
Social Security Number: _____
Are you proficient in any language, including American Sign Language, in addition to English? Yes ☐ No ☐ If yes, please list: _____
_____
_____
E-Mail Address: _____

2. GOVERNMENT PROGRAMS

Individual Medicaid Number 1: _____ State1: _____
Effective Date _____ Expiration Date: _____
Individual Medicaid Number 2: _____ State2: _____
Effective Date _____ Expiration Date: _____
Individual Medicare Number: _____
Effective Date _____ Expiration Date: _____
UPIN Number: _____

3. CERTIFICATION INFORMATION

Optometrists:
Please check highest certification level achieved: DPA Certified: Yes ☐ No ☐
TPA Certified: Yes ☐ No ☐

MD/DO Board Certified: Yes ☐ No ☐
If "yes," provide Board Certification Date: ___/___/___
MD/DO Board Re-Certification Date: ___/___/___

For Davis Vision use only:
Practitioner Number: _____
Affiliated office Number: _____

Kit	☐	Kitless	☐	Exam	☐	Discount	☐
EPO	☐	PPO	☐	Assoc.	☐	Other	☐

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VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

4. DISASTER/EMERGENCY INFORMATION

*Home Address:_____
_____
_____
_____

*City: _____ *State: _____ *Zip: _____
*Home Phone: (_____) _____- _____ *Cell Phone: (_____) _____- _____
*Pager: (_____) _____- _____ *E-Mail Address: _____

*This information is requested in the event that we are unable to contact your office due to a natural disaster or other emergency.

5. CONFIDENTIALITY OF PATIENT INFORMATION

- Are Medical Records stored in a secure location within the office? Yes ☐ No ☐
- Is access to Medical Records restricted to authorized personnel? Yes ☐ No ☐

6. EDUCATION/TRAINING

Education

	School	Degree	Year Graduated
Undergraduate:	_____	_____	_____
Optometry/Medical:	_____	_____	_____
Other/Post Graduate:	_____	_____	_____

Training

Training Record 1 – Please check training type and complete other fields:

Training Type: ☐ Internship, ☐ Residency, ☐ Fellowship, ☐ Other

Institution Name: _____ Start Date: ___/___/___ End Date: ___/___/___
Address: _____
_____
_____
City: _____ State: _____ Zip: _____ Country: _____

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VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

Training Record 2 – Please check training type and complete other fields:

Training Type: ☐ Internship, ☐Residency, ☐ Fellowship, ☐Other

Institution Name: _____ Start Date: ___/___/___ End Date: ___/___/___
Address: _____
_____
_____
City: _____ State: _____ Zip: _____ Country: _____

Please attach separate sheet(s) for additional training information; use same format.

7. LICENSURE

License Number	**State**	**Date Issued**	**Date License Expires**
_____	____	___/___/___	___/___/___
_____	____	___/___/___	___/___/___
_____	____	___/___/___	___/___/___
_____	____	___/___/___	___/___/___

Controlled Substance Registration Number (CSR)(If applicable): _____
Expiration Date: ___/___/___

DEA Number (If applicable): _____ Expiration Date: ___/___/___

8. PROFESSIONAL LIABILITY INSURANCE – PLEASE ATTACH A COPY OF CURRENT PROFESSIONAL LIABILITY POLICY (FACE SHEET OR CERTIFICATE OF INSURANCE)

Professional liability carrier name: _____
Policy Number: _____
Policy Start Date: ___/___/___ Policy End Date: ___/___/___
Coverage Limit Per Occurrence: $_____
Length of time with current carrier _____
Coverage Limit Aggregate: $ _____

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VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

9. HOSPITAL AFFILIATION INFORMATION (If Applicable)

1. Hospital Name:______________________________
   Address:______________________________
   Dates Affiliated:_____/_____/_____ to _____/_____/_____

2. Hospital Name:______________________________
   Address:______________________________
   Dates Affiliated:_____/_____/_____ to _____/_____/_____

3. Hospital Name:______________________________
   Address:______________________________
   Dates Affiliated:_____/_____/_____ to _____/_____/_____

**If you have additional affiliation information please attach a separate sheet; use same format.*

10. PROFESSIONAL EMPLOYMENT HISTORY **(Please list your work experience for the preceding five (5) years, <u>beginning with your most current work information.</u> Provide an explanation on a separate sheet for any gaps in work history that are of a duration of six months or greater.) In addition, you may attach a current curriculum vitae/ resume'. ***ALL FIELDS BELOW ARE REQUIRED*****

Year	Location	Dates
_____	**Location # 1 (include Address)** ______________________	___/__/___ through **Present**
	Location #2 (include Address) ______________________	___/__/___ through ___/___/___

Year	Location	Dates
_____	**Location #1 (include Address)** ______________________	___/__/___ through ___/___/___
	Location #2 (include Address) ______________________	___/__/___ through ___/___/___

Year	Location	Dates
_____	**Location #1 (include Address)** ______________________	___/__/___ through ___/___/___
	Location #2 (include Address) ______________________	___/__/___ through ___/___/___

Year	Location	Dates
_____	**Location #1 (include Address)** ______________________	___/__/___ through ___/___/___
	Location #2 (include Address) ______________________	___/__/___ through ___/___/___

Year	Location	Dates
_____	**Location #1 (include Address)** ______________________	___/__/___ through ___/___/___
	Location #2 (include Address) ______________________	___/__/___ through ___/___/___

Year	Location	Dates
_____	**Location #1 (include Address)** ______________________	___/__/___ through ___/___/___
	Location #2 (include Address) ______________________	___/__/___ through ___/___/___

