DAVISVISION
SEE LIFE

Ms. Linda Burk
ATTN: Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, NY 12239

April 25, 2011

Dear Ms. Burk:

Davis Vision is pleased to present our response to your request for proposal for New York State Vision Plan Services. As a New York corporation headquartered in Plainview, New York, with corporate offices in Latham and Syracuse, New York, we are invested in the growth of the State. Davis Vision is fully qualified to handle all aspects of the State's plan as documented in the attached response.

We are also fully committed to assisting the Department with achieving its goals for this project, including:

- Offering a quality eye care service experience to Enrollees and their covered dependents.
- Successfully administering the negotiated benefit structure including the Upgrade Program, Laser Vision Correction Program, Occupational Program and Medical Exception Program.
- Working with the Department to implement negotiated benefit changes on behalf of union populations.
- Offering a quality, national, credentialed Laser vision network with greater cost controls.

Our organization is designed to provide the highest quality experience for enrollees while adhering to contractual and benefit design obligations. We offer a wide array of materials within the defined plan allowances for frames and lenses, available in locations convenient to the enrollees. Davis Vision has an ongoing and significant investment in improving systems capabilities, Contact Center service capacity, innovative manufacturing processes and product selection. This focus on availability of multiple choices within the defined benefit plans coupled with the continuous improvement of our processes supports a unique enrollee experience with high levels of enrollee satisfaction.

Our entire organization is committed to partnering with the DCS for a long-term mutually productive partnership. We look forward to working through the procurement process with the Department. Please call Mr. Bernie Dal Cortivo at 800-229-8104 with any questions you may have.

Respectfully submitted,

Steve Holden
President

sholden@davisvision.com
800-328-4728, ext. 35434

Dale Paustian
SVP, Client Management &
Product Development
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800-229-8104

This proposal is subject to the FOIL redaction chart, Exhibit I.C annexed hereto.

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SECTION IV: TECHNICAL PROPOSAL

A. Plan Administration

1. Executive Summary

a. Required Submission

The Offeror must submit an Executive Summary outlining its overall program and its capacity to administer the NYS Vision Plan. The Executive Summary must include:

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;

Davis Vision, Inc. is a New York corporation. Davis Vision and its affiliates currently employ 1,586 associates residing in the state of New York (978 of whom are union members), with a total annual payroll of over $48.3 million. Main and branch office locations are listed below:

Main Office:	**Branch Office:**
Davis Vision, Inc.	Davis Vision Customer Relationship and
Corporate Headquarters	Information Technology Center
159 Express Street	711 Troy Schenectady Road
Plainview, NY 11803	Latham, NY 12110

Additional account support for the NYS Vision Plan will also be provided through our local office at 2921 Erie Boulevard, Syracuse, NY 13224. The proximity of Davis Vision's senior leadership and administrative facilities to Albany and New York City make consultations and face-to-face meetings easily accessible throughout the ongoing administration of the program.

Mr. Dale Paustian, Senior Vice President, Client Management & Product Development, will be the senior officer responsible for the New York State Department of Civil Service (DCS) account, functioning as overall corporate account support to the DCS client management team. Mr. Paustian has over 14 years' experience with Davis Vision and over 19 years' experience in health care, client relations, project management and corporate finance.

Davis Vision's **President, Mr. Steve Holden**, will be responsible for additional oversight of the DCS account. As President, Mr. Holden is responsible for all functions of Davis Vision and is the most senior executive of our organization. Mr. Holden, a 35-year veteran of the health care industry, is a founding Board member and past president of the NAVCP (National Association of Vision Care Plans), and currently serves on the Boards of the NASHO (National Association of Specialty Health Organizations) and Davis Vision, Inc., as well as various subsidiaries.

(2) A description of the Offeror's understanding of the requirements presented in the RFP and how the Offeror can assist the Department in accomplishing its objectives;

Davis Vision confirms our understanding of the requirements presented in this RFP. We are fully qualified to handle all aspects of the NYS Vision Plan as documented in our response.

We are fully committed to assisting the Department with achieving its goals for this project, including:

- Successfully administering the negotiated benefit structure including the Upgrade Program, Laser Vision Correction Program, Occupational Program and Medical Exception Program.
- Offering a quality eye care service experience to Enrollees and their covered dependents in terms of access to providers, availability of a broad selection of eyewear and lens materials and timely delivery of services.
- Creating high satisfaction among the Enrollee population.
- Working with the Department to implement negotiated benefit changes on behalf of union populations.
- Offering a quality, national, credentialed Laser vision network with greater cost controls.

Davis Vision will assist the Department in achieving these goals throughout the life of the contract by building on our successful track record of providing quality administration and products for large accounts coupled with the documented high satisfaction level of enrollees. This track record includes being the service administrator of the NYS Vision Plan for over 23 years.

Davis Vision's current administration system provides both comprehensive automated adjudication of the specified benefit plans as well as extensive reporting capabilities through the use of relational technology. This supports successful administration of the benefits of the program as well as extensive information on utilization and cost.

Quality processes and standards are reflected in the ISO 9001:2008 certification of both the Davis Vision manufacturing facility located in Plainview, NY and the Davis Vision Contact Center located in Latham, NY. This certification validates Davis Vision's adherence to strict standards and defines quality management procedures that result in the highest level of service for members and providers, with a focus on continual improvement.

Davis Vision supports building high satisfaction among Enrollees through the foundational goals of accurate benefit administration and a quality eye care service experience coupled with dedicated Davis Vision customer service representatives specifically trained in the Department's programs and customer interaction skills. Additionally, through clear member communications as well as extensive provider-oriented communications, the in-office experience of the Enrollee is enhanced.

Davis Vision's client team and vision care experts will work with the Department to provide input on current trends in routine vision care services and enrollee utilization in support of implementing negotiated benefit changes. Davis Vision

team members continuously evaluate new lens technologies and frame collections and will partner with the Department to provide regular updates.

A quality eye care service experience is supported by our provider network that will serve the NYS Vision Plan, which includes over 26,000 points of access nationwide. The network has increased greatly in the state of New York. In 2006, we had 1,300 providers at approximately 750 office locations in New York, whereas today, we have 2,332 providers at 1,204 locations – signifying our continuous commitment to growth in the State.

The network includes company-owned retail chains **Empire Vision** and **Eye Care Centers of America,** which were named the National 2010 Retailers of the Year by Transitions Optical, the number one manufacturer of photochromic lenses worldwide. **Empire Vision** is the largest retail chain in New York.

Davis Vision is one of a select few managed vision care companies in the country to be awarded a Credentialing Certificate by NCQA, an organization dedicated to measuring health care quality. Our most recent re-certification occurred in May 2010, where we received an overall score of 100%. This same credentialing process is applied to our Laser Vision network as outlined in our response.

Davis Vision's extensive industry knowledge dates back to 1917, when the first Davis Vision Optical store was opened in Brooklyn, New York. Our experience as the previous administrator of the NYS Vision Plan, with specific understanding of the history of that program, provides us with a unique perspective on how best to assist the Department in accomplishing its objectives. Through our continual efforts, all aspects of our vision care business have improved in recent years, which we believe positions us well to exceed the Department's expectations.

(3) A statement explaining the Offeror's previous experience managing the vision plans of other state or local government employers or any other organizations with over 100,000 covered lives. Detail how this experience qualifies the Offeror to undertake the functions and activities required by this RFP;

Davis Vision has extensive experience with large municipalities and public sector clients:

- In 2006, Davis Vision was awarded the contract to administer the BlueCross BlueShield Association's agreement with the Federal Office of Personnel Management to provide routine vision care services throughout the United States under the Federal Employees Dental and Vision Insurance Program (FEDVIP). This contract was awarded in October 2006 and successfully implemented on December 31, 2006. Today, the program provides services for 811,000 Federal Employees, annuitants and family members. This experience highlights our ability to provide services anywhere in the United States as well as the ability to effectively and efficiently implement large programs in short timeframes.
- We manage vision plans for over 350 large municipal, government and labor organizations representing 5.5 million lives, including 140 groups based in New York that cover 1.5 million lives. Our client list includes other large, New York-

based organizations such as [redacted] These experiences illustrate our familiarity and ability to work with the Department to implement negotiated benefits.

- Other large municipal or state organizations we serve include the [redacted]
- We manage plans for nearly 100 insurance carriers and health plans covering over 8 million lives. Customers include [redacted] This experience with large customers highlights our background with complex benefit arrangements and national provider networks.
- Davis Vision has experience administering benefits for state government employers. In addition to successfully administering the NYS Vision Plan from 1983 - 2006, we have also managed plans for [redacted]

Overall, Davis Vision directly manages vision plans for nearly 300 New York-based clients and covers over 4 million New York residents. We serve 32 groups nationally that each have more than 100,000 covered lives, 10 of which actually have over 500,000 lives each.

Davis Vision has a unionized laboratory, customer service and claims processing labor force and continues to serve its very first client, [redacted] who has enjoyed a Davis Vision plan for nearly 50 years. Through hundreds of organizations, unions and multi-employer health and welfare funds that are Davis Vision clients, we proudly serve nearly 3.5 million union members and their families.

(4) A detailed description of how the following functions will be allocated between the Offeror and any Key Subcontractor, if applicable (i.e., Will the role of the Offeror be limited to supervision of the Key Subcontractor, or will the Offeror perform any administrative functions?).

(a) Account Management

(b) Customer service

(c) Member and Provider Communications

(d) Enrollment Management

(e) Reporting

(f) Consulting

(g) Network Management

(h) Claims Processing

(i) Frame & Lens selection

(j) Contact Lens Selection

(k) Occupational Vision Program

(l) Medical Exception Program

(m) Upgrade Program

Davis Vision, as Offeror, will manage and perform all of the operations listed above.

2. General Qualifications

The NYS Vision Plan covers 269,000 lives and incurs a cost of approximately $20 million for 2010. The Offeror must have the experience, reliability and integrity to ensure that each Plan Member's vision care needs are addressed in a clinically appropriate and cost effective manner.

Davis Vision confirms.

a. Required Submission

The Offeror must demonstrate its acceptance of the program duties and responsibilities set forth in this RFP and ensure full compliance with the Program's benefit design. The Offeror must demonstrate that it has the financial and operational wherewithal to administer the Plan as required by this RFP. Offerors should provide detailed responses to the following:

(1) What experience does the Offeror have in managing a vision plan similar to the Plan described in this RFP?

With over 31 years of experience with similar projects for large municipal and government plans and nearly 50 years' overall experience administering vision care benefits for other large organizations, including Fortune 500 companies, unions and health plans, Davis Vision is well-positioned to deliver on the scope of services described in this RFP.

Davis Vision currently manages vision plans for over 350 large municipal, government and labor organizations representing 5.5 million lives. Customers

include other large local New York-based organizations such as [redacted]

Davis Vision conducts client surveys as a measurement tool to assess account service satisfaction. In 2010, virtually 100% of clients indicated their overall satisfaction with our account management services, and over the last 11 years, our results have consistently averaged virtually 100% overall. If a client indicates any concerns with their account management team, Davis Vision senior management contacts them and takes the necessary steps to achieve ultimate 100% client satisfaction.

Davis Vision has 23 years' experience working directly with the DCS to manage its vision plan prior to the incumbent carrier, from 1983 through 2006. During this time period, the patient satisfaction survey results were consistently in excess of 97%.

(2) Explain how the Offeror's account team will be prepared to administer the operational and clinical aspects of the Plan?

Davis Vision's hands-on approach to account management includes assigning a senior, dedicated, NY-based account team who will be in direct ongoing contact with the DCS to discuss the vision care program performance and respond immediately to any issues. Any member of this team may be contacted regarding any function or inquiry. This encompasses being easily accessible to address any questions or concerns and provide consultative advice on plan changes and trends, as needed.

Davis Vision's dedicated Client Management team has a combined 60 years of experience with our organization and nearly 80 years in the industry. This team includes members who have direct experience with the DCS, and will be supported by several other Davis Vision associates who are also familiar with the DCS Plan, including Mr. Paul Ennis, whose relationship with the DCS and affiliated accounts dates back to the mid-1990s. Mr. Ennis has over 20 years' experience in the implementation and management of groups and group installations, project management, client administration and customer service. While some of the operational and clinical aspects of the plan have undoubtedly changed, this invaluable level of familiarity shows that we are uniquely positioned to simplify the transition process from the current carrier.

Preparation to administer the unique operational and clinical aspects of the Plan will begin during the implementation process. We assign a full team, including

implementation representatives and Client Management team members, scheduling a kick-off meeting and regular implementation calls or on-site meetings to ensure a seamless transition. We include the Client Management team in the implementation process to ensure ongoing continuity of knowledge and operations as well as your ultimate satisfaction with Davis Vision.

(3) What financial actions would be taken to provide for ongoing operations if timely payments could not be made timely to the Contractors?

Davis Vision would provide ongoing operations, without financial penalty to DCS, if timely payments could not be made to us.

B. Program Services

The Offeror must demonstrate its capacity to provide the required Program Services described in this Section of the RFP.

Davis Vision confirms.

1. Account Team

The Department expects the successful Offeror to have in place a proactive, experienced leader and an experienced team who have the authority to coordinate the appropriate resources to implement and administer the Plan.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The Offeror must maintain, for the entire term of the Agreement, an organization of sufficient size with the skills and experience necessary to administer, manage, and oversee all aspects of the Plan during implementation and operation.

Davis Vision confirms.

(a) The Offeror's account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who will ensure that the operational, clinical and financial resources are in place to operate the Program in an efficient manner;

Davis Vision confirms.

(b) The Offeror must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all Program requirements and to address any issues that may arise during the performance of the Agreement.

Davis Vision confirms.

(2) The Offeror's assigned account team shall be experienced, accessible and sufficiently staffed to provide timely responses (no longer than 1 to 2 Business Days) to administrative concerns and inquiries posed by the Department or other staff on behalf of the Council on Employee Health Insurance for the duration of the Agreement to the satisfaction of the Department.

Davis Vision confirms.

(3) The Offeror's assigned account team must immediately notify the Department of actual or anticipated events impacting Plan costs and/or delivery of services to Plan Enrollees.

Davis Vision confirms.

(4) The Offeror's assigned account team must ensure that the Program is in compliance with all legislative and statutory requirements. If the Offeror is unable to comply with any legislative or statutory requirements, the Department must be notified immediately.

Davis Vision confirms.

b. <u>Required Submission</u>

(1) Provide an organizational chart and narrative description illustrating how the Offeror proposes to administer, manage, and oversee all aspects of the Plan. Include the names, qualifications, and job descriptions of the key individuals proposed to comprise the operational, clinical and management team for the Offeror and its Key Subcontractor(s) (if applicable). Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account management team. Where key individuals are not named, include qualifications of the individuals that you would seek to fill the positions. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other business

units of the Offeror such as the call center(s), quality assurance, reporting and network management within the Offeror's organization. Describe how the account management team interfaces with senior management and ultimate decision makers within the Offeror's organization;

Please find an organizational chart and Exhibit I.B, Biographical Sketch Form, completed for each key member of the Davis Vision Client Management team, appended as Attachment 1. The following is a narrative description illustrating how Davis Vision proposes to administer, manage and oversee all aspects of the Plan:

Operational

The following dedicated Client Management Team will oversee DCS's plan implementation and provide ongoing account management services and support:

Ms. Traci Small – *Regional Manager, Client Management* – will be assigned as the DCS's dedicated client manager with overall responsibility for ensuring the optimal performance of the Davis Vision plan. Ms. Small has over 11 years of experience in Client Relations and Account Management. She has built and maintained many relationships in the financial industry and manages such prestigious clients as [redacted] in Davis Vision's client portfolio. Ms. Small is based at Davis Vision's Corporate Headquarters located in Plainview, NY.

Mr. Dale Paustian – *Senior Vice President, Client Management & Product Development* – will provide executive-level account support to the DCS and has ultimate responsibility for your overall satisfaction with Davis Vision. He has 15 years' experience with Davis Vision and 20 years' experience in corporate finance, project management, client relations and health care. Mr. Paustian has led the implementation process for and continues to support ongoing account management for many of Davis Vision's key accounts, including [redacted] Mr. Paustian is based at Davis Vision's Corporate Headquarters located in Plainview, NY.

Ms. Jacalyn Palmer – *Client Manager* – will serve as local client management support to Ms. Small for the DCS. Ms. Palmer has been with Davis Vision for over 15 years in various customer service and account management support functions, with an extensive background in the vision care industry. Ms. Palmer is based in our Customer Relationship and Information Technology Center located in Latham, NY.

As the dedicated Client Manager for the DCS, Ms. Small's responsibilities will include:

- Participating as a core member of our account implementation team
- Building a consultative partnership with the DCS, with proactive outreach

- Acting as the single point of contact for the DCS, having dedicated touch points throughout our organization (including the call center, quality assurance, reporting and network management) to quickly address questions and escalate priority items
- Coordinating overall client communications including member communications, open enrollment promotion, health/benefit fair attendance and staff training
- Performing periodic client plan and service reviews

Ms. Small and Ms. Palmer will be supported by the following Client Management Team members who will provide additional account management support to ensure optimal results for your vision plan:

Ms. Denise Callahan – *Client Administrator* – Ms. Callahan will be responsible for assisting in the implementation of the program and providing ongoing member and client services support. Ms. Callahan has an extensive background in customer service within the health care industry. Prior to joining the Client Management department, she worked in Davis Vision's Quality Assurance Department where she served as Assistant Director, working with Davis Vision members and providers in resolving escalated complaints, grievances and appeals. Ms. Callahan is based at Davis Vision's Corporate Headquarters, located in Plainview, NY.

Mr. Tony Rosario – *Division Vice President, Client Management* – will function as an additional resource for the Davis Vision Client Management team. Mr. Rosario has over 18 years' experience in the health care industry with expertise in customer service, sales, account management and implementation. Mr. Rosario is based at Davis Vision's Corporate Headquarters, located in Plainview, NY.

Implementation

The following account support team members, based in our Customer Relationship and Information Technology Center in Latham, NY, will provide implementation support to the DCS:

Mr. John Graves – *Supervisor, Group Implementation* – will coordinate and facilitate all aspects of the DCS's vision program implementation and in partnership with the DCS will jointly develop the overall operations strategy. Mr. Graves has over 20 years' experience in the health care insurance industry with expertise in systems configuration, operations, customer service and provider relations.

Mr. Norman Brown – *Assistant Vice President, Customer Service* – has direct responsibility for all Client Implementations and Customer Service. Customer Service includes incoming calls and quality assurance for continuous improvement of member representatives. Mr. Brown and his team also monitor telephone statistics to support best practices within the Contact Center. There are many benefit designs offered by Davis Vision, each requiring a different staffing pattern. Contact Center management constantly monitors their

computerized telephone system to ensure that call response time is maintained within or less than established benchmarks. Staffing requirements are proactively reviewed for current and predicted call volume.

Ms. Rene Geoffrion-Blair – *Assistant Director, Contact Center Operations* – is the manager of Davis Vision's Customer Service Center and has direct responsibility for all incoming calls, quality assurance and client-specific education for continuous improvement of customer service associates. Ms. Geoffrion-Blair also monitors telephone statistics to support best practices within the Contact Center. Ms. Geoffrion-Blair has over 14 years' experience in the health care insurance industry (18 years in insurance overall), with a focus on customer service management.

Mr. Paul Ennis – *Vice President, Technical Support* – has direct responsibility for Davis Vision's Configuration (account and benefit installation) area, output services and facilities management. Mr. Ennis has a background in software development, and over 20 years' experience and in the implementation and management of groups and group installations, project management, client administration and customer service.

Clinical

Joseph Wende, O.D. – *Senior Vice President, Professional Affairs and Quality Management* – oversees the provider network and is responsible for the overall satisfaction of members enjoying the Davis Vision program. Dr. Wende has been an optometrist for over 25 years and has been involved in the administration of professional affairs and vision care programs on a national level for 15 years. Dr. Wende is supported by a staff of 42, plus 38 clinical staff.

Daniel B. Levy, O.D. – *Assistant Vice President, Professional Affairs* – helps manage and support Quality Assurance functions within the Provider Relations Department, including Utilization Review decisions and the activities of our Regional Quality Assurance Representatives. Dr. Levy also coordinates our Credentialing Committee activities and helps to maintain overall provider relations. Prior to joining our Professional Affairs team, he was a Davis Vision optometrist for 11 years.

Kathleen P. Milito – *Director of Quality Improvement* – provides leadership and guidance on issues related to regulatory compliance and accreditation to the Professional Affairs Department, including Utilization Review, Quality Assurance, Network Management and Credentialing. Ms. Milito has held managerial positions in managed care organizations for over 20 years.

Senior Support

Davis Vision's senior management team will be closely involved in all administrative aspects of the DCS's programs. This exceptional team of industry leaders is often recognized as one of the best in the business and provides the foundation to support all associates throughout the organization. The senior management team supports overall relationship management functions to ensure that the DCS is 100% satisfied with all aspects of the

program. The senior management team who will be directly involved in overseeing the DCS's program includes:

Mr. Steve Holden, CPA – *President* – is a 35-year veteran of the health care industry. Mr. Holden is past President and a founding Board member of the National Association of Vision Care Plans, and currently serves on the Board of HVHC Vision and a number of subsidiaries. Mr. Holden began his career at American Hospital Supply and Baxter Healthcare, holding senior positions before moving into pharmacy benefit management at both Caremark and Value Rx, now a part of Express Scripts. He has served as an industry speaker and consultant. He also has experience in optometric education, disease management, medical devices, home health care and health care systems and services. Mr. Holden holds a BA in Economics, Math and Physics, a MSBA in Finance and is a Certified Public Accountant.

Mr. Tom Davis – *Executive Vice President and Chief Marketing Officer* – is responsible for leading Davis Vision's sales and marketing strategies and heading the company's regional marketing focus. The founding president of the National Association of Vision Care Plans, Mr. Davis has over 20 years' experience as a key executive in the managed vision care industry.

Mr. Michael L. Thibdeau – *Executive Vice President and Chief Operating Officer* – is responsible for insurance services administration, regulatory operations, provider network services and eyewear manufacturing within Davis Vision. Prior to this role, he was Chief Information Officer for HVHC Inc., Davis Vision's parent company, and CIO for Davis Vision. As CIO he was accountable for utilizing Information Technology to drive sustainable business value within the enterprise. Areas of accountability included strategic IT planning, program/project management, applications solutions and IT infrastructure for the retail, wholesale brands and managed care groups within HVHC, Inc. Mr. Thibdeau has over 25 years' experience in health care insurance and administration, 14 of them with Davis Vision.

(2) Confirm that the account team will be readily accessible to the Program. Describe where the account team will be based.

Davis Vision confirms our account team will be readily accessible to the Program. Local account support will be based in our Customer Relationship and Information Technology Center, located in Latham, New York, and additional support will be provided from our Plainview, New York, Corporate Headquarters. Additional regional Client Management resources are located in Syracuse, New York.

(a) Describe how the Offeror proposes to ensure that timely responses (1 to 2 Business Days) are provided to administrative concerns and inquiries.

Our standard Client Management response time to client inquiries is within one business day, and at most two days. Davis Vision's Client Management Team members' office hours are typically from 8:30 a.m. to 6:00 p.m. Monday through Friday. In addition, team members will be available to the DCS via cell phone or e-mail after hours to assist.

(b) Describe the protocols that will be put into place to ensure the Department will be kept abreast of actual or anticipated events impacting Program costs and/or delivery of services to Program Enrollees. Provide a representative scenario.

Davis Vision is proposing a fixed price agreement for the DCS. This is a unique feature of our plan, and only changes pre-approved by the DCS could be implemented during the term of our agreement.

To keep our clients abreast of upcoming actual or anticipated events, we establish meetings (in person or via teleconference or videoconference) to discuss plan results (operational, service and financial), Davis Vision initiatives and plan and industry trends. This would occur at least quarterly in person and monthly via teleconference or videoconference for a client of this size. During the implementation process, weekly calls/meetings are the norm for a program of this size.

We also provide all clients with our bi-monthly *Sightwire* e-newsletter, featuring the latest news about eye health and wellness, the vision care industry, Davis Vision and other facts about the importance of proper eye care. Additionally, our Client Management team performs ad-hoc “care calls” throughout the month to our clients to keep in touch or address any time-sensitive matters that cannot wait for a scheduled meeting.

Our Client Management team meets weekly with implementation teams to ensure projects are on track. Additionally, weekly operations meetings of Davis Vision’s Senior Management, including Client Management, are held to prioritize issues and improvement opportunities.

Davis Vision’s dedicated Client Management team of four primary associates have a combined experience of nearly 50 years with our company and are all available to support the DCS and counsel as needed. All Client Management staff are equipped with cellular telephones, plus PDA devices for immediate access and response.

(3) Describe the corporate resources that will be available to the account team to ensure compliance with all legislative and statutory requirements. Confirm the Offeror’s commitment to notify the Department immediately if the Offeror were to be unable to comply with any legislative or statutory requirements and to work with the Department to take the appropriate remedial action to come into compliance as soon as practicable.

Heather N. Reynolds, Esq., Assistant Vice President of Contracting and Regulatory Compliance, will be available to your dedicated client management team to ensure compliance with all legislative and statutory requirements. Ms. Reynolds is an attorney admitted to practice in the State of New York for over 11 years. She has been involved in all aspects of contracting vision care programs on a national level for Davis Vision since 1999. Ms. Reynolds provides legal and contracting oversight

for the entire organization and oversees all aspects of corporate governance, with particular emphasis on regulatory compliance and provider contracting.

Ms. Reynolds will be supported by our additional resident legal services personnel and the extensive legal staff at our parent company, who routinely monitor both Federal and State mandates and legislative changes to remain in full compliance. Davis Vision is in full compliance and in good standing with all Federal and State laws and regulations.

Should a situation arise where Davis Vision were, initially, unable to comply with any legislative or statutory requirements, Davis Vision will work with the Department to take the appropriate remedial action to come into compliance as soon as practicable.

2. Plan Implementation

The Offeror must have a strong implementation plan to ensure that the Plan will be fully functioning on January 1, 2012. The Offeror's implementation plan must be detailed and comprehensive and exhibit a firm commitment by the Offeror to complete all Plan implementation activities by December 31, 2011.

Davis Vision confirms. Through our quality-focused implementation process, we have successfully achieved a 100% success rate for on-time implementations and commit to having the DCS program 100% operational, with all Plan implementation activities completed by December 31, 2011. Please find our detailed and comprehensive implementation plan, outlining the responsibilities of both the DCS and Davis Vision, appended as Attachment 2.

Setting up a new employer in the Davis Vision system is virtually automatic from the client's perspective. Our Implementation Manager, who heads the implementation department, put a strict testing process in place for each step of the implementation process, resulting in increased quality and decreased involvement for our clients. Testing is conducted on file uploading, system set-up and the benefit parameters prior to the effective date to ensure a seamless transition to Davis Vision.

In a typical implementation, the DCS's only responsibilities are to supply eligibility data, confirm billing/payment procedures, approve the final benefits, and review associated communication materials and the contract or policy. Everything else is handled by the Davis Vision Account Implementation Team.

We are pleased to offer a generous performance guarantee on this, as required below.

a. Duties and Responsibilities

(1) The Offeror must undertake and complete all start-up and implementation activities no later than December 31, 2011, so that the Plan as described in this RFP, including but not limited to those specific activities set forth below, is fully operational on January 1, 2012.

Davis Vision confirms.

(2) ***Implementation and Start-Up Service Level Standard:*** The Offeror must complete all Implementation and Start-Up activities no later than December 31, 2011, so that, effective January 1, 2012, the Offeror can assume full operational responsibility for the Plan. For the purpose of this Service Level Standard, the Offeror must, on January 1, 2012, have in place and operational:

Davis Vision confirms.

(a) Its contracted Participating Provider Network that meets the access standard set forth in Section IV.B.9.a.(1) of the RFP;

Davis Vision confirms.

(b) Its contracted Laser Vision Correction Participating Provider Network that provides reasonable access as defined by the Offeror in Section IV.B.10.b.(2) of the RFP;

Davis Vision confirms.

(c) A fully operational call center providing all aspects of customer service as set forth in Section IV.B.3.a. of this RFP;

Davis Vision confirms.

(d) A fully operational claims processing system that accurately reimburses claims in accordance with Plan provisions as set forth in Section IV.B.10.a of the RFP; utilizes accurate enrollment and eligibility data provided by the Department to accurately pay claims for eligible Enrollees/Dependents consistent with the Plan benefit design;

Davis Vision confirms.

(e) A fully functioning customized Plan website with a secure dedicated link from the Department's access to the specific website requirements as set forth in Section IV.B.3.a.(5)of this RFP.

Davis Vision confirms.

b. Required Submission

(1) Provide an implementation plan (narrative diagram and timeline) upon contract approval, on or about October 1, 2011 that results in the implementation of all Plan services by the required date of January 1, 2012, indicating: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as Member and Provider communications, training customer service staff, report generation, eligibility feeds and claims testing.

Our approach to implementation provides the DCS with a streamlined, efficient process where Davis Vision's dedicated Implementation team coordinates the entire process and your team enjoys a simple, cost-free implementation procedure. The Account Implementation Management team includes representatives from the DCS as well as our Implementation, Sales and Client Management teams. We will work together to develop a process customized for the DCS that results in benefit implementation on time and without disruption.

One of the greatest pitfalls to a successful implementation is communication between Davis Vision and the client's representatives. To mitigate this, our implantation process is closely tracked and highly visible. Our tracking system identifies milestones and requires electronic signoff by each department that work has been quality reviewed and completed. The status of each element is reported weekly and reviewed by department team leaders and senior management staff, and the entire process is coordinated by a dedicated senior implementation coordinator who will be in constant, direct contact with the DCS.

Implementation success factors include:

- Accurate projection of milestone dates
- Benefit design confirmation
- Timely review and approval of communication materials
- Confirm systems connections for eligibility, billing, etc.
- Update claims processing requirements for any plan changes
- Review and revise reporting requirements
- Integration of additional providers as needed

- Periodic progress updates/open communication

Within 30 days of the contract award, Mr. Graves will schedule a kick-off meeting to outline the key facets of plan setup, including the following:

- Contracting Elements
- System Setup
- Reporting
- Member/General Communications
- Member Services and Quality Assurance
- Billing/Banking Arrangements
- Benefits
- Enrollment and Eligibility Planning
- Web Support
- Service Review and Training
- Provider Network Development and Communications

A formal implementation plan will then be developed and managed by the Implementation Coordinator. It will contain a detailed outline of the responsibilities of both the DCS's team members and Davis Vision.

Weekly conference calls will ensure that the timeline's objectives are being met. Davis Vision's dedicated Client Manager and Account Executive will also be involved in this process, to provide guidance and continuity to the relationship. All aspects of the final plan will be developed with your input, to your specifications, in partnership.

Please find a sample implementation table, with the effective date of January 1, 2012, appended as Attachment 2, and a narrative diagram appended as Attachment 3.

(2) ***Implementation and Start-Up Performance Guarantee.*** The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in "2.a through 2.e" will be in place on or before December 31, 2011. The Offeror shall propose the forfeiture of a percentage of its Monthly Administrative Fees (prorated on a daily basis) for each day that all Implementation and Start-Up Guarantees are not met.

Amended March 29, 2011

The Standard Credit Amount for each day that all Implementation and Start-Up requirements are not met is fifty percent (50%) of the Monthly Administrative Fees (prorated on a daily basis). *However, Offerors may propose higher percentages.*

The Offeror must propose its Implementation and Start-Up Performance Guarantee in the format set forth below:

The Offeror's quoted percent to be credited for each day that all Implementation and Start-Up requirements are not met is _____ percent (%) of the Monthly Administrative Fees (prorated on a daily basis).

[redacted]

3. Customer Service

The Plan requires that the Offeror provide quality customer service to Plan Members. The Offeror must maintain a nationwide toll-free telephone number to service Plan Members and Providers. Through this toll-free telephone number Members and Providers must have access to representatives who respond to questions and inquiries regarding Plan benefits, the Participating Provider Network, the Laser Vision Correction Participating Provider Network, eligibility and claims status, and complaints. Accordingly, the Plan's required Program Services include customer service Service Level Standards that reflect strong commitments to quality customer service.

To ensure quality, Davis Vision's customer service operations, based in Latham, New York, were recently certified to the ISO 9001:2008 (w/o design), International Quality System Standard. The certification validates Davis Vision's adherence to strict standards and defining quality management procedures that result in the highest quality of service for members and providers, with a focus on continual improvement. These standards are recognized globally as the framework for well-managed, customer-centric business systems with great emphasis on quality management, continual improvement, achievement of business results and customer satisfaction.

Customer service is provided through our 24-hour-a-day, seven-day-a-week toll-free IVR and fully-interactive website as well as live customer service through our dedicated team of Customer Service Representatives who are available seven days a week, for a total of 86 hours. Our CSR team can respond to questions and inquiries regarding Plan benefits, the participating provider network, the laser vision correction participating provider network, eligibility and claims status, and complaints.

Davis Vision will provide a dedicated toll-free telephone number and service unit specifically supporting the DCS's employees. In addition, we will provide the DCS's administrative staff direct contact with Ms. Rene Geoffrion-Blair, Assistant Director, Contact Center Operations, who is the manager of Davis Vision's Customer Service Center and has direct responsibility for all incoming calls, quality assurance and client-specific education for continuous improvement of customer service associates. Ms. Geoffrion-Blair also monitors telephone statistics to support best practices within the Contact Center. Ms. Geoffrion-Blair has over 14 years' experience in the health care

insurance industry (18 years in insurance overall), with a focus on customer service management.

Plan benefit information is maintained online within Davis Vision's administrative system, which enables Customer Service Representatives/Claims Processors to access information in a real-time environment regarding all aspects of the member's benefit (e.g., eligibility, claim history, benefit design, network providers, member materials, etc.). Representatives can access all needed data at a keystroke in order to expeditiously answer member questions and provide needed information.

We are pleased to propose Call Center Telephone Performance Guarantees that exceed the DCS's quoted standards and credit amounts in all categories.

a. <u>Duties and Responsibilities</u>

The Offeror shall be responsible for all customer support and services including, but not limited to:

(1) Providing Members and Providers 24-hour access, except for regularly scheduled maintenance, to information on vision benefits and eligibility related to the NYS Vision Plan through a nationwide toll-free number.

Davis Vision confirms.

(2) Maintaining a call center located in the United States employing an adequate staff of fully trained customer service representatives, and supervisors available between the hours of 8:00 a.m. and 8:00 p.m. ET, Monday through Friday, and between the hours of 9:00 a.m. and 4:00 p.m. ET on Saturday, except for legal holidays observed by the State. These hours may be adjusted based on actual call volume by mutual agreement between the Department and the Offeror. Customer service representatives must be able to timely respond to questions, complaints and inquiries, including but not limited to, Plan benefits, Participating Provider and Laser Vision Correction Participating Provider locations, eligibility and claims status.

Davis Vision confirms.

(3) Customer service staff must use an integrated system to log and track all Member calls. The system must create a record of the Member contacting the call center, the call type and all customer service actions and resolutions.

Davis Vision confirms.

(4) Maintaining a back-up telephone system to be utilized in the event the primary telephone system fails or is unavailable.

Davis Vision confirms.

(5) Developing and maintaining a secure online customized website for Enrollees, 24 hours a day, 7 days a week, except for regularly scheduled maintenance throughout the term of the Agreement, which will provide access to information including, but not limited to: Plan benefits; Participating Provider locations; laser vision benefits and Laser Vision Correction Participating Provider locations; eligibility and claim status. The Offeror must establish a dedicated link to the website for the Plan from the Department's website and content is subject to the approval of the Department. Information from the link must be limited to information that pertains to the NYS Vision Plan. Any links should bring a viewer back to the Department website. No other links are permitted without the prior written approval of the Department. Any costs associated with customizing the website or establishing a dedicated link for the Plan shall be borne by the Offeror.

Davis Vision confirms.

(6) ***Call Center Telephone Service Level Standard:*** The Offeror must meet the following four (4) measures of service on the toll-free customer service number:

(a) ***Call Center Availability*****:** The Plan's Service Level Standard requires that the Offeror's telephone line will be operational and available to Members and Providers at least ninety-nine and five-tenths percent *(*99.5%) of the Offeror's proposed customer service telephone line availability (minimum scheduled time between the hours of 8:00 a.m. and 8:00 p.m. ET, Monday through Friday; and between the hours of 9:00 a.m. and 4:00 p.m. ET on Saturday, except for legal holidays observed by the State), calculated on an annual calendar year basis. The Offeror shall measure telephone system availability monthly and report the results to the Department quarterly;

(b) ***Call Center Telephone Response Time:*** The Plan's Service Level Standard requires that at least ninety percent (90%) of the incoming calls to the Offeror's

telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a customer service representative. The telephone response time shall be measured monthly and reported to the Department quarterly;

(c) ***Telephone Abandonment Rate:*** The Plan's Service Level Standard requires that the percentage of incoming calls in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be measured monthly and reported to the Department quarterly; and

(d) ***Telephone Blockage Rate*****:** The Plan's Service Level Standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be measured monthly and reported to the Department quarterly.

Davis Vision confirms.

b. <u>Required Submission</u>

(1) Confirm that the Offeror will maintain a call center located in the United States employing a staff of fully trained customer service representatives and supervisors available, at a minimum, between the hours of 8 a.m. and 8 p.m. ET, Monday through Friday and between the hours of 9 a.m. and 4 p.m. ET on Saturday, except for legal holidays observed by the State. If additional hours are proposed please state.

Davis Vision confirms. Our Latham, New York-based Customer Relationship and Information Technology Center (Contact Center) is available to members over 28% more hours per week than requested, a full 86 hours, seven days a week.

To provide the most convenient coverage nationwide, our Contact Center is open during the following times: Monday through Friday, 8:00 a.m. – 11:00 p.m. Eastern Time, Saturday, 9:00 a.m. – 4:00 p.m. and Sunday 12:00 p.m. – 4:00 p.m. In addition, our Interactive Voice Response (IVR) system and website are available 24 hours a day, seven days a week to address many of the most common questions.

Our Contact Center will be closed only on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas Day.

While there will be no live Customer Service Representatives available on these days, members can still access information through our IVR system and fully-interactive website.

In case of an emergency, we make a toll-free hotline available 24/7 for assistance nationwide. By calling the hotline, arrangements can be made to provide relief anywhere in the country. Members may also call a Davis Vision participating provider directly if emergency care is required. (As Davis Vision processes claims for routine vision care, rather than urgent or emergency care, the need for this type of option is minimal.)

(2) Describe the training that will be provided to customer service representatives before they go "live" on the phone with Members/Providers. Include:

Davis Vision's Customer Relationship and Information Technology Center (Contact Center) is staffed and managed to ensure that our customers receive the best care in the industry. Approximately 190 of the 360 employees based at our Latham, New York, facility are Customer Service Representatives (CSRs). Our customer service operations are certified to the ISO 9001:2008 (without design) International Quality System Standard.

Davis Vision will assign and train a dedicated unit to serve the DCS's members. We have extensive experience with the creation of dedicated team, on contracts such as the Federal Employee Program. In addition to going through our robust standard training program as outlined below, CSRs selected for DCS's dedicated team will go through a separate specialized training module to introduce them to the various plan designs and laser, medical exception and program upgrade details. This team will also get refresher training upon renegotiation of contracts when benefit designs change.

Our CSR staff is selected based on their experience and skill level with customer service, computers and communication. Also helpful are bilingual abilities and insurance experience. We require a minimum of one year of experience in a professional office environment and a high school diploma or equivalent.

Mr. Norman Brown, Assistant Vice President, Customer Service, manages our CSR staff at the Contact Center. Mr. Brown has direct responsibility for all client implementations and customer service, including incoming calls and quality assurance for continuous improvement of representatives. Mr. Brown and the management team also monitor telephone statistics to support best practices within the Contact Center. Contact Center management, headed by Mr. Brown, constantly monitors our computerized telephone system to ensure that call response time is maintained within or less than established service goals and measured objectives. Staffing requirements are proactively reviewed for current and predicted call volume.

In order to ensure client satisfaction with our CSR team, Davis Vision has created a focused training program that allows a prospective CSR to become familiar with our company, industry terminology, customers' plan designs and how ISO certification relates to everyday quality. The program also includes claims

processor training to allow for CSRs to process claims if we experience high claim volume. To ensure the highest level of ongoing knowledge, we also provide our CSR staff with opportunities to gain additional understanding through continuing education programs.

Our four-week training program begins with Induction Training, allowing all trainees to learn and familiarize themselves with the corporation, our customers, Davis Vision's Contact Center, ISO certification, vision insurance, vision care basics, customer service, information technology, retail store operations, our culture and other departments.

The four-week training program provides each CSR with:

- Exceptional customer service skills
- The ability to interact appropriately with both our members and participating providers and their staff
- Specific knowledge of the optical industry
- Expertise in our administrative system
- Knowledge of our benefit designs
- Maintenance of call traffic levels

Our ISO certification is an important part of our training program and is covered in multiple segments of the process. As part of the Induction Training, we conduct a branded "See ISO" training with all new hires, which highlights the ISO principles and instills the importance of our quality statement and associate expectations. The performance-based training is designed to reinforce the importance of standardization, continuous improvement and quality by demonstrating the appropriate use of resources to deliver a customer experience consistent with our quality statement.

Training is held in our on-site classroom, and includes one-on-one support from instructors who have, on average, over 18 years of either call center or training experience. Trainees demonstrate proficiency in the skills learned through role play, tests and live performance with side-by-side observation.

After formal instruction is completed, trainees remain in a controlled environment, taking calls in the presence of an instructor, who provides answers to questions and closely monitors all interactions with members. Once an associate can respond to customer inquiries with minimal instructor monitoring, they graduate from training.

Even after becoming a CSR, monitoring and training continues. All associates are on probation for their first 90 days, and are provided 30-day, 60-day and 90-day reviews to track progress.

We believe in continuous improvement for all associates. Even the most experienced CSRs need to continue their education during their career path with Davis Vision. Continuing education is developed and tailored according to the needs of each individual as well as the overall Contact Center. Professional

development topics include new group benefit information, providing quality customer experiences and specific competency development. Continuing education is coordinated through team-building sessions, learning workshops, coaching sessions and a monthly newsletter.

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Members/Providers;

Approximately 3-5 (1%) of each Customer Service Representative's calls are reviewed per week. Depending on the nature and frequency of the call observation findings, training and education is personalized to ensure that the associate fully understands the issues and works to correct any performance deficiencies. On a routine basis, as well as for instances where larger scale educational issues are noted, larger training classes are set up to reinforce core concepts and address hot-button issues to ensure all associates are up-to-date with the latest customer service issues.

(b) The first call resolution rate for the proposed call center;

[redacted]

(c) The call center location, average staff and turnover rate for call center employees;

Davis Vision's Customer Relationship and Information Technology Center is located at 711 Troy Schenectady Road in Latham, NY 12110.

The annual turnover rate for Davis Vision's Customer Service Representatives has trended at approximately 19% each year over the last three years.

The average tenure of a CSR is 2.5 years and the management team that supports our Contact Center operations has more than 16 years (on average) of health care industry experience.

(d) Ratio of management and supervisory staff to customer service representatives and;

Davis Vision's management and supervisory staff to Customer Service Representative ratio is 1:20.

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels.

Davis Vision will assign and train a dedicated unit to serve the DCS's members, including a dedicated toll-free telephone number. Based on our estimate of 2,000 calls per month, averaged across the entire year, we will staff the DCS's dedicated unit with an experienced team of approximately six Customer Service Representatives and leadership who are already familiar with the complex nature of the DCS's account. Additional staff may be required to support the rest of our contact center.

Our staffing model is based on the number of lives we serve and the number of calls we expect to receive per thousand lives, based on historical trends. We

would review both the historical data from the period we served the DCS account, along with other large, municipal clients with similar populations and complex plan design structures to benchmark the new staffing projections.

Overall Contact Center capacity is forecast to ensure that adequate human and equipment resources are available prior to the start of programs or anticipated periods of high volume. Specific to the DCS, we would work with your team during the implementation process to understand recent call volumes and project the precise needs and refine the staffing based on variances experienced by the Plan in recent years.

We have seamlessly added over one million new members to our book of business for each of the past several years. Forecasts, which are based on expected membership, expected utilization of the benefit and providers' experience with similar size clients, are critical in proactively avoiding challenges. Since our systems and workforce grow in accordance with our membership, phone lines can be easily added to our IVR system to accommodate increased volume or membership growth.

Davis Vision's Interactive Voice Response (IVR) system and website, davisvision.com, offer efficient self-service functionality to augment our current Customer Service Representative (CSR) staff. These systems efficiently resolve over 67% of member inquiries without any CSR involvement. Davis Vision has consistently met all of our customer service objectives.

(3) Describe the information, resources and capabilities that will be available for the customer service representatives to address and resolve member inquiries. Include:

Davis Vision's Customer Service Representatives use our proprietary Customer Service Portal system to respond to member and provider inquiries and provide information regarding member and group-specific benefit entitlements and eligibility. The Portal uses member demographics in our system to also provide information on participating provider locations, review claim history, issue authorizations for services, place eyeglass orders for fabrication, and send appropriate documentation to both members and providers. In addition, the Customer Service Portal tracks specific notes related to a member's experience along with providing a chronological history of dates/times called and documentation/activity requests related to a member's file.

(a) Whether any Interactive Voice Response (IVR) system is proposed;

Davis Vision maintains a comprehensive toll-free customer service telephone system consisting of over 400 lines and an Interactive Voice Response (IVR) system comprised of more than 120 24-hour automated agents.