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VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

11. QUESTIONS **(Other than an affirmative answer to question #1 below, all other affirmative answers should be detailed on a separate sheet.)**

1. For each of the preceding five years, have you received a minimum of six (6) hours of continuing education credits per year, or the minimum number of credits per year that are mandated by the state in which you practice? Yes ☐ No ☐

2. Have you been convicted of a felony or are you currently under indictment for a criminal offense in any state? Yes ☐ No ☐

3. Have any of your licenses been sanctioned, placed on probation, suspended, or revoked in any state? Yes ☐ No ☐

4. Have you been subject to any disciplinary action by any professional organization or by any licensing authority? Yes ☐ No ☐

5. Has your participation status in Medicare and/or Medicaid ever been modified, sanctioned, suspended, or terminated? Yes ☐ No ☐

6. Have you been subject to any loss or limitation of clinical privileges by any facility or by any organization with which you previously had privileges? Yes ☐ No ☐

7. Has any claim or suit alleging malpractice against you as a defendant, or against you as a co-defendant ever been filed, pended, or appealed by you or by your insurance carrier on your behalf? Yes ☐ No ☐

8. Has any malpractice judgment/settlement ever been entered against you? If yes, please provide documentation from insurer. Yes ☐ No ☐

9. Has your malpractice (professional liability) insurance ever been restricted, special-rated, not renewed, suspended and/or cancelled? Yes ☐ No ☐

10. Have you ever been suspended or terminated from panel participation by any network or third party program or insurer? Yes ☐ No ☐

12. MD's

1. Have you been refused membership on any hospital medical staff? Yes ☐ No ☐

2. Have your privileges at any hospital been diminished, suspended, revoked or not renewed? Yes ☐ No ☐

VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

3. Have you ever been denied membership or renewal of membership in any medical organization or have you been subject to any disciplinary action by any medical organization?

Yes ☐ No ☐

13. I ATTEST THAT:

There have been no changes in my physical or mental status that would impair my ability to care for a Davis Vision member.

- ✓ I am not impaired due to chemical dependence or substance abuse.
- ✓ I have no history of loss of license and/or felony convictions.
- ✓ I have no history of loss or limitation of privileges or disciplinary activity.
- ✓ I will cooperate with scheduled on-site visits including reviews of record documentation and when requested, I agree to submit copies of medical records for audit purposes.
- ✓ I hereby affirm and attest that this application is correct and complete.
- ✓ Should there be any changes to the information submitted on this application, especially sections 8, 10, 11 and 12, I will notify Davis Vision immediately.

Submission of the completed Vision Care Provider Application and/or the Participating Provider Agreement does not constitute acceptance as a Davis Vision Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by Davis Vision of the Vision Care Provider Application, and on the execution by practitioner of the Participating Provider Agreement, and on the receipt by practitioner of the forms, manual and samples required for participation. Davis Vision reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a Provider's acceptance by Davis Vision, should additional practitioner(s) join Provider's practice and provide Covered Services to the Participant(s) of Plans under Contract with Davis Vision, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in the Participating Provider Agreement to the same extent as the original signatories to the Agreement.

I understand that the provider's Bill of Rights and non-discrimination policy is available for viewing at **www.davisvision.com**.

I agree to permit Davis Vision to source verify credentials and access the National Practitioners Data Bank (NPDB) and other pertinent sources for history.

***Signature:** _____ **Date:** ___/___/___

***Print Name:** _____

*(Must sign and print name in full.)

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(OFFICE INFORMATION)

1. IDENTIFICATION

Practice/Corporation Name: _____

Owner/Principal Name 1: _____ Title: _____

Owner/Principal Name 2: _____ Title: _____

Structure Type: ☐ Corporation ☐ P.C. ☐ Partnership ☐ Sole Proprietor
☐ Franchise ☐ Other: _____

2. OFFICE ADDRESS/CONTACT INFORMATION

Office Address: _____

_____

_____

City:_____ State: _____ Zip: _____ County: _____

Appointment Telephone: ( ) _____- _____
Dispensing Telephone: ( ) _____- _____
Billing Telephone: ( ) _____- _____
FAX 1: ( ) _____- _____
FAX 2: ( ) _____- _____
FAX 3: ( ) _____- _____

Dedicated FAX: Yes ☐ No ☐

Is your office handicap accessible? Yes ☐ No ☐

For Davis Vision use only:
Office Number: _____

Kit ☐ Kitless ☐ Exam ☐ Discount ☐
EPO ☐ PPO ☐ Other ☐

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VISION CARE PROVIDER APPLICATION
(OFFICE INFORMATION)

Contact Information:

Contact Type: ☐ Office Manager ☐ Billing Manager ☐ Claims Manager
☐ Owner ☐ Doctor ☐ Customer Service Manager
Contact Name: _____
Phone Number: ( ) _____- _____ ***Ext.:*** _____
FAX #: ( ) _____- _____
E-Mail: _____

Additional Contact:

Contact Type: ☐ Office Manager ☐ Billing Manager ☐ Claims Manager
☐ Owner ☐ Doctor ☐ Customer Service Manager
Contact Name: _____
Phone Number: ( ) _____- _____ Ext.: _____
FAX #: ( ) _____- _____
E-Mail: _____

3. ADDITIONAL INFORMATION

Arrangements for Emergency Care:

☐ 24 hour telephone coverage

Answering Machine with: ☐ Pager

☐ Refer to Local Hospital/ER ☐ Refer to covering Ophthalmologist/Specialist

Arrangements for Medical Specialty Care:

☐ Refer to specific Ophthalmologist/Specialist

☐ Refer to Local Hospital/ER

☐ Specialist Available in the Office _____ day(s) per month

Specialist Available Days Per Month: _____

Number of Exam Rooms: _____ Overall Office Square Footage: _____

Internet Capabilities: Yes ☐ No ☐

Preferred Method of Claims Submission: Internet ☐ FAX ☐ Electronic Data File ☐

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THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(OFFICE INFORMATION)

Are you proficient in any language, including American Sign Language, in addition to English? Yes ☐ No ☐

If yes, please list all languages in which you are proficient: _____

_____

4. SHIPPING ADDRESS

Shipping Address: _____

_____

_____

City: _____ State: _____ Zip: _____ Country: _____

5. GROUP PROGRAM NUMBERS

Group Medicare Number: _____ State: _____
Group Medicaid Number: _____ State: _____
Group Medicaid Number: _____ State: _____

6. OFFICE HOURS

Exam Hours:

Monday _____ to_____ Tuesday _____ to _____ Wednesday _____to_____
Thursday _____ to _____ Friday _____ to _____
Saturday _____ to _____ Sunday _____ to _____

☐ *Check here if Dispensing Hours are the same as Exam Hours, otherwise complete below hrs.*

Dispensing Hours:

Monday _____ to_____ Tuesday _____ to _____ Wednesday _____to_____
Thursday _____ to _____ Friday _____ to _____
Saturday _____ to _____ Sunday _____ to _____

DAVIS VISION ™
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VISION CARE PROVIDER APPLICATION
(OFFICE INFORMATION)

7. SERVICES PROVIDED

☐ Routine comprehensive exam	☐ Visual Fields	☐ Fundus photography
☐ Spectacle dispensing	☐ Visual Training/Therapy	☐ External Photography
☐ Soft Contact Lens Fitting	☐ Low Vision Care	☐ Gonioscopy
☐ Rigid Contact Lens Fitting	☐ Therapeutic Eye Care	☐ Co-Mgmt-Laser Surgery

Other Services provided:

_____
_____
_____
_____

8. OFFICE INSTRUMENTATION

Please check ***Yes*** next to the instruments that you have in the office:

	Yes		***Yes***
78/90D Lens	☐	Ophthalmoscope (binoc)	☐
Auto Refractor	☐	Ophthalmoscope (monoc)	☐
Auto Visual Fields	☐	Phoroptor	☐
Biomicroscope	☐	Projector	☐
Central Field Test	☐	Retinoscope	☐
Color Vision Test	☐	Tonometer	☐
Fundus Camera	☐	Topographer	☐
Gonioscopy Lens	☐	Trial Frame	☐
Keratometer	☐	Trial Lens Set	☐
Lensometer	☐	Ultrasonography	☐
Low Vision Aids	☐	V.T. Equipment	☐
Near Cards	☐		

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(OFFICE INFORMATION)

9. CONFIDENTIALITY OF PATIENT INFORMATION

- Are Medical Records stored in a secure location within the office? Yes ☐ No ☐
- Is access to Medical Records restricted to authorized personnel? Yes ☐ No ☐

Submission of the completed Vision Care Provider Application and/or the Participating Provider Agreement does not constitute acceptance as a Davis Vision Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by Davis Vision of the Vision Care Provider Application, and on the execution by practitioner of the Participating Provider Agreement, and on the receipt by practitioner of the forms, manual and samples required for participation. Davis Vision reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a Provider's acceptance by Davis Vision, should additional practitioner(s) join Provider's practice and provide Covered Services to the Participant(s) of Plans under Contract with Davis Vision, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in the Participating Provider Agreement, to the same extent as the original signatories to the Agreement.

I agree to permit Davis Vision to source verify credentials and access the National Practitioners Data Bank (NPDB) and other pertinent sources for history.

***Signature:** _____ **Date:** _____
(Principal)

***Print Name:** _____

*(Must sign and print name in full.)

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(PAYEE INFORMATION)

1. IDENTIFICATION

Practice/Corporation Name: _____

2. PAYEE AND BILLING INFORMATION

Check "Payable To" Name: _____

Practice Structure Type:

☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other: (please describe)_____

_____

Federal Tax ID Number: _____

or Social Security Number: _____

Billing Address:

_____

_____

_____

City: _____ State: _____ Zip: _____ Country: _____

Please enclose a completed W-9 Form. This is an IRS requirement.

For Davis Vision use only:

Payee Number(s): _____

Associated Office Number(s): _____

Associated Practitioner Number(s): _____

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

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

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

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

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

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

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

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

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

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

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

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

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

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

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

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

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

Part II. Certification

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

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

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

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

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

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

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

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

What Name and Number To Give the Requester

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

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

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

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

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

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

DAVIS VISION, INC.

PARTICIPATING PROVIDER AGREEMENT
FOR THE COMMONWEALTH OF PENNSYLVANIA

This **PARTICIPATING PROVIDER AGREEMENT,** any **ADDENDA** and/or **AMENDMENTS** attached hereto (hereinafter the "Agreement"), is entered into as of the _____ day of _____, _____ (hereinafter the "Effective Date") by and between **DAVIS VISION, INC.**, having its principal place of business located at 159 Express Street, Plainview, New York 11803 ("**DAVIS**"), and _____ _____ having its, his or her principal place of
[Insert PROVIDER's complete legal entity name]
business located at _____
_____("**PROVIDER**").
[Insert PROVIDER's complete address]

RECITALS

WHEREAS, **DAVIS** has or intends to enter into agreements with health maintenance organizations, Medicare Advantage organizations, Pennsylvania Medical Assistance MCO Program organizations, and other purchasers of health care services ("**Plan**(s)") to provide or to arrange for the provision of health care services to persons enrolled as Participants of such Plans (the "**Contracts**"); and

WHEREAS, **DAVIS** and **PROVIDER** desire to enter into a contract whereby **PROVIDER** agrees to provide certain health care services on behalf of **DAVIS** to Participants of Plans under Contract with **DAVIS**.*****

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

I
DEFINITIONS

.1 "**Clean Claim**" means a claim for payment for services which contains the following information: (a) a valid authorization number referencing member, and Participant 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 Participant.