Davis Vision's IVR system allows a caller to move to an operator at any time during the call. The IVR system responds to incoming calls in two rings or eight seconds. If a member opts out of the IVR, the average time to reach a dedicated Customer Service Representative (CSR) trends at 24 seconds.

Through Davis Vision's IVR system, the DCS's members will be able to obtain basic benefit information, verify eligibility for all family members, locate a participating provider, obtain a claim form, obtain laser provider information and website details, and speak with a CSR in both English and Spanish.

The IVR accesses Davis Vision's administrative system on a real-time basis so any transactions entered are automatically reflected in data accessed by the IVR for all inquiries at any time.

(b) A sample of the IVR script and a description of customizable options, if any, the Offeror is proposing for the Plan;

Please find appended as Attachment 4 a sample of the standard Davis Vision IVR script.

We have the flexibility to accommodate customization in virtually any area of our proposed dedicated IVR for DCS, including:

- Personalized greetings with branded, DCS-specific language
- All menu navigation options
- Opt-out capabilities
- Benefits information descriptions
- Eligibility – current and next eligible date
- Routine provider locations information
- Laser benefit information description
- Medical exception (**Eye Health Connection**[SM] **Program**) benefit information description
- Customizable language and information prior to the effective date of programs for benefit changes

Additionally, we would be able to add the following capabilities specifically for the DCS:

- Directed speech navigation instead of touchtone
- The ability to transfer out of the IVR directly to a provider to schedule an appointment
- Claims status

We would work with the DCS staff during the implementation process to develop the IVR scripts and menus to best meet your needs.

(c) A description of the management reports and information that will be available from the system including any key statistics the Offeror is proposing to report;

Davis Vision's customer service tracking system can report on the following items:

- Average speed of answer
- Abandonment rate
- Average length of call
- Total number of calls received (volume of calls)
- Call answer time
- Maximum delay of answer
- The nature of the call
- First call resolution

Reports will be available on these items at any frequency desired by the DCS. Davis Vision's system qualifies each call to determine the nature of the call (i.e., what topic the enrollee is calling about). This can be reported on through our advanced systems as well.

(d) A description of the capabilities of the phone system to track call types, reasons and resolutions.

Davis Vision records 100% of calls that come into Davis Vision's Contact Center utilizing Voiceprint, a digital call recording, monitoring and records management program. These recordings can then be accessed in a variety of methods through precision search criteria. Davis Vision maintains calls for a minimum of six months; thereafter, they are deleted from the system.

Davis Vision's administrative system provides an online call tracking and documentation system, and provides the mechanism to measure quality as it integrates incoming call volume as well as the member challenge calls log. This system effectively monitors and logs customer service inquiries. The member challenge log is linked to the member's record and contains the date of the call, a description of the purpose of the call, the name of the Customer Service Representative handling the call and any additional associates to whom the issue was referred, details about the conversation and what was communicated to the member. Unlimited space is allotted for recording notes of the conversation. Reports may be generated in various formats, including tracking response time in specified time blocks by number and percentage of calls. Davis Vision will be able to report high-level summary reports to the DCS on a regular basis.

(4) Describe the Offeror's proposed back-up systems for its proposed primary telephone system which would be used in the event the primary telephone system fails or is unavailable. Indicate the number of times the back-up system has been utilized over the past two (2) years.

We have not needed to utilize our backup telephone system over the past two years, and in fact, our phone system has remained operational through some of the largest outages in the State, including the events of September 11, 2001, and the Northeast power grid failure in August 2003.

Davis Vision's telecommunications operations are handled by a sophisticated computerized telephone system, the Avaya (Lucent) PBX, which services external customers via an advanced Automatic Call Distribution (ACD) consisting of over 400 lines. Our Avaya PBXs are a current Avaya Release: Communications Manager 5.2. Our Contact Center uses Syntellect Voice Enabled IVRs, Avaya CenterVu CMS call center management, Audix voice messaging and CTI integration to support agent screen activation (screen pops). All of these peripheral systems, housed in our Latham, New York, data center, were upgraded in November 2009.

The entire system is fully redundant and uses UPS and diesel generator power to remain operational during unplanned power outages. The only time the system experiences downtime results from scheduled maintenance activities.

In the rare event of an outage, the same technology is installed in three additional proprietary locations and would be leveraged within a matter of minutes to maintain support of our business until our Latham Contact Center facility is once again operational. The primary disaster recovery center in located at our corporate headquarters in Plainview, NY, and our secondary locations are based in New Jersey and Texas, which could also support contact center functionality should the need arise.

(5) Describe the information and capabilities the Offeror's proposed website will provide to Members/Providers. Does the Offeror currently have customized websites for its clients? If so, describe the process utilized by the Offeror to establish customized websites for its clients.

Yes, Davis Vision offers customized websites for its clients. Our user-friendly website, davisvision.com, is easy to navigate and available in both English and Spanish. Overall, it receives an average of 10 million hits per year from members who want to find out information about Davis Vision, vision care wellness or log in to find out about their coverage and available providers.

To ensure our site is providing quality information, Davis Vision obtained Health Website Accreditation from the Utilization Review Accreditation Commission (URAC), an independent, nonprofit organization that is a well-known leader in promoting health care quality through its accreditation and certification programs. The accreditation process includes a thorough evaluation against more than 50 stringent standards to ensure our website delivers quality health content and services. In addition, our site secures private information using a VeriSign SSL Certificate, ensuring that the personal information of DCS members and dependents will remain secure.

The Davis Vision website focuses on vision care and wellness. DCS members and dependents will be able to access a wide variety of vision and wellness articles on topics such as Adult Eye Health, Children's Vision, Eye Conditions, Eye Safety and Protection, and Vision and the Workplace. The site also contains a glossary of vision-related terms so members can familiarize themselves with the terminology they will see on their benefit materials and may hear in the provider's office.

Our member website is in the process of undergoing a stylistic and technological overhaul, and the new site will be unveiled in the middle of 2011. It incorporates our "See Life" branding and modernizes the current features, including the frame finder, the ability to find a provider and review benefit information. The new site will also have a Kids Corner for parents to find information regarding children's eye health, including the connection between vision and literacy, and FAQs about the vision industry. The focus will be on eye health and wellness, and the ability to See Clearly and Safely.

During open enrollment, Davis Vision provides members with a client-specific code that allows them to review their benefit information and participating provider listings online prior to enrolling. Once enrolled, members are able to log in to the site and access plan- and member-specific information. Our fully-interactive site provides enrolled members with the ability to:

- Find a provider within range of any ZIP code nationally
- Use Google maps, without leaving the site, to get directions to the selected provider
- Access documents, including benefit summaries (the Member Welcome Kit), identification cards and out-of-network claim forms
- Check eligibility for the member and their dependents
- View our exclusive Collection of frames
- Obtain a confirmation number for laser vision correction services
- Complete a patient satisfaction survey
- Link to the LENS123® website for mail-order contact lenses
- Change their password and password hint
- Review eye health and wellness information
- Contact Davis Vision for assistance

Provider Services

A critical component in providing efficient service to members is an informed, up-to-date participating provider network. Davis Vision supports a provider website widely recognized throughout the provider community as one of the most user-friendly websites available. Each provider can customize their view according to the needs of the practice. Over 60% of all material orders are received through this website.

Once a provider logs in to the secure provider website, they can:

- Review the Davis Vision provider manual.
- Verify eligibility of members for services.
- Report claims.
- Generate authorizations for member services (exams and/or materials).
- Place orders for services or materials.

- Track the status of orders placed.

Providers can also access the quarterly provider newsletter, view the frame Collection, send an e-mail for support and view frequently asked questions.

Custom Websites

The administrative ease and flexibility of the Davis Vision program extends to our website capabilities. We will work with you to customize a website tailored to your specific needs. These customized individual Web pages could cost a client thousands of dollars if purchased directly, but is provided free of charge to Davis Vision clients.

The Davis Vision website is customizable based on pre-set options on each page that can be populated to the member's Web page in the member portal. This allows the client to dictate what can be seen by the member on their Davis Vision Member page and allows our clients the flexibility to be able to enhance or limit the website features.

(6) ***Call Center Telephone Performance Guarantees*:** For each of the four (4) Call Center Telephone Service Level Standards above, the Offeror shall propose the forfeiture of a specific dollar amount of the Monthly Administrative Fee, for failure to meet the Offeror's proposed Performance Guarantee.

[redacted]

(a) *Call Center Availability Performance Guarantee*:

The Standard Credit Amount for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone line is not operational and available to Members and Providers during the Offeror's Call Center Hours as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Call Center Availability Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed standard of____%) that the Offeror's telephone line is not operational and available to Members and Providers during

the Offeror's Call Center Hours as calculated on a calendar year basis, is $_____."

[redacted]

(b) ***Call Center Telephone Response Time Performance Guarantee*****:**

The Standard Credit Amount for each .01 to 1.0% below the standard of ninety percent (90%) of incoming calls to the Offeror's customer service toll-free telephone line that are not answered by a customer service representative within sixty (60) seconds, as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Call Center Telephone Response Time Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed standard of ___%) that incoming calls to the Offeror's customer service toll-free line that are not answered by a customer service representative within sixty (60) seconds, as calculated on a calendar year basis, is $_____."

[redacted]

(c) ***Telephone Abandonment Rate Performance Guarantee*****:**

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three

percent (3%), as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Telephone Abandonment Rate Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) (or the Offeror's proposed standard of ___%), as calculated on a calendar year basis, is $_____."

[redacted]

(d) ***Telephone Blockage Rate Performance Guarantee*****:**

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of three percent (3%), as calculated on a calendar year basis, is $5,000. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Telephone Blockage Rate Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of three percent (3%) (or the Offeror's proposed standard of ___%), as calculated on a Calendar Year basis, is $_____."

[redacted]

4. Member Communication Support

The Offeror shall be required to create Plan materials that enhance a Member's understanding of Plan benefits. All Member communications are subject to the review and approval of the Department.

Davis Vision confirms we will provide plan materials that enhance a Member's understanding of Plan benefits, creating both a custom campaign to announce the new benefits and providing communication materials that outline the plan benefits and how to use them. All member communications will be reviewed and approved by the Department prior to their finalization.

a. Duties and Responsibilities

The Offeror shall be responsible for providing Member communication support and services including but not limited to:

(1) Designing and producing all necessary claim forms, benefit booklets, Participating Provider directories, and other printed materials in sufficient quantities to promote and operate the Plan. All such materials are subject to the Department's review and approval.

Davis Vision confirms.

(2) Developing, printing and mailing to Enrollees' homes within 90 days of the Contractor's implementation date a directory of Participating Providers (or customized listing of such providers) and a Vision Plan Summary of Benefits booklet which states the Plan benefits applicable to each Member and summarizes Plan provisions, including eligibility criteria. Vision Plan Summary of Benefit booklets are not required for Enrollees represented by SEHP;

Davis Vision confirms.

(3) Distributing to the Health Benefits Administrators (HBAs) of each State Agency and Participating Employer, a sufficient quantity of Vision Plan Summary of Benefits booklets for the Plan to provide a copy to each newly eligible employee throughout the term of the Agreement. The initial shipment of Vision Plan Summary of Benefit Booklets will equal 5% of the Agency's Enrollee count by

bargaining unit as of January 1, 2012. The Enrollee count by State agency by bargaining unit is included as Exhibit II.F for informational purposes.
Davis Vision confirms.

(4) Developing an order entry process for HBAs to order replacement copies of Plan materials and fulfilling and shipping such orders to HBAs in an expeditious manner.
Davis Vision confirms.

(5) Developing, printing and mailing to Enrollees' homes notification of benefit modifications and any other communications materials that may be required by the Department during the term of the Agreement, in cooperation with and subject to the approval of the Department and in accordance with Article VIII; Paragraph 8.3.0 of the Agreement.
Davis Vision confirms.

(6) Accounting and paying for all development, production and mailing costs incurred to disseminate Plan communications materials to Enrollees and HBAs.
Davis Vision confirms.

(7) The Department shall:

(a) Retain editorial control over all aspects of the Plan material, including final determination on the content and tone. The Department will provide expeditious final approval of all print and/or other materials developed for the Plan;
Davis Vision confirms.

(b) Make available, if possible, any records or information which the Offeror clearly needs to design and implement effective communication strategies; and
Davis Vision confirms.

(c) Assist the Offeror as necessary in communicating with Enrollees and Providers but at no additional expense to the State, except as provided in Article IX, Paragraph 8.3.0 of the Agreement.
Davis Vision confirms.

(8) The Offeror shall retain no proprietary or literary rights with respect to communication material developed solely for the Plan and shall execute any assignment found necessary to release proprietary rights.

Davis Vision confirms.

(9) Attending health benefit fairs, conferences, and benefit design information sessions, located in New York State, at the request of the Department.

Davis Vision confirms.

(10) ***Website Maintenance Service Level Standard:*** The Offeror must accurately update the Plan's customized website within thirty (30) days of notification by the Department.

Davis Vision confirms.

b. Required Submission

(1) Provide an outline of the communications campaign the Offeror is proposing for the Plan's first year; including the timeline for developing, printing and mailing Enrollee and Provider Plan materials.

Enrollee Materials

Choosing benefits can be an important time for both members and human resource executives. We want your employees to be fully informed about their eye care benefits. We will work with you to determine the communications campaign that best meets your needs, selecting which member communication materials you'll need to provide a full benefit overview to your employees. Our new website allows the DCS to choose their own member education materials from our vision wellness library. Simply choose the collateral that works best for your employees and we will tailor the information to your benefit design. Our library of member education materials include vision articles underscoring the importance of an eye examination, the clinical value of early detection of disease, how and where to use your vision benefit, and savings tables illustrating the financial benefit of a vision plan. Our goal is to educate the member on how to utilize their vision benefit fully to reduce vision plan management questions to the employer.

Consider the following GEICO case study, which illustrates the value of tailoring member education to the specific needs of the employee population as well as our ability to provide marketing solutions specific to the employer and the plan type. Please find our GEICO case study flyer appended as Attachment 5.

In addition to the customized plan outlined above, our member communication strategy includes providing customized communication materials at no additional

charge to our clients. Pre-enrollment materials are provided during the open enrollment period for member education, and after the open enrollment period, a Member Welcome Kit is supplied to all those who enroll. All of our materials are available in both English and Spanish, and our system can be programmed to send the appropriate materials to each individual if that information is provided on the enrollment file.

Pre-Enrollment

Pre-Enrollment Flyers that educate members on the importance of vision care and other topics that can be selected through our new website will be customized with the DCS's name and/or logo, the enrollment process and a summary of plan benefits. The **Pre-Enrollment Flyer** educates members about the importance of routine vision care, eye health and the ways they can save with their Davis Vision plan.

These flyers will be delivered to the DCS or a designated fulfillment vendor, as an electronic file, and/or in hard copy (via bulk shipment) for distribution to eligible enrollees and new hires/eligibles.

Post-Enrollment

After open enrollment, Davis Vision sends a **Member Welcome Kit** to all new enrollees. The DCS's members will also be able to obtain additional materials online or by telephone.

Davis Vision's **Member Welcome Kit** will then be customized to include the DCS's name and/or logo and is printed in black ink on pre-designed color paper. The **Member Welcome Kit** includes:

- A summary of the vision benefits and coverages.
- Customized provider listing of local participating providers' names, addresses and telephone numbers.
- Two Member Identification Cards containing the member name, identification number, group name/affiliation, toll-free customer service telephone number and website address.

Please find sample Member Communication Materials, in both English and Spanish, appended as Attachment 6.

Provider Communications

Davis Vision provides many avenues for network provider communications, including Provider Service Representatives available by calling our Customer Relationship Center located in Latham, New York; 24/7 access to real-time program information and services via the provider portal on our website, davisvision.com; a team of Regional Quality Assurance Representatives and Professional Field Consultants that serve as local liaisons to the provider network and who physically visit providers offices in the field; and an annual Provider Satisfaction Survey. In addition, Davis Vision offers extensive training to providers

through local seminars and a comprehensive provider manual. Specific communications and training would be customized for providers, should Davis Vision be awarded the DCS contract.

In conjunction with the production of member materials, provider materials notifying providers of the award of the contract would be produced, including:

- Benefit alerts announcing our selection as the vision plan administrator for the New York State Vision Plan Services will be posted to our provider website within 30 days of DCS's approval;
- Use established provider communications, including our Provider Network Newsletter distributed via e-mail, to promote knowledge of and familiarity with the new Plan
- Provide follow-up materials as reminders to providers after the effective date.

We would provide ongoing provider education about the specifics of the DCS plan to providers during the entire tenure of the contract.

(2) Does the Offeror have staff within its organization or a Key Subcontractor that specializes in enrollee communications? What is their capacity to provide the communication support described above?

Yes. Our internal marketing department has a communications and design team to assist in the development of collateral that addresses enrollee questions and how and where the vision benefit can be utilized. In conjunction with the dedicated Client Management team led by Ms. Traci Small, this talented and creative team would support all communication support requests from the DCS.

(3) Confirm that upon request, subject to the approval of DCS, on an "as needed" basis, the Offeror shall provide staff to attend health benefit fairs, conferences, and benefit design information sessions. **The Offeror agrees that the costs associated with these services are included in the Offeror's Monthly Administrative Fee.** Describe the experience and qualifications of the staff who will be assigned to attend such events when so requested by the Department.

Davis Vision confirms. We will support and attend the DCS health benefit fairs, conferences and benefit design information sessions as needed at no additional cost. These events are critical for employees to better understand and appreciate the benefits of their vision program. Davis Vision's Client Management representatives would attend targeted events to explain the vision care program, distribute open enrollment materials and answer questions from members.

Our representatives attend over 1,000 such client events annually and are industry leaders in this area of client support. Such on-site support has been a key component of our client services for many years and is coordinated through our dedicated Client Management Team. Primary support for attendance will be with

the DCS Client Management Team (which has 60 years of Davis Vision and industry experience). Supplemental support is also provided by other local Davis Vision Client Management representatives throughout the state as needed. All representatives attending such events are fully trained and knowledgeable regarding our services and client-specific benefits and plan provisions.

As further support, we also provide the following at no additional cost:

- **Staff Training**: Our experienced Client Management Team, headed by Ms. Traci Small, will conduct "Train the Trainer" sessions to educate the DCS Human Resources and Benefits staff on the various features of the vision plan. A presentation will also be developed for ongoing reference.
- **Health and Wellness Communications/Education Outreach**: Sightwire is Davis Vision's electronic newsletter sent to clients six times a year. At your request, we can send PDF versions to post on your website or to further distribute via e-mail. Each issue is designed to keep our clients and members informed about the latest in eye health and vision care news. Sightwire is comprised of four sections:
  - "Spotlight on Vision" features a full-length article about an eye health-related subject, such as cataracts, age-related macular degeneration, diabetic retinopathy, etc. The articles are linked as full-color PDFs that may be downloaded and printed for members.
  - "Be Well, See Well" focuses on topical features related to vision benefits and wellness.
  - "See the Difference" includes the latest Davis Vision news.
  - "Have You Seen?" offers a compilation of external news links with current vision care information, treatments and breakthroughs.

(4) State the Offeror's agreement to work with the Department to develop appropriate customized forms and letters for the Program, including but not limited to Enrollee claim forms, disruption letters, etc., and that all such communications must be approved by the Department.

We agree to would work with the Department to develop customized out-of-network claims forms, appeal and denial letter language and member materials. All communication materials will be approved by the Department prior to their finalization.

(5) ***Website Maintenance Performance Guarantee*****:**

The Plan's Service Level Standard requires that all Plan benefit changes be accurately updated by the Offeror to the Plan's customized website within thirty (30) days of notification by the Department.

The Standard Credit Amount for each calendar day beyond thirty (30) days notification by the Department that all Plan benefit changes are not accurately updated to the Plan's customized website is $500. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Website Maintenance Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each calendar day in excess of the thirty (30) day standard that Plan benefit changes are not accurately updated to the Plan's customized website, is $_____."

5. Enrollment Management

The Plan requires the Offeror to ensure timely addition of enrollment data as well as cancellation of benefits in accordance with Plan eligibility rules. EBD utilizes a web-based enrollment system for the administration of employee benefits. The system is referred to as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all NYS Vision Plan Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A and II.B.

Note: The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

Davis Vision confirms.

a. Duties and Responsibilities

The Offeror shall be responsible for the maintenance of an accurate, complete and up-to-date enrollment file based on information provided by the Department. This

enrollment file shall be used by the Offeror to process claims, provide customer service, and produce management reports. The Offeror is required to provide enrollment management services including, but not limited to:

(1) ***Initial testing***

(a) Performing an initial enrollment load to commence upon receipt of a test file from the Department during Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)) or a custom file format. The determination will be made by the Department;
Davis Vision confirms.

(b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The selected Offeror shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;
Davis Vision confirms.

(2) Providing an enrollment system capable of receiving secure enrollment transactions and having all transactions fully loaded to the claims processing system within forty-eight (48) hours of release of a retrievable file by the Department. The Offeror shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within forty eight (48) hours of their release, as required. The Offeror must have a process in place to correct any records that cannot be loaded programmatically in a timely manner. The Department will transmit enrollment transactions changes to the Offeror in an electronic format weekly. The format of these transactions will be in EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department (see Exhibit II.G for a detailed record layout).

The Offeror must also have the capability to receive any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required; and

Davis Vision confirms.

(3) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party. The Offeror shall store this information in their system so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's website would go to the person designated in the QMCSO;

Davis Vision confirms.

(4) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. The Offeror must have an Information Security Plan (ISP) acceptable to the Department in place on the effective date of the Agreement, which states all of the security policies and procedures for the protection of data, equipment and facilities, including receipt of and transmission of data in accordance with Department standards, policies and procedures. The ISP must, at a minimum conform to the requirements of the Department of Civil Service Information Security Policy (**Exhibit I.X**); and agree to the policies, terms and conditions stated in this RFP, the Agreement and Appendices A, B and C. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process;

Davis Vision confirms.

(5) Cooperating fully with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement.

Davis Vision confirms.

(6) Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Offeror's staff with access to current Program enrollment information. Offeror's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of State holidays;

Davis Vision confirms.

(7) Providing a back-up system in the event that the primary enrollment system fails or cannot be accessed so that there is no interruption of service to Members.

Davis Vision confirms.

Amended March 29, 2011

(8) Verifying dependent child full-time student status for all employee groups (except for those covered by SEHP) for Dependents age nineteen through twenty-five, prior to authorization of Vision Plan services. Student status is not maintained in NYBEAS. Dependent children of Employees who are in SEHP are covered up to age twenty-six regardless of student status.

Davis Vision confirms.

(9) ***Enrollment Management Service Level Standard*:** The Program's Service Level Standard requires that one hundred percent (100%) of all Plan enrollment records that meet the quality standards for loading must be loaded into the Offeror's enrollment system within forty-eight (48) hours of release by the Department.

Davis Vision confirms.

b. <u>Required Submission</u>

(1) Describe the Offeror's proposed testing plan to ensure that the initial enrollment load is accurately updated to the Offeror's system and that the Offeror's enrollment system interfaces correctly with the Offeror's claims system.

We have a long history of successful electronic enrollment implementations and secure data transfers in accordance with HIPAA guidelines dating back to 1996. We are also fully compliant with the HIPAA EDI standards established with the Administrative Simplification provisions of the HIPAA legislation put in place in 2003. While not all transactions apply under the referenced legislation, or are used

by Davis Vision and our trading partners, we are fully compliant with those transactions that do apply, e.g. 837P (Professional Claim), etc.

(a) Describe what quality controls will be performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system.

Davis Vision implemented state-of-the-art enrollment processing tools in 2009 that allow our Data Administration team to configure, test and review enrollment files, and process ongoing production files within a single restricted proprietary application. This application includes stringent controls that 1) prohibit any updates to submitted enrollment files; 2) identify variances within full replacement files that would result in a large number of enrollment records that were to term by absence if that file were applied; 3) using the defined file frequency track the receipt of incoming files against their expected receipt date to flag any files that are overdue; 4) identify and report records that do not adhere to the minimum data requirements necessary to load to our processing systems while also making available a one-stop shop resource for all file processing statistics and reporting.

(b) Describe how the Offeror's system will identify transactions that will not load into the Offeror's enrollment system. What exceptions will cause enrollment transactions to fail to load into the enrollment system? What steps will be taken to resolve the exceptions, and what is the proposed turnaround time for the exception records to be added to the enrollment file?

Davis Vision executes the following proven steps required to successfully implement electronic enrollment processing:

Definition:

a) Establish designated contacts for file transfer and file layout
b) Agree on file transfer methodology
c) Establish file transfer frequency
d) Review layout and content
e) Determine connectivity and error reporting distribution and transfer methodology

Iterative Testing:

a) Test file transfers
b) Validate HIPAA compliancy for EDI 834 files
c) Identify targeted test scenarios
d) Verify file content against data requirements
e) Load and review results in dedicated enrollment test region

f) Provide test file processing feedback

g) Perform additional iterations as needed to fulfill testing requirements

Production Update:

a) Initiate production full file transfer

b) Validate HIPAA compliancy for EDI 834 files

c) Data Validation

d) Review enrollment staging reports

e) Davis Vision Approval of initial file for update

f) DCS Approval of Initial file for update

g) Member Welcome Kit generation validation, proof review, if applicable

Ongoing production enrollment file updates validate:

a) Timing of enrollment file receipt against defined expected file frequency

b) Error reporting review and follow-up

c) Validation of production update

Davis Vision processes electronic enrollment files in two phases: Staging and Production Update. The staging process generates summary and detail error reporting that is reviewed internally as well as being sent securely to the designated secure site for DCS retrieval prior to approving the file to update production.

Data Exceptions that result in enrollment records being rejected from the enrollment update process include:

- Missing or unjustified Employee Identification Number
- Missing or invalid benefit plan information
- Missing or invalid DCS-specific identifiers
- Missing employee or dependent first or last names
- Missing “Enrollment Processing Required Member Categories” – data defined during implementation as required
- Non-compliant HIPAA EDI 834 files

System-required fields resulting from the conversion of the HIPAA-compliant 834 format to our proprietary file layout include:

- Missing Header / Trailer Record
- Missing or invalid file status identifying (T)est, (P)roduction or (O)pen Enrollment File
- Missing or invalid file types identifying (F)ull file all active lives, (T)full file with terminations or (C)hange transaction file
- Missing or invalid record type identifying (S)ubscriber or employee, or (D)ependent

(2) Describe the Offeror's system capabilities for retrieving and maintaining enrollment information within forty-eight (48) hours of its release by the Department as well as:

(a) How the Offeror's system will maintain a history of enrollment transactions and how long enrollment history will be kept online. Indicate whether or not there will be a limit as to the quantity of historic transactions that can be kept online.

Davis Vision's automated enrollment file processing system can pull files from the Department's system or receive secure transmitted files in a variety of formats and on various schedules. The detailed implementation process specifies frequency, method of transmittal and confirmation of receipt in support of the Department's processes. Received files are validated through our data administration team prior to loading. Error and warning reports are produced and reviewed and can be shared with the Department to ensure accurate information is being loaded.

Davis Vision's system capabilities are used today to load daily enrollment files from multiple sources with loads in excess of a million records a day. Capacity is planned and managed to ensure rapid turnaround for clients and would incorporate the Department's needs for a 48 hour or faster timeline.

(b) How the Offeror's system will handle retroactive changes and corrections to enrollment data.

Davis Vision's proprietary system accepts both future and retroactive effective and termination dates. No authorizations will be issued for services where the authorization date is equal to or greater than the termination. In the event that an authorization has been issued to a provider prior to receiving an enrollee's termination date, Davis Vision would continue to process and pay in-network claims to the provider for up to a 90-day period, despite the member being terminated in our system. Services are typically provided to patients within 10 days of the issuance of an authorization. We would be pleased to discuss this process and tailor it for the DCS as appropriate.

Upon receipt of a member termination date, Davis Vision would no longer process in-network authorizations and out-of-network claims with dates of service after the termination date for the member. Davis Vision would deny such claims and provide the member with appeals rights.

(c) Confirm that the Offeror's enrollment and claims processing system has and will have the capability to administer a social security number and Employee identification number. Indicate whether or not the system has any special requirements to accommodate these Enrollee identification numbers? Explain how Dependents will be linked to the Enrollee in the enrollment and claims processing systems.

Davis Vision's administrative system has an open architecture with the ability to accept and/or generate a Social Security Number and alternate identification numbers, each of which are safeguarded within our systems at all times.

Currently, Davis Vision accepts alternate ID numbers from a variety of clients, and we also use alternate ID numbers for our associates to ensure the privacy and security of their Social Security Numbers. Davis Vision's proprietary administrative system can easily accommodate alternate identifiers contingent upon the following:

- The alternate ID number should not consist of exactly nine characters and cannot have more than 12 characters. It is preferable that the alternate ID number consists of eight, 10 or 11 characters to avoid potentially matching existing social security numbers in the system.
- Only numeric characters will be accepted. Alpha characters and characters such as "*" and "#" cannot be accepted by our administrative system or Davis Vision's Interactive Voice Response system.

In addition, should a client group send Social Security Numbers as member identification numbers, the Social Security Number is stored in a dedicated field and an alternate ID may be used as a member's identification number to further protect the communication of Social Security Numbers.

Dependents are linked to the Enrollee in the enrollment and claims processing system through a combination of a Davis Vision-assigned Contract ID number (or the DCS-assigned Enrollee Identification number) and a Davis Vision assigned dependent number.

(3) Describe the Offeror's ability to meet the administrative requirements for national Medical Support Orders and Dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in the Offeror's system so that information about the Dependent is only released to the individual named in the QMCSO.

Davis Vision is fully equipped to comply with National Medical Child Support Orders and Qualified Medical Child Support Orders. Our information systems are capable of loading and storing alternate addresses (if applicable) and parent custodial arrangements at the life level.

QMCSO and NMSO covered dependents' records are flagged and alternate addresses, if applicable, are kept strictly confidential. All documentation applicable to a QMCSO or NMSO covered dependent is mailed to the dependent's custodial parent, pursuant to QMCSO and NMSO guidelines.

Davis Vision can support the loading of QMCSO and NMSO information both electronically and manually.

(4) Describe the process the Offeror will utilize to verify a dependent child's full time student status prior to authorization of Vision Plan services. Confirm whether this process is utilized for other customers.

To verify a dependent child's full-time student status prior to authorization of vision plan services, proof documentation would be required from the member based on the DCS's specifications, including documentation from the registrar's office, a school schedule or written documentation from the subscriber. Each proof submission will need to contain the subscriber's name and identification for the student status to be updated in a timely manner. No matter the documentation required, the proof would be sent to our manual enrollment team via e-mail, fax or mail (e-mail is the preferred method). Proof would only be required for each service, when a dependent is eligible, not for each semester.

Once proof is received by our manual enrollment team, it is reviewed. If the documentation is adequate based on the DCS's rules, the dependent's file would be updated until the end of the semester (spring semester coverage ends August 31, and fall semester coverage ends December 31), or the time period determined by the DCS.

If the proof sent does not meet the DCS's requirements and a telephone number has been included with the paperwork or is on file, a telephone eligibility representative will reach out to the member for clarification.

If the proof submitted does not have enough identifying information to associate it with a record, the student's name and the date proof was received is added to a file for future reference should an enrollee indicate that student status verification was sent and the file is not updated.

Davis Vision confirms that this process is utilized for a number of other customers, including government groups similar to the DCS.

(5) Describe how the Offeror's enrollment system data transfer and procedure for handling data are HIPAA compliant.

Davis Vision is fully compliant with all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations. Davis Vision is also fully compliant with HIPAA Security provisions.

Critical data such as claims information and Protected Health Information (PHI) is stored in our Customer Relationship and Information Technology Center in Latham, New York. This facility is managed by Davis Vision's Senior Vice President, Administration, Mr. Tom Iachetta.

Davis Vision has a Privacy Office and a Privacy Officer to oversee all aspects of the HIPAA Privacy implementation and compliance requirements. Ms. Heather N. Reynolds, Esq., Assistant Vice President of Contracting and Regulatory Compliance, is the Chief Privacy Officer and responsible for Davis Vision's Privacy and Security Office. Davis Vision's administrative system is built with internal security access architecture to ensure that records containing PHI are secure.

System Safeguards

The inherent safeguards within our administrative system begin with eligibility and continue through the manufacture and delivery of eyewear materials. Claims for

funded programs are entered at the time of material order entry, uniquely integrating the two functions and guaranteeing that professional services and materials match. This means that a provider can only be paid for the actual services provided and only at a predetermined level. Additionally, Davis Vision has been evaluating the HIPAA Security regulations since their publication in the Federal Register on February 20, 2003. As part of Davis Vision's compliance with the HIPAA Privacy Rules, we implemented technological and administrative safeguards to protect the health information of individuals, including the following stringent authentication procedures:

- Davis Vision's associates only have access to information, including PHI that is required to perform their job functions. Our administrative system allows for differentiation between users and includes a periodically changed password system (stored in encrypted form). Additionally, while Davis Vision's security administrator may issue a new password for an associate, no associate may view or use another associate's password. A periodic audit is done to ensure that all users are at the appropriate level of access given their current role and responsibility within the company. Additionally, all of Davis Vision's associates have been trained in the requirements of the HIPAA Privacy Rule and the processes impacted by the Rule.
- Davis Vision's Interactive Voice Response (IVR) logic has been modified to follow the identity and authority verification processes established. The IVR system will note any discrepancies before transferring the caller to a Member Services Representative (CSR), who will follow strict protocols when responding to the caller. Additionally, an "individual rights" indicator has been developed for confidential communications and restrictions on the system. If the indicator is present on the member or any dependent's profile, the call will be redirected to a CSR for appropriate response.
- Davis Vision's website, davisvision.com, has also been modified to follow the identity and authority verification processes. If the authentication fails or there is an Individual Rights Indicator present on the enrollment record, the user will receive a message to contact Davis Vision for information.
- Davis Vision has partnered with Zix Corporation to use the ZixMail and ZixMessaging Services. The package ensures that all outbound e-mail messages that contain protected health information are encrypted and provide the receiver with a no-cost means to decrypt. Attachments that contain protected health information are also secured using the Zix Corporation products.
- Additionally, a comprehensive control structure is in place to ensure the integrity of Davis Vision's proprietary claims processing application and its supporting hardware. Davis Vision undergoes a Statement on Auditing Standards (SAS) 70 review by an independent auditing firm every year. This review assures Davis Vision's clients, vendors, members and providers that the controls in place adequately safeguard the integrity of our systems, applications and facilities.

Physical Safeguards

Davis Vision's Enterprise Systems Server, web systems, contact center systems and other major client server systems are housed in our world-class Latham facility with advanced environmental control systems, a back-up 350 KVA diesel generator, sophisticated fire suppression and electronic security access. Systems are monitored from a "command center" enabling constant display of critical system performance metrics. All significant systems are redundant, thus minimizing single points of failure. This redundancy includes diverse telephone entrances and central offices for our phone service and alternate power supplies. This facility, occupied in September 2001, was specifically built and designed for Davis Vision and ensures our compliance with HIPAA privacy and security regulations.

These procedures also provide the necessary quality control to help ensure that critical data is not created, changed or destroyed without proper authorization. As part of supporting those procedures, Davis Vision has extensive internal control processes such as daily review and documentation of security logs, reports to clients on enrollment and eligibility file loads, audit reconciliation with client files, semi-annual employee access reviews and reporting of encounter/claim data.

(6) Confirm that the Offeror will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be able available to access enrollment information through NYBEAS during the required hours.

Davis Vision will maintain and provide a read-only connection to the NYBEAS enrollment system for verifying enrollment coverage to the appropriate resources based on access and role-based security levels. We have established outside system access for enrollment confirmation for many accounts supported by documented policies and procedures, and as the previous administrator for the NYS Vision Plan, Davis Vision has extensive experience with NYBEAS.

(7) Describe the Offeror's backup system, process or policy that will be used in the event that enrollment information is not immediately available.

Davis Vision builds in contingency plans for enrollment confirmation on escalated inquiries by establishing appropriate contacts at each organization to funnel inquiries and obtain corresponding verification. We have a dedicated eligibility team trained to handle such escalations to verify coverage, partnering with our clients to ensure a positive member experience.

(8) ***Enrollment Management Performance Guarantee*:** The Program's Service Level Standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading be loaded into the Offeror's enrollment system within forty-eight (48) hours of release by the Department. The Offeror shall propose the forfeiture of a specific dollar amount of the Monthly Administrative Fee for failure to meet this level of standard.

The Standard Credit Amount for each twenty- four (24) hour period beyond forty-eight (48) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $500. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Enrollment Maintenance Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Monthly Administrative Fee for each twenty- four (24) hour period beyond forty-eight (48) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $____."

[redacted]

6. Reporting

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with Participating Providers and Laser Vision Correction Participating Providers and the terms of the Agreement. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames. The Program requires that the Offeror provide accurate claims data information on a monthly basis as well as specific summary reports concerning the Plan and its administration.
Davis Vision confirms.

a. Duties and Responsibilities

The selected Offeror will be responsible for reporting services including, but not limited to:

(1) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, and analysis of the Plan. These reports must tie to the amounts billed to the Plan. The final format of reports is subject to the Department review and approval;
Davis Vision confirms.

(2) Providing Ad Hoc reports and other data analysis at no additional cost to the State. The exact format, frequency and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

(a) Forecasting and trend analysis

(b) Benefit design Modeling

(c) Reports to meet clinical program review needs

Davis Vision confirms.

(3) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Semi-Annual, Quarterly and Monthly Reports below and include the time frames for each report's submittal to the Department:
Davis Vision confirms.

Semi-Annual Reports

Utilization Reports: The Offeror must submit reports that detail utilization by type of service and employee group for both network(s) and non-network claims, including services provided under the Occupational Vision Program and the Medical Exception Program as well as the Laser Vision Correction Program. Additionally, for the Medical Exception Program, the Offeror must report the number of authorized services, by medical condition and employee group. The reports are due on a semi-annual basis, thirty (30) days after the end of the reporting period.

Davis Vision confirms.

Enrollee Satisfaction Survey Summary Report: The Offeror must submit a semi-annual report which summarizes, by employee group, the results of Enrollee satisfaction surveys designed to evaluate the level of Enrollee satisfaction with the Plan. The survey should seek Enrollee satisfaction with:

(i) Quality of Professional care provided, including eye examinations, contact lens fittings and eyewear dispensing;

(ii) Quality of frames and lenses;

(iii) Technical competency, familiarity with Plan benefit design, and customer service skills of the Participating Provider staff; and

(iv) Adequacy of Provider access, including ease of making an appointment and convenience of office hours.

The format of the report is subject to Department input and approval and must include free form reporting of all Enrollee comments and an accounting and resolution of any Enrollee issues. This report is due on a semi-annual basis, ninety (90) Days after the end of the reporting period.
Davis Vision confirms.

Quarterly Reports

Quarterly Performance Guarantee Report: The Offeror must submit quarterly the Plan's Performance Guarantee report that details the Offeror's compliance with all of the Offeror's Performance Guarantees. The report shall include, at a minimum, the areas of Plan implementation, customer service (telephone availability, response time, blockage rate, abandonment rate), eyewear turnaround time, enrollment management reports, and Participating Provider access. Documentation of compliance/non-compliance is to be included with this report. The report is due thirty (30) Days after the end of the quarter.
Davis Vision confirms.

Monthly Reports

Monthly Payment Summary: The Offeror is required to submit a monthly report that provides summarized claims processed, issued and paid on behalf of the NYS Vision Plan during the reporting period. Such report shall separately identify claims for State employees from those of Participating Employers (PE) and include a summarized breakout by service type. This report will be used for PE billings, thus should include sufficient claims detail for a PE to verify that it was correctly billed. The report must identify separately paid claims on behalf of direct pay Enrollees (i.e. COBRA) of PEs. This report shall serve as the billing to the NYS Vision Plan, and is due ten (10) Days after the end of the month. The exact format will be specified by the Department but should include, at a minimum, the data elements outlined in Exhibit II.E.

Davis Vision confirms.

Monthly Claims File: The Offeror shall provide a Microsoft Access database file containing the claims payment information for the month, in accordance with the specifications presented in Exhibit II.E. The monthly file is due fifteen (15) Days after the end of the month.

Davis Vision confirms.

(4) ***Management Reports and Claim File Service Level Standard:*** The Plan's Service Level Standard requires that accurate management reports and claim files, as specified in Section IV.B.6.a.(3) of this RFP, be delivered to the Department no later than their respective due dates, inclusive of the date of receipt.

Davis Vision confirms.

b. Required Submission

(1) The Offeror must submit examples of the financial, utilization and Enrollee satisfaction survey reports that have been listed without a specified format in the reporting requirements above, as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the NYS

Vision Plan. Provide an overview of the Offeror's reporting capabilities and the value the Offeror believes it will bring to the Plan.

Davis Vision confirms our capability to provide semi-annual, quarterly and monthly reports including utilization, enrollee satisfaction, payment and claims in any formats requested. The new generation of our claims processing system allows for industry-leading reporting capabilities. Our new management reporting package presents the information needed by DCS staff in a simple, easy-to-read format that can be tailored to the specific needs of the DCS.

Keeping track of the performance of your vision plan through comprehensive, client-specific reports will allow you to continually monitor enrollee's usage of the plan. Davis Vision's reporting package is available at no additional cost, and reports will be provided at any frequency you specify.

Our simplified report structure provides information on claims, utilization, member services, plan value and more, including:

- In-network utilization and services obtained
- Number of in-network vs. out-of-network claims
- Enrollment and average membership
- Patient satisfaction survey results
- The number of calls to Member Services
- The reasons members call
- Percentage of member calls resolved on first contact
- Member website usage
- Member usage of lens options
- Member savings with our fixed, discounted lens option pricing

Please find a sample of our management reporting package appended as Attachment 7.

(2) Confirm that the Offeror will provide reports in the specified format (paper and or electronic- Microsoft Access, Excel, Word) as determined by the Department.

Davis Vision confirms that all reports will be provided in the specific format requested by the Department.

(3) Confirm that the Offeror will provide direct, secure access to its claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement the Offeror proposes, if any, for Department staff to execute in order to obtain system access.

Davis Vision confirms. We will provide secure access to our systems through a dedicated line between the Department and Davis Vision. Additionally, to exceed the Department's requirements, the following tools would be available, if desired, to supplement that direct access:

- Davis Vision can provide customized static reports in PDF format through our employer portal, Benefit Manager™, as well as through secure e-mail.
- Additionally, e-Bill is a secure online system that will provide the DCS with the ability to view invoices (both current and past), view details that support invoices (for fee-for-service claim activity) and download or save the data into Microsoft Excel to allow the DCS to manipulate it for reports they require. e-Bill will also allow the DCS to pay Davis Vision through EFT transactions and to view past payments. e-Bill streamlines the billing process by eliminating the need for paper invoices and remitting checks for payment.

Upon award of the contract, we will partner with the Department to gain a comprehensive understanding of your data access and sharing needs, and will provide any and all tools necessary to support these needs.

Please find a copy of Davis Vision's proposed data sharing agreement appended as Attachment 8.

(4) Confirm the Offeror's ability and willingness to provide Ad Hoc reports and other data analysis. Provide examples of Ad Hoc reporting that the Offeror has performed for other clients.

Davis Vision confirms. Ad-hoc reports are available, both for our standard reporting formats and additional reports. We capture a number of data elements in order to satisfy the reporting requirements of our clients, including:

- Eligibility and History (retained online for up to five years, or longer, depending upon client requirements)
- Authorization Status
- Laboratory Order Placed (examination and/or materials)
- Status of Completion
- Payment Status (out-of-network)
- Other Information Pertinent to the Member

All of these elements can ultimately be reported on in a variety of ways. The industry standard coding used by our proprietary administration system provides for the highest level of specificity in our reporting.

Your dedicated Client Management team will review the results of regularly-produced reports and ad-hoc reports to continually assess the value of the Davis Vision program for both the DCS and enrollees.

In addition to our extensive ad-hoc reporting capabilities based on the variety of data elements we track in our systems, we could also provide access to our e-Bill

utility, which provides self-service capabilities, including the ability to download data into Microsoft Excel for manipulation of that data for required reports.

Please find examples of ad-hoc reports performed for other clients appended as Attachment 9. Please note that any identifiable information has been de-identified.

(5) ***Management Reports and Claims File Performance Guarantee*:** The Plan's Service Level Standard requires that, for the management reports and claim files listed in Section IV.B.6.a.(3) of this RFP, accurate management reports and claims files will be delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Monthly Administrative Fee.

The Standard Credit Amount for each management report or claim file that is not received by its respective due dates is $500 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Management Reports and Claims File Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee for each management report or claim file listed in Section IV.B.6.a.(3) that is not received by its respective due date, is $_____ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt."

[redacted]

[redacted]

7. Consulting

The Department expects the Offeror to be an expert in the vision services industry. Thus, the State may request the advice and recommendations of the selected Offeror to provide the State with up-to-date developments in the vision services field. The State expects the selected Offeror to proactively provide advice and recommendations that are related to the clinical quality and cost management of the Plan. Such recommendations must include preliminary analysis of financial and enrollee impact of proposed and contemplated benefit design changes.