.2 "**Contracts"** means the agreements between **DAVIS** and Plans to provide or arrange for the provision of health care services to persons enrolled as Participants of such Plans.

.3 "**Copayment" or "Deductible"** means those charges for health care services which shall be collected directly by **PROVIDER** from Participant as payment in addition to the fees paid to **PROVIDER** by **DAVIS**, in accordance with the Participant's benefit plan.

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

.5 "**Medically Appropriate"** means services or treatment which a Participant requires as determined by one or more Participating Provider(s), in accordance with accepted professional practices and standards prevailing at the time of treatment and adopted by **DAVIS**.

.6 **"Non-Covered Services"** means those health care services which are not Covered Services.

.7 "**Participant"** means a person who is enrolled in a Plan (including enrolled dependents) and is entitled to receive Covered Services.

.8 "**Participating Provider"** means a licensed health facility which, or a licensed health professional who, has entered into an agreement with a Plan or with **DAVIS** to provide Covered Services to Participants.

.9 "**Plans"** means health maintenance organizations, Medicare Advantage organizations, and other purchasers of health care services.

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

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

.12 **"Medicare"** means the federal program providing medical assistance to elderly and disabled persons pursuant to 42 U.S.C. § 1395 et seq.

.13 **"Pennsylvania (PA) Medical Assistance MCO Program"** means the Commonwealth's mandatory managed care program for Medical Assistance recipients residing in designated Pennsylvania counties which may include, but is not limited to, the "HealthChoices" program.

.14 **"DPW"** means the Commonwealth's Department of Public Welfare.

II

SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **Services: PROVIDER** shall provide all Medically Appropriate Covered Services to Participants within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Participant to ensure that it is cost-effective and Medically Appropriate.

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

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

.3 **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 Plans; and (2) promptly provide **DAVIS** and Plans with copies of treatment records when requested; and (3) shall keep treatment records confidential.

.4 **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 patients covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** agrees not to differentiate or discriminate in the treatment of persons covered under the Plans as to the quality of service delivered because of race, sex, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status or method of payment; and to promote, observe and protect the rights of patients covered under the Plans.

.5 **Open Clinical Dialogue**: Nothing contained herein shall preclude **PROVIDER** from engaging in open clinical dialogue with Participants, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are Covered Services under the applicable **DAVIS** plan designs. Throughout the term of this Agreement, Davis and Provider are prohibited from instituting gag clauses for their employees, subcontractors, or agents that would limit the ability of said employees, subcontractors or agents to share information with Plan(s) and/or any or all regulatory agencies regarding the PA Medical Assistance MCO Program and Medicare program.

III

COMPENSATION

.1 **Compensation:** **DAVIS** shall pay **PROVIDER** the compensation amounts communicated to **PROVIDER** by **DAVIS** from time to time, and hereby incorporated by reference, as full compensation for the Covered Services provided by **PROVIDER** to Participants under an applicable Plan pursuant to this Agreement. **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 Health Care Financing Administration, Department of Health and Human Services. In part, these sections govern physician incentive plans operated by Federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. As applicable and pursuant to 42 CFR §417.479 and 42 CFR §434.70, no specific payment will be made directly or indirectly, under Plans hereunder, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a Participant.

.2 **Payment of Compensation:** Payment shall be made within thirty (30) days of receipt of a "clean claim" by **DAVIS**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Participant, less any Copayment and Deductible collected or to be collected from the Participant. For all Covered Services rendered by **PROVIDER** to a Participant hereunder, **PROVIDER** shall, within sixty (60) days following the provision of Covered Services, submit to **DAVIS** a statement. (Such statement may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**.) Failure of **PROVIDER** to submit said statement within sixty (60) days of service delivery will, at **DAVIS'** option, result in nonpayment by payor to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, erroneous claim payments or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

.3 **Patient Billing/Hold Harmless:** Except as provided in Section III.4 below, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Participants and shall at no time seek compensation from Participants for Covered Services even if **DAVIS**, for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Participant shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Participant's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, shall survive termination of this Agreement, regardless of the reason for termination, shall be construed to be for the benefit of the Participant(s), and may not be changed without the approval of appropriate regulatory authorities.

.4 **Patient Responsibility:** **PROVIDER** shall bill and collect all Copayments and Deductibles specifically permitted in a Participant's benefit plan from the Participant. **PROVIDER** shall further bill and collect all charges from a Participant for those non-Covered Services provided to a Participant. Provider may bill a Medicaid or Medicare Participant for a non-compensable service or item, if the recipient is told by Provider in writing, before the service is rendered, that it is not covered by the Medicaid or Medicare program. Under no circumstances shall the Provider bill any Participant, except for authorized co-payments, deductibles, or co-insurances, for services authorized by Davis or Plans or covered under this Agreement. Plan Participants participating in the PA Medical Assistance MCO program are under no circumstances to be charged a co-payment. Provider shall provider services to Medicaid consumers who have selected Plan, but whose coverage is not yet effective. Services for these Medicaid consumers should be

invoiced to Pennsylvania (PA) Medical Assistance MCO Program on a fee-for-service basis. To the extent permitted by law, **PROVIDER** shall provide a courtesy discount of twenty percent (20%) off **PROVIDER'**s usual and customary fees to Participant(s) for the purchase of materials not covered by a Plan.

.5 **Plan Hold Harmless Provisions: PROVIDER** agrees that he/she/it shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold harmless each Plan from any obligation to compensate **PROVIDER** for Covered Services.

IV

OBLIGATIONS OF PROVIDER

.1 **Hours: PROVIDER** agrees to be available to provide Covered Services for Medically Appropriate emergency care and shall be accessible twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year, through an answering service or answering machine which provides a pager number. Services not requiring emergency care shall be provided on a timely basis.

.2 **COB Obligation of PROVIDER: PROVIDER** shall cooperate with **DAVIS** with respect to Coordination of Benefits (COB) and will bill and collect from other payers such charges for which the other payer(s) are responsible. **PROVIDER** shall report all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this Section IV.2 when billing is submitted to **DAVIS** for payment.

.3 **Malpractice Insurance:** Unless otherwise agreed upon in a writing by and between the parties hereto, **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire term of this Agreement maintain a policy of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants or employees, and **PROVIDER** shall provide proof of such insurance to **DAVIS** if so requested.

.4 **Performance: PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Participant(s). **PROVIDER** shall use his/her/its best efforts to ensure that health care services provided under this Agreement are of a quality that is consistent with accepted professional practices. **PROVIDER** agrees to abide by the standards established by **DAVIS** and Plan(s)**,** including, but not limited to, standards relating to the utilization and quality of health care services.

.5 **Compliance with Law and Ethical Standards:** During the term of this Agreement, **PROVIDER, DAVIS,** and Plan(s) shall at all times, comply with all applicable federal, state or municipal statutes or ordinances, all applicable rules and regulations, and the ethical standards of the appropriate professional society. 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 timely notify **DAVIS,** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as otherwise provided herein. **PROVIDER** agrees to cooperate with **DAVIS** so that **DAVIS** may meet any requirements imposed on **DAVIS** by state and federal law, as amended, and all regulations issued pursuant thereto. As may be required by law, **PROVIDER** agrees to maintain such records and provide such information to **DAVIS** and to contracting Plans, and to applicable state and federal regulatory agencies for compliance. **PROVIDER** agrees to retain such books and records for a term of at least ten (10) years from

and after the provision of Covered Services and in the case of a minor who receives services from **PROVIDER**, for a minimum of ten (10) years from the time such minor attains the age of majority. **PROVIDER**'s obligations contained in Section IV.5 herein shall survive termination of this Agreement.

.6 **Provider Roster: PROVIDER** agrees that **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER'**s name, address, phone number, type of practice, and willingness to accept new patients in the **DAVIS** or Plan roster of provider participants. The roster may be inspected by, and is intended to be used by, prospective patients and others.

.7 **Compliance with DAVIS Rules: PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS**, including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes **DAVIS** may, from time to time, amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

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

.9 **Notice of Non-Compliance and Malpractice Actions: PROVIDER** shall notify **DAVIS** immediately, in writing, should he/she/it be in violation of any portion of this Article IV. 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.

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

.11 **Credentialing: PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**.

.12 **Verification of Eligibility: PROVIDER** shall verify eligibility of Participant(s) by calling the appropriate toll-free (800/888) number supplied by **DAVIS** or by receiving from Participant(s) a valid pre-certified voucher.

.13 **Office Visits: PROVIDER** shall cooperate with all office visits made by **DAVIS**, any external review organization or regulatory agency.

V

TERM OF THE AGREEMENT

.1 **Term:** This Agreement shall become effective on the date first written above and shall thereafter be effective for an initial period of twelve (12**)** months.

.2 **Renewals**: This Agreement shall be automatically renewed for successive, twelve (12) month periods on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

VI

TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause:** After the initial twelve (12) month term, this Agreement may be terminated by either party, without cause, upon ninety (90) days prior written notice. If **DAVIS** elects to terminate this Agreement other than at the end of a term hereof, or for a reason other than those set forth in Section VI.2 hereof, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**'s request.

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

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

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

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

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

(e) conviction of a felony;

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

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

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

(i) the death of **PROVIDER**;

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

"Cause" for the purposes of suspension shall mean:

(a) a failure by **PROVIDER** to maintain malpractice insurance coverage as provided in Section IV.3 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section IV.5 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section IV.7 hereof;

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section VIII.1 hereof;

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section IX.12 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 Participant in seeking appropriate Covered Services, or files a complaint, grievance or appeal. **DAVIS** shall notify **PROVIDER**, in writing, of the reason for denial, suspension and/or termination.

.3 **Responsibility for Participants at Termination:** In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section IV.5 hereof), **PROVIDER** shall continue to provide Covered Services to a Participant who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement until the Covered Services being rendered to the Participant by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a patient), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Participant pursuant to this Section VI.3 (prior to and following the effective termination date of this Agreement) at the rates contemplated in this Agreement for Covered Services.

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

.5 **Return of Materials and Payments of Amounts Due:** On termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including, but not limited to, frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** may setoff any monies due from **DAVIS** to **PROVIDER** if **PROVIDER** owes any monies to **DAVIS**. **DAVIS** retains the right to reclaim the frame selection at any time during the term of this Agreement.