Davis Vision confirms. With nearly 50 years in the vision services industry, we are one of the most experienced partners in business today. Our unique integrated corporate structure within HVHC Inc., our parent company, gives us unparalleled insights into all aspects of the industry. From vision benefits, insurance and managed care; to laboratory operations and frame manufacturing; to vision care delivery through private practices and wholly owned retail locations. Additionally, our parent company's position as a leading health insurer also provides us with added resources and insights into both clinical quality and cost management connections between eye and overall health care.

The hallmark of the Davis Vision model is our consultative approach. We pride ourselves on our partnerships with existing and prospective clients and we work together to determine what their needs are and how we can best meet those needs. We have extensive capabilities to customize plan benefits and services to optimize both the clinical quality and cost management aspects of our vision plans. The best indicator of the success of our programs is our experience with voluntary groups, showing annual increases in participation as a result of better communication of the benefit, and coverage modifications based on plan usage. While the Department's plan is a funded benefit, our annual increases in voluntary plan enrollment demonstrates the extent of our partnership with our clients to deliver the message of the importance of vision care in overall health improvement, as well as its value in terms of benefit/cost savings. We routinely see steady participation increases in voluntary plans each year as a result of these joint efforts with our clients. Additionally, Davis Vision's Diabetic Outreach program has been very successful in yielding increased utilization results when compared to standard plans. Exam utilization through this program is approximately 60% higher than for non-diabetic members.

Our dedicated Client Management Team would partner with the Department to proactively share advice and recommendations and discuss Department requests to ensure optimal plan performance and that the Department's goals are met and exceeded. This dedicated team supports such efforts on a regular basis and also coordinates the involvement of any other Davis Vision internal experts (i.e., clinical, financial, customer service and other operations) as needed to ensure that all stakeholder (client, members, providers, operations, etc.) perspectives are included in the analysis and final recommendations. With many local and national government and labor organizations among our clientele and our own internal management/labor structure (many of our associates are organized through

various unions), we are uniquely positioned and experienced to support the State's consulting needs.

a. Duties and Responsibilities

The selected Offeror will be responsible for providing advice and recommendations regarding the Plan. Such responsibility shall include, but not be limited to:

(1) Informing the State in a timely manner concerning such matters as innovative cost containment strategies, new products, technological improvements, and State/Federal legislation that may affect the Plan. The Offeror must also make available to the State one or more members of the account management team to discuss the implications of these new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

Davis Vision confirms.

(2) Assisting the State with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate Plan modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed Plan modifications and contemplated benefit design changes on Enrollees.

Davis Vision confirms.

(3) If a significant change in benefits occurs during the term of the Agreement which, determined by the Department in its sole discretion, materially impacts the Contractor's Level of effort/cost, the State reserves the right to and at its sole discretion may renegotiate the unit rates contained in the Participating Provider and Laser Vision Surgery Fee Schedules and/or the Monthly Administrative Fees.

Davis Vision confirms.

b. Required Submission

(1) What resources will the Offeror utilize to ensure the Plan is kept abreast of the latest developments in the vision services field? How does the Offeror propose to communicate trends, pending legislation and industry information to the Department?

Davis Vision's approach to ongoing account management entails assigning a dedicated account team who will be in direct ongoing contact with the DCS on a regular basis to discuss the vision care plan performance. This team will be easily accessible to address any questions or concerns and provide consultative advice on plan changes and trends, as needed. Davis Vision has client service guidelines for groups of like size to the DCS that call for quarterly Plan Review meetings and at least monthly calls to key contacts. These service levels can be changed further to meet the Department's own unique needs as well.

Plan Reviews, conducted either on the telephone or in person, generally include a discussion of utilization and claims experience, patient satisfaction results, other group trends, network utilization, administrative and operational results, industry trends and the recommendation of possible plan changes and improvements. In addition to attending regularly scheduled meetings or conference calls with the Department, Davis Vision's client service satisfaction monitoring process includes an ongoing "Care Calling" program by our Client Management Team to proactively reach out to key client contacts to discuss any needs and to ensure open communication and 100% satisfaction. Davis Vision also administers a formal Client Satisfaction Survey tool to solicit regular input from our customers on our account management services and overall Plan satisfaction. These results are shared with senior management to ensure appropriate oversight of our relationship.

Davis Vision also provides our clients with a bi-monthly client e-newsletter (*Sightwire*) that provides updates on Davis Vision news, product and services, industry trends and interesting vision care facts. We also give our clients access to a wealth of vision care and eye health and wellness articles through our on-line Vision & Wellness Library.

To keep abreast of the latest developments in the vision services field, we are active members in both the National Association of Vision Care Plans (NAVCP) and the National Association of Specialty Health Organizations (NASHO). Many associates from Davis Vision's various client and provider support departments also attend Vision Expo East and Vision Expo West, the optical industry's annual trade shows. Our sister company, Viva International Group, is one of the leading frame manufacturers internationally, and our integrated organizational structure allows us to use their knowledge to keep on top of global developments as well. Additionally, we utilize resources within our affiliated companies at HM Insurance Group and Highmark Inc. to supplement our own regulatory and legislative oversight efforts to monitor changes within the State of New York and nationally.

8. Transition and Termination of Contract

The Offeror shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Members with uninterrupted access to their vision benefits and associated customer services through final termination of the Agreement. This includes, but is not limited to: ensuring that Members can continue to receive services from network(s) providers as necessary, processing all network(s) and non-network claims; verification of enrollment; and, providing sufficient staffing to ensure Enrollees continue to receive good customer service even after the termination date of the Agreement. It is also imperative that the Plan continue to have dialogue with key personnel of the Offeror, maintain access to online systems and receive data/reports and other information regarding the Plan after the effective end date of the Agreement. In addition, the Offeror and the selected successor shall fully cooperate with the Department to create and establish a transition plan in a timely manner.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The Offeror must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the Plan.

Davis Vision confirms.

Amended March 29, 2011

(2) The Offeror must, within ninety (90) days of the end of the Agreement resulting from this RFP, or within forty-five (45) Days of notification of termination, if the Agreement resulting from this RFP is terminated prior to the end of its term, provide the Department with a detailed written plan for transition, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

Davis Vision confirms.

(a) Electronic transition of Plan data including, but not limited to, the most recent date of service for Enrollees and Dependents and unique information required for a smooth transition to a successor contractor including providing a test file to the successor contractor in advance of the implementation date; and

Davis Vision confirms.

(b) Completion of all such Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement.
Davis Vision confirms.

(3) Within fifteen (15) business days from receipt of the Transition Plan, the Department shall either approve the Transition Plan or notify the Offeror, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department.
Davis Vision confirms.

(4) Within fifteen (15) business days from the Offeror's receipt of the required changes, the Offeror shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department for approval.
Davis Vision confirms.

(5) The selected Offeror shall be responsible for transitioning the Plan in accordance with the approved Transition Plan.
Davis Vision confirms.

(6) To ensure that the transition to a successor organization provides Enrollees with uninterrupted access to their Vision benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Offeror is required to provide the following Contractor related obligations to the Program through the final financial settlement of the Agreement which includes but is not limited to:
Davis Vision confirms.

(a) Providing an electronic file of the most recent date of service for Enrollees and covered Dependents, including Laser Vision Correction Surgery Services in a format to be specified by the Department, no later than thirty (30) days prior to termination of the Agreement. A lag file must be provided fifteen (15) days after termination and monthly thereafter until the 90-day benefit period has elapsed;
Davis Vision confirms.

(b) Providing all Contractor provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not

limited to paying network claims and, manual submit claims, and retaining NYBEAS access.

Davis Vision confirms.

(c) Completing all required reports in the reporting section of this RFP;

Davis Vision confirms.

(d) Providing the Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

Davis Vision confirms.

(e) Agreeing to fully cooperate with all the Department or Office of the NYS Comptroller (OSC) audits consistent with the requirements of Appendices A and B;

Davis Vision confirms.

(f) Performing timely reviews and responses to audit findings submitted by the Department and the OSC's audit unit in accordance with the requirements set forth in Article XV "Audit Authority," Section VII, Contract Provisions; and

Davis Vision confirms.

(g) Remitting reimbursement due the Program in a timely manner upon final audit determination consistent with the process specified in Article XV "Audit Authority" of Section VII, Contract Provisions and Appendix B.

Davis Vision confirms.

(7) The selected Offeror is required to reach agreement with the Department on receiving and applying enrollment updates, keeping phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjusting phone scripts, and transferring calls to a successor contractor's lines.

Davis Vision confirms.

(8) If the selected Offeror does not meet all of the Transition Plan requirements, the selected Offeror **will permanently forfeit 100%** of all Monthly Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

Davis Vision confirms.

b. Required Submission

(1) Provide an outline of the key elements and tasks that the Offeror proposed would be included in its Transition Plan to ensure that all the required duties and responsibilities are completed if the Offeror were to be the incumbent contractor. Include a brief explanation on how the Offeror would accomplish this with the successor contractor.

If the contract is terminated, Davis Vision would be fully committed to ensuring a timely, smooth transfer of information necessary to administer the plan. The key elements and tasks included in the detailed transition plan (which would be provided to the DCS at least 45 days prior to the termination date) would include:

- Processing all claims incurred during the term of contract and administer run-out claims at no additional charge through a mutually agreed upon time period.
- Transitioning Plan data, history, report formats and unique information if required by the DCS.
- Completing all such Offeror-provided services associated with claims incurred on or before the scheduled termination date of the agreement.
- Providing the necessary support in order to ensure a smooth transition process.

Please find a sample transition plan appended as Attachment 10.

(2) Detail the level of customer service that the Offeror would provide after the termination date of the Agreement.

After the termination date of the agreement, Davis Vision would maintain the availability of a dedicated toll-free number into its Contact Center to support membership inquiries related to claim statuses, previous usage inquiries, etc. for a minimum of six months. This period could be extended at your request.

We would support inquiries related to prior usage, from both designated employees of the DCS and/or designated employees of the Administrative Successor, until such time that the DCS feels such services are no longer required, or the volume of such inquiries is reduced to the point that the DCS determines that level of support to no longer be necessary.

(3) Confirm the Offeror's agreement to ***permanently*** **forfeit 100%** of all Monthly Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

Davis Vision confirms.

9. Network Management

Vision Plan Enrollees and Dependents reside primarily in New York State and contiguous states. For this reason, the selected Offeror must have a comprehensive Participating Provider Network in place to allow adequate access for Plan Members. The Plan establishes minimum standards for Participating Provider Network access. Although the access standards only apply to New York State, Offerors are encouraged to propose a nationwide network that would provide access to Members residing or traveling in areas outside of New York.

[redacted]

Participating Provider Network

The current Plan includes a regional Participating Provider Network. The selected Offeror must have a credentialed Participating Provider Network in place January 1, 2012, that meets the Plan's minimum access standards. The selected Offeror must also illustrate and attest that it has the capability and contractual right to effectively audit its Participating Provider Network.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The Offeror must maintain a credentialed and contracted Participating Provider Network that meets or exceeds the Program's minimum access standards throughout the term of the Agreement.

Davis Vision confirms.

(2) ***Participating Provider Network Service Level Standard***: The selected Offeror must have a Participating Provider Network that throughout the term of the Agreement, meets or exceeds the Department's minimum access standards within New York State as follows:

(a) Ninety-five (95%) of Enrollees in urban areas of New York State will have access to at least one (1) Participating Provider within five (5) miles;

Davis Vision confirms.

(b) Ninety-five (95%) of Enrollees in suburban areas of New York State will have access to at least one (1) Participating Provider within fifteen (15) miles, and

Davis Vision confirms.

(c) Ninety-five (95%) of Enrollees in rural areas of New York State will have access to at least one (1) Participating Provider within thirty (30) miles;

Davis Vision confirms.

Note: In calculating whether the Offeror meets the minimum access standards, all Enrollees residing in New York State must be counted; no Enrollee may be excluded even if a provider is not located within the minimum access area. Offerors should propose a Performance Guarantee for each of the three (3) measurements and areas (urban, suburban and rural).

These standards are based on the distance, in miles, from an Enrollee's home zip code to the nearest Participating Provider location.

Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may propose Performance Guarantees with better

access than the minimums, but the access proposed must follow the same structure as the above minimum (i.e., access for each of the three (3) areas based on the NYS Vision Plan population in New York State).

Davis Vision confirms.

b. Required Submission

(1) Propose access standards for the Plan's Participating Provider Network that meet or exceed the minimum access standard set forth below. The access standard must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access standards stipulated below.

NYS Enrollee Location	Access Standard – At least 1 Provider within
Urban	5 miles
Suburban	15 miles
Rural	30 miles

Davis Vision proposes the following access standards:

NYS Enrollee Location	Access Standard - At least 1 Provider within	Percentage with Access
Urban	**5 miles**	[redacted]
Suburban	**15 miles**	
Rural	**30 miles**	

Please find appended as Attachment 11 a sample network provider directory for the State of New York.

(2) Confirm that if selected, the Offeror shall provide an updated Exhibit I.Y on December 1, 2011 confirming that the proposed Participating Provider Network will be implemented as required on January 1, 2012.

Davis Vision confirms.

(3) Describe the approach(es) the Offeror would use to solicit additional providers to enhance its proposed Participating Provider Network or to fulfill a request to add a Participating Provider.

Davis Vision's provider network is extensive and mature and has the depth and breadth currently to provide the access and services described herein. However, it is also dynamic and historically, capacity has grown in conjunction with client group needs and will be expanded and customized as necessary to meet the DCS's accessibility requirements. Davis Vision's provider network offers the DCS exceptional access to a highly qualified, credentialed participating provider panel.

Davis Vision recruits doctors on an ongoing basis to serve our ever-expanding client needs, and will make every effort to expand the network as necessary in any areas where members do not have adequate access. Through a proactive screening process, we carefully review potential network doctors to target only the most qualified providers in a given area. Furthermore, in order to serve our continuously growing national membership, network expansion is ongoing nationwide.

Part of the network expansion strategy would entail Davis Vision partnering with the DCS to assess the feasibility of integrating many of the most active eye care providers who are currently serving your membership. Another mechanism to ensure continuity of care would be to invite those members previously using non-Davis Vision providers to submit a Provider Nomination Form, to recommend their current doctors for possible inclusion in our network. These identified providers would then be reviewed for inclusion subject to credentialing review and geographic need. This close cooperation will help ensure members' satisfaction and seamless plan activation.

Prior to the effective date, Davis Vision's implementation team would meet with DCS's representatives to assess any perceived network gaps and jointly develop a plan to address those areas.

(4) If a national network of Participating Providers is proposed, explain whether Members traveling or residing outside of New York State will have access to the same level of benefits as those offered by Participating Providers located in New York State.

Davis Vision's provider network is comprised of over 32,000 providers geographically distributed in all 50 states, Washington, D.C., Puerto Rico, Guam and Saipan. Our national network will provide members traveling or residing outside of New York State with access to the same level of benefits offered by participating providers located in New York State.

(5) ***Participating Provider Access Performance Guarantees*:** The Offeror must guarantee that throughout the term of the Agreement, Enrollees living in urban, suburban and rural areas of New York State will have access to a Participating Provider. The Offeror must propose an access standard that meets or exceeds the minimum access standards set forth in the "Participating Provider Network" Section of this RFP. The Offeror shall propose the forfeiture of a specific dollar amount of the Monthly Administrative Fee for failure to meet these guarantees.

(a) *The Standard Credit Amount for each .01% to 1.0% below the ninety-five percent (95%) minimum access standard in which the Participating Provider Access for Urban Areas of New York State is not met by the Offeror, as calculated on a Calendar Year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Participating Provider Access for Urban Areas of New York State Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee is $_____ for each .01 to 1.0% below the ninety-five percent (95%) minimum access standard (or the Offeror's standard of __%) for any Calendar Year in which the Participating Provider Access for Urban Areas of New York State Performance Guarantee, as calculated on a Calendar Year basis, is not met by the Offeror."

(b) *The Standard Credit Amount for each .01% to 10% below the ninety-five percent (95%) minimum access standard in which the Participating Provider Access for Suburban Areas of New York State is not met by the Offeror, as calculated on a Calendar Year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Participating Provider Access for Suburban Areas of New York State Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee is $_____ for each .01 to 1.0% below the ninety-five percent (95%) minimum access standard (or the Offeror's proposed standard of __%) for any Calendar Year in which the Participating Provider Access for Suburban Areas of New York State Performance Guarantee, as calculated on a Calendar Year basis, is not met by the Offeror.

(c) *The Standard Credit Amount for each .01% to 1.0% below the ninety-five percent (95%) minimum access standard in which the Participating Provider Access for Rural Areas of New York State is not met by the Offeror, as calculated on a Calendar Year basis, is $5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror must propose its Participating Provider Access for Rural Areas of New York State Performance Guarantee in the format set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee is $_____ for each .01 to 1.0% below the ninety-five percent (95%) minimum access standard (or the Offeror's proposed standard of __%) for any Calendar Year in which the Participating Provider Access for Rural Areas of New York State Performance Guarantee, as calculated on a Calendar Year basis, is not met by the Offeror."

[redacted]

Laser Vision Correction Participating Provider Network

The Offeror must develop and contract a network of Laser Vision Correction Participating Providers to provide eligible Enrollees with a covered laser vision correction benefit. The

covered benefit includes a pre-operative evaluation, laser vision correction surgery, and necessary follow-up visits once every five (5) years. Prior utilization data for the covered benefit is set forth in Exhibit III.H. of this RFP.

Ineligible Enrollees and Dependents are, however, provided with an Enrollee-pay-all discounted Laser Vision Correction program through the Offeror's contracted Laser Vision Correction Network. The incumbent contractor currently offers a minimum fifteen percent (15%) discount off usual and customary fees. Utilization data for the discount program is not available.

Laser Vision Correction benefits are available to Enrollees and Dependents as set forth in the Summary of Covered Benefits, by Group in Exhibit II.D of this RFP.
Davis Vision confirms.

a. <u>Duties and Responsibilities</u>

(1) The Offeror must develop and maintain a regional network of qualified, credentialed ophthalmologists that provides reasonable access to Enrollees and Dependents to provide laser vision correction services through both a covered benefit and discount program.
Davis Vision confirms.

(2) The Offeror must effectively communicate the availability of the Laser Vision Correction Network to eligible Members, in addition to notifying them of their benefit and how to access their benefit. Eligible Members are eligible to use their laser vision correction benefit once every five years.
Davis Vision confirms.

(3) At the request of the Department, the Offeror must solicit additional Laser Vision Correction Participating Providers to participate in the Laser Vision Correction Network.
Davis Vision confirms.

b. Required Submission

(1) Indicate whether or not the Offeror currently has, and is proposing, a contracted Laser Vision Correction Network that provides both a covered benefit and a discount program. If so, please provide a listing of the proposed Laser Vision Correction Participating Providers located in New York State.

Davis Vision currently has a national network of credentialed laser vision correction providers that provide covered benefits for a few clients, as well as discounts to nearly all of our current clients.

Please find a sample laser vision correction provider directory appended as Attachment 12.

(2) Propose the Offeror's definition of "reasonable access" as regards the Laser Vision Correction Network.

Reasonable access as regards the Laser Vision Correction Network is defined as follows:

NYS Enrollee Location	Access Standard - At least 1 Provider within	Percentage with Access
Urban	10 miles	90%
Suburban	25 miles	90%
Rural	50 miles	80%

(3) What is the minimum, maximum and average discount offered by Laser Vision Correction Participating Providers, expressed as a percentage? **Do not include any cost information in the Technical Proposal**.

Our proposed funded benefit will result in average savings to the DCS of approximately 25% off typical retail charges for each procedure.

For those employees and family members who do not have a funded laser benefit, our Laser Vision Correction Discount program is included in the proposed plan at no additional cost. Each enrollee will receive the same discounted pricing as the DCS, resulting in a discount of up to 25% off the providers' usual and customary fees, or a 5% discount from the laser center's advertised specials, whichever is lower. Some participating laser centers provide a fixed fee schedule equating to these discount levels. Davis Vision is pleased to extend this benefit to the SEHP (GSEU and CUNY) and M/C retirees, PEs & other unrepresented enrollees that do not currently have this benefit.

Our laser providers are credentialed according to NCQA standards and represent ophthalmologists and surgeons who use the latest, most advanced instrumentation.

Both the funded and discount programs are applicable to LASIK (including custom intralase, custom wavefront LASIK, and traditional intralase) and PRK.

(4) Confirm that the Offeror will solicit additional Laser Vision Correction Participating Providers at the Department's request.

Davis Vision confirms.

Participating Provider and Laser Vision Correction Provider Credentialing

Offerors must ensure that their Participating Providers and Laser Vision Correction Participating Providers meet the licensing standards required by the State in which they operate. Participating Providers and Laser Vision Correction Participating Providers are also required to meet the credentialing criteria established by the Offeror. This additional criteria should be designed by the Offeror to ensure quality vision services.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The selected Offeror must assure its network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

Davis Vision confirms.

(2) The Offeror must credential Participating Providers and Laser Vision Correction Participating Providers to ensure the quality of the network. The Offeror must also credential Participating Providers and Laser Vision Correction Participating Providers in a timely manner and shall have an effective process by which to confirm Participating Provider's and Laser Vision Correction Participating Provider's continuing compliance with credentialing standards.

Davis Vision confirms.

b. Required Submission

(1) Describe the Offeror's proposed process to ensure that the Participating Providers and Laser Vision Correction Participating Providers meet the applicable state

licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information that will be used by the Offeror to verify this information?

Our NCQA-certified credentialing process is overseen by our Director of Credentialing to ensure all aspects of the program are compliant with our established procedures as well as state requirements, federal and state laws, rules and regulations.

All prospective optometrists, ophthalmologists and laser vision care providers must submit an application in order to be credentialed. We use the Council for Affordable Quality Healthcare (CAQH)'s credentialing repository of provider data, currently used by nearly 90% of providers. Providers complete a single CAQH or state-mandated application on the website and submit all of their current documentation as appropriate, including licenses, malpractice information, board certification, etc. directly to CAQH. Our Credentialing staff members partner with the doctor or their representative to ensure that all necessary documentation is available in the CAQH system.

Credentialing staff members conduct primary source verification of education, licensure and board certification, and DEA registration (where applicable) is obtained and the National Practitioner Data Bank is queried for all applicants.

Once a Credentialing associate obtains and verifies all of the required information, the provider's file is submitted to the Credentialing Committee, which is chaired by Davis Vision's Assistant Vice President, Professional Affairs. The Committee conducts an assessment of each provider's credentials based upon our organization's guidelines for professional and office qualifications, outlined below.

Specific items reviewed by the Credentialing Committee include submission of the following information and related documents (exact documentation varies by state):

- **Licenses/Certifications:**
  - State licensure (must be active and in good standing in state of licensure)
  - Board certification/eligibility (ophthalmology only)
  - DEA (if applicable)
  - Certification to use diagnostic pharmaceutical agents (optometry only)
  - Certification to use therapeutic pharmaceutical agents (optometry only)
- **Office Information:**
  - Office location
  - Handicapped accessibility
  - Range of services available, including dispensing of eyewear and fitting of contact lenses
  - Availability of adequate hours of operation for both examination and dispensing of eyewear. It is expected that a comprehensive eye

examination will require 30 minutes. Providers must agree to examine all Davis Vision patients without discrimination and provide them with the same level of courtesy and services provided to any private patient.

- Acceptable credentials of technical and support staff

- **Insurance Requirements/Credentialing Procedures:**
  - Each doctor must provide evidence of coverage indicating professional liability insurance in the minimum amount of $1 million per occurrence and $3 million aggregate or as their applicable state mandates.
  - Each provider's application is subject to Committee review of any malpractice or professional discipline history and/or felony convictions.
  - Each provider must complete an application, which demonstrates appropriate pre- and post-professional education obtained at an accredited medical school or college of optometry, and provide professional memberships and professional employment history for the past 5 years (up to the "present") including beginning and ending months and years as well as documentation of work history gaps of 30 days or more.
  - Statement by the provider attesting to the lack of impairment due to chemical or substance abuse.

The credentialing and recredentialing of providers is ongoing. Recredentialing is conducted at least once every three years and is based on a review of updated documentation (licensure, National Practitioner Data Bank inquiry, malpractice history, etc.), as well as reports generated through the patient satisfaction feedback mechanism, complaint logs and the Quality Assurance Program, including site visits.

(2) Describe the Offeror's proposed approach for credentialing Participating Providers and Laser Vision Correction Participating Providers. Specify if the Offeror is proposing to utilize an external credentialing verification organization. When was the credentialing verification process last completed? What is the Offeror's process for confirming continued compliance with credentialing standards? How often does/will the Offeror conduct a complete review?

We have used an internal credentialing process certified by the National Committee for Quality Assurance (NCQA) since 2004. Our most recent recertification occurred in May 2010, where we received an overall score of 100%. Davis Vision is one of a select few vision care programs in the entire country to have earned this certification, and we maintain it as a testament to our commitment to quality in all aspects of our program.

The credentialing and recredentialing of providers is ongoing. Recredentialing is conducted at least once every three years and is based on a review of updated documentation (licensure, National Practitioner Data Bank inquiry, malpractice history, etc.), as well as reports generated through the patient satisfaction feedback

mechanism, complaint logs and the Quality Assurance Program, including site visits.

(3) What steps will the Offeror take between credentialing periods to ensure that Participating Providers and Laser Vision Correction Participating Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Participating Provider Network and/or Laser Vision Correction Network as soon as possible? What steps will the Offeror take, if any, to advise members when a Participating Provider/Laser Vision Correction Participating Provider has been removed from the associated network(s)?

Davis Vision is registered with the Council for Affordable Quality Healthcare (CAQH) for monthly monitoring of providers between credentialing periods.

CAQH monthly review includes direct verification with optometrist, ophthalmologist and Doctor of Osteopathy state boards in New York. In addition, Davis Vision conducts monthly monitoring directly with the Office of the Inspector General, Office of Personnel Management and New York Medicare Opt-Out to ensure all sanctioned/disciplined providers in New York State are reviewed by the Credentialing Committee to determine future participation. If a provider is terminated from the network due to adverse findings within credentialing cycles, the Credentialing Department notifies the Client Management team so they can reach out directly to the client.

For routine, ongoing changes in the vision care provider network Davis Vision does not directly notify employers or plan participants. In order to provide the most up-to-the-minute information, the Davis Vision website and Interactive Voice Response (IVR) system are updated real-time. Davis Vision's website, davisvision.com, and IVR system are available to members 24 hours a day, seven days a week for benefit, eligibility and participating provider information.

In the event of termination, a provider is contractually obligated to continue to render services to any Davis Vision member who is receiving care until treatment is completed. This provision is consistent with existing medical, ethical and/or legal requirements for providing continuity of care for patients. Davis Vision may alternately make reasonable and medically appropriate provisions for coordinating the continuation of care by another participating provider.

Participating Provider and Laser Vision Correction Provider Contracting

Contracts with Participating Providers and Laser Vision Correction Providers should be written to utilize the Plan's market strength to obtain cost-effective pricing while ensuring Plan access standards are met, where applicable. Contracting staff should keep abreast of

current market conditions and have the wherewithal to adjust contracts that reflect the best interests of the Plan. The Offeror must ensure that all Participating Providers and Laser Vision Correction Participating Providers contractually agree and comply with the Plan's requirements and benefit design.

Davis Vision confirms.

a. Duties and Responsibilities

The Offeror will be responsible for providing Participating Provider and Laser Vision Correction Participating Provider contracting services including but not limited to:

(1) Ensuring that all Participating Providers and Laser Vision Correction Participating Providers contractually agree to and comply with all of the Plan's requirements and benefit design specifications.

Davis Vision confirms.

(2) Ensuring that Participating Providers and Laser Vision Correction Participating Providers accept as payment-in-full the Offeror's reimbursement, plus copayments and upgrade fees, as applicable, for covered services.

Davis Vision confirms.

b. Required Submission

(1) Explain the Offeror's proposed contracting process. Describe the type of data analysis or access analysis that is/will be performed before extending participation into your network(s) to a new Provider. Provide a copy of the Offeror's proposed Participating Provider and Laser Vision Correction Participating Provider contracts, rate sheets (if applicable), and provider manual.

New providers are recruited based on quality and geographic need. Our Professional Affairs Department identifies potential providers through a variety of sources, including recommendations from existing providers, organizational directories, network contacts, suggestions from clients and member nominations. Accessibility analyses would be performed to ensure that we exceed the access

standards proposed in Question 1, Segment 9, Network Management, for all enrollees.

Please find sample copies of our participating provider contracts for the state of New York appended as Attachment 13 and our current provider manual appended as Attachment 14.

(2) Explain the legal and operational relationship between the Offeror and any optical labs that are used to supply materials provided by Participating Providers.

Davis Vision owns and directly operates the union-staffed optical laboratory facilities that produce the eyewear provided by participating private providers in our program.

Independent providers who participate in the Davis Vision program are required to use our laboratories. This centralized approach allows us to maintain overall quality and take advantage of the purchasing power associated with large-volume purchases, ultimately providing our clients with competitive rates and quality products. Retail providers who participate in our program use their own materials and laboratories.

Our three state-of-the-art, quality-focused laboratories, with a combined total of 75,500 square feet, are regionally located to provide the fastest service to our national membership.

East Coast Regional Laboratory
170 Express Street
Plainview, NY 11803

Mid-Atlantic Regional Laboratory
3805 West Chester Pike, Building D
Newtown Square, PA 19073

West Coast Regional Laboratory
5555 W. Badura Avenue, Suite 160
Las Vegas, NV 89118

The production of quality eyewear requires a dual investment in technology and an experienced workforce.

Each of our laboratory locations has been updated in the last five years, ensuring that we continue to keep fabrication costs down, providing increased value for our clients. We are constantly evaluating new production technologies, ophthalmic trends and products, and recently upgraded our surfacing laboratory systems to produce digital, free-form progressive lenses. Digital, free-form progressives are the newest technology that further enhances a patient's vision by moving the progressive design to the back of the lens, closer to the eye, reducing distortion.

Our automated, Internet-based order tracking and delivery confirmation system allows our Customer Service Representatives and providers to track each order from the moment it is placed until it is delivered to the provider's office, allowing for real-time updates when a patient inquires about the status of their order.

Davis Vision's laboratories, staffed with nearly 300 highly trained craftsmen and women, are led by a team of managers with approximately 175 years' combined experience in the optical industry. One hundred percent of all operatives, laborers and helpers in Davis Vision's union laboratories, Customer Relationship Center and

shipping departments are organized and represented by either Local 408, IUE/CWA AFC-CIO Optical Workers Union or Local 947 of the United Service Workers Union, which is affiliated with the International Union of Journeymen and Allied Trades.

Quality Focus

The operation of our proprietary laboratory system is governed by a Quality Management System (QMS), consisting of the following elements: quality manual; quality policy and objectives; standard operating procedures; work instructions; flowcharts and forms.

These elements come together to outline the quality standards for all aspects of the manufacturing process so our members receive quality eyewear.

Operations, information technology, retail, finance and administrative systems are all coordinated to ensure compliance with federal and other governing regulations, such as HIPAA, ANSI standards, NCQA and our externally-validated COLTS and ISO certifications.

External Validation

To ensure ongoing quality in our laboratories, our Senior Vice President of Manufacturing sought out external validation of our processes and standards. Our laboratories have both COLTS and ISO certification, and we are the only managed vision care laboratory network certified by both ISO 9001:2008 and COLTS for Prescription Accuracy and FDA conformance.

Our entire laboratory system has been certified to ISO 9001:2008 standards, which ensures processes result in consistent, high quality products. The International Organization for Standardization with ISO 9001 is the international reference for quality management requirements and is effective for three years, with audits for continued compliance every six months.

In addition to COLTS Certification for Prescription Accuracy and FDA Conformance for impact resistance, our products are also validated by COLTS through their “Prescription Quality Program,” a semi-annual mystery shopping of the products we manufacture. COLTS Laboratories periodically orders a pair of eyeglasses through one of our laboratories and then examines the eyeglasses to review the general quality of the job and ensure they meet all applicable ANSI standards. Our laboratory consistently receives high marks for these reviews, resulting in an overall Gold award, representing quality in 90% to 100% of orders.

Network Administration and Quality Assurance

The successful Offeror should have a good working relationship with Participating Providers and Laser Vision Correction Participating Providers to ensure that NYS Vision Plan initiatives are accurately communicated and implemented, Enrollee questions or complaints

are resolved timely, and that quality eyewear products are dispensed on a timely basis by Participating Providers. Network administration duties shall include, but not be limited to:

a. Duties and Responsibilities

The Offeror shall be responsible for:

(1) Developing and distributing communication materials to Participating Providers and Laser Vision Correction Participating Providers introducing the Plan and describing changes, when necessary;
Davis Vision confirms.

(2) Working with Participating Providers and Laser Vision Correction Participating Providers to resolve Enrollee billing disputes and complaints about the quality of services or eyewear received , including on-site audits of facilities, as needed; and
Davis Vision confirms.

(3) Notifying the Department in writing of any decision where a Participating Provider or Laser Vision Correction Participating Provider is suspended or terminated from participation as a result of serious quality deficiencies.
Davis Vision confirms.

(4) ***Turnaround Time for Receiving Eyewear Service Level Standard***:
The Plan's Service Level Standard requires that ninety-five percent (95%) of all orders placed with a Participating Provider for covered eyewear will be available to the Member within seven (7) Calendar Days after placing the order.
Davis Vision confirms.

b. Required Submission

(1) Describe the Offeror's proposed method(s) for communicating with Participating Providers and Laser Vision Correction Participating Providers to advise them of Plan benefits and modifications. Include copies of newsletters or other correspondence, as applicable.

A critical component in providing efficient service to members is an informed, up-to-date participating provider network. We communicate with providers through our Customer Service Representatives, with a quarterly newsletter and via a dedicated, state-of-the-art provider website.

Telephonic Communications

Davis Vision's Customer Relationship Center is located in Latham, New York and accepts provider calls between 8:00 a.m. and 8:00 p.m. Eastern Time, Monday through Friday, and from 9:00 a.m. to 4:00 p.m. on Saturday. An extensive staff of dedicated Customer Service Representatives (CSRs), who are continuously in touch with our network doctors providing benefit, eligibility and authorization information. Provider Service Representatives (PSRs) also speak with network doctors on a daily basis, providing technical, benefit, billing and payment information and accepting orders. This continuous communication with our doctors provides the platform for constant and positive bi-directional feedback, and allows the plan to operate at benchmark levels of efficiency and satisfaction.

Our Interactive Voice Response (IVR) system augments our CSR/PSR staff by providing toll-free access to needed information and services 24 hours a day, seven days a week. Through the Voice Response System, providers have the ability to verify/obtain eligibility information, obtain authorization for services, submit "examination only" claims and order service record forms.

Regional Quality Assurance Representatives and Professional Field Consultants

These professionals serve as local liaisons to the provider network, ensuring that participating doctors are informed of all aspects of the program through in-person training and telephonic support.

Provider Network Newsletter

The *Provider Network Newsletter* is a quarterly publication that goes out electronically to all providers in the Davis Vision network. It supplies news and features that are both relevant and helpful to our providers. The newsletter typically features approximately 10 articles, from several different internal departments, that are of interest to providers. Included are articles about our products and programs, health information privacy information, Professional Affairs features, laboratory news, credentialing bulletins and updates on Davis Vision's community outreach initiatives and new technologies.

Provider Website

Davis Vision supports a provider website widely recognized throughout the provider community as one of the most user-friendly websites available. Each provider can customize their view according to the needs of the practice. Over 60% of all material orders are received through this website.

Once a provider logs into the secure provider website, they can:

- Review the Davis Vision provider manual
- Verify eligibility of members for services
- Report claims
- Generate authorizations for member services (exams and/or materials)
- Place orders for services or materials
- Track the status of orders placed

Providers can also access the quarterly provider newsletter, view the frame Collection, send an e-mail for support and view frequently asked questions.

Please find sample provider newsletters appended as Attachment 15.

(2) How does/will the Offeror monitor Participating Provider and Laser Vision Correction Participating Providers compliance with Plan benefits? What steps will the Offeror take when notified by an enrollee of a billing dispute with a Participating Provider/ Laser Vision Correction Participating Provider or dissatisfaction with services received?

Member complaints are shared with the specific provider or office in question. Davis Vision's Quality Assurance department will reach out to the specific provider while gathering information pertaining to a complaint in order to obtain a full understanding of the situation.

Patient satisfaction survey results are shared with participating providers in the form of a Provider Report Card for members who visited his/her office and completed a Patient Satisfaction Survey. Provider Report Cards are distributed to providers twice a year.

All customer complaints, including those related to a network provider and/or quality of delivered goods, are acknowledged in writing and fully investigated by one of Davis Vision's Quality Assurance associates. Davis Vision documents all member complaints, identifies trends, and reports complaint statistics to the Quality Management Committee quarterly. Providers and/or Davis Vision associates are re-educated as appropriate. Complaint resolution is communicated either directly to the complainant or to the group intermediary.

When appropriate to the investigation, the associate obtains copies of the patient's medical records from the provider. If the complaint involves a clinical issue, all supporting documentation is reviewed by a clinical peer reviewer. At the conclusion of the investigation, a determination is made and a complaint resolution letter is sent to the member. All complaints related to network providers are tracked and trended and considered during recredentialing.

Complaint Workflow:

1) Complaint received
2) Complaint triaged by Senior Quality Assurance associate, logged and assigned for investigation

3) Written acknowledgment sent to member
4) Complaint investigated and medical records requested as appropriate
5) Clinical issues are reviewed by clinician
6) Administrative issues are reviewed by QA associate
7) Complaint resolution letter is sent to member via e-mail
8) Acknowledgment and complaint resolution letters are scanned into electronic record.

(3) ***Turnaround Time for Receiving Eyewear Performance Guarantee:*** The Plan's Service Level Standard requires that ninety-five percent (95%) of all orders placed with a Participating Provider for covered eyewear will be available to the Member within seven (7) Calendar Days after placing the order. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Monthly Administrative Fee for failure to meet this standard.

The Standard Credit Amount for each .01 to 1.0% below the standard of ninety-fine percent (95%) of all orders from a Participating Provider for covered eyewear that are not available to the Member within seven (7) Calendar Days after placing the order, is as calculated on a Calendar Year basis, $500. However, Offerors may propose higher or lesser amounts.

The Offeror must propose its Turnaround Time for Receiving Eyewear Performance Guarantee in the format as set forth below:

"The Offeror's quoted amount to be credited against the Offeror's Monthly Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed standard of __%) of all orders from a Participating Provider for covered eyewear that are not available to the Member within seven (7) Calendar Days of placing the order, as calculated on an annual calendar year basis, is $_____.

[redacted]

[redacted]

10. Claims Processing

The Offeror is required to process all claims submitted under the Plan. The selected Offeror must be capable of processing Participating Providers and Laser Vision Correction Participating Provider claims as well as Enrollee submitted claims for non-network benefits. Enrollees are required to submit claim forms to the Offeror for non-network services no later than ninety (90) days after the end of the calendar year in which the vision services were rendered, unless it was not reasonably possible for the Enrollee to meet this deadline. The Plan's claim utilization data for Participating Providers, non-network services and Laser Vision Correction Participating Providers and can be found in Exhibits III.A, III.A.1, III.B and III.H, respectively.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The Offeror must provide all aspects of claims processing. Such responsibility shall include, but not be limited to:

(a) Verifying that the Plan's benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;
Davis Vision confirms.

(b) Accurate and timely processing of all claims submitted under the Plan in accordance with the benefit design(s) applicable to the Enrollee at the time the claim was incurred as specified to the Offeror by the Department.
Davis Vision confirms.

(c) Charging the Plan consistent with the Offeror's proposed pricing quotes.
Davis Vision confirms.

(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered services only.
Davis Vision confirms.

(e) Maintaining records necessary to support claim payments, legal responsibilities, and reporting, and providing direct access to all NYS Vision Plan records for State audit requests;
Davis Vision confirms.

(f) Utilizing the auditing tools and performance measures proposed by the Contractor to identify potential fraud and abuse by Participating and Laser Vision Correction Participating Providers;
Davis Vision confirms.

(g) Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for up to six (6) years with procedures to easily retrieve and load claim records;
Davis Vision confirms.

(h) Reversing all attributes of claim records processed in error or due to fraud or abuse and crediting the Plan for all costs associated such claim:
Davis Vision confirms.

(i) Maintaining the security of the claim files and ensuring HIPAA compliance;
Davis Vision confirms.

(j) Agreeing that all claim data is the property of the State. Upon request of the Plan, the Offeror shall share appropriate claims data with other Department consultants and contractors for various program analysis. The Offeror cannot sell, release, or make the data available to third parties in any manner without the prior consent of the Department.
Davis Vision confirms.

(2) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

Davis Vision confirms.

(3) Analyzing and monitoring claim submission to identify errors, fraud or abuse and reporting to the Department in a timely fashion in accordance with a Department approved process. The Plan will be charged for only accurate (i.e., the correct dollar amount) claims payments of covered expenses. The Offeror shall credit the Plan the amount of any overpayment regardless of whether any overpayments are recovered from Provider and/or Enrollees in instances where a claim is paid in error due to Offeror error or due to fraud or abuse. In cases of overpayments resulting from errors found to be the responsibility of the Department, the Offeror shall use reasonable efforts to recover any overpayment and credit them to the Plan upon receipt; however, the Offeror is not responsible to credit amounts that are not recovered. The Offeror shall report fraud and abuse to the appropriate authorities.

Davis Vision confirms.

(4) Processing Enrollee submitted claims using the non-network fee schedule set forth in Exhibit III.E.

Davis Vision confirms.

b. <u>Required Submission</u>

(1) Provide a flow chart and step-by-step description of the Offeror's proposed methodology for processing Participating Provider, Laser Vision Correction Participating Provider and Enrollee-submitted claims for the Plan. Provide a description of the edits implemented to ensure proper claim adjudication.

100% of in-network claims are submitted by the participating provider or laser vision correction participating provider. Members are only responsible for submitting out-of-network claims, trending at just 5% of overall claims.

The in-network benefit is simple – the member calls to schedule an appointment with a participating provider, and the provider does the rest. The member does not have to fill out any paperwork for Davis Vision. If the DCS desires the inclusion of ID cards, two identification cards are provided in each Member Welcome Kit per family; however, they are not required when a member uses their benefit.

For any spectacle lens options prescribed and selected, such as progressive addition lenses or anti-reflective coatings, members pay the doctor directly according to the fixed, discounted price schedule of the Davis Vision plan.

Upon request, Davis Vision can produce an Explanation of Benefits form for in-network claims that can be sent to the member for use with an FSA program.

When an out-of-network provider is selected, the member is responsible for full payment to the provider. Out-of-network claim forms are available on the member website, by calling a Customer Service Representative or using the Interactive Voice Response System. The member must complete the form and submit it to the address provided. The member will receive payment up to the plan-specified out-of-network schedule, along with an Explanation of Benefits.

Please find the in-network member benefit process and out-of-network claim process flow charts appended as Attachment 16.

Davis Vision's proprietary claims processing system is an integrated claim processing and payment system that electronically adjudicates claims. The in-network claim payment process is fully automated and requires very little manual intervention, since eligibility is pre-certified and claims are paid based on eyewear ordered. Our proprietary administrative system exclusively provides the internal audit platform to ensure the accuracy of claims processing input and payment outputs. Claims are entered at the time of material order entry, uniquely integrating the two functions and guaranteeing that professional services and materials match.

Our proprietary claims administrative system allows for the preauthorization of in-network services, currently trending at 95% of all claims by providers, by linking the member enrollment, eligibility, benefit design and provider information prior to services being submitted for payment. When the services are delivered to the patient, the provider submits the claim and the eyewear order using the authorization previously obtained. The details for fabricating the eyewear are submitted by the provider via Web, IVR, fax or phone, and our system automatically adjudicates both the claim payment and the laboratory order. Because the claims are pre-authorized, inappropriate billing and the submission of non-covered materials is essentially eliminated. The provider can only be paid for the actual services provided and only at a predetermined level. This is an extremely significant cost control mechanism. Also the claim payment is tied to the DCS's fee schedule and is date sensitive, ensuring that claim payments are consistent with the in-force contract between the DCS and Davis Vision.

For out-of-network (OON) claims (<5% of all claims), the member submits an OON claim directly to Davis Vision for reimbursement up to the limits of the specified OON schedule. Davis Vision's Claim Processors also utilize our integrated system to process OON claims. A random sampling of 10% to 15% of all manually processed claims is audited each day. This audit occurs on a pre-disbursement basis, so financial and coding errors are caught and corrected prior to the release of payment. If errors are found, feedback is given to the claims examiner and the claim is corrected within one business day.

Davis Vision also utilizes the MACESS application for the imaging of all paper claims received. Once imaged, the claims are "vertexed" (i.e., data entry is done to identify key data elements on the claim for routing and processing purposes), then the claims are processed by Claim Examiners. The use of MACESS allows Davis Vision to better handle paper claims storage, workflow and processing.

The prevention of fraud and abuse is a key concern, and proactive controls have been built in at all levels of Davis Vision's benchmark auto-adjudication claims system. Our administrative system provides multiple computer edit checks to control abuse and ensure efficiency. Built-in safeguards begin with eligibility and continue through the manufacture and delivery of eyewear materials. The in-network claim payment process is fully automated, since eligibility is pre-certified and claims are paid based on eyewear ordered.