.6 **Provider Notification to Participants upon Termination:** Should **PROVIDER** terminate this Agreement pursuant to Section VI.1 above, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Participant(s) under this Agreement, **PROVIDER** agrees to notify affected Participant(s) a minimum of thirty (30) days prior to the effective date of the termination.

VII

DOCUMENTATION AND AMENDMENT

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

VIII

UTILIZATION REVIEW, QUALITY MANAGEMENT AND GRIEVANCE PROCEDURES

.1 **Utilization Review and Quality Management Procedures:** 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 Participant(s). 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 Section VIII.1 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 that 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 Participant which are determined to be not Medically Appropriate or of poor quality or for which **PROVIDER** failed to receive a prior authorization to treat a Participant.

.2 **Grievance and Appeal Procedure:** A grievance and appeal procedure shall be established for the processing of any patient or **PROVIDER** complaint regarding Covered Services. Such procedure will be established by **DAVIS** and contracting Plans, in their sole and absolute discretion. **PROVIDER** shall comply with and, subject to **PROVIDER'**s rights of appeal, shall be bound by such grievance procedure.

IX

GENERAL PROVISIONS

.1 **Notices:** Any notices required or permitted to be given hereunder by either party to the other may be given by personal delivery in writing or by first class mail. Notices shall be addressed to the parties at the addresses appearing in the introductory paragraph on the first page of this Agreement, but each party may change its address by written notice given in accordance with this Section IX.1. Notices delivered personally will be deemed communicated as of actual receipt; mailed notices will be deemed communicated as of three (3) days after mailing.

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

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

.4 **Arbitration:** Any controversy or claim arising out of or relating to this Agreement or the breach thereof will be settled by arbitration in accordance with the rules of commercial arbitration 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. The arbitrator(s) may in any such proceeding award attorneys' fees and costs to the prevailing party.

.5 **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 Participant, in the state in which **PROVIDER** rendered services to that Participant.

.6 **Assignment:** This Agreement shall be binding upon, and shall inure to the benefit of, the parties to it and their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, **PROVIDER** may not assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior written consent of **DAVIS**.

.7 **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**.

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

.9 **Waiver:** The waiver of any provision, or of the breach of any provision, of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

.10 **Headings:** The subject headings of the articles and sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

.11 **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.

.12 **Non-Solicitation of Participants:** 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 Participants, Plans or any employer of said Participants 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 Participant or Plan to discontinue his/her/its relationship with **DAVIS** or (ii) a Participant or an employer of any Participant to disenroll from a Plan contracting with **DAVIS**. A breach of this Section IX.12 shall be grounds for immediate termination of this Agreement.

.13 **Use of Name: PROVIDER** shall not use **DAVIS'** or any Plan's name or logo without the written authorization of **DAVIS** or such Plan.

.14 **Proprietary Information: PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Participant, including, but not limited to, the Participant's name, address and telephone number ("Participant 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 Participant 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 Participant if Medically Appropriate for the proper treatment of such Participant or upon the express prior written permission of **DAVIS**, the Plan in which the Participant is enrolled, and the Participant.

-SIGNATURE PAGE TO FOLLOW-

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

DAVIS VISION, INC.:

By: _____
Name: _____
Title: _____
Date: _____

PROVIDER:

By: _____
Print Name: _____
Print Title: _____
Date: _____
(PROVIDER MUST sign, print name, print title and date)

***** Submission of a completed Vision Care Provider Application and/or submission of a signed Participating Provider Agreement does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of the Vision Care Provider Application and, on the execution by practitioner of the Participating Provider Agreement and, on the receipt by practitioner of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following a **PROVIDER's** acceptance by **DAVIS,** should additional practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Participants of Plans under Contract with **DAVIS**, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in this Agreement to the same extent as the original signatories to this Agreement.

DAVIS VISION, INC.

PARTICIPATING PROVIDER AGREEMENT

ADDENDUM

FOR CONTRACTS COVERING

PARTICIPANTS WHO ARE MEMBERS OF HEALTH MAINTENANCE ORGANIZATIONS

IN PENNSYLVANIA

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

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

2. Nothing in the Agreement is intended to limit:

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

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

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

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

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

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

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

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

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

DAVIS VISION, INC.

ADDENDUM TO THE PARTICIPATING PROVIDER AGREEMENT FOR THE COMMONWEALTH OF PENNSYLVANIA

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

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

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

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

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

1. RELATIONSHIP TO THE AGREEMENT.

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

2. DEFINITIONS.

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

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

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

2.3 **"Medicare Advantage Program"** shall mean a Network Product established by Plan pursuant to a contract with CMS which complies with all applicable requirements of Part C of the Social Security Act, as amended from time to time, and which is available to individuals entitled to and enrolled in Medicare or any successor program(s) thereto regardless of the name(s) thereof.

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

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

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

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

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

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

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

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

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

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

2.14 **"Members," "Enrollees," and/or "Participants,"** shall mean those persons who are enrolled (including enrolled dependents) in a Medicare Advantage Program, AdultBasic Insurance Coverage Program, Children's Health Insurance Program, PA Medical Assistance MCO Program, and/or an Act 68, plan, program, or product.

2.15 **"Practitioner(s)"** shall mean those persons who provide health care services or who provide covered services to a Member, Enrollee, and/or Participant hereunder.

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

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

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

3. INTERPRETATION OF AGREEMENT AND ADDENDUM.

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

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

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

3.4 Davis and Provider acknowledge and agree that Davis contracts with providers to create a network of Participating Providers on its own behalf and on behalf of Plan(s) in order to provide adequate access to Covered Services for Members, Enrollees, and/or Participants in a Medicare Advantage Program(s), in adultBasic Insurance Coverage Program(s), in Children's Health Insurance Program(s), in PA Medical Assistance MCO Program(s) and Act 68 Program(s).

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

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

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

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

4.4 Provider shall promptly advise Davis of any change in Provider's and/or practitioner's compliance with the Medicare Advantage participation criteria, as applicable to Provider and/or practitioners, and as described in Section 4 herein. Provider understands and agrees that any change in Provider's or practitioner's compliance with the Medicare participation criteria or the Medicare Advantage participation criteria may, in Davis' sole discretion, result in the termination of the Agreement by Davis. Further, any such change in compliance may result in the setoff of future amounts owed to Provider by Davis, or in the repayment by Provider to Davis of overpayments.

4.5 Provider will comply with, and will ensure that Provider's practitioners comply with all applicable requirements set forth in Articles XXI and XXIII of Act 68. Provider represents that he/she/it has complied with, that each of Provider's practitioners have complied with, and that Provider will ensure his/her/its continued compliance and ensure the continued compliance of Provider's practitioners during the term of this Addendum and the Agreement, with all federal, state, municipal, and local laws, rules and regulations applicable to its activities in rendering Covered Services to Members, Enrollees and/or Participants under this Addendum and Agreement; including without limitation, Act 68 and the regulations promulgated thereunder by the PID and the DOH for implementation of Act 68; Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Sections 2000d *et seq.*); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Sections 701 *et*

seq.); the Age Discrimination Act of 1975 (42 U.S.C. Sections 6101 *et seq.);* the provisions of the Americans with Disabilities Act (42 U.S.C. Sections 12101 *et seq.*); the Pennsylvania Human Relations Act of 1955 (43 P.S. Sections 951 *et seq.*, as amended); and general provisions relating to nondiscrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of Federal funds.

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

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

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

6. RECORDS AND ACCESS TO RECORDS.

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

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

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

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

6.1.4 any information and data necessary for Davis and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies; and

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

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

6.2 With respect to Act 68 or PA Medical Assistance MCO Program Members, Enrollees or Participants, Provider and Provider's practitioners shall keep confidential all records relating to Act 68 and PA Medical Assistance MCO Program Members, Enrollees, or Participants in accordance with Section 2131 of Act 68 and with the requirements of the PA Medical Assistance MCO Programs, and all other applicable laws. Provider shall also, to the extent required by Pennsylvania law, permit the DOH, PID, any other official body access to Provider's records and to the records of Provider's practitioner(s) for the purpose of quality assurance, investigation of complaints or Act 68 Grievances, and enforcement or other activities related to compliance with Pennsylvania law; provided however, that such records shall only be accessible to employees of those departments having direct responsibilities for the activities recited herein.

6.3 Records. Provider agrees to:

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

6.3.2 Safeguard all information about Members, Enrollees or Participants according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members, Enrollees or Participants or potential Members, Enrollees or Participants, which is provided to or obtained by or through Provider's performance under this Addendum, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of his/her obligations and securement of his/her rights under this Addendum. Neither Davis nor Provider shall share confidential information with any Members', Enrollees' or Participants' employer, absent the Members', Enrollees' or Participants' consent for such disclosure. Provider agrees to comply and agrees to require its practitioners to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with Davis in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws. Provider and Davis acknowledge that the activities conducted to perform the obligations undertaken in this Addendum are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. Provider and Davis agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. Provider and Davis further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, Provider and Davis shall conduct good faith negotiations to amend this Addendum. Provider shall maintain, and shall require its practitioners to maintain, adequate medical, financial and administrative records

related to covered services rendered by Provider, and by Provider's practitioners in accordance with federal and state law.

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

6.3.4 That all records shall be made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

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

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

7.1 Should Davis deny payment to Provider or to Provider's practitioner(s) due to the failure of Provider or the failure of Provider's practitioner(s) to comply with any of the provisions of the Agreement, or this Addendum, Provider shall not bill or seek remuneration from the Member, Enrollees and Participants for the denied amounts. Davis and Provider acknowledge and agree that the hold harmless provisions contained in Section III.3 of the Agreement are hereby specifically incorporated into this Addendum. Provider acknowledges and agrees that no specific payment that Davis or the applicable Plan(s) makes to Provider is an inducement to reduce or limit services or products that Provider and Provider's practitioners determine are medically necessary and appropriate within the scope of their practice and in accordance with applicable laws and ethical standards for those Members, Enrollees, and Participants for whom Provider provides Covered Services hereunder.

7.2 No provision of the Agreement or this Addendum shall be construed to limit or prohibit any Provider's right, or the right of any of Provider's practitioners, to discuss with any Member, Enrollee, or Participant, or to discuss with any representative of a Member, Enrollee, or Participant (a) the process that Davis uses on its own behalf or on behalf of the Plan(s) to deny payment for a health care service; (b) any medically necessary and appropriate care, within the scope of Provider's practice, available to a Member, Enrollee, or Participant; including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternative treatments, or consultations and tests regardless of benefit coverage limitations under the terms of the Plan(s)' documents or medical policy determinations; and (c) the decision of Davis on its own behalf or on the behalf of Plan(s) to deny payment for a health care service.

8. MEMBER COMPLAINTS, GRIEVANCES AND APPEALS.

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

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

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

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

9.1 As applicable, Provider agrees, and shall ensure that Provider's practitioner(s) agree to participate in, cooperate with, comply with, and abide by decisions of Davis and/or Plan(s) with respect to Davis' and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review. Provider further agrees, and shall ensure that Practitioners as applicable, shall comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Provider Services for Medicare Advantage, adultBasic, CHIP, PA Medical Assistance MCO Program, and Act 68 Members, Enrollees, and Participants.