Claims are entered at the time of material order entry, uniquely integrating the two functions and guaranteeing that a provider can only be paid for the actual services provided, at a predetermined level. When a member and spouse (or member and a dependent child) are both covered by the DCS for vision, software edit checks prevent duplicate coverage. This serves as a significant cost control factor available to the DCS. The following steps ensure that duplicate claims are not paid and ineligible plan members cannot use the vision benefit:

- Member/dependent must be eligible at the time the authorization is issued.
- At the time authorization is given, the provider is advised of specific benefit eligibility for the member/dependent in question.
- Authorizations expire per system requirements. Re-verification of eligibility occurs again at the time the order is taken (when the claim is processed).

Once the member/dependent has exhausted their benefit that cycle, another authorization cannot be issued, nor can a claim be paid, until they are again eligible.

(2) Describe the Offeror's claims processing system platform including any backup system utilized. Describe the Offeror's disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure. What will be the process for Enrollees trying to receive Vision Plan Services when the claim payment system is down or not available?

Davis Vision provides routine vision and eye care services, including: routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. Davis Vision does not provide or manufacture life-saving equipment nor does Davis Vision authorize or provide medical treatment (emergency or routine).

Davis Vision maintains a Disaster Recovery plan and a Business Continuity Plan. These plans are tested periodically by recovering key technical services to the contracted disaster recovery site hosted by Sungard Availability Services. The current plan deals with two scenarios – the loss of the Davis Vision data center or the loss of access to a key facility. For Davis Vision, the loss of the data center and

the loss of the administrative center are the same since they are co-located. For laboratory and corporate office functions, the loss of the data center and the loss of access to the facility are not connected. That is, one of the labs becoming unavailable is not related to whether the data center is not available. Due to the unique nature of a possible pandemic, different planning assumptions are necessary.

Since Davis Vision provides routine vision care services, the demand for such services is projected to drop during a severe pandemic as individuals postpone routine care to deal with the demands of urgent care both for themselves and for family members. Accordingly, call volumes and demand for services may fall as much as 50%.

Currently, over half of all customer service calls are handled by automated systems, half of all eyewear orders are taken electronically over the Internet and 85% of enrollment confirmations are issued via automation.

Should our claims system go down, we would regain claims processing capabilities within 72 hours of a decision by the business recovery team, which is led by our CIO, to execute the Disaster Recovery Plan. Davis Vision has a comprehensive enterprise-wide Disaster Recovery Plan that has been in place for over ten years. Davis Vision has contracted with Iron Mountain in a partnering arrangement that includes the transportation to an off-site storage of Enterprise System Server and client server system back-up cartridges, on a weekly basis. In the event of a disaster, Iron Mountain is required, under contract, to deliver these tapes to Sungard Availability Services. Additionally, Davis Vision creates daily encrypted system back-up media, which are stored with a local off-site secure vendor and recycled every three weeks.

Sungard Availability Services' network connectivity options support the testing of Davis Vision's Disaster Recovery Plan to ensure recovery from an unplanned outage. Davis Vision tests its Disaster Recovery/Business Continuity plan at least twice annually. The last test was successfully completed in October 2010.

Davis Vision has contracted with Sungard Availability Services to maintain a hot site in its Disaster Recovery facility. Davis Vision's cold sites are located in our Plainview, New York, and Syracuse, New York, administrative offices, which both house back-up hardware and software for full restoration, if necessary. Davis Vision has a comprehensive outage notification tree in the event of a prolonged system/network outage, and arrangements can be made to include the DCS's contacts if requested.

In addition to our enterprise-wide Disaster Recovery Plan, Davis Vision has a comprehensive Business Continuity Plan (BCP) for all departments that covers all critical internal functions to our business, including claims, customer service, provider service, laboratory order processing, business reporting, systems set-up, benefit administration, etc. This BCP includes provisions for initial critical process handling in the event of a declared disaster (days one through five) as well as process handling for days six through 30 in our designated alternate recovery work site. Isolating these critical processes for each BCP allows Davis Vision to continue

to deliver customer service and claims/order processing should an event occur, while making plans for longer term contingencies should they be required.

Davis Vision has a comprehensive maintenance and back-up plan that includes daily incremental back-ups and weekly full back-ups. All daily back-up tapes are stored off-site with a secure (bonded) courier. The weekly backup tapes are stored with our data storage vendor, Iron Mountain.

All back-up tapes are on a three-week re-use cycle, at which point they are re-used and all data is overlaid with a new backup. The back-up tapes are used during our Disaster Recovery/Business Continuity tests twice a year to ensure that all data can be recovered in the event of an actual operational outage. All back-up tapes are encrypted prior to release to our storage vendor.

Davis Vision's processing platform exceeded an availability of 99.75% in 2010. During a system failure, most Customer Service functions are still operational in the rare instance the claims processing platform is down, and during these times our Customer Service Representatives are still able to provide answers to routine questions regarding benefit descriptions and supply provider location information. Additionally, providers are required to attain confirmation of eligibility prior to the services being rendered. In the event of an intermittent outage, enrollees may be asked to call back in an appropriate amount of time accounting for the anticipated duration of the impact. Long-term impacts are covered under the organization's Business Continuity Plan, described above.

(3) Describe the capabilities of the Offeror's claim processing system addressing each of the following Plan components:

(a) Eligibility verification;

Eligibility verification starts with the up-front, pre-enrollment process that ensures the integrity of the enrollment files prior to the eligibility information being loaded into our system. During the implementation process, eligibility transfer protocol would be set up and tested until all files are transferred correctly, ensuring that future files would transfer successfully using the same parameters. Should there ever be a question regarding an enrollee not on file, our Customer Service Representative would utilize the NYBEAS system, and/or contact the designated DCS contact person to determine eligibility.

Our unique, proprietary administrative system, CVX, integrates enrollment, eligibility and claims data. Participating providers receive a service authorization prior to administering in-network services, ensuring that only eligible services are provided to a member.

Davis Vision's electronic enrollment process has a number of quality assurance mechanisms in place to ensure that the loading of data is complete and accurate. The Production Control department has a schedule of expected files they use to make sure that all necessary files are received on a daily basis. Should a file not be received, the department associate would follow up with the designated client contact to determine the reason for the delay in submission.

Davis Vision could also provide the DCS's associates with access to our Benefit Manager™ application, which would provide access to view the DCS's enrollment in our system.

(b) Prior authorization for Medical Exception Program benefits;

Our flexible administrative system can process prior authorizations in a number of ways, and the final setup would be determined by the DCS. Davis Vision offers different levels of disease management and wellness programs, and believes our **Eye Health Connection**[SM] **Program** is the best solution for the DCS. This program captures diagnosis data from claims submissions and flags enrollees as having designated conditions that would entitle them to the Medical Exception Program benefits. Rather than denying enrollees initially and requiring providers/enrollees to submit information supporting medical needs, we could flag enrollees based on claim activity we capture and drive the provision of more frequent services based on that data.

Our medical exception program has a formal structure that begins with logging in the request and goes through a number of steps to determine the appropriate response. Please find an outline of our Medical Exception Program Prior Approval Process appended as Attachment 17.

(c) Variations in covered Plan benefits for various employer groups;

We have the ability to define plan benefits to enrollees at the employer group level provided that the State has the ability to communicate the employer group identifier(s) to us. Our administrative system is flexible, and we can either provide indicators needed from our system to assign each member to the various employer group, or we can do the mapping on our end based upon indicators provided by the DCS.

(d) Duplicate claims; and

The prevention of fraud and abuse is a key concern, and proactive controls have been built in at all levels of Davis Vision's benchmark auto-adjudication claims system. Our administrative system provides multiple computer edit checks to control abuse and ensure efficiency. Built-in safeguards begin with eligibility and continue through the manufacture and delivery of eyewear materials. The in-network claim payment process is fully automated, since eligibility is pre-certified and claims are paid based on eyewear ordered.

Claims are entered at the time of material order entry, uniquely integrating the two functions and guaranteeing that a provider can only be paid for the actual services provided, at a predetermined level. When a member and spouse (or member and a dependent child) are both covered by the DCS for vision, software edit checks prevent duplicate coverage. This serves as a significant cost control factor available to the DCS. The following steps ensure that duplicate claims are not paid and ineligible plan members cannot use the vision benefit:

- Member/dependent must be eligible at the time the authorization is issued.

- At the time authorization is given, the provider is advised of specific benefit eligibility for the member/dependent in question.
- Authorizations expire per system requirements. Re-verification of eligibility occurs again at the time the order is taken (when the claim is processed).

Once the member/dependent has exhausted their benefit that cycle, another authorization cannot be issued, nor can a claim be paid, until they are again eligible.

(e) Accurate claims pricing.

Claims pricing is determined by either the manufacturing process, in cases where eyewear is produced in a Davis Vision proprietary laboratory and what is ordered results in the coding of procedures on the claim, or through the claims submission process in instances where eyewear is not manufactured by Davis Vision.

Quality results are the ultimate goal of our system, and layers of testing during the implementation process ensure accurate claims pricing following the effective date. The implementation team coordinates the input of data into the systems, which is then disseminated throughout the various administration departments within Davis Vision, and finally through a configuration process that includes two levels of quality review using an environment that is dedicated to testing.

In addition to our extensive quality processes that are followed during the initial configuration of benefits into our system, a series of pre-implementation tests are conducted to produce post-production results, which are verified to ensure that the contracted pricing schedules are accurately reflected in final billing.

Since our claims system directly interacts with the order entry system, only the materials and services claimed by a provider are adjudicated on each claim.

(4) Describe how any changes to the benefit design would be monitored, verified and tested for the Plan, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Plan.

Benefit design changes are monitored through a coordinated process between the Client Management and Implementation teams. To ensure that changes to other benefit programs would not impact the Plan, end-to-end testing is conducted through all facing systems (IVR, website, customer service portal) prior to the effective date of any benefit changes for any client, to validate results. Davis Vision's quality assurance processes ensure that plan set-up and benefit design are thoroughly reviewed by multiple associates prior to claims being paid. This includes a thorough review of the benefit design and fee schedule prior to the first claims being paid by our administrative system. Effective-dated benefit riders/plan designs are assigned at the life level based on plan affiliation information provided by DCS.

Davis Vision's Implementation team communicates the plan design for set-up, account structure, eligibility rules and rates. The Implementation team coordinates the input of plan benefit changes affecting other business units.

Davis Vision's proprietary claims and administrative system is a comprehensive, flexible administrative application that enables our associates to load plan designs, benefits and fee schedules in a systematic and consistent manner. The process of benefit set-up for each client is part of a comprehensive, controlled process that includes multiple departments, detailed documentation and multiple quality assurance steps to ensure that all set-ups are authorized, accurate and complete. This ensures that changes to other client benefit programs will not impact the Plan.

(5) What steps will you take to ensure that Participating Providers and Laser Vision Correction Participating Providers comply with the HIPAA requirement for use of National Provider Identifiers for all electronic claims submissions?

All claims received via the EDI claims submission process require a valid National Provider Identifier (NPI). If there are any records missing a valid (or any) NPI, the entire EDI file is rejected back to the trading partner for correction and resubmission.

(6) Describe how the Offeror's adjudication system will feed the reporting and billing systems.

Claims are adjudicated through Davis Vision's state-of-the-art claims processing system, which has extensive controls in place to ensure payment is accurate and timely. On a weekly basis, adjudicated claims are processed for payment that generate checks or electronic payments to members and/or participating providers. Closed claims are then fed into the designated client billing cycle based on a mutually-agreed upon schedule and subsequently made available for client-specific billing and downstream reporting.

11. Frame and Lens Selections

The Offeror may propose a standardized selection of Plan frames available at each Participating Provider or a frame allowance. The incumbent contractor utilizes a frame allowance with price points set at $80, $100 and $130 for basic, standard and enhanced frames. Participating Providers must offer all covered Lens types and options, as set forth in the Summary of Covered Benefits in Exhibit II.D of this RFP. Frame and Lens Plan Utilization data is set forth in Exhibit III.A and III.A.1 of this RFP.

Davis Vision is proposing a standardized selection of plan frames complemented by a frame allowance, described below in Answer 1.

a. Duties and Responsibilities

(1) The Offeror shall be responsible for ensuring that Participating Providers maintain a varied and contemporary selection of Plan frames, including but not limited to styles in metal or plastic for men, women and children, half-eye styles, protective sport goggles and designer models. Plan frames must be available at three separate benefit levels, Basic, Standard, and Enhanced. The Offeror must contractually require Participating Providers to stock a minimum of 10 Basic frame styles, 25 Standard frame styles and 10 Enhanced frame styles. The Offeror may not count a different size or different color of the same frame when assessing compliance with the minimum frame selection.
Davis Vision confirms, and has exceeded the minimum frame selection.

(2) The Offeror is responsible for ensuring that all Participating Providers will dispense all covered lens types and lens options, including combination of two or more lens types and options.
Davis Vision confirms.

(3) The Offeror must provide a one-year unconditional warranty against breakage for all Plan frames and lenses that are fabricated in laboratories at manufacturing companies that are either a parent or subsidiary company of the Offeror.
Davis Vision confirms.

b. Required Submission

(1) Describe in detail how the Offeror proposes to develop and maintain the three levels of Plan frames required under the Plan, including whether the Offeror is proposing a standardized Plan frame selection or allowance method, a description of the variety of frame options, and the minimum contractual and average number of frames available in each level. How will Plan Enrollees be made aware of the available Plan frame selection when receiving services from a Participating Provider (i.e., separate location of frames, color coding of UPC codes, price tag, etc….)?
Our proposed frame program includes three levels of frames and complies with the Plan's Basic, Standard and Enhanced frame style structure. We have included three levels of frames in our programs since prior to the inception of the original DCS vision care program. The Fashion, Designer and Premier frame selections are

developed by our retail partners at Eye Care Centers of America in partnership with our sister company, Viva International Group, a worldwide leader in frame and sunglass design, distribution and manufacturing. This Collection has over 200 frames, which far exceeds the minimum requirements specified by the DCS. It is broken down by a minimum of 80 Fashion, 86 Designer and 56 Premier frames.

In participating provider offices, the Davis Vision Collection is located separately from the provider's other frames and is displayed on a tower. Each level of the Collection, Fashion, Designer and Premier, are shown with different colored price tags (yellow, red and blue, respectively). In our proprietary retail locations, including Empire Vision Centers in the Capital Region, the Davis Vision Collection is supplemented by additional frame styles available at no additional member cost.

Davis Vision's program is designed to be flexible in order to best meet the needs of our members. Our dual-choice frame benefit ensures that the member has maximum choice while incurring little or no out-of-pocket expense.

Retail Frame Allowance: Members may utilize the plan-specified allowance toward any frame on the market today, with no limitations. If the cost of the frame exceeds the allowance, the member will also receive a 20% discount off the overage. The frame allowance is the same at all provider locations and covers thousands of available frames in full.

Davis Vision Frame Collection: Members may select from Davis Vision's exclusive Frame Collection, in lieu of the allowance. The Collection contains over 200 frames representing more than 400 total variations of size and color. The Collection ensures beneficiaries a uniform, quality selection of frames regardless of network office location.

The exclusive Collection represents the most popular looks in eyewear, including designers such as Candies, Gant, Jill Stuart, Steve Madden, Elizabeth Arden, Cosmopolitan, Bongo®, Converse, Perry Ellis, Catherine Deneuve and Harley Davidson®. Participating retail providers typically do not display the Collection, but are contractually required to maintain a comparable selection (in both quantity and quality) of frames that would be covered in full, with no additional member out-of-pocket expense.

(2) State the retail price points for a standard collection or the Offeror's proposed allowances for frames covered at each of the three (3) levels. If an allowance method is proposed, confirm the allowances are adequate to ensure that Participating Providers stock the minimum contractual number of frames.

Our proposed allowances for frames covered at each of the three levels match the current benefit and are:

- $80
- $100
- $130

To supplement the allowances provided in the current plan, we are also offering access to our standard Collection of frames. The retail price points for the three levels of the Davis Vision Collection frames are as follows:

- Fashion: up to $125
- Designer: up to $175
- Premier: up to $225

While there is no required minimum number of frames each provider location must carry, participating providers typically carry 400 to 1,500 frames, depending on the type of practice. In addition, each Davis Vision independent participating provider office is required to carry our exclusive Collection, which consists of nearly 200 frame samples representing more than 400 total SKUs (many of which will be covered in full in most of the programs). The Collection ensures a greater number of frames that each independent network provider location carries, ensuring unparalleled member choice.

Participating retail providers typically do not display the Collection, but are contractually required to maintain a comparable selection (in both quantity and quality) of frames that would be covered in full, with no additional member out-of-pocket expense.

(3) Describe in detail how lens types and lens options will be classified as either Standard (covered) material or premium material, eligible for the upgrade program.

The programs offered by Davis Vision will provide the same lens types as the current plan at no out-of-pocket costs for enrollees, and includes some enhancements.

(a) Provide a listing of the currently manufactured lens products that are/will be classified as Standard or premium for the following categories of lens types: progressive, high index, photochromatic and polycarbonate.

Standard lens types for all groups, except for SEHP, will continue to include glass, plastic, single vision, bifocal, blended bifocals, progressive lenses, photosensitive glass (single vision and multifocal), post-cataract lenses, tints, ultraviolet coatings and sunglasses. The scratch-resistant coating will also be included for all groups in our program. High index, photochromatic and polycarbonate lenses are not broken out into standard and premium categories.

There are virtually no limits on brands or manufacturers. We have agreements with the world's leading lens manufacturers to provide the vast majority of spectacle lenses available on the market today, such as Varilux®, Kodak, Carl Zeiss, Seiko and Hoya, and specialized lens treatments and coatings such as Crizal®, Avancé, Reflection Free®, Teflon®, Carat®, Carat® Advantage, Transitions®, Sunsensors® and Photogrey Extra. Please find a list of the progressive lens types included in the standard and premium categories appended as Attachment 18.

(b) Confirm which covered lens options are/will be available in both basic and premium classifications.

Progressive lenses and anti-reflective coatings are the only covered lens options that are available in multiple classifications. In the Davis Vision program, enrollees will have access to both standard and premium progressive lenses at no additional member charge. Anti-reflective coatings will be available in three levels: standard, premium and ultra and would be subject to the relevant copayments as part of the upgrade program.

(c) Confirm that Enrollees eligible for multiple covered lens types and options will be able to select a combination of covered eyewear with no out-of-pocket cost, for example, a photochromatic single vision high index lens with Standard scratch-resistance and ultraviolet coating.

Davis Vision confirms that Enrollees eligible for multiple covered lens types and options will be able to select a combination of covered eyewear with no out-of-pocket cost, for example, a Photochromic single vision high index lens with Standard scratch-resistance and ultraviolet coating.

(4) Describe the Offeror's proposed product guarantees for Plan frames and lenses dispensed by a Participating Provider. How does/will the Offeror ensure that Participating Providers perform product repairs and replacements for eyewear which are under warranty?

In the Davis Vision program, all eyeglasses come with a free breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The one-year breakage warranty applies to all plan-covered eyeglasses (i.e., all spectacle lenses, Davis Vision Collection frames and national retailer frames, where our exclusive Frame Collection is not displayed).

Providers are contractually obligated to honor our repair and replacement warranty, and have no adverse financial effects to provider as materials are provided by Davis Vision's laboratory. Should there be a minor repair necessary, like a screw falling out, the provider would take care of it immediately in their office.

12. Contact Lens Selection

The Offeror may propose a standardized contact lens selection or a contact lens allowance for PEF, GSEU, M/C and unrepresented Employees and their covered Dependents. A $200 contact lens allowance benefit is available for the other employee groups.

Davis Vision is proposing a contact lens allowance complemented by our Contact Lens Collection, as described in answer 2 below.

a. Duties and Responsibilities

(1) The Offeror must ensure that Participating Providers maintain a varied selection of Plan contact lenses, including soft, daily-wear, planned replacement and disposable contact lenses, subject to Plan benefit coverages set forth in Exhibit II.D.

Davis Vision confirms.

(2) If proposed, the standardized contact lens selection should be updated periodically to reflect current products and preferences. Conversely, if an allowance method is proposed, the allowances must be adequate to ensure a wide variety of contact lens selection.

Davis Vision confirms.

(3) The Offeror must administer a $200 contact lens benefit for Enrollees and covered Dependents in NYSCOPBA, Council 82, ALESU, PBA and PIA, which includes the cost of the eye examination, standard or premium contact lens fitting and contact lens material.

Davis Vision confirms.

b. Required Submission

(1) State whether a Standardized contact lens selection or contact lens allowance is proposed.

Davis Vision is proposing a contact lens allowance complemented by our Contact Lens Collection.

(2) If a Standardized contact lens selection is proposed:

Contact lenses are increasingly becoming a practical option for those previously not candidates for contact lens wear. We have designed our contact lens benefit to provide a covered-in-full benefit whenever possible.

The Davis Vision contact lens Collection offers a wide variety of covered-in-full contact lenses from today's top manufacturers, including CooperVision® and Vistakon®, in both traditional and silicone hydrogel materials. The Collection is updated regularly to reflect industry trends and provide participating providers with

access to the brands they commonly prescribe. When a patient is prescribed Collection contact lenses, the evaluation, fitting and follow-up visits are all covered in full, as well as the materials. Please find a completed Exhibit III.G, NYS Vision Plan Listing of Plan Contact Lenses completed and appended as Attachment 19.

For contact lens wearers who are prescribed contact lenses that are not available in the Collection, we provide a generous allowance toward any contact lenses prescribed by the doctor, plus members receive a 15% discount off any overage. In addition, the evaluation, fitting and follow-up is covered in full.

(a) Describe how the Offeror will develop and maintain the selection of Plan contact lenses. Complete Exhibit III.G, Summary of Contact Lenses Covered by the Plan to detail the Plan contact lenses the Offeror is proposing.

Davis Vision's Assistant Vice President of Professional Affairs leads a committee of industry professionals who monitor national contact lens trends on usage and product advancements within the industry on a quarterly basis. Our contact lens Collection is based on this national trends analysis and includes the most updated contact lens brands/styles in the industry, which are most often prescribed by providers. The quality of new and improved contact lens modalities takes precedence when they are being considered for addition to the Collection.

(b) State the Offeror's proposed criteria for classifying contact lenses as either standard or premium (which are subject to the higher copay level for PEF, GSEU, M/C and unrepresented Employee and their covered Dependents).

Davis Vision's two-tier formulary is based upon contact lens types traditionally classified as standard and specialty. Planned replacement lenses and disposable lenses are provided at a $25 member copayment and one day, toric and multifocal disposables are included at a $45 copayment.

(3) If a contact lens allowance is proposed, state the proposed allowance for standard and premium contact lenses. Do not include any cost information in the Technical Proposal.

Davis Vision has matched the current allowances for standard and premium allowances that are in place today, as outlined in the chart below:

Group	Allowance[1]
ALESU	Materials allowance of $105
Council 82 Arb. Eligible & Contract Affected	Materials allowance of $105
SEHP (GSEU and CUNY)	Contact Lens Collection only
M/C, Retirees, PEs & other un-	$105 for soft, daily wear or planned

Group	Allowance[1]
represented	replacement $125 for disposable
NYSCOPBA Arb. Eligible & Contract Affected & UUP Lifeguards	Materials allowance of $105 for soft, daily wear or planned replacement Materials allowance of $125 for disposable
PBA Troopers	$105
PBA Supervisors	$105
PEF	$105 for soft, daily wear or planned replacement $125 for disposable
PIA	$105

[1] *Excluding copayment, where applicable.*

(4) State how the Offeror proposes to administer the $200 contact lens benefit for other employee groups, and confirm that the eye exam, contact lens fitting, and contact lens material will be included.

Davis Vision confirms we will administer the $200 contact lens benefit for ALESU, Council 82 Arb. Eligible & Contract Affected and NYSCOPBA Arb. Eligible & Contract Affected & UUP Lifeguards as it is administered today. Enrollees will continue to receive an eye examination, contact lens fitting and follow up and $105 materials allowance.

13. Occupational Vision Program

The Plan's Occupational Vision Program enables eligible Enrollees to obtain a second eyewear selection (intended for occupational use) from a Participating Provider, at the time the primary eyewear is ordered. The occupational eyewear must differ from the primary eyewear based on criteria established by the Offeror and consistent with the Occupational Vision Program benefits specified in the Summary of Covered Benefit by Group, Exhibit II.D of this RFP. The Occupational Vision Program is not available to Dependents. Further, as a health and safety measure, Enrollees in the State Police covered under PBA-Troopers, PBA-Supervisors and PIA are entitled to an additional set of occupational lenses, if needed, for insertion into respirators. See insert specifications on Exhibit II.H of this RFP.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The Offeror must develop sound eligibility criteria for the Occupational Vision Program, e.g., variations in lens type, strength, or tint, for occupational vision needs, in accordance with the negotiated benefit design by employee group;

Davis Vision confirms.

(2) The Offeror must communicate Occupation Vision Program eligibility criteria to Participating Providers and ensure that they properly administer the program.

Davis Vision confirms.

(3) The Offeror must work with the Department and the State Police to develop a procedure to order and fabricate prescription lenses for insertion into respirators.

Davis Vision confirms.

b. Required Submission

(1) Does the Offeror currently administer an Occupational Vision Program for an Employer? If so, please describe the Offeror's experience administering an Occupational Vision Program and state what percentage of Enrollees receive Occupational Vision eyewear for a similar client, using the same criteria that the Offeror proposes for the NYS Plan.

Yes, we have extensive experience administering Occupational Vision programs for a number of employer groups since 1980, including the New York State Thruway Authority and historical experience as the DCS's vision benefits administrator for nearly 25 years.

For similar programs, utilization of occupational vision eyewear averages 23.7%.

(2) State the Offeror's proposed eligibility criteria for the Occupational Vision Program. Be specific. Based on the proposed criteria, are there additional procedures outside of the regular, comprehensive eye examination required under this Program that Participating Providers will be required to perform? If so, please describe the additional procedures.

When an Enrollee is eligible for the Occupational Vision Program, the occupational eyeglasses must be different from the dress eyewear in at least one of the following ways:

- The prescription must have at least a 0.5 diopter difference
- The segment height must have a 5.0 mm change
- The spectacle lens type must be different (i.e., single vision lenses to bifocal)

Additional procedures include applying the testing standards of the American Optometric Association. Our protocol includes the following elements performed in addition to a standard eye examination: procedures to assess visual acuity, refractive status and binocular function at the computer distance, color vision and stereopsis (depth perception).

(3) Does the Offeror's lens fabricator have experience with or the ability to fabricate lenses for insertion into respirators, as specified in Exhibit II.H? If so, please describe that experience.

Yes, we have both experience with and the continued ability to fabricate lenses for insertion into respirators, having successfully provided these services to the State from the inception of the respirator benefit through 2006, and we continue to provide them to the employees of the New York State Thruway Authority.

Davis Vision will continue providing the prescription portion of the full-face respirator spectacle kits, and we have the laboratory flexibility to accommodate any kits described.

(4) Describe how the Offeror will communicate the Occupational Vision Program and monitor Participating Provider compliance.

We utilize a number of outlets to regularly communicate with our participating providers, including giving each provider materials for every new group when they join the Davis Vision program. These materials outline the benefits the enrollees are entitled to, including dress and occupational programs. With nearly 25 years' experience with administering occupational vision programs and as the current administrator of the New York State Thruway Authority's occupational vision program, we are positive that we have the depth of experience to administer this benefit successfully.

Participating Provider compliance with the Occupational Vision Program is ensured by the edits programmed into our proprietary laboratory system, where the materials are produced. These edits ensure that the minimum criteria for the occupational program are met each time occupational eyeglasses are ordered.

14. Medical Exception Program

The Plan's Medical Exception Program benefit is available to eligible Enrollees and Dependents as specified in the Summary of Benefit Variances by Group, Exhibit II.C of the RFP. Under the Medical Exception Program, Enrollees and Dependents with a medical condition that may impact vision refraction, when referred by the physician caring for that medical condition, are eligible for benefits sooner than the usual twenty-four (24) month period, but not less than one year from last exam. Medical Exception Program utilization is presented in Exhibit III.F of this RFP.

Davis Vision confirms. We are offering our comprehensive **Eye Health Connection℠ Program (Level 3)** to operate as the medical exception program, which will provide additional capabilities for the DCS.

The most effective health and wellness and disease management programs are the ones most specifically targeted to individual members' health care needs. Davis Vision's goal is to elevate the level of benefits offered to members living with disease so that their overall health is positively impacted while our clients' total health care expenditures are reduced.

- **DavisVision's Eye Health & Wellness Program®** provides clients and members access to our vision library and Eye Health & Wellness website. Copies of Sightwire, a newsletter regarding eye care topics released six times a year, are available free of charge for clients to share with employees.
- **Diabetic Outreach** is a collaborative effort between Davis Vision and our client to coordinate with their existing disease management program. This program is intended to improve HEDIS scores for diabetic measure. HEDIS is a measure of performance for health plans. *Encounter file reporting is free of charge.*
- The **Eye Health Connection℠ Program** is our disease management program, which focuses on detection of four ocular diseases and provides additional benefits including increased communications, additional eye examinations and eyewear enhancements. Based on a patient's medical condition, they may be allotted enhanced benefits as part of the benefit plan design:
  - **Level 1:** A member flagged as having diabetes, glaucoma, cataracts or age-related macular degeneration may subscribe to the Eye Health & Wellness website to receive informational communications via the Davis Vision website.
  - **Level 2:** Allows for additional eye examinations including dilation within a benefit cycle.
  - **Level 3:** Offers enhanced materials benefits including covered-in-full lens options relevant to the member's condition.

Upon identification of one or more of the four targeted conditions, our members can receive communications throughout the year, including an introductory letter, periodic e-mail notices and an annual e-mail to remind them it has been one year since their last examination. Additionally, our enhanced website provides easy access to educational

information for eye health conditions, signs and symptoms, and the importance of routine eye examinations.

a. Duties and Responsibilities

(1) The Offeror must communicate Medical Exception Program eligibility criteria to Participating Providers and ensure that they properly administer the program.

Davis Vision confirms.

(2) In consultation with their medical director, the Offeror must establish and maintain a listing of medical conditions that would qualify an Enrollee or Dependent to receive services under the program. The listing of medical conditions must include, but not be limited to: diabetes, cataracts, keratoconus, eye surgery within two years of last Rx, taking a prescription drug whose side effects cause vision changes, and any other documented medical condition which could reasonably be expected to result in a change in refractive status, and;

Davis Vision confirms.

(3) The Offeror must administer a process for Participating Providers to request prior authorization of medical exception benefits for eligible Enrollees and Dependents. As part of this process, the Offeror must develop sound criteria for authorizing eyewear benefits.

Davis Vision confirms.

b. Required Submission

(1) Does the Offeror currently administer a Medical Exception Program for an employer? If so, please describe the Offeror's experience administering a Medical Exception Program.

Yes, Davis Vision administers "Medical Exception" programs for numerous existing customers. Client-specific parameters around the presenting conditions that may result in a covered individual receiving more frequent services are communicated to network providers. The **Eye Health Connection℠ Program** enables Davis Vision to monitor four designated conditions and systematically control the provision of additional services when appropriate. In addition, our Prior Approval process introduces a workflow for reviewing and authorizing (when deemed appropriate, and

supported by the required documentation) more frequent services for conditions outside those addressed by **Eye Health Connection℠ Program**.

(2) Provide a listing of medical conditions that the Offeror is proposing to use to qualify an Enrollee or Dependent to receive services under this program.

Our **Eye Health Connection℠ Program** is designed to treat enrollees and dependents flagged as having diabetes, glaucoma, cataracts or age-related macular degeneration. We can also accommodate enrollees and dependents who are taking prescription drugs that cause vision changes and other conditions that could reasonably be expected to cause a significant change in refractive status. As long as a medical condition has an industry-standard diagnosis code associated with it, our systems can include that condition in the DCS's Medical Exception Program. We would look forward to evaluating the DCS's specific needs and altering the qualifications to best meet your needs.

(3) Describe the Offeror's proposed authorization process for the Medical Exception Program. Include a sample of any Medical Exception Program authorization forms that the Offeror is proposing to use under the program, timeframes for authorization and eyewear benefit criteria.

Our flexible administrative system can process prior authorizations in a number of ways, and the final setup would be determined by DCS. Davis Vision offers different levels of disease management and wellness programs, and believes our **Eye Health Connection℠ Program** is the best solution for the DCS. This program captures diagnosis data from claims submissions and flags enrollees as having designated conditions that would entitle them to the Medical Exception Program benefits. Rather than denying enrollees initially and requiring providers/enrollees to submit authorization forms supporting medical needs, we could flag enrollees based on claim activity we capture and drive the provision of more frequent services based on that data. Please find a sample of the Medical Exception Program authorization form, applicable only if the **Eye Health Connection℠ Program** is not selected, appended as Attachment 20.

Our Medical Exception Program has a formal structure that begins with logging in the request and goes through a number of steps to determine the appropriate response. Please find an outline of our Medical Exception Program Prior Approval Process appended as Attachment 17.

(4) Describe how the Offeror will communicate the Medical Exception Program and monitor Participating Provider compliance.

We utilize a number of outlets to regularly communicate with our participating providers, including giving each provider materials for every new group when they join the Davis Vision program. These materials outline the benefits the enrollees are entitled to, including dress and occupational programs. With nearly 25 years' experience in administering the Plan's benefits, and as the current administrator of a variety of Medical Exception Programs, we are positive that we have the depth of experience to administer this benefit.

In the Medical Exception Program, the onus is on the provider to submit the required documentation for an enrollee to obtain eyewear under the Medical Exception Program. Each request is reviewed on a case-by-case basis by both administrative and clinical staff for approval, ensuring that enrollees are eligible according to the authorization criteria established for the program.

Should the DCS select our **Eye Health Connection℠ Program** instead, patients would be flagged in our system as eligible for additional materials. Providers are contractually obligated to adhere to these diagnoses, and our 37 nationally-distributed Regional Quality Assurance Representatives, all optometrists, conduct periodic audits of provider records to ensure compliance with Davis Vision provider policies and procedures.

15. Upgrade Program

Through the Upgrade Program, eligible Enrollees and their Dependents may select certain non-Plan eyewear from a Participating Provider and pay a discounted surcharge (in addition to the Participating Provider fee paid by the Plan). The goal of the program is to make available, at a discounted price, a wider selection of frames, lens types (including contact lenses) and lens options, than is otherwise covered under the Plan.

Davis Vision confirms.

a. Duties and Responsibilities

(1) The Offeror must communicate the Upgrade Program requirements and pricing methodology to Participating Providers and ensure that they properly administer the Program.

Davis Vision confirms.

(2) The Offeror must provide a minimum discount off of retail pricing for upgrade selections that are not a covered benefit for any Employee Group covered under the Plan. The Offeror must set the Upgrade Program surcharges for selections that are a covered benefit for one or more Employee Groups under the Plan equal to the fee paid by the Plan, as set forth by the Offeror in Exhibit IV.A of the RFP.

Davis Vision confirms.

b. Required Submission

(1) Does the Offeror currently administer an Upgrade Program for an employer? If so, please describe the Offeror's experience in administering an upgrade program. What direction does the Offeror give to Participating Providers regarding up selling?

The hallmark of our program is that it is designed to result in the lowest out-of-pocket costs for members and includes all ranges of prescriptions, all lens powers, all lens sizes including oversize lenses, tinting of plastic lenses and scratch-resistant coating at no charge to the member. Polycarbonate lenses are also covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

In addition, our plans include popular lens options like progressives, plastic photosensitive lenses, ultraviolet protection and anti-reflective coatings at fixed, discounted member prices that are the same nationally. **Members, on average, save 40% - 60% off retail prices.**

Providers are standardly reimbursed according to a discounted fee schedule (uniform regionally) for performing comprehensive eye examinations and dispensing services. Providers receive no compensation for materials, thus eliminating the major financial incentive for selling eyeglasses or providing the more expensive types of eyeglasses (i.e., bifocals vs. single vision) and helping to avoid excess utilization while maintaining the quality of care. Providers receive a fixed minimal dispensing fee for eyeglasses and for contact lens fitting. No bonuses or incentives exist. Davis Vision's provider contracts and standard plan protocols prohibit network providers from collecting any additional fees for covered services with the exception of plan designated copayments.

Since Davis Vision manufactures the eyewear provided by our participating providers through our proprietary union laboratory system, it limits the opportunity and financial incentive for providers to up sell. This allows us to control member out-of-pocket costs, in contrast with our competitors.

(2) Propose a minimum discount off of retail pricing for upgrade selections that are not a covered benefit for any Employee Group covered under the Plan. Propose a methodology for charging Enrollees for these options under the Upgrade Program, including examples of the pricing methodology for frames with a retail cost of $200 or more, premium progressive lenses and premium anti-reflective lens coating.

After the plan allowance is applied, Davis Vision's in-network discount for non-plan frames and contact lenses is calculated as a percentage off retail (20% discount off retail pricing for frames and 15% for contact lenses). Spectacle lens options that are included in the upgrade program will be available at fixed, discounted prices offering savings of up to 60% off when compared to Average Retail Prices, as opposed to other plans in which savings are typically only 10%-20%.

The pricing for a frame with a retail cost of $200 would be as follows, using the $130 frame allowance available to NYSCOPBA, PBA Troopers, PBA Supervisors, PEF and PIA:

Retail Cost of Frame:	$200
Less $130 retail allowance -	$130
Subtotal:	$ 70
Less 20% off overage -	$ 14
Total Out-of-Pocket Cost	**$ 56**

Premium progressive lenses will be available to members with no additional out-of-pocket cost. Premium anti-reflective coating will be available at a member cost of $48, and ultra anti-reflective coating will be available at a member cost of $60.

(3) Confirm that the Enrollee surcharge for Upgrade Program selections that are a covered benefit for one or more Employee Groups covered under the Plan will be equal to the Plan fees set forth in Exhibit IV.A. (**Note:** Do not specify the actual amount of the Participating Provider Fee Schedule when responding to this question. The amount of the Participating Provider Fee Schedule should be included in the Cost Proposal only.)

Davis Vision confirms.

TABLE OF ATTACHMENTS

1. Davis Vision Organizational Chart and completed Biographical Sketch Forms
2. Sample Implementation Plan
3. Narrative Implementation Diagram
4. IVR Menu
5. GEICO Flyer
6. Sample Member Communications Materials
7. Sample Management Report Package
8. Proposed Data Sharing Agreement
9. Sample Ad-Hoc Reports
10. Sample Transition Plan
11. Sample New York State Provider Directory
12. Sample Laser Vision Provider Directory
13. New York Provider Contracts
14. Provider Manual
15. Sample Provider Newsletters
16. In-Network Benefit Process and Out-of-Network Claims Process Flow Charts
17. Medical Exception Prior Approval Process
18. Progressive Lens Categories
19. Exhibit III.G, NYS Vision Plan Listing of Plan Contact Lenses
20. Sample Medical Exception Prior Approval Form

Davis Vision's Organizational Chart

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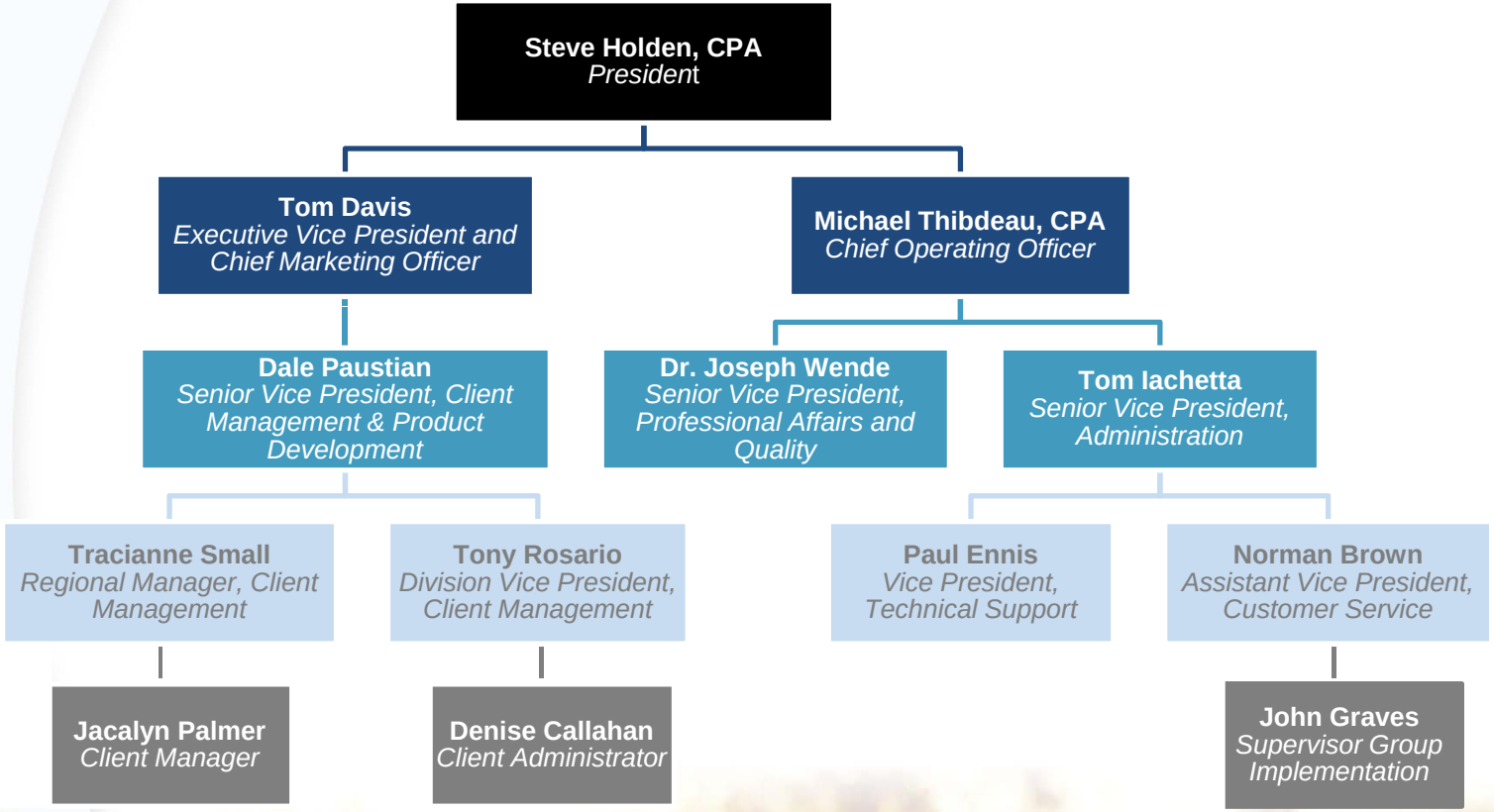

Biographical Sketch Forms

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INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Dale Paustian

Job Title: Senior Vice President, Client Management & Product Development

Relationship to Project: Mr. Paustian will provide executive level account support and has ultimate responsibility for the Department's overall satisfaction with Davis Vision.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Bradley University, Peoria, IL	BA	1991	International Business-Finance

Summa Cum Laude, Beta Gamma Sigma and Phi Kappa Phi honor societies
Bradley University and National Dean's Lists

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
10/09- present	Davis Vision, Inc.	SVP, Client Management & Product Development
4/09-10/09	Davis Vision, Inc.	SVP, Marketing/Client Management
9/97-6/06	Davis Vision, Inc.	VP, Marketing/Client Relations
8/96-9/97	Davis Vision, Inc.	VP, National Accounts
12/95-8/96	Empire BCBS	Associate Director, Cost Control and Productivity
7/94-12/95	General Electric Co.	Financial Analyst, Medical Benefits, Health Care Management Programs
7/92-7/94	GE Capital	Financial Management Program (FMP)
5/91-7/92	Transtechnology Electronics / Contract Administrator	
5/90-1/91	GE Plastics	Manufacturing Financial Analyst

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Mr. Paustian leads the overall product development and management to support Davis Vision's overall new/existing business development goals. He supports overall corporate account management functions to ensure attainment of national client retention, growth and satisfaction goals for Davis Vision's vision care business. He is also a New York State licensed resident Life and Health insurance agent, as well as a licensed non-resident agent nationally.

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Tracianne Small

Job Title: Regional Manager, Client Management

Relationship to Project: Ms. Small will be assigned as the dedicated client manager with overall responsibility for ensuring the optimal performance of the Davis Vision plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
St. Francis College, Brooklyn, NY	BS	1997	Management

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2009 - Present	Davis Vision, Inc.	Regional Manager, Client Management
2005 - 2009	Davis Vision, Inc.	Client Manager
1999 - 2001	Alliance Capital, Ltd.	National Account Manager
2001 - 2003	Alliance Capital, Ltd.	Associate National Account Manager
1997 - 1999	Oppenheimerfunds, Inc.	Marketing Associate

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Ms. Small develops relationships with clients and consultants to ensure the retention and growth of Davis Vision market share in the managed care vision industry. She meets with clients frequently to perform plan reviews and product updates and works with clients to structure cost-effective vision care benefits for their employees.

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Jacalyn Palmer

Job Title: Client Manager

Relationship to Project: Ms. Palmer will serve as local client management support to Ms. Small.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Schenectady County Community College	N/A	1994	Travel & Tourism
College of St. Rose	Certificate	2002	Business

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2010 to Present	Davis Vision	Client Manager
2005 – 2010	Davis Vision	Escalations and Quality Assurance, Manager
1999 – 2005	Davis Vision	Provider Services Team Coach
1996 – 1999	Davis Vision	Customer Service Technical Assistant

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Ms. Palmer has a strong health care background that includes over 15 years' experience in the vision care industry, with a concentration in customer service and management positions. She partner closely with clients to ensure expectations are continually exceeded and works with clients in a consultative manner to ensure membership satisfaction.

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Denise Callahan

Job Title: Client Administrator

Relationship to Project: Ms. Callahan will be responsible for assisting in the implementation of the program and providing ongoing member and client services support.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Adelphi University, Garden City, NY	BA	2003	Psychology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
7/07-present	Davis Vision	Client Administrator
9/03-7/07	Davis Vision	Asst. Director, Quality Assurance
11/99-9/03	Davis Vision	Receptionist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Dedicated Davis Vision employee who has had the opportunity to grow and develop with the company. Ms. Callahan is customer service-driven with an emphasis on ensuring 100% customer satisfaction. Knowledge of the retail, customer service and marketing facets of the company allow for effective support.

Ms. Callahan supports the Client Management team in daily activities involving client relations and ensuring overall client satisfaction, including assisting with renewals, delivering utilization reports and providing all levels of administrative functions needed on a day to day and ad-hoc basis.

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Antonio Rosario

Job Title: Division Vice President

Relationship to Project: Mr. Rosario will function as an additional resource for the Davis Vision Client Management team.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
CW Post, LI University, Greenvale, NY	BA	1992	Psychology
SUNY Farmingdale College, Farmingdale, NY	AA	1990	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2009-Current	Davis Vision, Inc.	VP, Client Management
2003-2009	Davis Vision, Inc.	AVP, Client Relations and Marketing
2000-2003	Davis Vision, Inc.	Senior Director, Client Relations and Marketing
1999-2000	Davis Vision, Inc.	Director, Client Relations
1997-1999	USI Administrators	Account Manager, Medical Benefits
1994-1997	The Equitable, AXA	Financial Services Sales Agent

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Mr. Rosario has nearly 20 years of experience in the healthcare industry, with expertise including product development, account management, new and existing business sales, renewal analysis and overall departmental support.

New York State DCS - Sample Implementation Plan Target Effective Date: January 1, 2012					
ITEM #	**PROJECT TASKS**	**STATUS**	**START DATE**	**COMPLETION DATE**	**PARTY(IES) RESPONSIBLE**
SECTION A - IMPLEMENTATION MEETING					
1	Attend Implementation Meeting - Identify Responsible Associates	pending	10/3/2011	10/3/2011	New York State DCS/Davis Vision
Comment					
2	Determine Schedule for Update Meetings/Conference Calls	pending	10/3/2011	10/10/2011	New York State DCS/Davis Vision
Comment					
SECTION B - CONTRACT					
1	Draft Main Contract	pending	10/24/2011	11/14/2011	Davis Vision
Comment					
2	Determine if BAA will be part of the Main Contract	pending	10/24/2011	11/14/2011	New York State DCS/Davis Vision
Comment					
3	Review Draft Contract	pending	11/14/2011	12/5/2011	New York State DCS
Comment					
4	Finalize and Execute Contract	pending	12/5/2011	12/15/2011	New York State DCS/Davis Vision
Comment					
SECTION C - BENEFIT PLANNING					
1	Finalize Benefit Designs	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Finalize Benefit Cycles (Calendar Year, Contract Month, Date of Service)	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
3	Finalize Co-payments & Allowances	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
SECTION D - SYSTEM SETUP					
1	Develop Internal Communication Detailing Benefits	pending	10/24/2011	11/14/2011	Davis Vision
Comment					
2	Setup System with Benefits	pending	11/14/2011	12/5/2011	Davis Vision
Comment					
3	Review System for Setup Accuracy	pending	12/5/2011	12/15/2011	Davis Vision
Comment					

New York State DCS - Sample Implementation Plan Target Effective Date: January 1, 2012					
SECTION E - ENROLLMENT AND ELIGIBILITY PLANNING					
1	Review Required Fields for Eligibility Files	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Develop File Layout	pending	10/3/2011	10/24/2011	New York State DCS
Comment					
3	Finalize Eligibility Transfer Medium	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
4	Finalize Eligibility File Layout	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
5	Finalize Eligibility File Delivery Frequency	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
	Test Eligibility Feed:				
6	Send Initial Test File to Davis Vision	pending	11/14/2011	11/15/2011	New York State DCS
7	Review Initial File	pending	11/16/2011	11/17/2011	Davis Vision
8	Eligibility Systems Development and Testing	pending	11/18/2011	11/21/2011	Davis Vision
Comment					
	Production Initial Load:				
9	Transfer Full Positive File To Davis Vision	pending	12/5/2011	12/6/2011	New York State DCS
10	Davis Vision Loads File	pending	12/7/2011	12/8/2011	Davis Vision
11	Audit Live Data	pending	12/9/2011	12/11/2011	Davis Vision
12	Design Discrepancy Report	pending	as needed	as needed	Davis Vision
13	Audit Discrepancies	pending	12/14/2011	12/16/2011	New York State DCS/Davis Vision
	Scheduled Maintenance:				
14	Pass First File (Changes or Full Positive)	pending	TBD	TBD	New York State DCS
15	Davis Vision Loads File	pending	TBD	w/in 24 hrs of receipt	Davis Vision
16	Audit Production Files	pending	TBD	ongoing	Davis Vision

New York State DCS - Sample Implementation Plan Target Effective Date: January 1, 2012					
SECTION F - CLAIM HISTORY FILE TRANSFER					
1	Review History File Requirements	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Share History File Layout (or review alternate layout)	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
3	Finalize History Transfer Medium	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
4	Finalize History File Layout	pending	10/24/2011	11/14/2011	New York State DCS/Davis Vision
Comment					
5	Finalize History File Delivery Frequency	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
	Test History Feed:				
6	Send Initial Test File to Davis Vision	pending	11/14/2011	11/15/2011	New York State DCS
7	Review Initial File	pending	11/16/2011	11/17/2011	Davis Vision
8	History Systems Development and Testing	pending	11/18/2011	11/21/2011	Davis Vision
	Production Initial Load:				
9	Transfer Full Positive File To Davis Vision	pending	12/5/2011	12/6/2011	New York State DCS
10	Davis Vision Loads File	pending	12/7/2011	12/8/2011	Davis Vision
11	Audit Live Data	pending	12/9/2011	12/11/2011	Davis Vision
12	Design Discrepancy Report	pending	as needed	as needed	Davis Vision
13	Audit Discrepancies	pending	12/14/2011	12/16/2011	New York State DCS/Davis Vision
	Scheduled Maintenance:				
14	Pass First File (Changes or Full Positive)	pending	TBD	TBD	New York State DCS
15	Davis Vision Loads File	pending	TBD	w/in 24 hrs of receipt	Davis Vision
16	Audit Production Files	pending	TBD	ongoing (run outs?)	Davis Vision

New York State DCS - Sample Implementation Plan Target Effective Date: January 1, 2012					
SECTION G - REPORTING					
1	Review Management Level Reporting Requirements	pending	10/3/2011	10/24/2011	Davis Vision
Comment					
SECTION H - WEB SUPPORT					
1	Determine Level of Web Support Required (Benefit Manager, etc.)	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Implement Web Based Support	pending	11/14/2011	12/5/2011	New York State DCS/Davis Vision
Comment					
SECTION I - MEMBER SERVICES & QUALITY ASSURANCE					
1	Review Standard Protocols for Denials, Complaints and Grievances	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Review Eligibility Verification Routines	pending	10/24/2011	11/14/2011	New York State DCS/Davis Vision
Comment					
3	Finalize IVR Number to be Used	pending	10/3/2011	10/24/2011	Davis Vision
Comment					
4	Develop MSR Scripts	pending	11/14/2011	12/5/2011	Davis Vision
Comment					
SECTION J - SERVICE REVIEW AND TRAINING					
1	Review Staffing Requirements	pending	11/14/2011	12/5/2011	Davis Vision
Comment					
2	Conduct Internal Training of Member Service/Claims/Provider Relations	pending	12/5/2011	12/15/2011	Davis Vision
Comment					
3	Conduct On-Site Training of New York State DCS Staff	pending	as needed	as needed	New York State DCS/Davis Vision
Comment					
4	On-Site Review by New York State DCS Systems & Procedure Staff	pending	as needed	as needed	New York State DCS/Davis Vision
Comment					

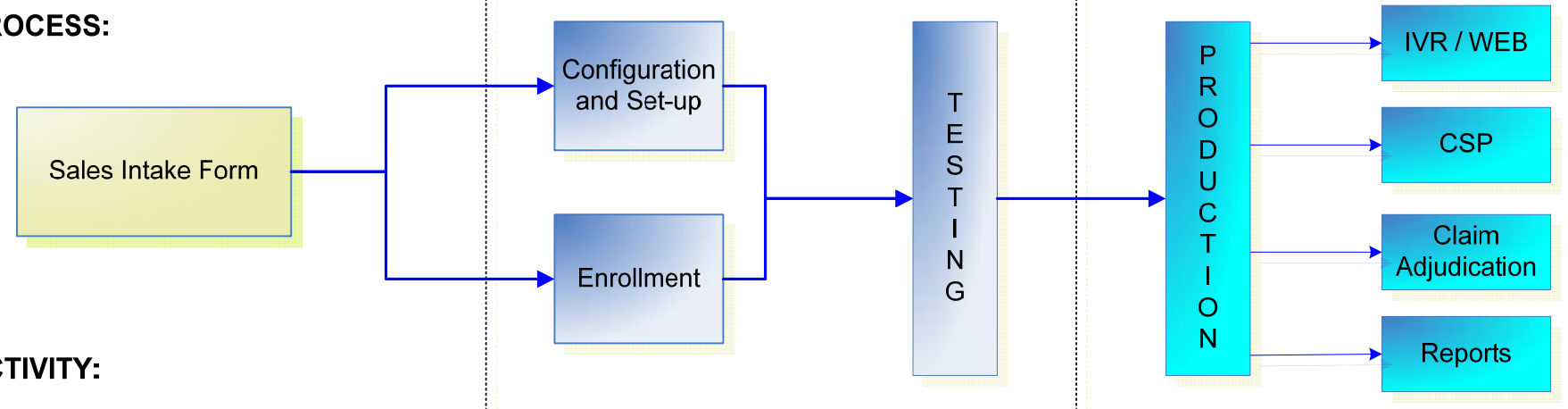
New York State DCS - Sample Implementation Plan Target Effective Date: January 1, 2012					
SECTION K - MEMBER / GENERAL COMMUNICATIONS					
1	Determine Implementation Communication Needs	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Share Communication Timelines	pending	10/3/2011	10/24/2011	New York State DCS
Comment					
3	Implement Standard Out-of-Network Claim Form	pending	10/24/2011	11/14/2011	New York State DCS/Davis Vision
Comment					
4	Share Draft Member Communication Materials	pending	10/24/2011	11/14/2011	Davis Vision
Comment					
5	Finalize Member Communication Materials	pending	11/14/2011	12/5/2011	New York State DCS/Davis Vision
Comment					
6	Determine Member Announcement Responsibilities	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
7	Produce Member Materials	pending	as needed	as needed	New York State DCS
Comment					
8	Mail/Distribute Member Materials	pending	as needed	as needed	New York State DCS
Comment					

New York State DCS - Sample Implementation Plan Target Effective Date: January 1, 2012					
SECTION L - PROVIDER NETWORK DEVELOPMENT & COMMUNICATION					
1	Determine Scope of Recruitment Needs	pending	as needed	as needed	Davis Vision
Comment					
2	Provide Updates on Recruitment Process	pending	as needed	ongoing	Davis Vision
Comment					
3	Update Provider Directory as Provider Contracts are Finalized	pending	ongoing	ongoing	Davis Vision
Comment					
4	Develop Provider Communication Materials	pending	12/5/2011	12/15/2011	Davis Vision
Comment					
5	Post Provider Communication Materials	pending	12/15/2011	ongoing	Davis Vision
Comment					
SECTION M - BILLING/BANKING ARRANGEMENTS					
1	Determine Billing Arrangements	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
2	Determine Payment Schedule	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
3	Determine Payment Method	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
4	Develop Invoicing Adjustment Process	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
5	Provide Sample Capitation Report	pending	10/3/2011	10/24/2011	New York State DCS
Comment					
6	Define Limit for Retro Adjustments on Capitated Report	pending	10/3/2011	10/24/2011	New York State DCS/Davis Vision
Comment					
7	Implement Billing Processes	pending	12/20/2011	1/1/2012	New York State DCS/Davis Vision
Comment					
SECTION N - CLAIMS					
1	Review any OON Claims Processing Requirements	pending	10/3/2011	10/3/2011	New York State DCS/Davis Vision
Comment					
2	Testing of Specific OON Claims Processing Requirements	pending	11/1/2011	11/15/2011	Davis Vision
Comment					
3	Implement OON Claims Processing	pending	1/1/2012	ongoing	Davis Vision
Comment					
SECTION O - ADDITIONAL SERVICE REQUIREMENTS					
1	Review any Additional Service Requirements	pending	ongoing	ongoing	New York State DCS/Davis Vision
Comment					
2	Implement Additional Service Requirements	pending	ongoing	ongoing	New York State DCS/Davis Vision
Comment					
LAUNCH		**January 1, 2012**			New York State DCS/Davis Vision

Senior Management Sponsorship
Implementation Coordinator
Client Manager

Pre-Implementation | **Implementation & Testing** | **Production**

PROCESS:



ACTIVITY:

Pre-Implementation	Implementation & Testing	Production
1.) Develop Program Strategy	1.) Conduct Operational / Technical Walkthroughs	1.) Post Production Review
2.) Complete Implementation Questionnaire	2.) Manage Project Plan Activities	2.) Operational Performance Measured and Tuned
3.) Form Joint Project Team	3.) Complete System Setup and Configuration	3.) Billing, Performance and Utilization Reporting
4.) Define Operational Exchanges	4. Complete End to End Testing	4.) Final Signoff
5.) Develop Detailed Project Plan		

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Member Services Interactive Voice Response System

Members Call: Dedicated 800#

Welcome to Davis Vision
(**Press 2** for Spanish)
Please enter **Member's ID number**
If not on file/unsuccessful login will be transferred to CSR

Main Menu:

Press 1: For information on how to use your vision benefit

Press 2: For current eligibility

Press 3: For participating providers

Press 4: For claim information

Press 5: For all laser vision correction information

Press 6: For Web site information

Press 9: To repeat these options

Menu Option 1:
Basic Benefit information on how to use your In-Network benefits

Menu Option 2:
Press 1: For member information
Press 2: For spouse
Press 3: For child
Press *: To return to the Main Menu
(IVR will prompt caller for DOB and give options based on individual member benefits)

Menu Option 3:
Press 1: To listen to providers locations
Press 2: Request provider listing to be shipped to you (confirm ZIP code of address)
Press *: To return to the Main Menu

Menu Option 4:
Press 1: To request a claim form
Press 2: To inquire about the status of an out-of-network claim
Press *: To return to the Main Menu

Press 1: For member information
Press 2: For spouse
Press 3: For child
Press *: To return to the Main Menu
(IVR will prompt caller for DOB and give options based on individual member benefits)

Advises of claim information
Press 1: To repeat information
Press 2: To continue to next claim
Press 3: To inquire on a claim for another family member
Press *: To return to the Main Menu

Menu Option 5:
Press 1: For information about the laser correction benefit offered to your group
Press 2: To learn how to tell if you might be a candidate for laser surgery
Press 3: To listen to participating providers in your area
Press 4: To obtain a confirmation number for laser surgery, or to speak to a CSP
Press 9: To repeat this menu
Press *: To return to the Main Menu

Menu Option 6:
For the fastest service and privacy information. Visit our Web site at
<<Your website listed here>>
Press 1: To repeat message
Press *: To return to the Main Menu

DAVISVISION® SEE LIFE & GEICO®

A Case Study in Collaboration

The Vision Plan:

To get your employees the highest-quality vision care program with the lowest out-of-pocket costs, you need a partner with proven vision benefits experience. An organization that makes it easier for you to focus on the bigger challenges of today's difficult economy. Davis Vision is the solution that allows you to SEE LIFE.

The Client Challenge:

GEICO is a large organization, with multiple locations nationwide, and had never offered a vision program to their employees before. They selected Davis Vision knowing we would deliver a quality benefit that best matched the needs of their employees. GEICO needed a partner that could develop a solution that would drive enrollment, and we built a co-branded campaign to do just that. A consultative approach emerged based on this need, and our Client Management, Sales and Marketing teams worked closely with GEICO's Human Resources department to develop a targeted marketing campaign and contest to drive enrollment – all in a very short timeframe. Materials were created using the GEICO logo as well as their mascot, The Gecko®. We were able to successfully infuse their own branding into our materials, even putting The Gecko® in eyeglasses!

The Marketing Plan:

The targeted campaign included multiple pieces mailed to employee homes and delivered electronically to employee work e-mail addresses. We placed The Gecko® in obscure places within the marketing materials and asked the employees to "Find The Gecko®." 25 randomly selected contest winners received free eyeglasses, sunglasses or readers at one of our affiliated retail stores.

The Basic Client Need:

The contest addressed three needs for GEICO:

- Increasing voluntary enrollment for their new vision benefit
- Engaging their employees and delivering vision benefit information in a consistent format
- Increasing Davis Vision brand recognition without sacrificing their own brand identity

Measuring Benchmarks:

The success of this outreach effort can be measured against a number of parameters – typical enrollment for a voluntary program is approximately 35%-40%. GEICO's Human Resources team was hoping for a 60% enrollment as a result of our enhanced marketing efforts.

Return on Investment:

GEICO established benchmarks for Davis Vision plan enrollment based on previous enrollment for medical and specialty products of 30% of eligible employees. Through our collaborative marketing efforts we were able to double the expected enrollment level and exceed GEICO's expectations.

Continued Partnership:

Our Marketing department is a collaborative partner with all of our clients. Our dedicated team of Client Managers will work with your Human Resources department to tailor campaigns to drive voluntary enrollment and provide education about vision benefits.

Let's partner to achieve success for your company as well!

Pre-Enrollment Flyer

English

DAVISVISION®
SEE LIFE

DAVISVISION®
SEE LIFE

[Group Name]

[Designer] Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. With the rising cost of eyewear you can't afford not to be covered through a managed vision care plan. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment/Discount Plan section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

DAVISVISION · Empire Vision Centers · Total Vision Care · EyeMasters · cambridge Eye Doctors · VISION WORLD · Binyon's · Dr. Bizer's VisionWorld · EYE DRx · Dr. Bizer's Valu Vision · Doctors Valu Vision · HOUR EYES · Stein Optical Express · Visionworks · VISION WORLD

Contact your [Benefits or Human Resources] department today to enroll.

For more details about the plan, just log on to the Open Enrollment/Discount Plan section of our Member site at **davisvision.com** or call [**1.877.923.2847**] and enter Client Code [**1234**].

[1] The Davis Vision Collection is available at most participating independent provider locations.
[2] For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
[3] Additional discounts not applicable at Walmart locations.
[4] Transitions® is a registered trademark of Transitions Optical Inc.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

IN-NETWORK BENEFITS	
Eye Examination	Every [12 months], **Covered in full** [after $xx copayment]
Eyeglasses	
Spectacle Lenses	Every [12 months], **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses [after $xx copayment]
Frames	Every [12 months], **Covered in full** $[130] retail allowance toward any frame from provider[, plus 20% off balance[3]] OR Any [Fashion or Designer] frame from Davis Vision's Collection[1] (value up to $[175])
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every [12 months], **Covered in full** For Standard Contacts[: after $xx copayment] OR For Specialty Contacts: $[60] allowance with 15% off balance [after $xx copayment]
Contact Lenses (in lieu of [eyeglasses])	Every [12 months], **Covered in full** $[130] retail allowance toward provider's lenses[, plus 15% off balance[3]] OR Any contact lenses from Davis Vision's Contact Lens Collection[1] [after $xx copayment]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$20	$0
Polycarbonate Lenses	$64	$0[2]-[$30]
Standard Anti-Reflective (AR) Coating	$62	[$35]
Standard Progressives (no-line bifocal)	$154	[$50]
Plastic Photosensitive (Transitions®[4])	$126	[$65]

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$75	[$xx]
Lenses		
Bifocals	$80	[$xx]
Scratch-Resistant Coating	$20	$0
Transitions®[4]	$126	[$xx]
Frame	$130	[$xx]
Total	$431	[$xx]

Savings up to: ***$xxx***

Employee Contributions	Monthly	Annually
Employee	[$x.xx]	[$x.xx]
Employee plus Spouse	[$x.xx]	[$x.xx]
Employee plus Child(ren)	[$x.xx]	[$x.xx]
Employee plus Family	[$x.xx]	[$x.xx]

Davis Vision plans offer....

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Replacement contacts through Lens 123!® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact Info

For more details about the plan, just log on to the Open Enrollment/Discount Plan section of our Member site at davisvision.com or call [1.877.923.2847] and enter Client Code [1234].

ADDITIONAL LENS OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
All Ranges of Prescriptions and Sizes	**$60-$120**	**$0**
Plastic or Glass Lenses	**$30-$35**	**$0**
Oversized Lenses	**$25**	**$0**
Fashion Gradient Tinting	**$20**	**$0**
Scratch-Resistant Coating	**$20**	**$0**
Polycarbonate Lenses	$64	$0[1] or [$30]
Ultraviolet Coating	$26	[$12]
Standard Anti-Reflective (AR) Coating	$62	[$35]
Premium AR Coating	$76	[$48]
Ultra AR Coating	$114	[$60]
Standard Progressive Addition Lenses	$154	[$50]
Premium Progressives (Varilux™[2], etc.)	$225	[$90]
High-Index Lenses	$121	[$55]
Polarized Lenses	$95	[$75]
Photochromic Glass Lenses	$50	[$20]
Plastic Photosensitive Lenses	$126	[$65]
Intermediate Lenses	$160	[$30]
Blended Segment Lenses	$50	[$20]
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2] Varilux® is a registered trademark of Societe Essilor International

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to [$30] | Frame up to [$30] Spectacle Lenses (per pair) up to: Single Vision [$25], Bifocal [$35], Trifocal [$45], Lenticular [$60] Elective Contacts up to [$75], Medically Necessary Contacts up to [$225]

Sample Member Welcome Kit

English

DAVISVISION®
SEE LIFE

GroupName

DAVISVISION SEE LIFE

Welcome to Davis Vision!

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

John Doe
123 Main Street
Anytown, AB, 00000

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through GROUPNAME. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Your Davis Vision Designer Plan Benefits

Benefit	Frequency Once every -	In-network Copay	In-network Coverage
Eye Examination	12 months	$0	Covered in full. *Includes dilation when professionally indicated.*
Spectacle Lenses	12 months	$10	Clear glass or plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	12 months	$10	**Frame Allowance:** $130 towards any frame from provider plus 20% off any balance[/1]. No copay required. **OR, Covered in Full Frames:** After copay, any Fashion or Designer level frame from Davis Vision's Collection[/2] (retail value, up to $175).
Contact Lens Evaluation, Fitting & Follow Up Care	12 months	$20	**Standard, Soft Contacts**: After copay, covered in full. **Specialty Contacts**[/3]: $60 allowance less copay plus 15% off balance[/1]. **Davis Vision Collection Contacts**: After copay, covered in full.
Contact Lenses (in lieu of eyeglasses)	12 months	$10	**Contact Lens Allowance**: $130 allowance toward any contacts from provider's supply plus 15% off balance.[/1] No copay required. **OR, Covered in Full Contacts**: From Davis Vision's Collection[/2], after copay, up to: Standard/Daily Wear: One pair Planned Replacement: Two boxes/multi-packs Disposable: Four boxes/multi-packs **OR, Medically Necessary Contacts**: After copay, covered in full with prior approval. Covered in full with prior approval.

Significant savings on optional frames, lens types and coatings! Member Price

Davis Vision Collection Frames: Fashion | Designer | Premier	$0 | $0 | $25
Tinting of Plastic Lenses or Glass Grey #3 Lenses	$0
Oversize Lenses	$0
Scratch Protection	$20
Ultraviolet Coating	$12
Anti-Reflective Coating: Standard | Premium | Ultra	$35 | $48 | $60
Polycarbonate Lenses	$0[/4]-$30
High-Index Lenses	$55
Progressive Lenses: Standard | Premium	$50 | $90
Polarized Lenses	$75
Photosensitive Lenses: Plastic | Glass	$65 | $20
Intermediate Lenses	$30
Blended Segment Lenses	$20

[1] Additional discounts not applicable at Walmart locations.
[2] The Davis Vision Collection is available at most participating independent provider locations.
[3] Including, but not limited to toric, multifocal and gas permeable contact lenses.
[4] For dependent children, monocular patients and patients with prescriptions of +/- 6.00 diopters or greater.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees [above the evaluation and fitting allowance] are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers.

DAVISVISION SEE LIFE Group Logo

ID #: 000000012345
Name: John Doe
Group Name/#: Group Name
Effective Date: 01-01-11

www.davisvision.com | 1.800.999.5431

Fully insured product underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

DAVISVISION SEE LIFE Group Logo

ID #: 000000012345
Name: John Doe
Group Name/#: Group Name
Effective Date: 01-01-11

www.davisvision.com | 1.800.999.5431

Fully insured product underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

Cards may be used as proof of identification to receive vision care benefits.The provider will check with Davis Vision to verify your eligibility. For additional copies of your ID card, visit our Member site at davisvision.com.

Actual size 8.5 x 14

Frequently Asked Questions

How can I contact Member Services?
Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m. - 11 p.m. | Saturday, 9 a.m. - 4 p.m. | Sunday, 12 p.m. - 4 p.m. (Eastern Time). (TYY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full after your copay. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. Complete eyeglasses must be obtained at one time, from one provider. You may not split between a network and out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $35 | single vision lenses - $25 | bifocal - $35 | trifocal - $45 | lenticular - $60 | frame - $30 | elective contacts - $75 | medically necessary contacts - $225.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings At most participating network locations, members receive up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 10% off disposable contact lenses.[5]

Mail Order Contact Lenses Free membership in Lens123!®, our mail order contact lens program with the lowest prices guaranteed on replacement contacts (once your benefit is exhausted). Log on to our member Web site for details.

Laser Vision Correction Up to 25% discount off participating provider's U&C or 5% off advertised special (whichever is lower). Log on to our member Web site for details and to locate a provider.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities, or more information about Davis Vision, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

[5]Additional discounts not applicable at Walmart locations.

Local Participating Provider Listing

LONG BEACH
SAMPLE DOC, O.D.
SAMPLE DOC 2, O.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, O.D.
SAMPLE DOC 2, O.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

LONG BRANCH
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

MEDFORD
SAMPLE DOC, O.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, O.D.
SAMPLE DOC 2, O.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, O.D.
SAMPLE DOC 2, O.D.
612 E. PARK AVE.
(516) 431-3838
Long Beach, NY 11561
(516) 376-8159

PATCHOGUE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, O.D.
SAMPLE DOC 2, O.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

EYE DOC STORE
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

SAMPLE DOC, O.D.
SAMPLE DOC 2, O.D.
612 E. PARK AVE.
(516) 431-3838

SMITHTOWN
SAMPLE DOC, M.D.
612 E. PARK AVE.
(516) 431-3838

To locate more network providers, log on to our Member site at davisvision.com and use the "Find a Provider" tool.

Present this card to your Davis Vision network provider to access your vision benefits. The provider will verify your current eligibility.

Davis Vision Providers:
To verify eligibility and obtain authorization visit www.davisvision.com.

Present this card to your Davis Vision network provider to access your vision benefits. The provider will verify your current eligibility.

Davis Vision Providers:
To verify eligibility and obtain authorization visit www.davisvision.com.

Actual size 8.5 x 14

Pre-Enrollment Flyer

Spanish

DAVISVISION®
SEE LIFE

DAVISVISION®
SEE LIFE

ABC COMPANY

Plan Designer Vision

Ojos sanos y buena visión son una parte importante de su salud general y de su calidad de vida. Con el costo creciente de las gafas usted no puede arriesgarse a no tener cobertura a través de un plan administrado de atención de la visión. Su plan de la visión le ayuda a cuidar de sus ojos mientras le ahorra dinero al ofrecerle:

¡Exámenes oculares, gafas y lentes de contacto pagos en su totalidad!

Colección de monturas: Su plan incluye una selección de monturas de diseñadores de marca que están completamente cubiertas en su totalidad.[1]

Colección de lentes de contacto: Seleccione los lentes de contacto que son más populares hoy en el mercado con la “Collection” de lentes de contacto de Davis Vision.[1]

¡Garantía por un año por rotura para todos las gafas incluidas en el plan sin costo adicional!

Cómo localizar un proveedor de la red...

Simplemente ingrese a la sección Open Enrollment/Discount Plan (Inscripción abierta/Plan de descuento) de nuestro sitio para miembros en davisvision.com y haga clic en “Find a Provider” (“Buscar un proveedor”) para ubicar a un proveedor cerca de usted que incluya:

DAVIS VISION · Empire Vision Centers · Total Vision Care · EyeMasters · cambridge Eye Doctors · Vision World · Binyon's · Dr. Bizer's VisionWorld · EYE DRx · Dr. Bizer's ValuVision · Doctors ValuVision · HOUR EYES · SteinOptical EXPRESS · Visionworks · VISIONWORLD

Comuníquese con su departamento de Recursos Humanos hoy para inscribirse.

Para más detalles sobre el plan, simplemente ingrese a la sección Open Enrollment/Discount Plan (Inscripción abierta/Plan de descuento) de nuestro sitio para miembros en **davisvision.com** o llame al **1.877.923.2847** e ingrese el código del cliente xxxx.

[1] La "Collection" de Davis Vision está disponible en la mayoría de los establecimientos de proveedores participantes independientes.
[2] Para hijos dependientes, pacientes monoculares y pacientes con prescripciones de 6.00 dioptrías o más.
[3] No se aplican descuentos adicionales en establecimientos Walmart.
[4] Transitions® es una marca comercial registrada de Transitions Optical Inc.

Davis Vision se ha esforzado para resumir correctamente las características de su plan de la visión en este documento. En caso de que surja un conflicto entre esta información y el contrato de su organización con Davis Vision, prevalecerán los términos y condiciones del contrato o póliza de seguro.

BENEFICIOS DENTRO DE LA RED	
Examen ocular	Cada 1° de julio, **cubierto en su totalidad** después de cubrir el copago de $0
Gafas	
Lentes para gafas	Cada 1° de julio, **cubiertos en su totalidad** Para lentes de visión simple estándar, bifocales con línea o trifocales después de cubrir el copago de $0
Monturas	Cada 1° de julio, **cubiertas en su totalidad** Monto admisible al valor minorista de $130 para cualquier montura del proveedor, más 20% de descuento sobre el saldo [3] O Cualquier montura Fashion o Designer de la "Collection" de Davis Vision[1] (valor de hasta $175)
Lentes de contacto	
Evaluación, ajuste y seguimiento de lentes de contacto	Cada 1° de julio, **cubiertos en su totalidad** Para lentes de contacto estándar: después de cubrir el copago de $0 O Para lentes de contacto especiales: monto admisible de $60 con 15% de descuento sobre el saldo después de cubrir el copago de $0
Lentes de contacto (en lugar de gafas)	Cada 1° de julio, **cubiertos en su totalidad** Monto admisible al valor minorista de $130 para lentes del proveedor, más 15% de descuento sobre el saldo[3] O Cualquier lente de contacto de la "Collection" de lentes contacto de Davis Vision[1]

OPCIONES ADICIONALES DE LENTES Y CAPAS CON DESCUENTO		
OPCIONES MÁS POPULARES Ahorros basados en el uso dentro de la red y en precios minoristas promedio.	Sin Davis Vision	Con Davis Vision
Capa resistente a rayaduras	$20	$0
Lentes de policarbonato	$64	$0[2]-$30
Capa antirreflectiva estándar (AR)	$62	$35
Progresivos estándar (bifocales sin línea)	$154	$50
Fotosensitivos de plástico (Transitions®[4])	$126	$65

¡Costos más bajos y más beneficios! *¡Vea los ahorros!*

Servicio	Sin Davis Vision	Con Davis Vision
Examen ocular	$75	$0
Lentes		
Bifocales	$80	$0
Capa resistente a rayaduras	$20	$0
Transitions®[4]	$126	$65
Montura	$130	$0
Total	$431	$65

Ahorros de hasta:
$366

Contribuciones de los empleados	Mensualmente	Anualmente
Empleado		
Empleado más uno		
Empleado más la familia		

Los planes de Davis Vision ofrecen....

Valor para nuestros miembros

Un beneficio integral que les asegura a los miembros y a sus familias bajos gastos de bolsillo. Nuestro objetivo es 100% de satisfacción de los miembros.

Ubicaciones convenientes dentro de la red

Una red nacional de proveedores preferidos acreditados en todos los 50 estados.

Libertad para elegir

Acceso a la atención a través de nuestra red de médicos independientes en práctica privada (optometristas y oftalmólogos) o socios minoristas seleccionados.

Características que agregan valor:

- Lentes de contacto de reemplazo a través del servicio de reemplazo de lentes de contacto con orden por correo de Lens 1-2-3!® que le ahorrarán tiempo y dinero.
- Servicios láser para corrección de la visión con descuentos de hasta 25% sobre los honorarios Habituales y regulares del proveedor, ó 5% de descuento sobre las ofertas especiales publicitadas, lo que sea menor.

Información de contacto

Para más detalles sobre el plan, simplemente ingrese a la sección Open Enrollment/Discount Plan (Inscripción abierta/Plan de descuento) de nuestro sitio para miembros en davisvision.com o llame al 1.877.923.2847 e ingrese el código del cliente xxxx.

OPCIONES ADICIONALES DE LENTES	SIN DAVIS VISION	CON DAVIS VISION
Toda la gama de prescripciones y tamaños	**$60-$120**	**$0**
Lentes de vidrio o plástico	**$30-$35**	**$0**
Lentes extra grandes	**$25**	**$0**
De moda con tinte gradual	**$20**	**$0**
Capa resistente a rayaduras	**$20**	**$0**
Montura Premier	$225	$25
Lentes de policarbonato	$64	$0[1/] ó $30
Capa ultravioleta (UV)	$26	$12
Capa antirreflectiva estándar (AR)	$62	$35
Capa antirreflectiva Premium (AR)	$76	$48
Capa antirreflectiva Ultra (AR)	$114	$60
Lentes de adición progresiva estándar	$154	$50
Progresivos Premium (Varilux™[2/] etc.)	$225	$90
Lentes de alto índice	$121	$55
Lentes polarizados	$95	$75
Lentes de vidrio fotocrómicos	$50	$20
Lentes de plástico fotosensibles	$126	$65
Plan de protección contra rayaduras (Lentes de visión simple | multifocales)		$20 | $40

[1/] Los lentes de policarbonato tienen cobertura completa para hijos dependientes, pacientes monoculares y pacientes con prescripciones de 6.00 dioptrías o más.

[2/] Varilux® es una marca comercial registrada de Societe Essilor International

Beneficios fuera de la red

Puede recibir servicios de un proveedor fuera de la red, aunque recibirá el mayor valor y maximizará el dinero que destine a sus beneficios si selecciona un proveedor de la red. Si escoge un proveedor fuera de la red, tendrá que pagar directamente al proveedor todos los cargos y luego presentar una reclamación para obtener un reembolso a:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

PROGRAMA DE REEMBOLSO FUERA DE RED
Examen ocular hasta $30 | Montura hasta $30 Lentes para gafas (por par) hasta: Visión simple $25, bifocales $35, trifocales $45, lenticulares $60 Lentes de contacto electivos hasta $75, lentes de contacto médicamente necesarios hasta $225

Sample Member Welcome Kit

Spanish

DAVISVISION®
SEE LIFE

ABC Company, Inc.

DAVISVISION SEE LIFE

¡Bienvenido a Davis Vision!

¡Nos complace ofrecerle información sobre sus beneficios de la visión para ayudarle a cuidar de su visión y la salud de sus ojos - una parte clave de la salud y el bienestar general!

Nombre del paciente
Línea 1 para domicilio
Línea 2 para domicilio
Ciudad, Estado, Código Postal

¡Utilizar sus beneficios es fácil!

Sólo ingrese a nuestro sitio para miembros en davisvision.com y haga clic en "Find a Provider" ("Buscar a un proveedor") o comuníquese con nosotros llamando al 1.800.999.5431.

Haga una cita. Dígale a su proveedor que usted es un miembro de Davis Vision con cobertura a través de ABC Company, Inc. Proporcione su número de identificación, nombre y fecha de nacimiento, y haga lo mismo para sus dependientes cubiertos que necesiten servicios para visión. Su proveedor se encargará del resto.

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Sus Beneficios del Plan Designer de Davis Vision

Beneficio	Frecuencia Una vez cada -	Copago dentro de la red	Cobertura dentro de la red
Examen ocular	1 de julio	$0	Cubierto en su totalidad. *Incluye dilatación cuando un profesional lo indica.*
Lentes para gafas	1 de julio	$0	Lentes de vidrio o de plástico transparentes para todas las prescripciones de visión simple, bifocales, trifocales o lenticulares. Cubiertos en su totalidad. (Ver a continuación opciones adicionales de lentes y capas).
Montura	1 de julio	$0	**Monturas cubiertas en su totalidad:** Todas las monturas del nivel Fashion o Designer de la "Collection" de Davis Vision[2] (valor minorista, hasta $175). **O, Monto admisible para la montura:** $130 para cualquier montura del proveedor más un descuento de 20% sobre cualquier saldo.[1] No requiere copago.
Evaluación, ajuste y seguimiento de lentes de contacto	1 de julio	$0	**Lentes de contacto de la "Collection" de Davis Vision:** Después de cubrir el copago, cubiertos en su totalidad. **Lentes de contacto estándar, blandos:** Después de cubrir el copago, cubiertos en su totalidad. **Lentes de contacto especiales**[3]: $60 de monto admisible menos el copago, más un 15% de descuento sobre el saldo[1]
Lentes de contacto (en lugar de gafas)	1 de julio	$0	**Lentes de contacto cubiertos en su totalidad:** De la "Collection" de Davis Vision[2], hasta: Estándar/de uso diario: Un par De reemplazo planificado: Dos cajas/paquetes múltiples Desechables: Ocho cajas/paquetes múltiples **O, Monto admisible para lentes de contacto:** Monto admisible de $130 para lentes de contacto del suministro del proveedor más un descuento de 15% sobre el saldo.[1] No requiere copago. **O, Lentes de contacto médicamente necesarios:** Cubiertos en su totalidad con aprobación previa.

¡Descuentos significativos en monturas, tipos de lente o capas opcionales!

	Precio para el miembro
Monturas de la "Collection" de Davis Vision: Fashion | Designer | Premier	$0 | $0 | $25
Coloración de lentes de plástico o de vidrio gris #3	$0
Lentes extra grandes	$0
Capa resistente a rayaduras	$0
Capa ultravioleta	$12
Capa antirreflectiva: Estándar | Premium | Ultra	$35 | $48 | $60
Lentes de policarbonato	$0[4]-$30
Lentes de alto índice	$55
Lentes de adición progresiva: Estándar | Premium	$50 | $90
Lentes polarizados	$75
Lentes fotosensibles: Plástico | Vidrio	$65 | $20
Lentes de visión intermedia	$30
Lentes segmentados sin línea	$20
Plan de protección contra rayaduras: Lentes de visión simple | Multifocales	$20 | $40

[1] *Los descuentos adicionales no están disponibles en establecimientos Walmart.*
[2] *La "Collection" de Davis Vision está disponible en la mayoría de los establecimientos de proveedores independientes participantes.*
[3] *Incluidos pero no limitados, lentes de contacto tóricos, multifocales y permeables al gas.*
[4] *Para hijos dependientes, pacientes monoculares y pacientes con prescripciones de +/- 6.00 dioptrías o más.*

Tenga en cuenta que su proveedor se reserva el derecho de no proporcionar materiales hasta que todos los costos de membresía, cuotas y copagos aplicables hayan sido cobrados. Lentes de contacto: Los exámenes oculares de rutina no incluyen los servicios profesionales para evaluaciones de lentes de contacto. Cualquier cargo aplicable sobre el monto admisible de la evaluación y ajuste son responsabilidad del miembro. Si se seleccionan los lentes de contacto y se hacen los ajustes a los lentes, éstos no se pueden cambiar por gafas. Lentes progresivos: Si usted no puede adaptarse a los lentes de adición progresiva que compró, se le suministrarán lentes bifocales convencionales sin costo adicional; no obstante, no hay reembolso para el copago. No combinable con otros descuentos y ofertas.

DAVISVISION SEE LIFE

No. de identificación:
Nombre:
Afiliación:

www.davisvision.com | 1.800.999.5431

Plan completamente asegurado financiado por HM Life Insurance Company of New York. Administrado por Davis Vision, que podría operar como Davis Vision Insurance Administrators en California.

DAVISVISION SEE LIFE

No. de identificación:
Nombre:
Afiliación:

www.davisvision.com | 1.800.999.5431

Plan completamente asegurado financiado por HM Life Insurance Company of New York. Administrado por Davis Vision, que podría operar como Davis Vision Insurance Administrators en California.

Pueden utilizarse tarjetas como prueba de la identidad para recibir beneficios de atención de la visión. El proveedor consultará con Davis Vision para verificar su elegibilidad. Para obtener copias adicionales de su tarjeta de identificación, visite nuestro sitio para miembros en davisvision.com.

Actual size 8.5 x 14

Preguntas frecuentes

¿Cómo puedo comunicarme con Servicios a los miembros?
Llame al 1.800.999.5431 para obtener ayuda automática las 24 horas del día, los 7 días de la semana. La ayuda directa también está disponible los siete días de la semana: de lunes a viernes, de 8 a.m. a 11 p.m. | Sábados, de 9 a.m. a 4 p.m. | Domingo, de 12 p.m. a 4 p.m. (Hora del este). (Servicios TYY: 1.800.523.2847).

¿Qué monturas pertenecen a la "Collection" de Davis Vision?
Nuestra "Collection" ofrece una gran selección de monturas modernas y de diseñador, mucha de las cuales están cubiertas en su totalidad. No es de extrañar que 8 de cada 10 miembros elijan una montura de la "Collection". Ingrese a nuestro sitio web en davisvision.com y eche un vistazo.

¿Cuándo recibiré mis gafas?
Sus gafas serán enviadas a su proveedor de la red generalmente dentro de un período de cinco días hábiles a partir de la recepción del pedido. Las prescripciones especiales, las capas para lentes, las monturas del proveedor, o las monturas que estén fuera del inventario pueden demorar el tiempo de entrega estándar.

¿Necesito un formulario de reclamación?
Sólo se requieren formularios de reclamación si usted visita a un proveedor fuera de la red. Los formularios de reclamación están disponibles en nuestro sitio web para miembros.

¿Puedo dividir mis beneficios?
Puede dividir sus beneficios y recibir su examen ocular y sus gafas o lentes de contacto en fechas diferentes o por medio de diferentes ubicaciones de proveedores. Para maximizar el valor de sus beneficios le recomendamos que obtenga todos los servicios a través de un proveedor de la red.

¿Puedo utilizar un proveedor fuera de la red?
Sí; sin embargo, usted recibe el mayor valor seleccionando un proveedor de la red. Si usted sale de la red, pague al proveedor al momento del servicio y luego presente una reclamación a Davis Vision para obtener un reembolso, de hasta los siguiente montos: examen ocular - $30 | lentes de visión simple - $25 | bifocales - $35 | trifocales - $45 | lenticulares - $60 | montura - $30 | lentes de contacto optativos - $75 | lentes de contacto médicamente necesarios - $225.

¿Existe alguna exclusión a los beneficios para la visión?
Su plan de la visión no cubre el tratamiento médico de enfermedades o lesiones oculares; terapia de la visión; diseños o capas especiales para lentes, que no sean los aquí descritos; reemplazo de gafas extraviadas; lentes sin receta (plano); lentes de contacto y gafas en el mismo ciclo de beneficios; servicios realizados por personal no autorizado; dos pares de gafas en lugar de un par de gafas bifocales.

¡EXTRAS de DAVIS VISION!

Garantía por un año por rotura Reparación o reemplazo de sus lentes para gafas cubiertos por el plan, de una montura de la "Collection" o una montura de un establecimiento minorista de la red donde la "Collection" no se exhibe.

Ahorros adicionales En la mayoría de los establecimientos participantes de la red, los miembros reciben un descuento de hasta 20% en gafas adicionales, lentes de sol y productos no cubiertos por el beneficio y de 10% en lentes de contacto desechables.[5]

Lentes de contacto a pedido por correo Membresía gratuita en Lens1-2-3!®, nuestro programa de lentes de contacto a pedido por correo con los precios más bajos garantizados en lentes de contacto de reemplazo (una vez que su beneficio esté agotado). Ingrese a nuestro sitio web para miembros para obtener más detalles.

Láser para corrección de la visión Descuento de hasta 25% sobre los honorarios habituales y regulares de los proveedores participantes o del 5% de descuento sobre cualquier oferta especial promocionada (lo que sea menor). Ingrese a nuestro sitio web para miembros para obtener más detalles y para localizar a un proveedor.

Servicios para visión baja Exámenes integrales de visión baja una vez cada cinco años y elementos para visión baja hasta el máximo del plan. Se cubrirán hasta cuatro visitas de seguimiento durante un periodo de cinco años.

Salud y bienestar de los ojos Conéctese y aprenda más acerca de la salud y el bienestar de sus ojos; de enfermedades oculares comunes que pueden dificultar la visión; y de qué puede hacer usted para asegurarse de tener ojos saludables y una vida más sana.