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

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

9.1.2 consider the needs of the enrolled population; and

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

9.1.4 are reviewed and updated periodically; and

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

9.2 Provider and Provider's practitioner(s) shall, at his/her/its expense, make all books, records, documents and other evidence relating to Covered Services rendered under this Addendum available for audit, review, and evaluation by Davis, by Plan(s) and/or by the official bodies of the Commonwealth of Pennsylvania, including but not limited to the DOH, PID, the DHHS, the Comptroller General of the United States or their designees, and the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), its successors and assigns. Provider and Provider's practitioner(s) shall retain such books and records and shall make such books and records available for a period of no less than ten (10) years from the final date of the contract period or the completion of any audit, whichever is later. Further, Provider

and Provider's practitioner(s) shall make such books and records available onsite during normal business hours or, as requested by Davis, the Plans, the official bodies of the Commonwealth of Pennsylvania, the DOH, PID, DHHS, the Comptroller General of the United States, or the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), its successors and assigns, within the specified timeframes. Such books and records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. Provider and Provider's practitioner(s) shall cooperate with any such review or audit by assisting in the identification and collection of any books, records, data, or clinical records, and shall make appropriate practitioner(s), employees, and involved parties available for interviews, as requested. Provider and provider's practitioner(s) shall hold harmless and indemnify Davis and/or Plan(s) for any fines or penalties they may incur due to Provider's submission, or the submission by Provider's practitioner(s) of inaccurate or incomplete books and records.

10. PROVISION OF AND AVAILABILITY OF PROVIDER SERVICES.

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

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

10.3 Provider and Davis acknowledge and agree that equal access and non-discrimination provisions contained in Section II.4 of the Agreement are hereby specifically incorporated in this Addendum. Provider understands and acknowledges that Davis and Plan(s) must ensure that Covered Services are provided in a culturally competent manner to all Members, Enrollees, and Participants, including those with limited English language proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities. As requested by Davis or Plan(s), Provider and Provider's practitioners agree(s) to cooperate with and assist Davis and Plan(s) in meeting these obligations.

10.4 To the extent required by law, Davis and/or Plan(s) provide coverage of emergency services for Members, Enrollees, and Participants. Where applicable, Davis and/or Plan(s) shall reimburse Provider for emergency services rendered to Member, Enrollee, or Participant in accordance with the terms and conditions contained in applicable laws and administrative requirements, and with the terms of Act 68, adultBasic, CHIP, and the PA Medical Assistance MCO Program and without regard to prior authorization. Provider also agrees to notify Davis of emergency services rendered and any necessary follow-up services rendered to any Member, Enrollee, or Participant, in accordance with the terms and conditions contained in applicable laws and administrative requirements, and with the terms of Act 68, adultBasic, CHIP and the PA Medical Assistance MCO Program.

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

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

12. SUBCONTRACTORS.

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

12.1.1 an agreement by the subcontractor or leaseholder to comply with all of Provider's and, where applicable, practitioner's obligations in this Addendum and in the Agreement; and
12.1.2 a prompt payment provision as negotiated by Provider and the subcontractor or leaseholder; and
12.1.3 a provision setting forth the terms of payment and any additional payment arrangements; and
12.1.4 a provision setting forth the term of the subcontract or lease (preferably a minimum of one [1] year); and
12.1.5 dated signature of all parties to the subcontract.

13. REIMBURSEMENT.

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

14. AMENDMENT.

14.1 This Addendum may be amended in accordance with Section VII of the Agreement, unless the amendment is required by applicable laws and/or regulations in which case, thirty (30) days advance written notice shall not be required.

15. TERM/TERMINATION.

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

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

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

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

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

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

15.2.1 A decision by Davis and/or Plan(s) to discontinue its/their participation in the Medicare Advantage Programs; or

15.2.2 A decision by Davis and/or Plan(s) to utilize another network for Medicare Advantage Programs; or

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

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

16. PROVIDER OBLIGATIONS UPON TERMINATION.

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

16.2 In consultation with Plan(s), the Act 68 or PA Medical Assistance MCO Program Member and/or the Provider and the Provider's practitioner(s) may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents and/or accrediting standards. Provider and Provider's practitioner(s) shall continue to provide Covered Services to such Act 68 Member(s) and the parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Addendum and the Agreement (including reimbursement rates) that are effective as of the date of termination.

16.3 Should Davis and/or Plan(s) initiate termination of the Agreement and/or addenda thereto, Provider and Provider's practitioner(s) shall comply with Provider obligations as set forth in Sections VI.3, VI.4, VI.5, VI.6, and IX.12 of the Agreement

17. NOTICE AND APPEAL RIGHT.

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

18. SURVIVAL.

18.1 The provisions in Sections 6, 7, 8.2, 8.3, 9.2 and 16 of this Addendum shall survive the termination of the Agreement and/or this Addendum regardless of the cause giving rise to such termination. In addition, any of the other terms and covenants contained in this Addendum which require the performance or inaction of either party after the termination shall survive said termination. Termination of this Addendum does not constitute termination of the Agreement and of the HMO Addendum. The terms and covenants contained in the Agreement and the HMO Addendum shall survive termination of this Addendum. However, should the Agreement, the HMO Addendum, and this Addendum be terminated concurrently, the provisions in Sections II, III, IV, VI.3, VI.4, VI.5, VI.6, and IX.12 of the Agreement shall survive termination.