Para obtener más detalles… acerca de sus beneficios para la visión, los derechos y responsabilidades de los pacientes, o más información sobre Davis Vision, ingrese a nuestro sitio web para miembros o comuníquese con nosotros al 1.800.999.5431.

Davis Vision se ha esforzado para resumir correctamente las características de su plan de la visión en este documento. En caso de que surja un conflicto entre esta información y el contrato de su organización con Davis Vision, prevalecerán los términos y condiciones del contrato.

[5] *Los descuentos adicionales no están disponibles en establecimientos Walmart.*

Listado de proveedores locales participantes

Presente esta tarjeta a su proveedor de la red de Davis Vision para acceder a sus beneficios para visión. El proveedor verificará su elegibilidad actual.

Proveedores de Davis Vision:

Para verificar la elegibilidad y obtener autorización visite www.davisvision.com.

Presente esta tarjeta a su proveedor de la red de Davis Vision para acceder a sus beneficios para visión. El proveedor verificará su elegibilidad actual.

Proveedores de Davis Vision:

Para verificar la elegibilidad y obtener autorización visite www.davisvision.com.

Sample Management Reporting Package

Self-Insured

DAVISVISION®
SEE LIFE

Davis Vision Client Review

Group: XXXXXXXX

Reporting Period: January 2010 - December 2010

The following provides an overview of your Davis Vision Plan.

Utilization: The In Network utilization for the reporting period is: **100%**

The distribution of vision care services for your membership for the reporting period is:

[redacted]

Claims: The number of claims paid in the reporting period is: [redacted]

Enrollment: [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Davis Vision Client Review

Group: XXXXXXXX

Reporting Period: January 2010 - December 2010

Client Statistics

Shown for the following Date Range

	Jan-10 thru Dec-10	Jan-09 thru Dec-09
Average Number of Covered Subscribers	[redacted]	[redacted]
Average Number of Covered Dependents	[redacted]	[redacted]
Average Number of Covered Lives	[redacted]	[redacted]
Number of In-Network Claims	[redacted]	[redacted]
Number of Out-of-Network Claims	[redacted]	[redacted]
Overall Utilization Rate	[redacted]	[redacted]

Utilization by Service (#/%)

Shown for the following Date Range

	Jan-10 thru Dec-10		Jan-09 thru Dec-09	
	XXXXXXXX	Similar Business Segment*	XXXXXXXX	Similar Business Segment*
Eye Examinations	[redacted]	[redacted]	[redacted]	[redacted]
Plan Frame	[redacted]	[redacted]	[redacted]	[redacted]
Non-Plan Frame	[redacted]	[redacted]	[redacted]	[redacted]
TOTAL FRAMES	[redacted]		[redacted]	
Single Vision Lenses	[redacted]	[redacted]	[redacted]	[redacted]
Bifocal Lenses	[redacted]	[redacted]	[redacted]	[redacted]
Trifocal Lenses	[redacted]	[redacted]	[redacted]	[redacted]
Medically Necessary Contact Lenses	[redacted]	[redacted]	[redacted]	[redacted]
Contact Lenses	[redacted]	[redacted]	[redacted]	[redacted]
TOTAL LENSES	[redacted]		[redacted]	

***Similar Business Segment** — *Hi-Tech* — *Hi-Tech*

Group Code - XXX/Report limited to the following SubGroup(s):

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

Davis Vision Client Review

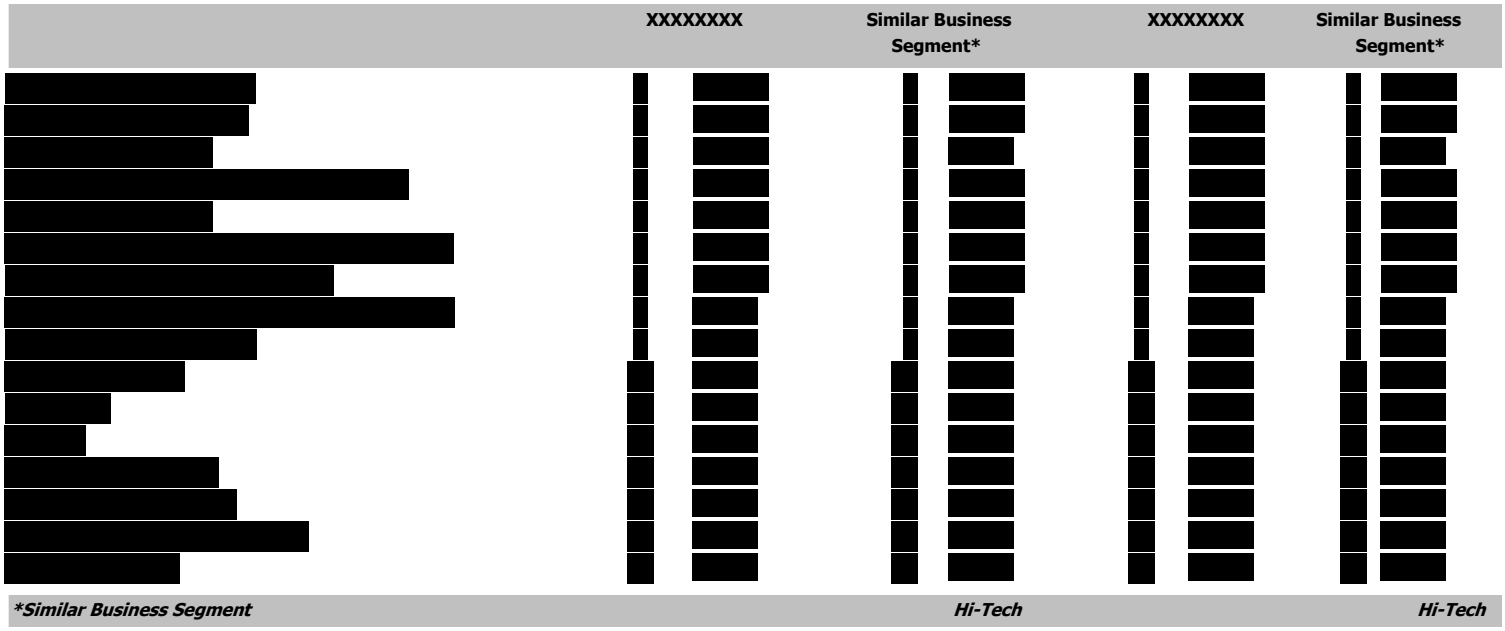
Group: XXXXXXXX

Reporting Period: January 2010 - December 2010

Lens Options Ranking

Shown for the following Date Range

Jan-10 thru Dec-10 | **Jan-09 thru Dec-09**



Utilization

Period	Subscriber Count	Dependent Count	Total Lives	# of Claims	Claims Expense	Avg. Expense per Claim	% of Utilization
2010/1							
2010/2							
2010/3							
2010/4							
2010/5							
2010/6							
2010/7							
2010/8							
2010/9							
2010/10							
2010/11							
2010/12							
Total							

Group Code - XXX/Report limited to the following SubGroup(s):

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

Lens Option Value

[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]

Group Code - XXX/Report limited to the following SubGroup(s):

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

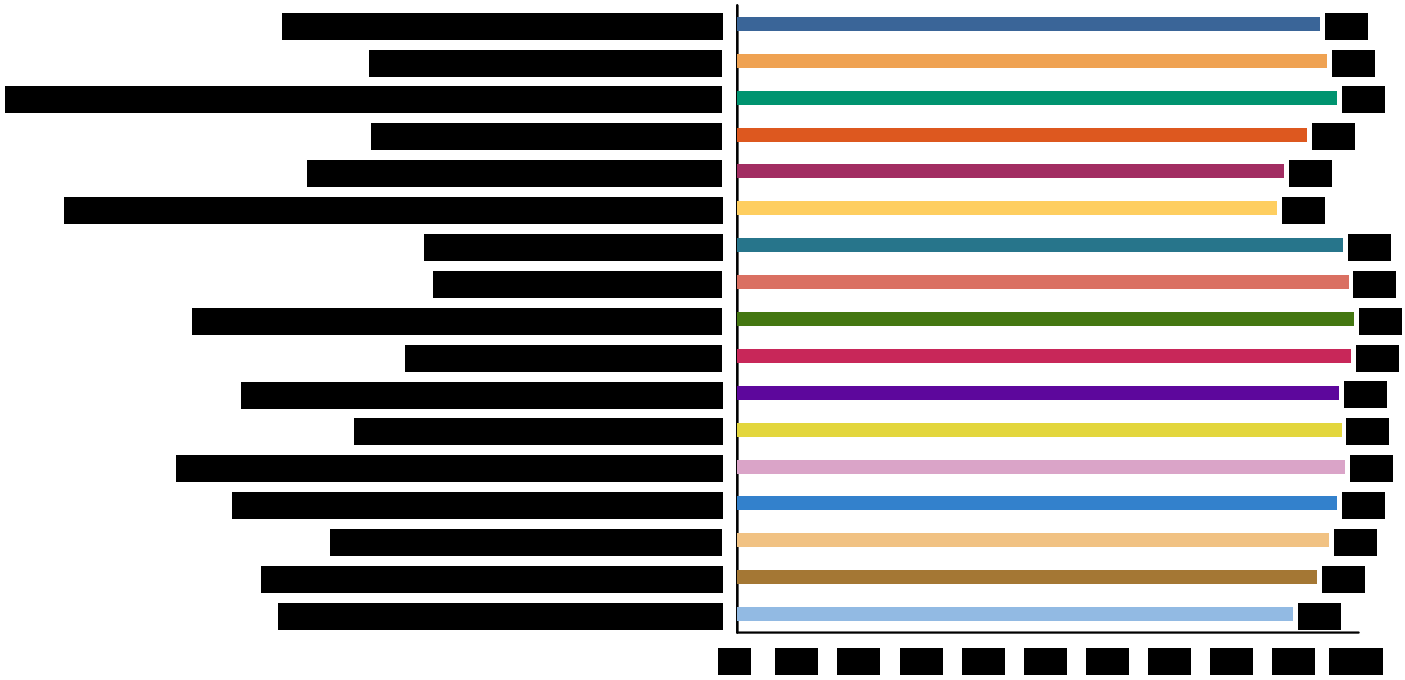
Davis Vision Client Review

Group: XXXXXXXX

Reporting Period: January 2010 - December 2010

Patient Satisfaction

Total Responses: 2241



Group Code - XXX/Report limited to the following SubGroup(s):

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

Davis Vision Client Review

Group: XXXXXXXXX

Reporting Period: January 2010 - December 2010

Member Website Usage Detail

Member Logins

[redacted]

Customer Service Calls Breakdown

Provider Call	[redacted]
Asking if Eligible	[redacted]
Benefit Explanation	[redacted]
Benefit Design	[redacted]
Provider Locate (Verbal)	[redacted]
In Network	[redacted]
Internet Inquiry	[redacted]
Claim Inquiry	[redacted]
How to Login	[redacted]
Out of Network	[redacted]
Generic	[redacted]
Requests	[redacted]
Private Office	[redacted]
Benefit Group Inquiry	[redacted]
How to Locate Function	[redacted]
Explanation Of Benefits	[redacted]
Retail Office	[redacted]

Group Code - XXX/Report limited to the following SubGroup(s):

XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX XXX

DATA SHARING AGREEMENT

THIS AGREEMENT, made on the __ day of _____, 201_, by and between _____, hereinafter referred to as "CLIENT," and Davis Vision, Inc. or "DAVIS." CLIENT and DAVIS shall be hereinafter collectively referred to as "the parties."

WITNESSETH;

WHEREAS, DAVIS acts in the capacity of a Third Party Administrator or an Administrative Services Only company performing certain services on behalf of its self-insured groups customers/employers; and

WHEREAS, CLIENT has agreed to engage DAVIS to arrange for certain vision and eye care services; and

WHEREAS, DAVIS has agreed to provide CLIENT with certain member coverage information (the "Information") concerning individuals who are insured by, or whose claims are administered by, DAVIS; and

WHEREAS, DAVIS has agreed to furnish to CLIENT the Information in the form of electronic data files containing necessary and reasonable information in a mutually agreed upon format. The specific details of said information shall be represented by the layout on **Exhibit A.**, attached hereto, subject to possible amendment upon which the parties shall mutually agree; and

WHEREAS, DAVIS shall furnish the above-referenced data files to CLIENT at a minimum of _____ intervals, or with greater frequency as mutually agreed upon by the parties and at agreed upon dates, methods and formats, and DAVIS shall only be required to provide the information that is maintained by DAVIS; and

WHEREAS, the parties agrees to honor and to follow any and all relevant laws concerning the subject matter of this Agreement, including but not limited to medical assistance subrogation rules, medical assistance statutes, and state insurance laws concerning reimbursement, and shall respect, honor, and abide by state third-party liability provisions generally; and

WHEREAS, this Agreement further obligates the parties hereto to comply with all applicable federal, state, and local statutes, rules, regulations, codes and ordinances in performing under this Agreement;

NOW, THEREFORE in consideration of the mutual promises and covenants set forth herein, the adequacy, sufficiency and receipt of which are hereby acknowledged, CLIENT and DAVIS hereby agree as follows:

1. Confidential Information. "Confidential Information," as used in this Agreement, shall mean all information of DAVIS including, but not limited to member information meeting the definition of Protected Health Information ("PHI") set forth in federal regulations at 45 C.F.R. § 160.103, including the medical records of DAVIS, and DAVIS' member information, customer lists, association lists, customer contracts, patents, copyrights, or any other information of or about DAVIS' business or businesses, or other data

of any kind, nature or description, without regard to whether any or all of the foregoing matters would be deemed confidential, material, or important as trade secrets. The parties hereto stipulate that, as between them, the same are important, material and confidential and affect DAVIS' business interests, effectiveness and goodwill. The term "Confidential Information" will not, however, include information which (i) is or becomes available to the public through no fault of CLIENT, or (ii) is disclosed to CLIENT by a third party who has the lawful right to do so.

2. Acknowledgment. CLIENT hereby agrees that all references to "CLIENT" herein shall be deemed to include all of its officers, employees and agents, and on behalf of same, it hereby acknowledges and agrees that: (a) the Confidential Information is valuable to DAVIS and that improper disclosure or unauthorized use of the Confidential Information may cause irreparable harm, loss, and/or damage to DAVIS; and (b) that it has been and will be conferred a benefit as a result of its knowledge of and access to the Confidential Information and its understanding of DAVIS' business; and (c) that it has agreed to the provisions contained in this Agreement. CLIENT further acknowledges that it has carefully considered the provisions of this Agreement and having done so, agrees to reasonably protect the goodwill and business interests of DAVIS.

3. Permitted use and disclosure of Confidential Information. CLIENT agrees that the Information, in particular the Confidential Information, disclosed under the terms of this Agreement may only be used and/or disclosed to the extent necessary for the purposes of benefits administration, health services program, or as otherwise may be required by law or mandatory legal process, and to the extent such use and/or disclosure is consistent with the terms of any current Business Associate agreements between CLIENT and DAVIS, where applicable, and in compliance with the federal regulations at 45 C.F.R. § 164.504(e)(1).

4. Obligations of CLIENT. In consideration of the disclosure to CLIENT of DAVIS' Confidential Information, CLIENT hereby specifically agrees that it shall not, whether during the term of this Agreement or subsequent to the termination of this Agreement, except as is expressly permitted under this Agreement or necessary to carry out the purposes described in paragraph 3, or as may otherwise be required by law or mandatory legal process, in any fashion, form or manner, either directly or indirectly, divulge, disclose or communicate to any person, firm, or corporation, any of DAVIS' Confidential Information, or any information of any kind, nature, or description concerning any matters effecting or relating to the DAVIS' Confidential Information, without prior written consent of a duly authorized officer of DAVIS. In addition, CLIENT agrees to undertake the following additional obligations with respect to the DAVIS' Confidential Information.

A. To retain all DAVIS' Confidential Information in strict confidence and not use or disclose the same except as otherwise provided or permitted in this Agreement;

B. CLIENT shall maintain complete and accurate records of its receipt and use of the Information provided by DAVIS pursuant to this Agreement. Upon DAVIS' request, CLIENT shall promptly return, destroy, or no longer use, the Information provided under this Agreement to DAVIS, including any copies, extracts and other derivative works containing the Information, where CLIENT is not the data owner of such Information;

C. Not to copy, or in any way memorialize, in whole or in part, DAVIS' Confidential Information, except to the extent necessary to achieve the purposes set forth in this Agreement;

5. Obligations of DAVIS. In consideration of the mutual promises stated herein, DAVIS hereby specifically agrees that it will furnish the Information referred to as data files at the indicated intervals, subject to the abilities of the Parties to mutually agree upon the details of the provision of such data.

6. Internet Access to Data. Upon agreement of the parties as to terms of use and data security, CLIENT may also be granted access to certain data, whether in whole or part of the Information, through a direct secure web portal or web-based reporting tool operated by DAVIS in order to perform certain necessary and reasonable functions under this Agreement. If DAVIS does not currently provide such access through such portals, DAVIS agrees that if at some time in the future it does so, it will provide such access to CLIENT, subject to such conditions and restrictions as the parties deem appropriate.

7. Limitation of Rights. Nothing contained in this Agreement shall be construed as granting or conferring any patent rights, or any other rights, whatsoever, express or implied, by licensing or otherwise, in DAVIS' Confidential Information as expressly provided herein. This Agreement is not intended and it shall not be construed to create any right in or upon any person or entity not a party to this Agreement.

8. Survival. The restrictions and obligations of the parties as contained in this Agreement shall survive the expiration, termination or cancellation of this Agreement, and shall continue in full force and effect indefinitely.

9. Governing Law. This Agreement shall be interpreted and construed according to, and governed by, the laws of the State of New York, excluding any such laws that might direct the application of the laws of another jurisdiction. The federal or state courts located in the State of New York shall have jurisdiction to hear any dispute under this Agreement.

10. Change in Law. The parties agree that if either party determines in good faith that a provision of this Agreement is inconsistent with any applicable law or regulation relating to the confidentiality or privacy of personal information or medical records, that party shall not be required to comply with that provision and the parties agree to negotiate in good faith to amend this Agreement so that it remains consistent with all applicable confidentiality or privacy laws.

11. Severability. If a court of competent jurisdiction holds any provisions of this Agreement invalid, such provision shall be deemed modified to eliminate the invalid element, and as so modified, such provision shall be deemed a part of this Agreement. If it is not possible to modify any such provision to eliminate the invalid element, such provision shall be deemed eliminated from this Agreement. The invalidity of any provision of this Agreement shall not affect the force and effect of the remaining provisions.

12. Successors and Assigns. This Agreement shall be binding upon and the benefits thereof, shall inure to the parties hereto and their respective legal representatives, heirs, successors, and assigns.

13. Amendment and Waiver. No provision of this Agreement may be altered, amended, and/or waived, except by a written document signed by both parties hereto setting forth

such alteration, amendment, and/or waiver. The parties hereto agree that the failure to enforce any provision or obligation under this Agreement shall not constitute a waiver thereof or serve as a bar to the subsequent enforcement of such provision or obligation under this Agreement.

14. Captions. Captions contained in this Agreement are inserted for reference and in no way define, limit, extend or describe the scope of this Agreement or the intent of any provision to this Agreement.

15. Authority to Execute. Each party hereto warrants and represents to the other party that this Agreement shall be binding upon it once executed, and that the individual executing this Agreement is duly authorized or has been empowered to do so in accordance with applicable law.

16. Notices. Any notice given under this Agreement shall be given in writing, and sent by hand delivery, overnight courier that provides confirmation of delivery, or certified mail, return receipt requested, to the applicable party at its address set forth below:

If to DAVIS:
Address:
189 Express Street
Plainview, NY 11758

If to CLIENT:
Address:
_____
_____
_____
_____

With a copy to:
Address:
_____
_____
_____
_____

17. Term. The term of this Agreement shall be for a period of one year, to renew automatically annually unless otherwise terminated as provided herein or by mutual agreement.

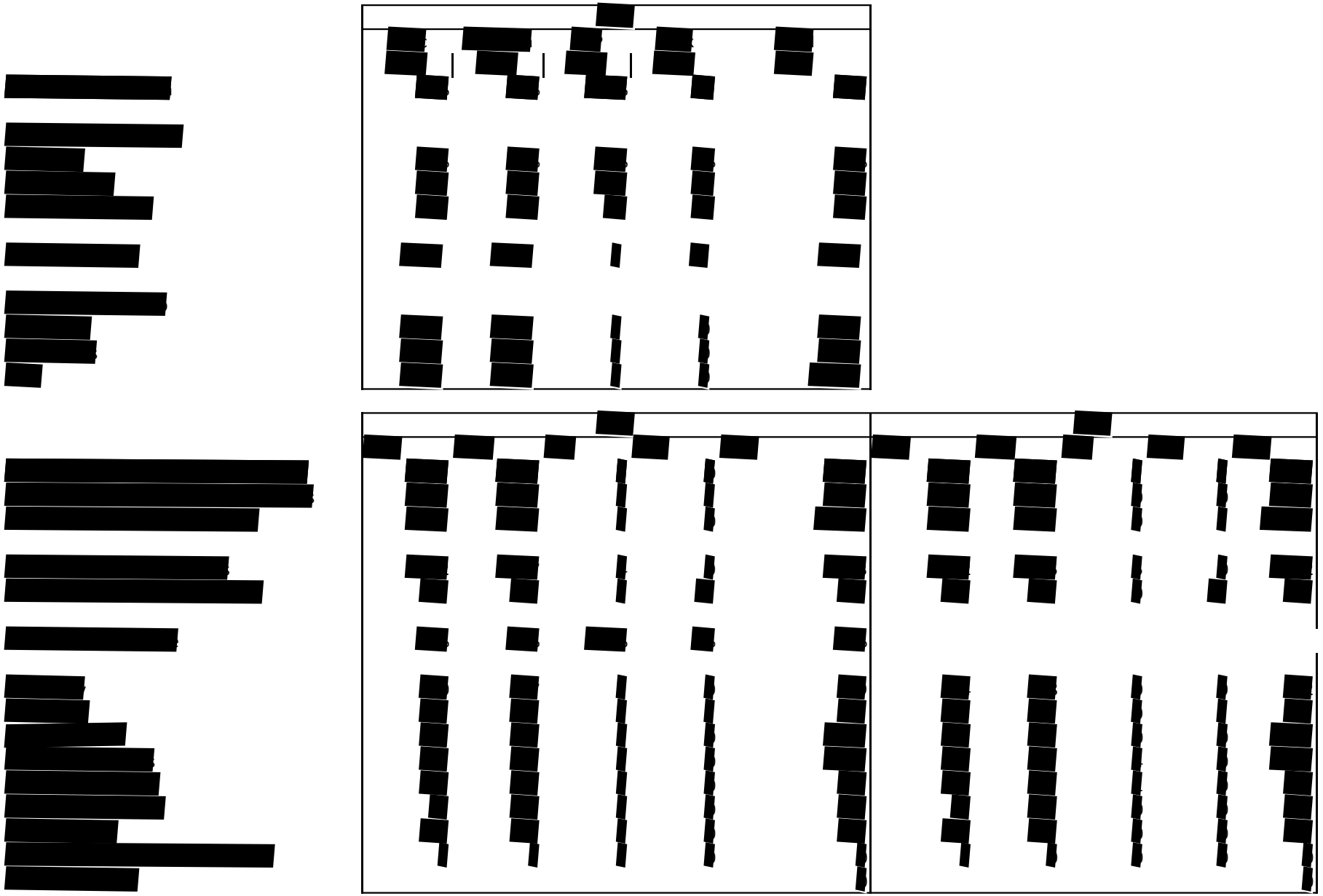
18. Termination. This Agreement may be terminated by either party without cause upon thirty (30) days prior written notice.

19. Entire Agreement. This Agreement constitutes the entire Agreement between the parties hereto and contains all of the agreements between said parties and supersedes any and all other agreements, whether written or oral, with respect to the subject matter hereof. There is no statement, promise, agreement or obligation in existence which may conflict with the term of this Agreement or may modify, enlarge, or invalidate this Agreement or any provision hereof.

IN WITNESS WHEREOF, DAVIS and CLIENT have caused this Agreement to be executed as of the day and year first written above.

(CLIENT)	**DAVIS VISION, INC.**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

Exhibit A – FILE LAYOUT



	Ranking									
	2010					2009				
Options	Basic	Prem	VAP	Lasik	Total	Basic	Prem	VAP	Lasik	Total
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]	[redacted]	[redacted]	[redacted]	0	[redacted]

Utilization

Basic

Month	Subscriber Count	Dependent Count	Tota Lives	# Claims	Claims Expense	Avg Exp per Claim	% Utilization
2010-01	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-02	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-03	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-04	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-07	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-09	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-11	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Premium	Subscriber Count	Dependent Count	Tota Lives	# Claims	Claims Expense	Avg Exp per Claim	% Utilization
2010-01	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-02	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-03	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-04	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-07	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-09	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-11	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Lasik	Subscriber Count	Dependent Count	Tota Lives	# Claims	Claims Expense	Avg Exp per Claim	% Utilization
2010-01	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-02	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-03	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-04	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-05	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-07	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-08	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-09	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-10	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-11	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2010-12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

Ranking

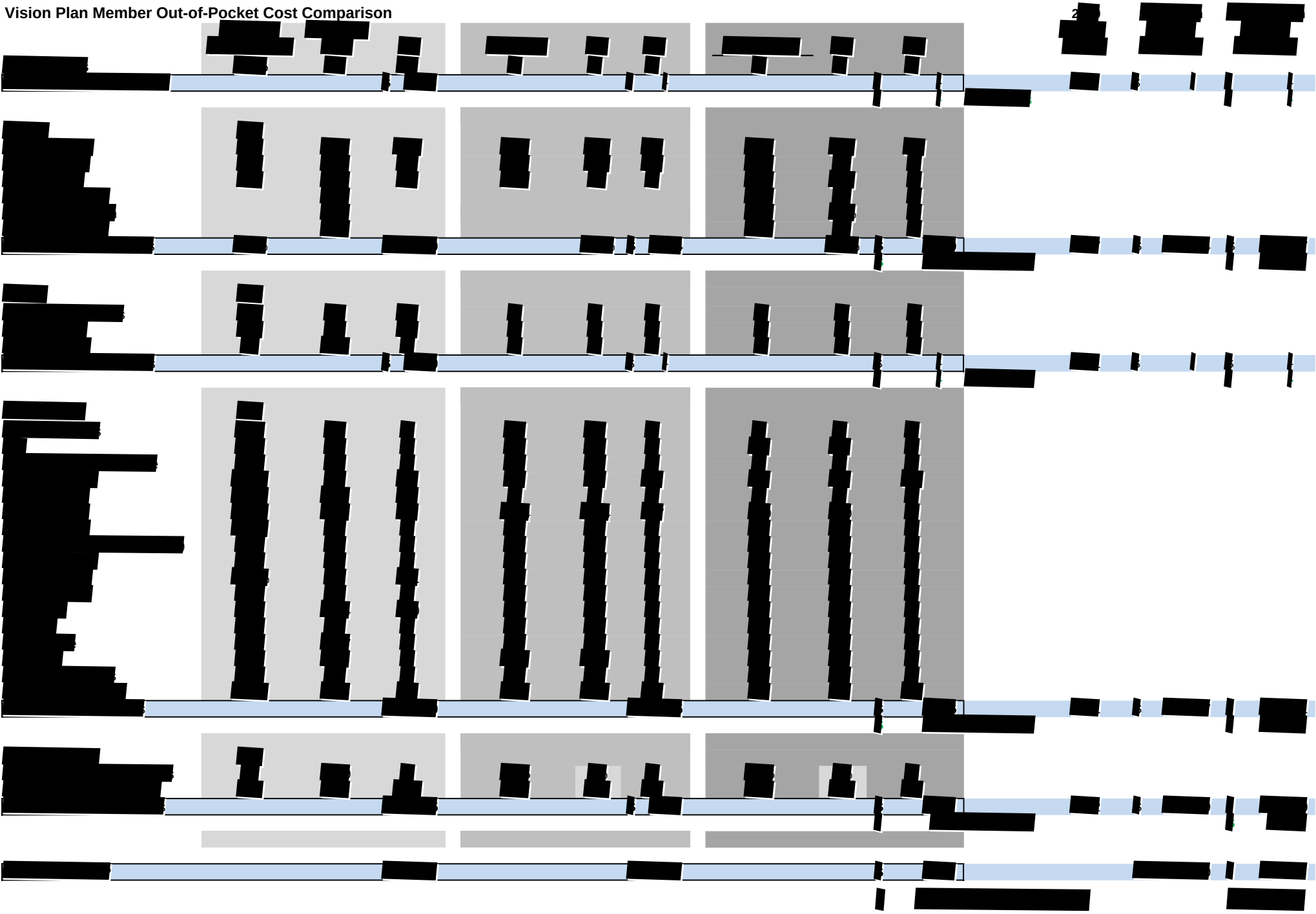
Options	2010						2009					
	Grp 1	Grp 2	Grp 3	2010 Total	Grp 1	Grp 2	Grp 3	2009 Total
[redacted]								

Option Counts

Options	2010						2009					
	Grp 1	Grp 2	Grp 3	2010 Total	Grp 1	Grp 2	Grp 3	2009 Total
[redacted]								

SAMPLE CLIENT

Vision Plan Member Out-of-Pocket Cost Comparison



Davis Vision, Inc.
SAMPLE CLIENT
Service Usage - Restated Historical Family Units [1, 6]

[1] Claims are reported on a paid basis.

[2] Average Family Units includes Employees and Retirees enrolled in one of the Vision plan options 2007, 2008, 2009 & 2010 as provided by the client, total lives are reported from Davis Vision.

3 Plan 1 Includes two different subgroups

4 Plan 2 Includes two other subgroups

[5] 2011 Estimate based on 2010 Cost Per Claim and Enrollment Projection provided by the client. Plan 1 utiliation projection based on weighted average of 2009 (80%) and 2010 (20%). Plan 2 utilization based on 2010 with 2% trend.

[6] 2011 Family Units projected from the client and total Lives calculated from Davis Vision Family Unit Size as of Jan 2011.

Prepared:
January 21, 2011

Updated 1/27/11

Davis Vision, Inc
Retailer vs Private Utilization Summary
SAMPLE CLIENT - Years 2009 - 2010

TYPE	Count of Member IDs
Private Doctor	[redacted]
Total Private Utilization	[redacted]
Retailer - [redacted]	[redacted]
Retailer - [redacted]	[redacted]
Retailer - [redacted]	[redacted]
Total Retailer Utilization	[redacted]

Davis Vision, Inc.
SAMPLE CLIENT GROUP
Membership & Claims
January 2009 - December 2010

Year	Month	# Members	# Lives	Claims	Claims $
2009	January				
2009	February				
2009	March				
2009	April				
2009	May				
2009	June				
2009	July				
2009	August				
2009	September				
2009	October				
2009	November				
2009	December				
2010	January				
2010	February				
2010	March				
2010	April				
2010	May				
2010	June				
2010	July				
2010	August				
2010	September				
2010	October				
2010	November				
2010	December				
Avg / Totals					

SAMPLE CLIENT
Diabetic Utilization
2010

Diabetic Population				
Month	Diabetic Membership [1]	[redacted]	[redacted]	[redacted]
January	17,430			
February	12,425			
March	9,622			
April	11,306			
May	11,361			
June	11,648			
July**	11,661			
August	11,696			
September	11,899			
October	12,041			
November	12,061			
December	12,255			
2010 Totals	**12,105**			
2009 Totals	**16,946**			
2008 Totals	**13,245**			
2007 Totals	**10,406**			

Footnotes

1. Total active Diabetic population.

2. The number of unique members who received a service.

3. The number of unique Diabetic Members who had an exam, routine or ancillary, during the month. (Counted once per member)

4. The Unique Diabetic Claimants Having an Exam divided by the Diabetic Members for the month expressed in a %

**2 files had to be specially downloaded, first file had small record count, this was not updated until August.

Total membership has been revised.

New York State
Dept. of Civil Service
Vision Care Plan
Transition Plan

Category	Task	Start Date	End Date	Note(s)	Accountability	Status
Enrollment	Process last maintenance file	TBD	TBD		Davis Vision	TBD
	Confirm "mass termination" records being sent	TBD	TBD		DCS	TBD
	Receive and process "mass" terminations	TBD	TBD		Davis Vision	TBD
	Verify no active enrollment records	TBD	TBD		Davis Vision	TBD
	Advise DCS of active enrollment findings	TBD	TBD		Davis Vision	TBD
	Advise Davis Vision of appropriate actions	TBD	TBD		DCS	TBD
Claim History	Agree on file format	TBD	TBD		Davis Vision/New Carrier	TBD
	Agree on file receiver	TBD	TBD		Davis Vision/DCS	TBD
	Prepare and send test files	TBD	TBD		Davis Vision	TBD
	Provide test file feedback/test results	TBD	TBD		New Carrier/DCS	TBD
	Send first production file	TBD	TBD		Davis Vision	TBD
	Send second production file	TBD	TBD		Davis Vision	TBD
	Send third production file	TBD	TBD		Davis Vision	TBD
	Send fourth production file	TBD	TBD		Davis Vision	TBD
	Send final production file	TBD	TBD		Davis Vision	TBD
Claims Payment	Process run out claim receipts	TBD	TBD		Davis Vision	TBD
	Deny all claim receipts back to submittor	TBD	TBD		Davis Vision	TBD
	Provide address to send mis-directed claims	TBD	TBD		DCS	TBD
	Forward mis-directed 2007 claims to new carrier	TBD	TBD		Davis Vision	TBD
Billing to DCS	Continue to send standard billing package	TBD	TBD		Davis Vision	TBD
	Billing to DCS ceases	TBD	TBD			TBD
Provider Communication	Notify providers of DV administration ending	TBD	TBD		Davis Vision	TBD
	Notify Laser network of administration ending	TBD	TBD		Davis Vision	TBD
Member Communications	Stop fulfillment of provider list requests	TBD	TBD			TBD
	Stop sending patient satisfaction forms	TBD	TBD		Davis Vision	TBD
	Stop sending out-of-network claim forms	TBD	TBD		Davis Vision	TBD
	Provide verbiage for special IVR message	TBD	TBD		DCS	TBD
	Add special message to DCS local number	TBD	TBD		Davis Vision	TBD
Authorization Issuance	Short-cycle authorizations to expire end of year 1	TBD	TBD		Davis Vision	TBD
	Short-cycle authorizations to expire end of year 2	TBD	TBD		Davis Vision	TBD
Other	Terminate NYBEAS access	TBD	TBD		DCS/Davis Vision	TBD
	Terminate DCS/DV FTP link	TBD	TBD		DCS/Davis Vision	TBD
	Disable "next eligible" date function on web	TBD	TBD		Davis Vision	TBD
	Disable web links	TBD	TBD		DCS/Davis Vision	TBD
	Provide Q & As for member service inquiry	TBD	TBD		DCS	TBD

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R-Russian Y-Yiddish O-Korean

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J-Japanese T-Cantonese
K-Pakistan M-Mandarin

Vision Care Participating Network Providers

Dr. Thomas H. Ophardt
15 Market St
Brockport NY 14420 #
(585) 395-9030 (*) (G)

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22 N. Main St
Brockport NY 14420 #
(585) 637-2121

BRONX

Dr. Martin A. Aviles
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(718) 933-1900 (S)

Dr. Peter S. Bae
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103 W. Kingsbridge Rd
Bronx NY 10468 #
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Ste 1K
3333 Henry Hudson Pkwy W.
Bronx NY 10463
(718) 432-2299 (*) <e>

Burnside Optical
Dr. Vincente A. Calderon
Dr. Anh V. Tran
54 W. Burnside Ave
Bronx NY 10453 #
(718) 299-5454 (*) (S)

Dr. Vincente A. Calderon
2604 Third Ave
Bronx NY 10454 #
(718) 292-0100 (*)

Dr. Evan C. Canellos
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2196 White Plains Rd
Bronx NY 10462 #
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Bronx NY 10462
(718) 863-8695 (*) <e>

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Dr. Leslie B. Cohen
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Bronx NY 10462 #
(718) 409-2200 (S)

Cohen's Fashion Optical
2856 Third Ave
Bronx NY 10455
(718) 585-5100 <d>

Cohen's Fashion Optical
3416 Jerome Ave
Bronx NY 10467
(718) 325-3160 <d>

Cohen's Fashion Optical
5572 Broadway
Bronx NY 10463
(718) 884-4297 (*) <d>

Cohen's Fashion Optical
Dr. Siew-Chua Sin
138 E. Fordham Rd
Bronx NY 10468 #
(718) 933-0187 (*)

Eyes & Optics
Dr. William E. Guerrero
234 E. 149 St
Bronx NY 10457 #
(718) 665-0611 (*) (S)

Dr. Ifeoma Ezekwo
3013 Grand Concourse
Bronx NY 10468 #
(718) 367-7888 (*) (S)

Dr. Gary R. Fishman
Dr. Marina Kotlyar
Ste 216-C
2100 Bartow Ave
Bronx NY 10475 #
(718) 862-3937 (*) (RS)

Fordham Eyes
Dr. Ralph E. Murray
Dr. Lucia Patino
213 E. Fordham Rd
Bronx NY 10458 #
(718) 562-5000 (*) (S)

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Dr. Diane Calderon
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Bronx NY 10458 #
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Bronx NY 10458 #
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Bronx NY 10469
(718) 519-1000 (*) <e> (S)

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Bronx NY 10455 #
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Dr. Harvey L. Halem
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Bronx NY 10455 #
(718) 292-9500 (*) (S)

Dr. Harvey L. Halem
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Bronx NY 10455 #
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Bronx NY 10459 #
(718) 860-2323 (*) (S)

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Co-Op City
120-1 Alcott Pl
Bronx NY 10475 #
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Dr. Michael D. Bernstein
Dr. Aarti Sharma
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Dr. Judith A. Stein
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Dr. Albert J. Contento
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Dr. Jiyoung Yoon
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Bronx NY 10467 #
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Dr. Mark M. Gordon
Dr. Jaclyn R. Johnson
Dr. Carson K. Wong
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Bronx NY 10454 #
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Dr. Austin M. White
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3071 Perry Ave
Bronx NY 10467
(718) 231-6700 (*) <e>

Dr. Paul Lieberman
Dr. Gerald N. Adams
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Bronx NY 10468 #
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Pelham Parkway Vision Center
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Bronx NY 10462 #
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76 E. 170th St
Bronx NY 10452 #
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Morris Heights Health Center
Dr. Katari D. Campbell
85 W. Burnside Ave
Bronx NY 10453
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New Trends Optical
Dr. Abraham J. Gottfried
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Bronx NY 10461 #
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Perfect Vision
Dr. Yajaira R. Fernandez
2210 Westchester Ave
Bronx NY 10462 #
(718) 823-5006 (*) (S)

(*) Handicap access.
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K-Pakistan M-Mandarin

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3730 E. Tremont Ave
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Bronx NY 10451 #
(718) 681-9741 (*) (S)

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Dr. Gordon Allen
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Bronx NY 10472 #
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(347) 498-1478 (*) (RS)

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Bronx NY 10460 #
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Dr. Henry Blum
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Bronx NY 10459 #
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Dr. Rozelle Francis
Dr. Sandra Goldman Cohen
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Brooklyn NY 11226 #
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Brooklyn NY 11211 #
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Brooklyn NY 11201 #
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Dr. Alysha K. Jacobs
Dr. Sean G. Walton
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Dr. Eric S. Dessner
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Dr. Aleksandr Zlotnik
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1st Floor
Brooklyn NY 11229 #
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Brooklyn NY 11205 #
(718) 399-6234 (*) (R)

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Dr. Akiva Mitzmacher
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Brooklyn NY 11229 #
(718) 627-8900 (*) (GHPRS)

Dr. Nadezhda Belous
30-5th Ave
Brooklyn NY 11217 #
(718) 622-2020 (*) (PR)

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1414 Ave M.
Brooklyn NY 11230 #
(718) 645-6068 (*) (HY)

Bklyn Eye Boutique, Inc.
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Brooklyn NY 11217 #
(718) 636-4316 <d> (S)

Dr. Agness Blumkin
1723 Ave U.
Brooklyn NY 11229 #
(718) 998-8400 (*) (R)

Bonafide Opticians
Dr. Gilbert E. Selvin
9508 Ave L.
Brooklyn NY 11236 #
(718) 444-3126 (S)

Bristol Opticians
949 Pennsylvania Ave
Brooklyn NY 11207 #
(718) 649-6526 (*) <d> (SY)

Brookdale Optical
2 Floor
1 Brookdale Plz
Brooklyn NY 11212 #
(718) 342-3937 (*) <d>

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Dr. Vlada Straton
519 5th Ave
Brooklyn NY 11215 #
(718) 768-1020 (*)

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Dr. Diana Simkhovich
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Brooklyn NY 11204 #
(718) 232-3907 (*) (R)

Dr. Joseph M. Capetola
218 Prospect Park W.
Brooklyn NY 11215 #
(718) 768-1498 (*) (S)

Dr. Andrew S. Cass
Dr. Daniel Hazai
4601-13th Ave
Brooklyn NY 11219 #
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Dr. Lucy E. Cederholm
420 Fulton St
Brooklyn NY 11201 #
(718) 802-7674 (*) (RS)

Dr. Yuho Cheng
755-759 61st St
Brooklyn NY 11220 #
(718) 680-8881 (*)

Inc Classic Vision
Classic Vision Inc
Dr. Leonard M. Unger
5314 18th Ave
Brooklyn NY 11204 #
(718) 621-5717 (*) (FH)

Clear Eyes Optical
148 Hooper St
Brooklyn NY 11211 #
(718) 875-9000 (*) <d> (FY)

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 # Tower frame collection.

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<d> Dispenses eyewear only
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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

Cohen's Fashion Optical
2167 86th St
Brooklyn NY 11214
(718) 946-3647 <d>

Cohen's Fashion Optical
298 7th Ave
Brooklyn NY 11215
(718) 768-3939 <d>

Cohen's Fashion Optical
5202 5th Ave
Brooklyn NY 11220
(718) 492-0515 <d>

Cohen's Fashion Optical
2504 Flatbush Ave
Brooklyn NY 11234
(718) 253-7700 <d>

Cohen's Fashion Optical
414 86th St
Brooklyn NY 11209
(718) 833-2320 (*) <d>

Cohen's Fashion Optical
51-71 Kings Plaza Mall
Brooklyn NY 11234
(718) 951-9800 (*) <d>

Dr. Eric S. Colman
Dr. Aliya Hot
332 9th St
Brooklyn NY 11215 #
(718) 965-2545 (*) (HPRS)

Dr. Antoine E. Copty
1321 55 St
Brooklyn NY 11219 #
(718) 724-8353 (*) (S)

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Dr. Karen S. Cummings
708 Flatbush Ave
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Dr. Rachel Eidlisz-Kahan
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Dr. Gary Eppel
1703 Ave M.
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Eye See You Optical
Dr. Yelena Kagan

Dr. Angelika Karalnik
1371 Coney Island Ave
Brooklyn NY 11230 #
(718) 253-9328 (*) (R)

Eyes & Optics
Dr. Eric Orava
2922 Ave L.
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Eyes and Optics
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Brooklyn NY 11211 #
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Brooklyn NY 11234 #
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Dr. Yihong Cai
Dr. Elzie Chan-Englander
Dr. Mary Y. Chen
Dr. Jason J. Chen
Dr. Timothy Ip
Dr. Dongsik Kim
Dr. David Yip
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Brooklyn NY 11220 #
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Dr. Asi E. Ressler
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Brooklyn NY 11234 #
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Dr. Judy Lo
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Dr. Maria Asprogerakas
Dr. Stephanie Giordano
Dr. Daniel Hazai
Dr. Lucia Patino
Dr. Daniella Rutner
Dr. Andre E. Stanberry
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Dr. Edward M. Goldberg
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Brooklyn NY 11206 #
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Ewear Grand Vision Ey
Boris Optics, Inc
Dr. Alexander J. Kabiri
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Dr. Dmitry Gutkovich
Dr. Ella Gelb
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Dr. Steven J. Hammer
Dr. George F. Hyman
350 Fulton St
Brooklyn NY 11201 #
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Dr. Mark Harooni
Dr. Sally Chetrit
Dr. Jane Kutsowsky
586-B President St
Brooklyn NY 11215 #
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Brooklyn NY 11209 #
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Brooklyn NY 11214 #
(718) 621-2020 (*) (CIRS)

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Hamilton Plaza Vision Center
1-37 12th St
Brooklyn NY 11215 #
(718) 499-4260 (*) (FS)

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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

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83 5th Ave
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Brooklyn NY 11235 #
(718) 646-5020 (*) <d>

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Brooklyn NY 11208 #
(718) 235-7900 (*) (S)

Dr. Clement E. Idehen
446 Knickerbocker Ave
Brooklyn NY 11237 #
(718) 455-6500 (*) (S)

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Brooklyn NY 11229 #
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Dr. Tanya D. Jacobson
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Brooklyn NY 11225 #
(718) 773-9391 (*) (FR)

Dr. Tanya D. Jacobson
2027 Emmons Ave
Brooklyn NY 11235 #
(718) 648-2020 (*) (FR)

Dr. Herbert Jaffe
2128 Ocean Ave
Brooklyn NY 11229 #
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James Leonard 4, Inc.
309 Smith St
Brooklyn NY 11231 #
(718) 222-8300 (*) <d> (R)

Jmb Optical
Dr. Alan H. Silverberg
2 Skillman St
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Dr. Alma J. Olivos-Asarian
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Brooklyn NY 11203 #
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Brooklyn NY 11204 #
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Brooklyn NY 11230 #
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ALT LANG: S-Spanish F-French C-Chinese I-Italian H-Hebrew
 # Tower frame collection.

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<d> Dispenses eyewear only
J-Japanese T-Cantonese K-Pakistan M-Mandarin

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ALT LANG: S-Spanish F-French
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(631) 447-1300 (*)

EAST SETAUKET

Davis Vision
Stony Brook Technology Park
Ste 13
33 Research Way
East Setauket NY 11733
(631) 444-4900 (*) <d>

Dr. Stuart Fourman
Dr. Shoshana B. Craig
Dr. Uyen K. Dao
Dr. Fadi Z. El Baba
Dr. Robert A. Honkanen
Dr. Nancy Kwon
Dr. Vivian Renta-Skyer
Dr. Dorothy J. Reynolds
Dr. Patrick Sibony
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33 Research Way
East Setauket NY 11733
(631) 444-4090 (*) <e>

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Dr. Kristin E. Orabone
The Pen and Pencil Bldg
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Dr. Andrew L. Goldstein
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Eastchester NY 10709 #
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Cohen's Fashion Optical
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Elmhurst NY 11373 #
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Elmhurst NY 11373 #
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Elmhurst NY 11373 #
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Dr. Liyi Li
Dr. Derek Chong
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Dr. Steven E. Goldenberg
Eye Contact By Kathy
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Dr. Ira Goldberg
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Far Rockaway NY 11691 #
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51-15 Beach Channel Dr
Far Rockaway NY 11694 #
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Dr. Michael S. Diamond
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National Vision Center
Dr. Martin E. Cohen
Dr. Melvin Munoz-Guzman
Dr. Morgan D. Wright
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25-37 A. Francis Lewis Blvd
Flushing NY 11358 #
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Dr. Yihong Cai
Dr. Elzie Chan-Englander
Dr. Mary Y. Chen
Dr. Jason J. Chen
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Dr. Jane Isakova
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Dr. Sangwoo Lee
Dr. Lily Y. Zhu-Tam
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Flushing NY 11355 #
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Flushing NY 11367 #
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Dr. Steven Ali
Dr. So Hyun Chung
Dr. Jennifer Q. Duan
Dr. Yoon Kim
Dr. James S. Li
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Dr. Yangzi Jiang
Dr. Jia Lao
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Flushing NY 11355 #
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Flushing NY 11354 #
(718) 559-0088 (*) (TM)

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Flushing NY 11365 #
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Flushing NY 11354 #
(718) 559-0088 (*) (TCMS)

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Dr. Jose A. Chan
Dr. Kum-Ting See
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Dr. Rumei Yuan
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133-36 41st Rd
Flushing NY 11355 #
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Forest Hills NY 11375
(718) 261-3366 (*) <e> (CFRS)

Dr. Cindy Chan
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Forest Hills NY 11375 #
(718) 261-1764 (*) (PR)

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Forest Hills NY 11375 #
(718) 544-2200 (*)

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Forest Hills NY 11375
(718) 261-0005 (*) <d>

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Ste 1 Jk
98 120 Queens Blvd
Forest Hills NY 11374 #
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Dr. Elena Feldman
Dr. Boris M. Kapelnik
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Forest Hills NY 11375 #
(718) 896-2020 (*) (R)

Dr. Michael Kakzanov
66-77 Selfridge St
Forest Hills NY 11375 #
(718) 268-4040 (*) (RS)

Dr. Svetlana Katanov
104-23 Queens Blvd
Forest Hills NY 11375 #
(718) 275-2500 (*) (RS)

Dr. Natalya Malakova
64-05 Yellowstone Blvd
Cfu 103
Forest Hills NY 11375 #
(718) 520-6500 (*)

Dr. Alahyar Nissany
118-11 Queens Blvd
Forest Hills NY 11375 #
(718) 793-2461 (*)

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Forest Hills NY 11375 #
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Dr. Arlene E. Schwartz
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Forest Hills NY 11375 #
(718) 263-6661 (*) (RS)

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Dr. Bradley W. Kaplan
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Fort Plain NY 13339 #
(518) 993-4743

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ALT LANG: S-Spanish F-French
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 # Tower frame collection.

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P-Polish A-Amer Sign G-German
R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese
K-Pakistan M-Mandarin

Vision Care Participating Network Providers

FRANKLIN SQUARE

Dr. Howard I. Cohen
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Franklin Square NY 11010 #
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Dr. Sherin George
918 Hempstead Tpke
Franklin Square NY 11010 #
(516) 354-4242 (*)

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Fredonia NY 14063 #
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Freeport NY 11520 #
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Dr. Michael Lolis
Dr. Scott A. Murray
Elks Plaza
185 W. Merrick Rd
Freeport NY 11520 #
(516) 867-1213

FRESH MEADOWS

Dr. Gary S. Hirshfield
Ste 110
176-60 Union Tpke
Fresh Meadows NY 11366 #
(718) 460-1200 (*) (RS)

Little Optics
192-13 Union Tpke
Fresh Meadows NY 11366 #
(718) 468-7500 (*) <d>

Dr. Roberta C. Schwartz
70-51 Parsons Blvd
Fresh Meadows NY 11365 #
(718) 380-7788 (*)

Unique Optical,Inc
161-02 Union Tpke
Fresh Meadows NY 11366 #
(718) 969-0090 (*) <d> (R)

FULTON

Empire Vision
Dr. Kent Kresovich
Corner Of Rochester & 2nd St
Fulton NY 13069
(315) 598-8505 (*)

GARDEN CITY

Dr. Steven J. Abrams
Roosevelt Field Shopping Ctr
Garden City NY 11530
(516) 294-0011 (*) <e>

Cohen's Fashion Optical
Roosevelt Field Mall
630 Old Country Rd
Garden City NY 11530
(516) 294-0011 <d>

Davis Vision
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Dr. Jeffrey C. Blum
Dr. Sameh A. Boules
Dr. Dina M. Castagnino
Dr. Samuel S. Choi
Dr. Jennifer Nim
Dr. Danielle M. Porcello
Dr. Mona Souferian
Dr. Vicki Spivack
Dr. Linda A. Zilli
Roosevelt Field Entrance
600 Old Country Rd
Garden City NY 11530
(516) 745-6565 (*)

Dr. Scott L. Derco
Dr. Chester S. Fichandler
743 Franklin Ave
Garden City NY 11530 #
(516) 746-2360 (*)

Dr. Steven M. Schoenbart
Dr. Paula I. Handell
Ste 202
901 Stewart Ave
Garden City NY 11530 #
(516) 794-0704 (*)

Dr. Marc S. Werner
450 Endo Blvd
Garden City NY 11530 #
(516) 832-8000 (*)

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Dr. Laura E. Dugo
Dr. Christoph I. Main
Dr. Stanton Tepfer
Pyramid Mall Rte 5 & 20
809 Canandaiqua Rd
Geneva NY 14456
(315) 781-1162 (*)

GLEN COVE

Dr. Robert I. Appel
34 Forest Ave
Glen Cove NY 11542 #
(516) 676-0210 (*)

GLEN OAKS

Dr. Vladimir Poley
Dr. Flora Levine
259-23 B. Union Tpke
Glen Oaks NY 11004 #
(718) 347-7470 (*) (RS)

GLENDALE

Euro Optical
65-43 Myrtle Ave
Glendale NY 11385 #
(718) 366-7850 (*)

Dr. Krishna Morar
73-09 Myrtle Ave 2nd Fl
Glendale NY 11385 #
(718) 456-9500 (*)

Precise Optometry
Dr. Farshad Haiimpour
Ste 6-116
80-28 Cooper Ave
Glendale NY 11385 #
(718) 416-3937 (*)

Precision Vision
Dr. Leonard M. Unger
69-28 Myrtle Ave
Glendale NY 11385 #
(718) 381-4577 (*) (RS)

GLENS FALLS

National Vision
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891 Rte 9
Glens Falls NY 12804
(518) 761-4139 <d>

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Dr. Linda Butler
575 Glen St
Glens Falls NY 12801 #
(518) 792-0518 (*)

GLOVERSVILLE

Corp. Fulton Optical
189 Second Ave
Gloversville NY 12078 #
(518) 725-3513 (*) <d>

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Dr. Rachel G. McCann
Dr. David A. Rojek
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Goshen NY 10924 #
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Dr. Grace Y. Burke
Dr. Manijeh Contractor

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77 W. Barney St
Gouverneur NY 13642 #
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R-Russian Y-Yiddish O-Korean

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J-Japanese T-Cantonese
K-Pakistan M-Mandarin

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HAMPTON BAYS

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Dr. Stefanie B. Beyer
Dr. Dina M. Castagnino
Dr. Marla Glick
Dr. Steven Ressel
Dr. Joanne M. Sciacca
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Hornell NY 14843 #
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<d> Dispenses eyewear only
J-Japanese T-Cantonese K-Pakistan M-Mandarin

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Dr. Charles J. Deluca
Dr. Bruce Wilde
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Howard Beach NY 11414 #
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Dr. Joel Rosenstraus
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Howard Beach NY 11414 #
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Dr. Sharon F. Hunt-Moriarty
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Hudson NY 12534 #
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Dr. Madeline Cohen
Dr. Arthur M. Cotliar
Dr. Paul L. Krawitz
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Dr. Marc M. Silverman
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Huntington Stat NY 11746
(631) 271-9898 <d>

Dr. Robert C. Davidowitz
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Huntington Stat NY 11746
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Dr. Ronald L. Hoffman
259 Walt Whitman Rd
Huntington Stat NY 11746
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Sterling Optical
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Ilion NY 13357 #
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Dr. Eric R. Verruto
Dr. Paul Galstian
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(866) 733-6254 (*) <e>

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Dr. Robert M. Mintz
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Dr. Jose A. Gomez
75-08 37th Ave
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Cohen's Fashion Optical
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Dr. Sharona Kohan
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1st Fl
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Jackson Heights NY 11372 #
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Dr. On Lam
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Laxmi American Optical
Dr. Keith Beylus
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Jackson Heights NY 11372 #
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Dr. Jorge Won
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Jackson Heights NY 11372 #
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Dr. Victoria Bulbin
Dr. Steven R. Levy
137-50 Jamaica Ave
Jamaica NY 11435 #
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Dr. Dmitry Gurevich
Dr. Phylis Gorelick
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Dr. Catherine M. Awad
89-14 Sutphin Blvd
Jamaica NY 11435 #
(718) 739-8939 (S)

Dr. Lisa T. Kirkland
122-21A Guy R. Brewer Blvd
Jamaica NY 11434 #
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Jamaica NY 11432 #
(718) 526-2332 (*) (S)

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Jamaica NY 11432 #
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Dr. Lily Jung
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Jamaica Estates NY 11366 #
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Jamestown NY 14701 #
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(*) Handicap access.
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J-Japanese T-Cantonese
K-Pakistan M-Mandarin

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Dr. Samantha D. Jenkins
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Dr. Maureen A. Sienko
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Dr. Ira M. Price
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Dr. Harriet Halstein
324 Smith Haven Mall
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(631) 361-7310 (*) <e> (CFRS)

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Lake Grove NY 11755
(631) 724-9055 (*) <e>

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124 Smith Haven Mall
Lake Grove NY 11755
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Dr. Elinor B. Descovich
Dr. Melvin Guzman
Dr. John R. Hammerer
Dr. Ellen Schaefer
1636 Ulster Ave
Lake Katrine NY 12449 #
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3 Delaware Dr
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Dr. Melvin Kalmenson
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Dr. Danielle M. Porcello
Dr. Mark G. Shafiroff
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Lindenhurst NY 11757
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Dr. Robert K. Norris
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Lindenhurst NY 11757 #
(631) 957-0033

(*) Handicap access.
ALT LANG: S-Spanish F-French C-Chinese I-Italian H-Hebrew # Tower frame collection.

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<d> Dispenses eyewear only J-Japanese T-Cantonese K-Pakistan M-Mandarin

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Dr. Sara Lloyd-Phillips
Dr. Deborah S. Rose-Siegall
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Little Neck NY 11362
(718) 225-0362 (*)

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Dr. Deborah Arenos
Dr. Eric R. Bella
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Lockport Optical
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Dr. Bradley P. Catton
Dr. Phil S. Dafler
Dr. Kjell Dahlen
Dr. Douglas S. Franz
Dr. Stanley W. Hatch
Dr. Robert W. Johnson
Dr. John S. King
Dr. Robert Raut
Dr. Frederick C. Shaw
14861 State Rte 30
Malone NY 12953 #
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Dr. Michael S. Ferri
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Mamaroneck NY 10543 #
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Dr. Neha Sheth
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Manhasset NY 11030 #
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Manhasset NY 11030
(516) 627-3232 (*) <e>

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(315) 764-1878 (*) <d>

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Dr. Ritu Bajaj
Dr. Grace Y. Burke
Dr. Manijeh Contractor
Dr. Mark Hershowitz
Dr. Robert M. Johnston
Dr. Debra A. Koloms
Dr. Jonathan Ludlow
Dr. Paul C. O'Donnell
Dr. Inez Reyna
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27 Hospital Dr
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K-Pakistan M-Mandarin

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Merrick NY 11566 #
(516) 546-4800 (*)

Dr. Terry R. Scheid
Dr. Bertram Mitchel
2126 Merrick Mall
Merrick NY 11566 #
(516) 546-3227 (*)

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Mexico NY 13114 #
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Dr. Andrew I. Hans
In Wal-Mart
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Middle Island NY 11953
(631) 345-0065

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Little Optics, Inc
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Middle Village NY 11379 #
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Galleria At Crystal Run
Middletown NY 10941
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Dr. Samantha Slotnick
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Dr. Bruce Yang
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New City NY 10956 #
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Dr. Michael S. Diamond
Dr. Robert D. Lemieux
4551 Commercial Dr
New Hartford NY 13413
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Dr. Anthony J. Palumbo
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New Hartford NY 13413 #
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Dr. Allen F. Zuck
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Center Court
New Hartford NY 13413 #
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New Hyde Park NY 11040 #
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Dr. Stuart Schrier
Dr. Joel Rosenstraus
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New Hyde Park NY 11040 #
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188 Main St
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(845) 255-8370 (*)

Dr. Scott Morrison
Dr. Stephanie M. Reeck
Ste 120
243 Main St
New Paltz NY 12561 #
(845) 255-4696 (*)

Dr. Richard A. Varricchio
Dr. Sharon B. Powell
Dr. Timothy F. Quinlan
12 New Paltz Plz
New Paltz NY 12561 #
(845) 255-6780

NEW ROCHELLE

Dr. Michael D. Bernstein
Dr. Hernando Alfonso
Dr. Aarti Sharma
499 Main St
New Rochelle NY 10801 #
(914) 235-5222 (*) (S)

Dr. Linda M. Collins
521 Main St
New Rochelle NY 10801 #
(914) 738-4500

Dr. Veronique B. Germaine
Ste 104
110 Lockwood Ave
New Rochelle NY 10801 #
(914) 636-5506 (*)

NEW WINDSOR

Dr. Joel J. Feintuch
Dr. Joseph Accettura
367 2 Windsor Hwy
New Windsor NY 12553 #
(845) 565-4100 (*) (S)

NEW YORK

Dr. Thomas Altman
Dr. James M. Sinoway
665 W. 181 St
New York NY 10033 #
(212) 927-1000 (*) (S)

Anca Optical
Anthony Aiden Opticians
Dr. Judith Mei
42 St Marks Pl
New York NY 10003 #
(212) 533-1577 (*) (MRS)

Associate Ophthalmologists
Ste 1800
150 Broadway
New York NY 10038 #
(212) 233-2344 <d>

Dr. Claire M. Azzam
167 W. 72nd St
New York NY 11023
(212) 769-1410 (*) <e>

Dr. Vijay Battu
Dr. Eric S. Dessner
150 E. 56th St
New York NY 10022 #
(212) 755-8808

Dr. Stuart S. Belfer
573 W. 207 St
New York NY 10034 #
(212) 569-3099 (*) (S)

Dr. Jonah B. Berman
430 Second Ave
New York NY 10010 #
(212) 481-6690 (*) (FRS)

Dr. Jonah B. Berman
Dr. Ann S. Chang
Dr. Myongwoon Yang
Dr. Qiang Yin
Dr. Ling Zhou
72 Mott St
New York NY 10013 #
(212) 267-8888 (*) (TMS)

Dr. Stefanie B. Beyer
33 Maiden Ln
New York NY 10038
(212) 232-0065 (*) <e>

Dr. Joseph Y. Bistricer
1st Floor
1125 Lexington Ave
New York NY 10075 #
(212) 628-8886 (*)

Dr. Joseph Y. Bistricer
1125 Lexington Ave
New York NY 10021
(212) 628-8886 (*) <e> (FHSY)

Dr. Stuart H. Blankman
Dr. Jeffrey D. Stark
2472 Broadway
New York NY 10025 #
(212) 362-8090 (*) (S)

Dr. Michael N. Block
Dr. Ann M. Nguyen
Dr. Mijin Sohn
Grand Central Optical
369 Madison Ave
New York NY 10017 #
(212) 599-1220 (*) (CHRS)

Dr. Michael N. Block
Dr. Ann M. Nguyen
Dr. Mijin Sohn
Grand Central Optical
Grand Central Terminal 62
New York NY 10017 #
(212) 599-1221 (*) (CHRS)

Dr. Jennifer L. Boggie
Dr. William E. Guerrero
1st Fl, Room 1D18
1901 1st Ave
New York NY 10029 #
(212) 423-0665 (*)

Dr. Paul Breuer
495 Fort Washington Ave
New York NY 10033
(212) 928-1171 (*) <e> (FGHY)

Broadway Vision Center
Dr. Charles I. Gold
Dr. Nicholas A. Radetzky
4047 Broadway
New York NY 10032 #
(212) 927-2020 (*) (FS)

Dr. William S. Brown
229 E. 79th St
New York NY 10021 #
(212) 861-6200 (*) (S)

Dr. Adria Burrows
Ste 802
425 Madison Ave
New York NY 10017 #
(212) 396-1188 (*) (FRS)

Dr. Diane Calderon
550 Park Ave
New York NY 10065 #
(212) 832-9228 (*) (CFRS)

Dr. Melissa L. Carr
151 W. 34th St
New York NY 10001 #
(212) 494-7300 (S)

Dr. Thomas Chang
Dr. Milly M. Mui
70 E. 10th St 1F
New York NY 10003 #
(212) 673-5650 (CF)

Dr. Henry Chaung
153 A-B Hester St
New York NY 10013 #
(212) 431-8466 (*) (C)

Dr. Michael C. Chernich
10 Sheridan Sq
New York NY 10014 #
(212) 242-6592 (*)

Dr. Wing K. Cheung
Dr. Angela Ng
87-89 Elizabeth St Gf
New York NY 10013 #
(212) 219-8260 (*) (TCJMS)

Cohen's Fashion Optical
117 Orchard St
New York NY 10002
(212) 674-1986 <d>

Cohen's Fashion Optical
86 W. 125th St
New York NY 10027
(212) 996-2676 <d>

Cohen's Fashion Optical
177 E. 86th St
New York NY 10028
(212) 426-1222 <d>

Cohen's Fashion Optical
33 Maiden Ln
New York NY 10038
(212) 232-0065 <d>

Cohen's Fashion Optical
681 Lexington Ave
New York NY 10022
(212) 317-0067 <d>

Cohen's Fashion Optical
106 E. 23rd St
New York NY 10010
(212) 677-3707 <d>

(*) Handicap access.
ALT LANG: S-Spanish F-French
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R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese
K-Pakistan M-Mandarin

Vision Care Participating Network Providers

Cohen's Fashion Optical
545 Fifth Ave
New York NY 10017
(212) 697-0915 <d>

Cohen's Fashion Optical
2565 Broadway
New York NY 10025
(212) 666-2615 <d>

Cohen's Fashion Optical
20 W. 14th St
New York NY 10011
(212) 229-1470 <d>

Cohen's Fashion Optical
167 W. 72nd St
New York NY 10023
(212) 362-4110 <d>

Cohen's Fashion Optical
2 W. 14th St
New York NY 10011
(212) 989-3937 <d>

Cohen's Fashion Optical
50 E 42nd St (At Madison Ave.)
New York NY 10017
(212) 697-1838 <d>

Cohen's Fashion Optical
805 Third Ave
New York NY 10022
(212) 750-9005 <d>

Cohen's Fashion Optical
2933 Broadway (At 114th St)
New York NY 10025
(212) 662-0400 <d>

Cohen's Fashion Optical
767 Lexington Ave (At 60th St)
New York NY 10021
(212) 751-6652 <d>

Cohen's Fashion Optical
841 Broadway
Between 13th & 14th
New York NY 10003
(212) 475-0999 <d>

Cohen's Fashion Optical
275 7th Ave At 25th St
New York NY 10001
(212) 691-1709 <d>

Cohen's Fashion Optical
5 Greenwich Ave
New York NY 10014
(212) 645-1395 (*) <d>

Dr. Michael R. Cohn
90 Delancey St
New York NY 10002 #
(212) 674-3748 (*) (CSY)

Dr. Joseph R. Cooper
454 Lenox Ave
New York NY 10037 #
(212) 368-2020 (*)

Dr. Arthur M. Cotliar
Dr. Rachelle Goller

Dr. Kevin D. Rosin
130 Ft Washington Ave 1M
New York NY 10032 #
(212) 568-2600 (*)

Dr. Laura E. Cozzarelli
Ste 9C
110 E. 59th St
New York NY 10022
(212) 583-2866 (*) <e>

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Dr. Yajaira R. Fernandez
3777 Broadway
New York NY 10032 #
(212) 926-0336 (*) (S)

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New York NY 10029 #
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(212) 228-0950 (*) (PRS)

Dr. Natan Dorfman
150 Second Ave
New York NY 10003 #
(212) 780-6080 (*)

Dr. Natan Dorfman
402 Broadway
2nd Floor
New York NY 10013 #
(212) 431-4059 (*) (PRS)

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Dr. Charles S. Chatman
Ste 8
101 Sherman Ave
New York NY 10034 #
(212) 569-2020 (*) (S)

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223 W. 14th St
New York NY 10011 #
(212) 243-4884 (*) <d> (FGHIS)

Eye Health Medical Llc
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161 Madison Ave
New York NY 10016
(917) 532-3923 (*) (RS)

Dr. Marvin Feinstein
17 Bowery
New York NY 10002 #
(212) 431-4910 (*) (CS)

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Dr. Yihong Cai
Dr. Elzie Chan-Englander
Dr. Mary Y. Chen
Dr. Jason J. Chen
Dr. Timothy Ip
Dr. Dongsik Kim
Dr. David Yip
109 Lafayette St
4th Floor
New York NY 10013 #
(212) 274-1900 (*) (C)

Dr. Lawrence S. Forgacs
Ste #802
425 Madison Ave
New York NY 10012 #
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17 E. 102nd St #1183
New York NY 10029
(212) 241-0939 (*) <e>

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New York NY 10011 #
(212) 675-5270

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New York NY 10029
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151 W. 34th St
New York NY 10001 #
(212) 494-7300 (*)

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Dr. Scott Dong
Dr. Esther C. Ha
Dr. David J. Tsai
52 Mott St
New York NY 10013 #
(212) 431-8188 (*) (C)

Dr. Ella Gelb
Dr. Gordon Allen
4526 Broadway
New York NY 10040 #
(212) 304-3585 (*) (RS)

Dr. Charles I. Gold
Dr. Nicholas A. Radetzky
3553 Broadway (145th St)
New York NY 10031 #
(212) 234-2020 (*)

Dr. David F. Gross
241 W. 23 St
New York NY 10011 #
(212) 243-5898 (*) (S)

Dr. David F. Gross
709 9th Ave
New York NY 10019 #
(212) 265-0300 (*) (R)

Dr. David F. Gross
169 1st Ave
New York NY 10003 #
(212) 460-9240 (*) (CRS)

Dr. David F. Gross
100 E. 96th St
New York NY 10128 #
(212) 722-9233 (*) (RS)

Dr. William E. Guerrero
2868 Broadway
New York NY 10025 #
(212) 865-9825 (S)

Dr. Nishi Gulati
17 E. 102nd St 8th Floor
New York NY 10029
(212) 241-0939 (*) <e>

Dr. Edmond Haddad
Dr. David E. Haddad
Eurovision Optical
107 W. 37th St
New York NY 10018
(212) 564-2112 (*) (FHS)

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1125 Park Ave
New York NY 10128
(212) 427-1246 <e>

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1403 St Nicholas Ave
New York NY 10023 #
(212) 543-4714 (*) (S)

Dr. Shari L. Hausman
4250 Broadway
New York NY 10033 #
(212) 795-5640 (*) (S)

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76 Orchard St
New York NY 10002 #
(212) 533-1707 (*)

Dr. David C. Ho
2058 B. Lexington Ave
New York NY 10035 #
(212) 360-7422 (*) (CS)

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Ste 316
25 W. 43rd St
New York NY 10036 #
(212) 921-1888

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3354 Broadway
New York NY 10031 #
(212) 234-7494 (*)

James Leonard Opticians
Dr. Bradley W. Kaplan
1010 2nd Ave
New York NY 10022 #
(212) 753-7733 (*) (R)

Jena Optical
Dr. Wendy K. Josephs
50 Lexington Ave
New York NY 10010 #
(212) 477-4250 (*)

Dr. Yangzi Jiang
Dr. My N. Huynh
Dr. Jia Lao
Dr. Jet T. Ruttanasee
Dr. Nancy Tsai
221 Grand St
New York NY 10013 #
(212) 227-8837 (*)

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R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese
K-Pakistan M-Mandarin

Vision Care Participating Network Providers

Dr. Deborah K. Kanarfogel
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187 E. 116th St
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New York NY 10013 #
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Dr. Yoonsung Kim
33 W. 32nd St
New York NY 10001 #
(212) 971-0911

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40 Mott St
New York NY 10013 #
(212) 267-1260 (*) (C)

Dr. Stella L. Lee
Ste 401
13-17 Elizabeth St
New York NY 10013 #
(212) 226-3937 (*)

Dr. Chang Q. Li
Ste 607
210 Canal St
New York NY 10013 #
(212) 513-1338 (*) (C)

Dr. Chang Q. Li
150 William St
New York NY 10038 #
(212) 227-9893 (*)

Lighthouse International
Dr. Shelly Agarwal
Dr. Kathy L. Allen-Aquilante
Dr. Debra Budick
Dr. Andrew S. Cass
Dr. Lisa Chan-O'Connell
Dr. Sara Erlich
Dr. Michael L. Fischer
Dr. Benjamin Freed
Dr. Andrea Hindes-Zimmerma
Dr. Sarah E. Klibanoff
Dr. Bruce P. Rosenthal
Dr. Adrian Wilck
111 E. 59th St
New York NY 10022 #
(212) 821-9624 (*) (H)

Dr. William Ling
Dr. Cindy Chan
Dr. Hei Yan Tam
Dr. Scott Tisdale
33 Mott St
New York NY 10013 #
(212) 349-8688 (*) (CS)

Lipton Eyecare
Dr. Evan J. Lipton
Lipton Eyecare
141 Division St
New York NY 10002 #
(212) 267-1787 (*) (S)

Dr. Judy Lo
Dr. Milly M. Mui
125 Walker St
New York NY 10013
(212) 226-3888 (*) <e> (M)

Dr. Jean C. Louis
2565 Broadway
New York NY 10025
(212) 666-2615 (*) <e> (F)

Dr. Martin O. Mark
Dr. Adam D. Mark
1966 3rd Ave Corner Of 108th
New York NY 10029 #
(212) 534-1020 (*)

Dr. Dana Mavrovich
117 Orchard St
New York NY 10002
(212) 674-1986 (*) <e>

Dr. Kenneth O. Mendelsohn
Ste 1204
130 E. 40th St
New York NY 10016 #
(212) 986-2153 (*)

Dr. Krishna Morar
Ste 202
2 W. 47th St
New York NY 10036 #
(212) 764-2020 (*)

Dr. Elaina Moyshelis
Dr. Aliya Hot
Dr. Gary J. Rocha
3929 Broadway
New York NY 10032 #
(212) 568-4693 (*) (S)

Dr. Tony Chi- Mui
158 Canal St
New York NY 10013 #
(212) 227-2978 (*) (TCM)

Dr. Jacob Nachum
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26 Broadway
New York NY 10004 #
(212) 425-2115

Dr. David L. Naparstek
Dr. Andrea Hindes-Zimmerma
Dr. Michele C. Maxwell
Battery Park City
101 Battery Pl
New York NY 10280 #
(212) 945-6789 (*)

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4767 Broadway
New York NY 10034 #
(212) 567-9351 (*) (S)

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Dr. Robert E. Behan
Dr. Traci M. Goldstein
Dr. Arthur D. Jung
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New York NY 10011 #
(212) 807-0019 (*) (S)

Optical Insight
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7 Hanover Sq
New York NY 10004 #
(212) 943-2360 (*) (S)

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Dr. Vladimir Dvoretsky
Dr. Eleonora Orloff
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New York NY 10033 #
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Pildesoptical
Dr. Eric S. Colman
2193 Broadway
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(212) 697-1838 (*) <e> (S)

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17 E. 102nd St #1183
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(212) 241-0939 (*) <e>

Revolution Eyes
82 W. Broadway
New York NY 10007 #
(212) 608-1111 (*) <d>

Dr. Michelle K. Rhee
17 E. 102nd St #1183
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(212) 241-0939 (*) <e>

Rogot Optical Inc
Dr. Clara E. Colmenares-Pasc
Dr. Gigi Frend-Frenkel
110 Dyckman St
New York NY 10040 #
(212) 567-6789 (*) (S)

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200 W. 24th St
New York NY 10011 #
(212) 929-3693 (*) (C)

Dr. Anthony Rusignuolo
167 W. 72nd St
New York NY 10023
(212) 769-1410 (*) <e>

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210 E. 86 St
New York NY 10028 #
(212) 717-2780

Dr. Edward Ruvio
79 Nassau St
New York NY 10038
(212) 349-1313 (*)

Dr. Edward Ruvio
79 Nassau St
New York NY 10038 #
(212) 349-1313 (*)

Sam & Anna Optics
Dr. Tiffany A. Lau
253 W. 72nd St
New York NY 10023 #
(212) 769-1174

Dr. Lillian E. Santana-Resto
All Eyes On Us, Inc
274 W. 125th St
New York NY 10027 #
(212) 663-1511 (*) (S)

Dr. Neil S. Schafran
87 Nassau St
New York NY 10038 #
(212) 233-8735

Dr. Alan B. Schlussel
200 E. 33rd St
New York NY 10016 #
(212) 683-2004 (*)

Dr. David J. Schwartz
Dr. Jamesina Chim
Dr. Nurit R. Harzvi
9 W. 14th St
New York NY 10011 #
(212) 242-0314 (*) (HS)

See Inc
Dr. Jessica T. Tran
207 Columbus Ave
New York NY 10023
(646) 335-4203 (*)

See, Inc
Dr. Andrea L. Liem
312 Bleeker St
New York NY 10014
(212) 989-7060 (*)

Dr. Ashish K. Sharma
82 W. Broadway
New York NY 10007
(212) 608-1111 (*) <e>

Dr. Gerald J. Shepps
Dr. Darren M. Wallis
Ste 1800
150 Broadway
New York NY 10038
(212) 233-2344 <e>

Dr. Irina Shiyan
1369 Third Ave
New York NY 10075 #
(212) 988-8505 (*) (FRS)

Dr. James M. Sinoway
Dr. Jason J. Chen
Ste 1501
425 Madison Ave
New York NY 10017 #
(212) 230-1780 (*) (S)

Dr. James M. Sinoway
Dr. Paul Lieberman
1884 3rd Ave
New York NY 10029 #
(212) 831-4733 (*) (S)

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K-Pakistan M-Mandarin

Dr. Louis I. Sobel
30 E. 76th St
New York NY 10021 #
(212) 472-1020 (*) (S)

Dr. Nathan Solat
Dr. Sean C. Fein
Cohen's Fashion Optical
225 Broadway
New York NY 10007 #
(212) 227-4208 (*) (S)

Sterling Optical
1125 Lexington Ave
New York NY 10021
(212) 628-8886 (*) <d>

Sterling Optical
794 Lexington Ave
New York NY 10021
(212) 755-8927 (*) <d>

Dr. Wayne N. Tabachnick
Dr. Yajaira R. Fernandez
Dr. Joanne Ramirez
648 W. 181 St
New York NY 10033 #
(212) 927-4444 (*) (S)

Dr. Bradford L. Tannen
Dr. Carol J. Lin
Dr. Theodora N. Petratos
17 E. 102nd St #1183
New York NY 10029
(212) 241-0939 (*) <e>

Dr. Jeffrey L. Taranto
106 E. 23rd St
New York NY 10010
(212) 677-3707 (*) <e>

Dr. Craig B. Tisch
Dr. Edward H. Miles
Dr. Dori I. Wolf
888 8th Ave
New York NY 10019 #
(212) 765-2660

Dr. Craig B. Tisch
Dr. Matthew C. Horowitz
Ste 207
450 7th Ave
New York NY 10123 #
(212) 279-4826 (*)

Dr. George Traykovski
Ste 1A
24 W. 69th St
New York NY 10023 #
(212) 877-2016 (*)

Universal Optical
Dr. Mary Y. Chen
Dr. Scott Dong
38 E. Broadway
New York NY 10002 #
(212) 966-8288 (*) (C)

University Optometric Center
33 W. 42nd St
New York NY 10036 #
(212) 938-4001 (*)

Dr. Laurie Vu
3210 Broadway
New York NY 10027 #
(212) 665-5051 (*)

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New York NY 10038 #
(212) 693-1111 (*) (FRS)

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Dr. Adriana C. Carpeniseanu
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2nd Floor-George Washington Br
Between 178 & 179
New York NY 10033 #
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Dr. Laura C. Sperazza
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New York NY 10023 #
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Dr. Marc G. Rubinstein
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New York NY 10017 #
(212) 593-9850 (*)

Dr. Marc S. Werner
2nd Fl
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New York NY 10016 #
(212) 689-7676 (*)

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Dr. Lisa N. Vo
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New York NY 10075 #
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Level 2
2 World Financial Ctr Lobby
New York NY 10281 #
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90-92 Bowery
New York NY 10013 #
(212) 219-3285 (*)

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New York NY 10026 #
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New York NY 10003 #
(212) 388-1668 (CS)

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81 Elizabeth St
New York NY 10013 #
(212) 966-5880 (*)

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New York NY 10013 #
(212) 966-8216 (*)

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Dr. Silgi R. Philip
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New York NY 10024 #
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New York Mills NY 13417 #
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Optical Dispensary
Dr. Zenon W. Ciopyk
Dr. George S. Kornfeld
Dr. Donald R. Wilson
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Newburgh NY 12550
(845) 564-3522 (*) <e>

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Dr. Joseph Birnbaum
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Newburgh NY 12550 #
(845) 561-0907

Jules Vision Center
Dr. Paul Collins
Newburgh Mall
1401 Rte 300
Newburgh NY 12550 #
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National Vision Center
In Wal-Mart
1201 Union Ave
Newburgh NY 12550
(845) 567-0068 <d>

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1201 Union Ave
Newburgh NY 12550
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Dr. Faith M. Schiff
47 N. Plank Rd
Newburgh NY 12550 #
(845) 562-6284 (*)

Sterling Optical
1401 Rte 300
Newburgh NY 12550
(845) 564-3522 (*) <d>

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Niagara Falls NY 14304 #
(716) 297-4465 (*) (F)

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Niagara Falls NY 14304 #
(716) 283-8746 (*) <d>

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Dr. Steven I. Bench
Ste 206
151 Buffalo Ave
Niagara Falls NY 14303 #
(716) 284-9449 (*)

Dr. Anthony P. Trzepkowski
7600 3rd Ave
Niagara Falls NY 14304 #
(716) 298-8182 (*)

Dr. Ralph R. Vogel
Dr. Amanda M. Sanford
7900 Buffalo Ave
Niagara Falls NY 14304
(716) 283-8745 (*) <e>

NORTH BABYLON

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Dr. Dina M. Castagnino
Dr. Sara Lloyd-Phillips
Dr. Edward F. Rubin
Deer Cross Commons
1498 Deer Park Ave
North Babylon NY 11703
(631) 242-6730 (*)

Dr. Ivan M. Klayman
Dr. Michael Levinson
1146 Deer Park Ave
North Babylon NY 11703 #
(631) 586-5055 (*)

NORTH BELLMORE

Dr. Jacquelyn Guida
542 Jerusalem Ave
North Bellmore NY 11710 #
(516) 679-5866 (*)

NORTH SYRACUSE

Empire Vision
Dr. Hemali K. Bhakta
Dr. Desiderio Catunto
Dr. Michael S. Diamond

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Tower frame collection.

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P-Polish A-Amer Sign G-German R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese K-Pakistan M-Mandarin

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(*) Handicap access.
ALT LANG: S-Spanish F-French
C-Chinese I-Italian H-Hebrew
 # Tower frame collection.

<e> Performs examinations only
P-Polish A-Amer Sign G-German
R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese
K-Pakistan M-Mandarin

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Cohen's Fashion Optical
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Dr. Marc Dinowitz
Dr. Daniel C. Hamou
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5467 Main St
Williamsville NY 14221 #
(716) 632-7944 (*)

WILLISTON PARK

Dr. Neil A. Falasca
Ste 99 I.
99 Hillside Ave
Williston Park NY 11596 #
(516) 747-8887

WILTON

Dr. Kerry Harbeck
16 Old Gick Rd
Wilton NY 12866
(518) 587-0258 (*) <e>

National Vision Center
In Wal-Mart
16 Old Gick Rd
Wilton NY 12866
(518) 587-0258 <d>

WOODHAVEN

Evan David Opticians, Inc
Dr. Natalie Bissoon
90-08 Jamaica Ave
Woodhaven NY 11421 #
(718) 805-2020 (*)

Dr. Peter F. Guidara
80-05 Jamaica Ave
Woodhaven NY 11421 #
(718) 526-2252 (*) (S)

Dr. Jeffrey M. Leiter
89-21 Jamaica Ave
Woodhaven NY 11421 #
(718) 847-1946 (*)

WOODSIDE

Dr. Peter F. Guidara
45-55 46 St
Woodside NY 11377 #
(718) 392-1244 (*) (S)

(*) Handicap access.
ALT LANG: S-Spanish F-French C-Chinese I-Italian H-Hebrew
Tower frame collection.

<e> Performs examinations only
P-Polish A-Amer Sign G-German R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese K-Pakistan M-Mandarin

Dr. Pauline Leong
69-09 Roosevelt Ave
Woodside NY 11377 #
(718) 639-1392 (*) (CS)

Little Optics
39-05 61st St
Woodside NY 11377 #
(718) 468-7500 (*) <d>

Dr. Gary J. Rocha
39-75 61st St
Woodside NY 11377 #
(718) 899-2121

YONKERS

Dr. Kenneth H. Braunstein
20 S. Broadway
Yonkers NY 10701 #
(914) 963-9787 (*)

Dr. David Karan
Dr. Michael D. Boron
30 S. Broadway
Yonkers NY 10701
(914) 968-4898 (*) <e>

Dr. Christina M. Gorman
984 N. Broadway
Yonkers NY 10701 #
(914) 965-6875 (*) (S)

Dr. Marc W. Greenberg
Dr. Martin Sigman
770 McLean Ave
Yonkers NY 10704 #
(914) 803-0500 (*) (S)

Dr. Edward A. Griggs Jr.
Ste 516
45 Ludlow St
Yonkers NY 10705
(914) 963-3322 (*) <e> (CS)

Dr. Alan Lax
2500 Central Park Ave
Yonkers NY 10710 #
(914) 337-2100 (S)

Dr. Biagio V. Mignone
Dr. Paul M. Mignone
Dr. Vernon A. Peryea, Jr.
1053 Yonkers Ave
Yonkers NY 10704 #
(914) 237-2002 (*) (IS)

Dr. Paul M. Mignone
Dr. Biagio V. Mignone
955 Yonkers Ave
Yonkers NY 10704 #
(914) 237-2002 (*) <e> (I)

Dr. Joseph Muscente
655 Yonkers Ave
Yonkers NY 10704 #
(914) 509-6660 (*) (IS)

Dr. Allen Shapiro
Dr. Carolyn Mohedano
Dr. Reesa L. Smart
7 Mall Walk
Yonkers NY 10704 #
(914) 968-2626 (*)

Dr. Aarti Sharma
Dr. Hernando Alfonso
Dr. Michael D. Bernstein
819 Yonkers Ave
Yonkers NY 10704 #
(914) 375-5775 (*) (S)

Sterling Optical
5570 Xavier Dr
Yonkers NY 10704
(914) 968-6600 (*) <d>

Dr. Kenneth H. Weisfeld
100 New Main St
Yonkers NY 10701 #
(914) 965-5367 (*) (S)

YORKTOWN HEIGHT

Sterling Optical
650 Lee Blvd
Yorktown Height NY 10598
(914) 245-8111 (*) <d>

YORKTOWN HTS

Dr. Andrew J. Freilich
650 Lee Blvd
Yorktown Hts NY 10598
(914) 245-8111 (*) <e>

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<d> Dispenses eyewear only J-Japanese T-Cantonese K-Pakistan M-Mandarin

Vision Care Participating Network Providers

ALABAMA

BIRMINGHAM

Dr. Price M. Kloess
Suite 150
790 Montclair Rd
Birmingham AL 35213
(205) 592-3911 (*)

Lasik Plus
Dr. Manuel J. Chaknis
3431 Colonnade Pkwy
Birmingham AL 35243
(800) 525-8299 (*)

Dr. Marc A. Michelson
327 Summit Blvd
Birmingham AL 35243
(205) 969-8100 (*)

Visionfirst Eye Center
Ste 100
3240 Edwards Lake Pkwy
Birmingham AL 35235
(877) 768-2020

ARKANSAS

HOT SPRINGS

McFarland Eye Center
Ste A.
3604 Central Ave
Hot Springs AR 71913
(877) 768-2020

JONESBORO

Dr. Thomas Stank, M.D
601 E. Matthews
Jonesboro AR 72401
(870) 935-6396 (*)

LITTLE ROCK

Dr. John N. Gillespie
Suite 303
11321 Interstate 30
Little Rock AR 72209
(501) 455-5656

McFarland Eye Center
Ste 440
17200 Chenal Pkwy
Little Rock AR 72212
(877) 768-2020

T.L.C. Laser Eye Center
Dr. Richard E. Brown
Ste 201
10809 Executive Cetner Dr
Little Rock AR 72211
(877) 768-2020

PINE BLUFF

McFarland Eye Center
3805 W. 28th
Pine Bluff AR 71603
(877) 768-2020

SPRINGDALE

Brandon Eye Clinic
1600 W. Sunset
Springdale AR 72764
(877) 768-2020

ARIZONA

CHANDLER

Lasik Plus
Dr. Gabriel J. Perry
Ste 14
2875 West Ray Rd
Chandler AZ 85224
(800) 525-8299

COTTONWOOD

Dr. Kevin J. Prendiville
Suite B.
270 South Candy Lane
Cottonwood AZ 86326
(928) 634-4202 (*)

PHOENIX

Dr. Gary S. Mackman
#408
1728 W. Colendale Ave
Phoenix AZ 85021
(602) 995-1166 (*) (S)

Newman Laser Eye Center
Ste 102
20819 N. Cave Creek Rd
Phoenix AZ 85024
(602) 788-8080 (*)

SCOTTSDALE

Lasik Plus
Dr. Gabriel J. Perry
16427 N. Scottsdale Rd
Scottsdale AZ 85254
(800) 525-8299 (*)

Dr. Jay L. Schwartz
Ste C. 101
8416 E. Shea Blvd
Scottsdale AZ 85260
(480) 483-3937 (*)

CALIFORNIA

BREA

T. L. C. Laser Eye Centers
910 East Birch St
Brea CA 92821
(714) 257-0560 (*)

CONCORD

Lasik Plus
Dr. George V. Simon
Suite 120
1390 Willow Pass Road
Concord CA 94520
(800) 525-8299

FOSTER CITY

Lasik Plus
Dr. George V. Simon
Suite 130
950 Tower Lane
Foster City CA 94404
(800) 525-8299 (*)

FRESNO

Dr. Jack Clark
7108 N. Fresno Street
Fresno CA 93720
(559) 439-1620

Tlc Fresno
1680 E. Herndon
Fresno CA 93720
(714) 257-0540 (*)

FULLERTON

Tlc @ Scco
2575 Yorba Linda Blvd
Fullerton CA 92831
(877) 768-2020

LAGUNA HILLS

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Laguna Hills CA 92653
(949) 951-4641 (*)

LOS ANGELES

Dr. Paul D. First
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7080 Hollywood Blvd
Los Angeles CA 90028
(323) 462-6753 (*)

NEWPORT BEACH

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Dr. Thomas S. Tooma
3501 Jamboree Rd
Newport Beach CA 92660
(877) 768-2020 (*)

ONTARIO

Nvision
Dr. Thomas S. Tooma
3155-D Sedona Ct
Ontario CA 91764
(909) 605-1975 (*)

PALM DESERT

T. L. C. Laser Eye Centers
Suite E. 2516
73-525 El Paseo
Palm Desert CA 92260
(877) 768-2020 (*)

PLEASANTON

Dr. Michael R. Gagnon
Ste 240
5575 W. Las Positas Blvd
Pleasanton CA 94588
(925) 460-5000 (*)

Valley Eye Care Center
Dr. Jonathan L. Savell
Ste 240
5575 Las Positas Blvd
Pleasanton CA 94588
(877) 768-2020

REDDING

Redding- Tlc Associate Cente
Dr. Thomas S. Tooma
Ste 110
310 Hemsted Dr
Redding CA 96002
(530) 221-0726 (*)

ROSEVILLE

Dr. Paris E. Royo
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Roseville CA 95661
(916) 783-7696 (*)

Dr. Stephen S. Wilmarth
1830 Sierra Gardens Drive 100
Roseville CA 95661
(916) 782-2111 (*)

SAN DIEGO

Lasik Plus
Dr. Randa M. Garrana
13522 Sabre Spring Pkwy
San Diego CA 92128
(800) 525-8299 (*)

T. L. C. Laser Eye Centers
Herst Towne Center
Suite 130
3655 Nobel Drive
San Diego CA 92122
(877) 768-2020 (*)

SAN FRANCISCO

Dr. Ella G. Faktorovich
One Daniel Burnham Court
San Francisco CA 94109
(415) 922-9500 (*)

SAN JOSE

Furlong Vision Center
Dr. Michael T. Furlong
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2107 N. 1st St
San Jose CA 95131
(800) 573-1010 (*)

Lasik Plus
Dr. George V. Simon
Ste 110
5300 Stephens Creek Blvd
San Jose CA 95129
(800) 525-8299 (*)

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Vision Care Participating Network Providers

TORRANCE

T. L. C. Laser Eye Centers
Suite 200
3445 Pacific Coast Hwy
Torrance CA 90505
(310) 784-2020 (*)

WOODLAND

Perlman Center For Eye
610 Cottonwood St
Woodland CA 95695
(877) 768-2020

COLORADO

COLORADO SPRING

T.L.C. Laser Eye Center
3462 Briargate Blvd
Colorado Spring CO 80906
(877) 768-2020

LAKEWOOD

Lasik Plus
Dr. Karen A. Heuer
7440 W. Alaska Dr
Lakewood CO 80226
(800) 525-8299 (*)

T. L. C. Laser Eye Centers
Dr. Robert B. Keyser
Dr. James A. Patterson
Suite 125
225 Union Blvd
Lakewood CO 80228
(303) 607-0174 (*)

CONNECTICUT

BRIDGEPORT

Dr. Kim Robbins
4695 Main St
Bridgeport CT 06606
(203) 371-5800 (*)

FAIRFIELD

T. L. C. Laser Center
75 Kings Hwy. Cutoff
Fairfield CT 06824
(203) 334-2020 (*)

T. L. C. The Laser Center
Dr. Eric D. Donnenfeld
75 Kings Hwy Cutoff
Fairfield CT 06825
(203) 323-2808 (*)

HARTFORD

Dr. Richard A. Fichman
178 Hartford Rd
Hartford CT 06040
(860) 649-9973 (*)

NORWALK

Dr. Scott Spector
605 West Ave
Norwalk CT 06850
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ORANGE

Lasik Plus
Dr. Anthony L. Salierno
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Orange CT 06477
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Stamford CT 06905
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WETHERSFIELD

Lasik Plus
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Wethersfield CT 06109
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DELAWARE

DOVER

Halpern Ophthalmology
885 S. Governors Blvd
Dover DE 19904
(877) 768-2020

MILLVILLE

Halpern Ophthalmology
14 Atlantic Ave
Millville DE 19967
(877) 768-2020

NEWARK

Kremer Laser Eye Center
Dr. Carol J. Hoffman
Flat Discount
Ste 1
4102 Ogeltown Stanton Rd
Newark DE 19801
(302) 657-0386 (*)

FLORIDA

CORAL GABLES

T. L. C. Laser Eye Center
220 Alhambra Circle
Coral Gables FL 33134
(877) 768-2020 (*)

FORT LAUDERDALE

Las Olas Laser Eye Center
450 E. Las Olas Blvd
Fort Lauderdale FL 33301
(877) 768-2020 (*)

FORT MEYERS

Gorovoy Md Eye Specialist
Ste 300
12381 S. Cleveland Ave
Fort Meyers FL 33907
(877) 768-2020

FORT MYERS

Dr. Jonathan M. Frantz
12731 New Brittany Blvd
Fort Myers FL 33907
(239) 418-0999 (*)

JACKSONVILLE

Bowden Eye Associates
Dr. Frank W. Bowden
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1215 Dunn Ave
Jacksonville FL 32218
(904) 696-9486 (*)

Bowden Eye Associates
Dr. Frank W. Bowden
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1235 San Marco Blvd
Jacksonville FL 32207
(904) 396-1908 (*)

Guliani Vision Institute
Ste 103
8075 Gate Pkwy West
Jacksonville FL 32216
(904) 296-7393 (*)

Lasik Plus
Dr. Joseph F. Faust
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8705 Perimeter Park Blvd
Jacksonville FL 32216
(800) 525-8299

Nicolitz Eye Consultants
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Jacksonville FL 32207
(877) 768-2020

MELBOURNE

Dr. Paul J. Befanis
665 Apollo Blvd
Melbourne FL 32901
(321) 984-3200

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Lasik Plus
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Miramar FL 33029
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ORANGE PARK

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Orange Park FL 32073
(904) 215-4600 (*)

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Lasik Plus
Dr. Lewis R. Groden
Dr. Jeffrey B. Robin
8701 Maitland Summit Blvd.
3rd Floor
Orlando FL 32810
(800) 525-8299 (*)

PANAMA CITY

Advanced Eye Care
2500 W. 3rd St
Panama City FL 32405
(877) 768-2020

PENSACOLA

Panhandle Vision Institute
1717 North E. St
Pensacola FL 32501
(877) 768-2020

SUNRISE

Dr. Cory Lessner
#410
1601 Sawgrass Corporate Pkwy
Sunrise FL 33323
(954) 835-0800 (*)

TAMPA

Lasik Plus
Dr. Lewis R. Groden
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2202 N. Westshore Blvd.
Tampa FL 33607
(800) 525-8299 (*)

T. L. C. Laser Eye Centers
1510 N. West Shore Blvd
Tampa FL 33607
(877) 768-2020 (*)

Vision America Laser Center
Suite 204
3104 W. Waters Ave
Tampa FL 33614
(813) 931-0500 (*)

WEST PALM BEACH

Dr. Alan N. Kohn
Ste 300
2505 Metrocentre Blvd
West Palm Beach FL 33407
(561) 478-2003 (*)

Presidential Eye Care
1501 Presidential Way
West Palm Beach FL 33401
(877) 768-2020

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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

GEORGIA

ALPHARETTA

Lasik Plus
Dr. Eugene Smith
Suite 420
5530 Windward Pkwy
Alpharetta GA 30004
(800) 525-8299 (*)

ATHENS

Dr. Richard H. Blue
651 S. Milledge Road
Athens GA 30605
(706) 546-9290 (*)

ATLANTA

Clear Vision Laser Centers
5667 Peachtree
Dunwoody Rd #250
Atlanta GA 30342
(404) 257-5545 (*)

Lasik Plus
Dr. Eugene Smith
Suite 200
200 Galleria Pky
Atlanta GA 30339
(800) 525-8299 (*)

Lasik Plus
Dr. Eugene Smith
1 Buckhead Loop
Atlanta GA 30326
(800) 525-8299 (*)

Southeast Eye Sur Ctr, PC
3200 Downwood Circle #200
Atlanta GA 30327
(404) 355-8721 (*)

T. L. C. Laser Eye Centers
Suite 240
5505 Peachtree Dunwoody Drive
Atlanta GA 30342
(877) 768-2020 (*)

AUGUSTA

Eye Care One-McG Eye Assoc
3152 Washington Rd
Augusta GA 30909
(877) 768-2020

COLUMBUS

The Eye Drs Vision Corr Cnt
1030 13th St
Columbus GA 31901
(877) 768-2020

DOUGLASVILLE

Dr. Herbert L. Blatt
Suite 120 B.
8954 Hospital Drive
Douglasville GA 30134
(770) 949-3885

DULUTH

Lasik Plus
Dr. Eugene Smith
Suite 175
3175 Satellite Blvd. Bldg 600
Duluth GA 30096
(800) 525-8299 (*)

KENNESAW

Dr. Richard H. Blue
1415 Wooten Lake Road
Kennesaw GA 30144
(770) 424-8101 (*)

ROME

Clear Vision Laser Centers
Harbin Clinic
1825 Martha Berry Blvd
Rome GA 30165
(404) 257-5545 (*)

IOWA

AMES

Wolfe Clinic
2020 Philadelphia St.
Ames IA 50010
(515) 232-2450 (*)

BETTENDORF

Dr. Richard Bedell
1875 Middle Rd
Bettendorf IA 52722
(563) 359-4446 (*)

BURLINGTON

Freedom Lasik Llc
Dr. Jonathan I. Cutler
Dr. Valerie K. Kounkel
2743 Mt Pleasant St
Burlington IA 52601
(319) 758-1107

CEDAR RAPIDS

Wolfe Clinic
Dr. Todd A. Gothard
1245 2nd Ave S.E.
Cedar Rapids IA 52403
(319) 362-8032 (*)

DES MOINES

T.L.C. Laser Eye Center
Ste 104
1225 Jordan Creek Pkwy
Des Moines IA 50266
(877) 768-2020

FORT DODGE

Wolfe Clinic
804 Kenyon Rd
Fort Dodge IA 50501
(515) 577-0103 (*)

MARSHALLTOWN

Wolfe Clinic
Dr. James A. Davison
309 E. Church St
Marshalltown IA 50158
(641) 754-6200 (*)

ROBINS

T. L. C. Laser Eye Centers
Dr. Carmen A. Foster-McLean
915 Robins Square Drive
Robins IA 52328
(877) 764-2020 (*)

WEST DES MOINES

Wolfe Clinic
Dr. James A. Davison
6200 Westown Pkwy
West Des Moines IA 50266
(515) 223-8685 (*)

IDAHO

BOISE

Intermountain Eye Clinic
Ste 210
999 N. Curtis Rd
Boise ID 83706
(208) 373-1200

IDAHO FALLS

Tlc Laser Eye Centers
2295 Coronado St
Idaho Falls ID 83404
(208) 524-8600

POCATELLO

Tlc Laser Eye Centers
Ste C.
1951 Bench Rd
Pocatello ID 83201
(208) 238-3377

ILLINOIS

ALTON

Surevision Surg & Laser Ctr
3 Professional Dr
Alton IL 62002
(618) 465-2020 (*)

ARLINGTON HTS

Surevision Surg & Laser Ctr
1602 W. Central Rd
Arlington Hts IL 60005
(847) 255-3515 (*)

Dr. Lawrence Wolin
1602 W. Central Rd
Arlington Hts IL 60005
(847) 255-3515 (*)

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Eye Center Physicians, Ltd
1725 West Harrison Street
#906
Chicago IL 60612
(312) 942-5315 (*)

Dr. Manus C. Kraff
Dr. Colman R. Kraff
Suite 300
3115 North Harlem
Chicago IL 60634
(773) 777-4444

Dr. Manus C. Kraff
Dr. Colman R. Kraff
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25 East Washington Street
Chicago IL 60602
(312) 444-1111 (*)

Lasik Plus
Dr. David Aymond
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939 W. North Ave
Chicago IL 60622
(800) 525-8299 (*)

Northshore Eye Associates
5600 W. Addison
Chicago IL 60634
(773) 283-2454 (*)

Northwestern Laser Vision Ce
Suite 15-300
675 N. St. Clair St.
Chicago IL 60611
(312) 695-2737

Rosin Eyecare
Ste 210
645 N. Michigan Ave
Chicago IL 60611 #
(866) 484-2020

Surevision Surg & Laser Ctr
3034 W. Peterson Ave
Chicago IL 60659
(773) 973-7432 (*)

DEERFIELD

Dr. Stuart Sondheimer
Ste A.
360 S. Waukegan Rd
Deerfield IL 60015
(866) 484-2020

DOWNERS GROVE

Rosin Eyecare
145 Odgen Ave
Downers Grove IL 60515
(866) 484-2020

GRANITE CITY

Surevision Surg & Laser Ctr
#12 Nameoki Village
Granite City IL 62040
(618) 451-7925 (*)

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Vision Care Participating Network Providers

GURNEE

Dr. Walter I. Fried
3477 Grand Ave
Gurnee IL 60031
(847) 249-4660 (*) (S)

NAPERVILLE

Lasik Plus
Dr. David Aymond
Dr. Gerald Horn
1555 Bond St
Naperville IL 60540
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NORTHBROOK

Rosin Eyecare
1947 Cherry Ln
Northbrook IL 60062
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OAK BROOK

Lasik Plus
Dr. Gerald Horn
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3021 Butterfield Rd
Oak Brook IL 60523
(800) 525-8299 (*)

OAKBROOK

Lasik Plus
Dr. David Aymond
Dr. Gerald Horn
Ste 200
3021 Butterfield Rd
Oakbrook IL 60523
(800) 525-8299

RIVER FOREST

Kirk Eye Center
7427 Lake St
River Forest IL 60305
(708) 771-3334 (*)

Surevision Surg & Laser Ctr
7427 West Lake St
River Forest IL 60305
(708) 488-1200 (*)

ROCK ISLAND

Borisuth Dr Navaneet
2202 18th St
Rock Island IL 61201
(309) 788-5524 (*)

Dr. Richard B. Phinney
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2570 24th St
Rock Island IL 61201
(866) 484-2020

SCHAUMBERG

Lasik Plus
Dr. David Aymond
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999 Plaza Dr
Schaumberg IL 60173
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(866) 484-2020

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Avon IN 46123
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EVANSVILLE

Dr. Gregory L. Hayden
1150 Lincoln Ave
Evansville IN 47714
(812) 477-3937 (*)

HAMMOND

Surevision Surg & Laser Ctr
6836 Hohman Ave
Hammond IN 46324
(219) 937-5063 (*)

Williams Eye Institute
6850 Hohman Ave
Hammond IN 46324
(219) 931-7509 (*)

INDIANAPOLIS

Lasik Plus
Dr. Jason Greenberg
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Indianapolis IN 46240
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T. L. C. Laser Eye Centers
Dr. Anthony J. Lombardo
Dr. Kevin L. Waltz
5875 Castle Creek Pkwy North
Indianapolis IN 46250
(317) 845-2020 (*)

LAPORTE

Dr. Carl Golightly-Laporte
1440 W. State Rd 2
Laporte IN 46350
(877) 768-2020

MERRILLVILLE

Deschamps Eye Care, P.C.
8510 Broadway St
Merrillville IN 46410
(219) 736-2200 (*)

Dr. Robert Moses
70 E. 68th Pl
Merrillville IN 46410
(877) 768-2020

Surevision Surg & Laser Ctr
8514 Broadway
Merrillville IN 46410
(219) 736-2200 (*)

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Dr. Carl Golightly
815 Washington St
Michigan City IN 46360
(877) 768-2020

MISHAWAKA

Grossnickle Eye Center
Dr. Steven P. Grossnickle
Dr. Christoph D. Knight
Ste A.
4430 Edison Lakes Pkwy
Mishawaka IN 46545
(888) 223-2030 (*)

Dr. Richard D. Weiss
Dr. Steven P. Checroun
Ste 100
230 E. Day Rd
Mishawaka IN 46545
(574) 271-3939 (S)

Dr. Richard D. Weiss
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230 E. Day Rd
Mishawaka IN 46545
(877) 768-2020

NOBLESVILLE

Dr. Anne E. Henley
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110 Lakeview Dr
Noblesville IN 46060
(317) 773-5555 (*)

VINCENNES

Wabash Valley Eye Center
2020 Clear View Dr
Vincennes IN 47591
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WARSAW

Grossnickle Eye Center
Dr. Steven P. Grossnickle
Dr. Christoph D. Knight
2251 Dubois Dr
Warsaw IN 46580
(800) 922-6975 (*)

WHITING

Dr. Steven Levin
1334 119th St
Whiting IN 46825
(877) 768-2020

KANSAS

KANSAS CITY

Medical Surgical Eye Care
Ste 226
8919 Parallel Pkwy
Kansas City KS 66112
(877) 768-2020

LEAWOOD

Lasik Plus
Dr. Dean R. Ellis
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11401 Nall Ave
Leawood KS 66211
(800) 525-8299

PRAIRIE VILLAGE

Mid-America Eye Center
3830 W. 75th St
Prairie Village KS 66208
(877) 768-2020

SHAWNEE MISSION

Heart Of America Eye Care
Ste 285
8901 W. 74th St
Shawnee Mission KS 66204
(877) 768-2020

WICHITA

Grene Vision Group
1851 N. Webb Rd
Wichita KS 67206
(877) 768-2020

KENTUCKY

GLASGOW

Downing-McPeak Vision Center
1507 Bravo Blvd
Glasgow KY 42141
(877) 768-2020

LEXINGTON

Dr. Bruce H. Koffler
Ste 431
120 North Eagle Creek Dr
Lexington KY 40509
(859) 263-4631 (*)

Lasik Plus
Dr. Mark Cassol
Dr. Jason Greenberg
Ste 140
2348 Nicholasville Rd
Lexington KY 40503
(800) 525-8299 (*)

LOUISVILLE

Dr. Tim Conrad
204 Breckenridge Lane
Louisville KY 40207
(502) 899-7778 (*)

(*) Handicap access.
ALT LANG: S-Spanish F-French
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P-Polish A-Amer Sign G-German
R-Russian Y-Yiddish O-Korean

<d> Dispenses eyewear only
J-Japanese T-Cantonese
K-Pakistan M-Mandarin

Vision Care Participating Network Providers

Dr. Richard A. Eiferman
Ste 220
6400 Dutchmans Pkwy
Louisville KY 40205
(502) 895-4200 (*)

Lasik Plus
Dr. Jason Greenberg
Ste 5F
4001 Dutchman's Ln
Louisville KY 40207
(800) 525-8299 (*)

The Eye Care Institute
1536 Story Ave
Louisville KY 40206
(877) 768-2020

LOUISIANA

BATON ROUGE

Dr. Charles H. Williamson
550 Connell's Park Lane
Baton Rouge LA 70806
(225) 927-2020 (*)

Dr. Mark A. Meadows
8777 Bluebonnet, Suite B.
Baton Rouge LA 70809
(225) 767-5525 (*)

MASSACHUSETTS

BROOKLINE

Dr. Samir A. Melki
Ste 6W
1101 Beacon St
Brookline MA 02446
(617) 277-4733

FAIRHAVEN

Dr. Kenneth Kenyon
70 Huttleston Ave
Fairhaven MA 02719
(508) 994-2020 (*)

FLORENCE

Dr. Nancy A. Balin
269 Locust St
Florence MA 01062
(413) 584-6666 (*)

GREENFIELD

Dr. Pierre R. Alfred
33 Riddell Street
Greenfield MA 01301
(413) 774-3797 (*)

MASHPEE

Dr. Daniel J. Oconnor
133 Falmouth Rd
Mashpee MA 02649
(508) 477-7833

NORWOOD

Dr. George A. Violin
95 Chapel St
Norwood MA 02062
(781) 762-9018 (*)

PLYMOUTH

Dr. Daniel J. Oconnor
40 Industral Park Rd
Plymouth MA 02360
(508) 746-8600 (*)

QUINCY

Dr. Steven A. Nielsen
Suite 201
300 Congress St
Quincy MA 02169
(617) 471-5665 (*)

SOUTH DENNIS

Dr. Daniel J. Oconnor
76 Airline Rd
South Dennis MA 02660
(508) 385-5550

TAUNTON

Dr. Kenneth Kenyon
64 Winthrop Street
Taunton MA 02780
(508) 823-5536 (*)

W SPRINGFIELD

Dr. John P. Frangie
1132 Westfield St
W. Springfield MA 01089
(413) 781-6352 (*)

WALTHAM

T. L. C. Laser Eye Centers
Suite 510
400 Fifth Ave
Waltham MA 02451
(781) 890-9922 (*)

MARYLAND

ANNAPOLIS

Lasik Plus
Dr. Sonny Goel
Dr. Jay Lustbader
Suite 104
116 Defense Hwy
Annapolis MD 21401
(800) 525-8299 (*)

T. L. C. Laser Center
Dr. Michael J. Dodd
Ste. 300
888 Bestgate Rd.
Annapolis MD 21401
(410) 224-8900 (*)

T. L. C. Laser Eye Centers
Suite 300
888 Bestgate Drive
Annapolis MD 21401
(877) 768-2020 (*)

BALTIMORE

Lasik Plus
Dr. Sonny Goel
Ste 105
22 West Rd
Baltimore MD 21204
(800) 525-8299 (*)

BETHESDA

Dr. J. Albert Martinez
Suite 610
6410 Rockledge Drive
Bethesda MD 20817
(301) 896-0890

BOWIE

Dr. William L. Gonzalez
Dr. Mark L. Gonzalez
Ste B128
4000 Mitchellville Rd
Bowie MD 20716
(301) 464-1192 (*)

COLUMBIA

Lasik Plus
Dr. Sonny Goel
Dr. Jay Lustbader
Ste 103
10025 Governor Warfield Pkwy
Columbia MD 21044
(800) 525-8299

FREDERICK

Whitten Laser Eye
Dr. Edward L. Perraut Jr.
Dr. Mark E. Whitten
A. T.L.C Associate Center
70 Thomas Johnson Dr, #120
Frederick MD 21702
(877) 768-2020 (*)

ROCKVILLE

Lasik Plus
Dr. Jay Lustbader
9850 Keywest Ave
Rockville MD 20850
(800) 525-8299 (*)

T. L. C. Laser Center
Dr. Edward L. Perraut Jr.
Dr. Mark E. Whitten
Ste 210
11200 Rockville Pike
Rockville MD 20852
(877) 768-2020 (*)

TOWSON

Katzen Eye Group
Ste 210
901 Dulaney Valley Rd
Towson MD 21204
(800) 617-3937 (*)

MAINE

WATERVILLE

Eye Center Of Central Maine
Dr. Peter Kohler
40 Airport Rd
Waterville ME 04901
(207) 873-6048 (*)

MICHIGAN

ANN ARBOR

T. L. C. Laser Center
Ste. 10
2350 E. Stadium Blvd.
Ann Arbor MI 48104
(877) 768-2020 (*)

FARMINGTON HILL

T. L. C. Laser Eye Centers
34405 W. Twelve Mile Rd
Farmington Hill MI 48331
(877) 768-2020 (*)

GAYLORD

Lazer Vue
850 N. Center St
Gaylord MI 49735
(888) 464-2020 (*)

LANSING

T. L. C. Laser Center
Ste. H.
1515 Lake Lansing Rd.
Lansing MI 48910
(877) 768-2020 (*)

MONROE

Reed Vision
1180 N. Monroe
Monroe MI 48162
(877) 768-2020

PORTAGE

T. L. C. Laser Eye Centers
Ste 110
1350 W. Centre Street
Portage MI 49104
(877) 768-2020 (*)

ST CLAIR SHORES

Dr. James W. Klein
21711 Greater Mack
St Clair Shores MI 48080
(586) 774-0393

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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

TROY

Dr. Daniel S. Haddad
355 E. Big Beaver Rd
Troy MI 48083
(248) 689-2020 (*)

MINNESOTA

BRAINARD

Northern Eye Center
2020 S. 6th St
Brainard MN 56401
(877) 768-2020

EDINA

Lasik Plus
Dr. Omar E. Awad
Dr. Chris T. Buntrock
Dr. Michael Richie
Dr. Matthew Sharpe
Ste 412
3300 Edinborough Way
Edina MN 55435
(800) 525-8299 (*)

MAPLE GROVE

Lasik Plus
Dr. Omar E. Awad
Dr. Chris T. Buntrock
Dr. Michael Richie
Dr. Matthew Sharpe
Ste 140
7767 Elm Creek Blvd
Maple Grove MN 55369
(800) 525-8299 (*)

OAKDALE

Lasik Plus
Dr. Omar E. Awad
Dr. Chris T. Buntrock
Dr. Michael Richie
Dr. Matthew Sharpe
8344 3rd Se N.
Oakdale MN 55128
(800) 525-8299 (*)

MISSOURI

BUTLER

Mid-American Eye Center
204 W. Chestnut
Butler MO 64730
(877) 768-2020

CHESTERFIELD

E. Clarkson Eyecar
Dr. Michael Donahoe
Dr. Joseph Gira
17249 Chesterfield Airport Rd
Chesterfield MO 63005
(636) 787-0088 (*)

EL DORADO

Mid-American Eye Center
1401 S. Park
El Dorado MO 64744
(877) 768-2020

FLORISSANT

Surevision Surg & Laser Ctr
215 Dunn Rd
Florissant MO 63031
(314) 921-2020

KANSAS CITY

Dr. Andrew L. Moyes
Ste 200
5844 Nw Barry Rd
Kansas City MO 64154
(816) 746-9800 (*)

Silverstein Eye Centers
Dr. Johann G. Ohly
Dr. Steven M. Silverstein
Dr. Kevin R. Skelsey
Ste 1000
4240 Blue Ridge Blvd
Kansas City MO 64133
(816) 358-3600 (*)

NEVADA

Mid-American Eye Center
111 N. Main
Nevada MO 64772
(877) 768-2020

SPRINGFIELD

T.L.C. Laser Eye Center
1701 S. Enterprise Ave
Springfield MO 65804
(877) 768-2020

ST. LOUIS

Lasik Plus
Dr. Therese M. Alban
Ste 150
12312 Olive Blvd
St. Louis MO 63141
(800) 525-8299

T. L. C. Laser Center
Ste. 230
425 N. New Ballas
St. Louis MO 63141
(877) 768-2020 (*)

MISSISSIPPI

GULFPORT

Dapremont Eye Specialists
428 Courthouse Rd
Gulfport MS 39507
(877) 768-2020

OCEAN SPRINGS

Dr. Erman F. Rawlings
3430 Bienville Blvd
Ocean Springs MS 39564
(228) 875-6658 (*)

PASCAGOULA

Dr. Erman F. Rawlings
3111 Shortcut Road
Pascagoula MS 39567
(228) 762-0772 (*)

MONTANA

BILLINGS

T. L. C. Laser Center
Dr. David A. Boes
Dr. Mark A. Kontos
2001 Rosebud Dr
Billings MT 59102
(406) 651-0202 (*)

NORTH CAROLINA

BREVARD

Dr. Dana Christianson
Ste C.
188 Medical Park Dr
Brevard NC 28712
(828) 884-7320 (*)

CARY

Dr. Dean I. Dornic
Ste 101
3701 Nw Cary Pkwy
Cary NC 27513
(919) 467-9955 (*)

CHAPEL HILL

Dr. James A. Bryan
Suite 140
55 Vilcom Circle
Chapel Hill NC 27514
(919) 967-4836 (*)

CHARLOTTE

T. L. C. Laser Eye Centers
Dr. Scott L. Jaben
Ste C.
2600 E. 7th St
Charlotte NC 28204
(877) 768-2020 (*)

DURHAM

North Carolina Eye, Ear,Nose
4102 N. Roxboro Rd
Durham NC 27704
(919) 595-2000 (*)

GREENSBORO

Dr. Mark T. Shapiro
1311 N. Elm Street
Greensboro NC 27401
(336) 378-9993 (*)

T. L. C. Laser Eye Centers
Dr. Karl G. Stonecipher
Ste 102
3312 Battleground Ave
Greensboro NC 27410
(877) 768-2020

HENDERSONVILLE

Dr. Alan Verm, MD
Dr. Alan Verm
215 Thompson St.
Hendersonville NC 28792
(828) 693-4161 (*)

MORGANTON

Dr. Andrew C. Davis
335 E. Parker Rd
Morganton NC 28655
(828) 433-1000

RALEIGH

Lasik Plus
Dr. Lori A. Travers
Suite 100
3126 Blue Ridge Road
Raleigh NC 27612
(800) 525-8299 (*)

T. L. C. Laser Eye Centers
Ste 120
2300 Rexwoods Drive
Raleigh NC 27607
(877) 768-2020 (*)

WILMINGTON

Dr. Alan W. Brown
Ste 140
1717 Shipyard Blvd
Wilmington NC 28403
(910) 796-8600 (*)

NORTH DAKOTA

FARGO

Valley Laser Eye Center
3003 32 Ave Sw
Fargo ND 58103
(877) 768-2020

NEBRASKA

COLUMBUS

Eye Physicians, PC
3772 43rd Ave
Columbus NE 68601
(877) 768-2020

FULLERTON

Eye Physicians, PC
220 Broadway
Fullerton NE 68638
(877) 768-2020

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Vision Care Participating Network Providers

KEARNEY

Kearney Eye Institute
Dr. Linda U. Blakely
411 W. 39 St
Kearney NE 68845
(877) 768-2020 (*)

Lind Eye Care
3811 29th Ave
Kearney NE 68845
(877) 768-2020

NELIGH

Eye Physicians, PC
304 N. Street
Neligh NE 68756
(877) 768-2020

NORFOLK

Eye Physicians, PC
2501 Lakeridge Dr
Norfolk NE 67801
(877) 768-2020

NORTH PLATTE

Mark Young, MD
1214 W. A. St
North Platte NE 69101
(877) 768-2020

OMAHA

Brumm Eye Center
Dr. Bruce H. Brumm
Ste 101
17001 Lakeside Hills Plaza
Omaha NE 68122
(877) 768-2020

Dr. Bruce H. Brumm
Dr. Bruce H. Brumm
Ste 105
6751 N. 72nd St
Omaha NE 68122
(402) 572-2020 (*)

Lasik Plus
Dr. Dean R. Ellis
Ste 106
15909 W. Maple Rd
Omaha NE 68116
(800) 525-8299 (*)

NEW JERSEY

BERGENFIELD

Dr. Joseph Dello Russo
1 N. Washington Ave.
Bergenfield NJ 07621
(800) 393-2273

CHERRY HILL

T. L. C. Laser Eye Centers
Dr. Debra S. Malley
457 Haddonfield Rd
Cherry Hill NJ 08002
(856) 910-9987 (*)

MT LAUREL

Lasik Plus
Dr. Chirag S. Shah
Ste 100
303 Fellowship Rd
Mt Laurel NJ 08054
(800) 525-8299

PARAMUS

Lasik Plus
Dr. Phillip J. Calenda
Ste 301
351 Evelyn St
Paramus NJ 07652
(800) 525-8299 (*)

PRINCETON

Dr. Barry N. Wasserman
Suite 112
100 Canal Pointe Boulevard
Princeton NJ 08540
(609) 243-8711 (*)

UNION

Dr. James E. Haberman
2401 Morris Ave
Union NJ 07083
(908) 688-4000 (*)

VINELAND

Eye Associates
2466 E. Chestnut Ave
Vineland NJ 08361
(856) 691-8188 (*)

WEST ORANGE

Dr. Theodore Perl
Ste 101
101 Old Short Hills Rd
West Orange NJ 07052
(973) 736-1313 (*)

NEW MEXICO

ALBUQUERQUE

Eye Associates Of New Mexico
Dr. Mark P. Lesher
Dr. Arthur J. Weinstein
Suite 203
101 Hospital Loop N. E.
Albuquerque NM 87109
(800) 748-5556 (*)

CLOVIS

Eye Associates Of New Mexico
Dr. Gregory S. Ogawa
2000 W. 21st Street,R-1
Clovis NM 88101
(505) 763-3445 (*)

FARMINGTON

Eye Associates Of New Mexico
622 West Maple, E.
Farmington NM 87401
(505) 325-4003 (*)

SANTA FE

Dr. Gary V. Puro
510 N. Guadalupe, Suite C.
Santa Fe NM 87501
(505) 986-2020 (*)

Eye Associates Of New Mexico
Dr. Arthur J. Weinstein
2947 Rodeo Park East
Santa Fe NM 87501
(505) 989-8878 (*)

NEVADA

CARSON CITY

Dr. Michael J. Fischer
3839 North Carson Street
Carson City NV 89706
(775) 882-2988 (*)

Dr. Mehdi M. Vazeen
412 W. John St
Carson City NV 89703
(775) 881-1515

LAS VEGAS

Dr. Jon L. Siems
10777 W. Twain Ave
Las Vegas NV 89135
(702) 948-2010

NEW YORK

ALBANY

Dr. Jordan Kassoff
Ste 101
63 Shaker Rd
Albany NY 12204
(518) 434-1042 (*)

Lasik Plus
Dr. Jessica C. Fleishman
12 Corporate Woods Blvd.
Albany NY 12211
(800) 525-8299 (*)

T. L. C. Laser Eye Centers
8 Southwoods Blvd
Albany NY 12211
(518) 598-0202 (*)

BRONX

Dr. Richard E. Dankner
1625 St Peters Ave
Bronx NY 10461
(718) 823-9227 (*)

BROOKLYN

Dr. Alan Jordan
149 Pierrepont St
Brooklyn NY 11201
(718) 834-1976 (*)

Dr. William I. Kestin
2613 E. 16th St
Brooklyn NY 11235
(718) 332-1313 (*) (IRS)

Dr. Mark A. Lebowitz
1301 Ave J.
Brooklyn NY 11230
(718) 645-0600 (*) (CFHIP)

Dr. David Ritterband
2785 Ocean Parkway
Brooklyn NY 11235
(718) 646-2200 (*)

CARLE PLACE

Dr. David Nelson
Dr. Richard G. Davis
Dr. Henry Perry
255 Glen Cove Rd
Carle Place NY 11514
(516) 877-2400 (*)

CHEEKTOWAGA

Dr. Amar S. Atwal
3095 Harlem Rd
Cheektowaga NY 14225
(716) 896-8831 (*)

DEWITT

Cny Eye Care
Dr. Robert W. Weisenthal
5770 Commons Park
Dewitt NY 13214
(315) 445-1577 (*)

E SETAUKET

The Ophthalmic Center
Dr. Vincent P. Basilice
Ste 107
3400 Nesconset Hwy
E. Setauket NY 11733
(631) 751-2020 (*)

EAST SETAUKET

Stony Brook Ophthalmology
Dr. Timothy Y. Chou
33 Research Way
East Setauket NY 11733
(631) 444-4996 (*)

ELIZABETHTOWN

Eye Care For The Adirondacks
Dr. Benjamin F. Vilbert
Elizabethtown Comm. Hospital
75 Park St
Elizabethtown NY 12932
(518) 873-6377 (*)

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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

FLUSHING

Dr. Wilson Ko
136-25 Maple Ave
Flushing NY 11355
(718) 358-5900 (*)

FOREST HILLS

Dr. Harvey Rosenblum
102-30 Queens Blvd
Forest Hills NY 11375
(718) 896-2344 (*)

GARDEN CITY

Dr. Benjamin Chang
450 Endo Blvd
Garden City NY 11530
(516) 832-8000 (*)

Dr. Susie Hahn
450 Endo Blvd
Garden City NY 11530
(516) 832-8000 (*)

Dr. Thierry Hufnagel
450 Endo Blvd
Garden City NY 11530
(516) 832-8000 (*)

T. L. C. Laser Eye Centers
Dr. Eric D. Donnenfeld
Dr. Richard J. Nattis
200 Garden City Plaza
Garden City NY 11530
(516) 742-2020 (*)

Dr. Marc S. Werner
450 Endo Blvd
Garden City NY 11530
(516) 832-8000 (*) (S)

HAUPPAUGE

Stahl Eye Center
Dr. Thierry Hufnagel
Dr. Marc S. Werner
200 Motor Pkwy
Hauppauge NY 11788
(631) 952-8000 (*)

MALONE

Eye Care For The Adirondacks
Dr. Benjamin F. Vilbert
14861 State Rt 30
Malone NY 12953
(518) 483-0065 (*)

NEW HARTFORD

Dr. Anthony J. Palumbo
4350 Middle Settlement Rd
New Hartford NY 13413
(315) 733-2020 (*)

NEW ROCHELLE

Dr. Jay Lippman
828 Pelharndale Ave
New Rochelle NY 10801
(914) 636-3600 (*)

NEW YORK

Dr. Richard E. Dankner
52 East 72nd St
New York NY 10021
(212) 439-9797 (*)

Dr. Richard Koplin
310 E. 14th St
New York NY 10003
(212) 505-6550 (*) (S)

Dr. Harry R. Koster
Suite 1E
10 Downing St
New York NY 10014
(212) 243-2300 (*)

Laser One
101 Park Ave
New York NY 10004
(888) 882-2020 (*)

Dr. Eric R. Mandel
Mandel Vision
211 East 70th Street
New York NY 10021
(212) 734-0111 (*)

Ophthalmic Consultants
New York Eye & Ear Infirmary
310 E. 14th St
New York NY 10003
(212) 505-6550 (*)

Dr. David C. Ritterband
New York Eye & Ear Infirmary
310 E. 14th St
New York NY 10003
(212) 505-6550 (*)

Dr. David C. Ritterband
101 Park Ave
New York NY 10004
(888) 882-2020 (*)

Dr. Harvey Rosenblum
101 Park Ave
New York NY 10178
(888) 882-2020 (*)

Stahl Eye Center
Dr. Thierry Hufnagel
Dr. Marc S. Werner
2nd Floor
185 Madison Ave
New York NY 10016
(212) 689-7676 (*)

T. L. C. Laser Eye Centers
Dr. Eric D. Donnenfeld
Dr. Mark G. Speaker
115 East 57th St
New York NY 10022
(212) 588-0200 (*)

PLATTSBURGH

Eye Care For The Adirondacks
Dr. Kjell Dahlen
Dr. Benjamin F. Vilbert
450 Margaret St
Plattsburgh NY 12901
(518) 562-3937 (*)

RICHMOND HILL

Dr. Harry R. Koster
119-15 Atlantic Ave
Richmond Hill NY 11418
(718) 805-0700 (*) (FS)

SARANAC LAKE

Eye Care For The Adirondacks
Dr. Benjamin F. Vilbert
51 Woodruff St
Saranac Lake NY 12983
(518) 891-8412 (*)

SMITHTOWN

Dr. Jeffrey L. Martin
Ste 201
260 Middle County Rd
Smithtown NY 11787
(631) 265-8780

Dr. Larry C. Zweibel
Dr. Jeffrey L. Martin
North Shore Eye Care
Ste 201
260 Middle Country Rd
Smithtown NY 11787
(631) 265-8780 (*)

SOMERS

Dr. Liviu B. Saimovici
380 Rt 202
Somers NY 10589
(914) 277-5550 (*)

UTICA

Francis Eye
10 Business Park Court
Utica NY 13502
(315) 735-2100

VALHALLA

Dr. Gerald W. Zaidman
Westchester Medical Ctr
Dept Of Ophthalmology
Valhalla NY 10595
(914) 493-1599 (*)

VALLEY STREAM

Dr. Gerard D'Aversa
65 Roosevelt Avenue
Valley Stream NY 11581
(516) 374-4199

WEBSTER

Dr. Allan M. Robbins
1678 Empire Boulevard
Webster NY 14580
(585) 787-2020 (*)

WESTBURY

Lasik Plus
Dr. Damon J. Pettinelli
Ste 180N
865 Merrick Ave
Westbury NY 11590
(800) 525-8299 (*)

WHITE PLAINS

T. L. C. Laser Eye Centers
Dr. Jodi L. Abramson
220 Westchester Ave West
White Plains NY 10604
(914) 997-2222 (*)

OHIO

AKRON

Dr. Thomas A. Repko
Ste 120
95 Arch St
Akron OH 44304
(330) 535-2521

BRECKSVILLE

Clear Choice Laser Eye Ctr
6960 S. Edgerton
Brecksville OH 44141
(877) 768-2020

CENTERVILLE

Lasik Plus
Dr. Vincent J. Marino
6470 Centerville Business Pkwy
Centerville OH 45459
(800) 525-8299

CINCINNATI

Lasik Plus
Dr. Vincent J. Marino
7840 Montgomery Road
Cincinnati OH 45236
(800) 525-8299 (*)

Dr. David M. Schneider
Dr. James J. Sanitato
Ste 305
4452 Eastgate Blvd
Cincinnati OH 45245
(513) 752-5700 (*)

COLUMBUS

Dr. Alice T. Epitropoulos
Ste 430
262 Neil Ave
Columbus OH 43215
(614) 221-7464 (*) (AS)

Lasik Plus
Dr. Joseph M. Thomas
Ste 220
4030 Easton Station
Columbus OH 43219
(800) 525-8299

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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

T. L. C. Laser Eye Centers
Ste 120
8415 Pulsar Place
Columbus OH 43240
(877) 768-2020 (*)

DAYTON

Patrick L. Spencer, Do Inc
Ste 1002
425 W. Grand Ave
Dayton OH 45405
(877) 768-2020

INDEPENDENCE

Lasik Plus
Dr. Joseph M. Thomas
Unit A.
6800 Rockside Rd
Independence OH 44131
(800) 525-8299

T. L. C. The Laser Center
Dr. Gregory A. Eippert
Suite 100
6500 Rockside Road
Independence OH 44131
(216) 901-9393 (*)

KENT

Northeast Ohio Eye Surgeons
Dr. Lawrence E. Lohman
2013 State
Rte 59
Kent OH 44240
(330) 678-0201 (*)

TALLMADGE

Dr. Todd L. Beyer
518 West Ave
Tallmadge OH 44278
(330) 630-9699

TOLEDO

Reed Vision
4600 Tallmadge Rd
Toledo OH 43623
(877) 768-2020

The Eye Center Of Toledo
Dr. Ronald N. Brown
Ste. 100
3000 Regency Court
Toledo OH 43623
(877) 768-2020 (*)

YOUNGSTOWN

Belmont Eye Surgery
Dr. Sherif I. Hanna
3020 Belmont Ave
Youngstown OH 44505
(330) 759-7672 (*)

OKLAHOMA

OKLAHOMA CITY

T. L. C. Laser Eye Centers
Dr. Bradley D. Britton
Dr. Edward D. Jones
Dr. Bradley C. Taylor
Dr. Thomas C. Wolf
Ste 140
4141 Northwest Expwy
Oklahoma City OK 73116
(877) 768-2020 (*)

TULSA

T. L. C. Laser Eye Centers
Dr. Bradley D. Britton
Dr. John T. Romano
Suite 120
9445 S. Mingo Rd.
Tulsa OK 74133
(877) 768-2020 (*)

OREGON

TIGARD

Lasik Plus
Dr. Floyd M. Cornell
7421 Sw Bridgeport Rd
Tigard OR 97224
(800) 525-8299 (*)

PENNSYLVANIA

ALLENTOWN

Lehigh Valley Center For Sig
Dr. Mark E. Moran
1739 Fairmont St
Allentown PA 18104
(610) 437-4988 (*)

Lehigh Valley Eye Center, PC
Ste 102
400 N. 17 St
Allentown PA 18104
(610) 439-8910 (*)

BALA CYNWYD

Ciates Nevyas Eye Asso
Dr. Vipin K. Goyal
Dr. Herbert Nevyas
Dr. Anita Nevyas-Wallace
333 E. City Ave
Two Bala Plaza
Bala Cynwyd PA 19004
(610) 668-2777 (*)

BUTLER

Dr. Timothy C. McKernan
Dr. William C. Christie
Dr. Shawn D. Thomas
357 N. Main St
Butler PA 16066
(724) 282-6420 (*)

CAMP HILL

Dr. John R. Dailey
1857 Center St
Camp Hill PA 17011
(717) 761-3011 (*)

CHADDS FORD

Lasik Plus
223 Wilmington
West Chester Pike-Rt 202
Chadds Ford PA 19317
(800) 525-8299

CRANBERRY TWP

Dr. Timothy C. McKernan
Dr. Christoph N. Carver
Dr. William C. Christie
Dr. Anita M. Cichon
Dr. Daniel R. Peters
Dr. Shawn D. Thomas
20215 Rte 19
Cranberry Twp PA 16066
(724) 772-9090 (*)

HARRISBURG

Lasik Plus
Dr. Sandeep K. Kakaria
Ste 60
4640 High Point Blvd
Harrisburg PA 17111
(800) 525-8299 (*)

Premier Eye Care Group, Inc
92 Tuscarora Street
Harrisburg PA 17104
(800) 731-3937

KING OF PRUSSIA

Kremer Laser Eye Center
Dr. Carol J. Hoffman
Dr. George R. Pronesti
Flat Discount
200 Mall Blvd
King Of Prussia PA 19406
(610) 337-1580 (*)

Lasik Plus
Dr. Chirag S. Shah
Ste 100
216 Mall Blvd
King Of Prussia PA 19406
(800) 525-8299

LANCASTER

Dr. Thomas F. Krulewski
Suite 103
810 Plaza Blvd.
Lancaster PA 17601
(717) 735-6700 (*)

Manning and Rommel Associate
2128 Embassy Dr
Lancaster PA 17603
(717) 358-9821 (*)

LANGHORNE

Dr. Guy S. Mullin
409 Executive Drive
Langhorne PA 19047
(215) 860-3400 (*)

NATRONA HEIGHTS

Allegheny Ophthalmology Asso
2853 Freeport Rd
Natrona Heights PA 15065
(724) 224-4240 (*)

PITTSBURG

Dr. Michael E. Rom
5000 McKnight Rd
Pittsburg PA 15237
(800) 525-8299 (*)

PITTSBURGH

Allegheny Ophthalmology Asso
1324 E. Carson St
Pittsburgh PA 15203
(412) 381-1542

Dr. Timothy C. McKernan
Dr. Christoph N. Carver
Dr. William C. Christie
Dr. Anita M. Cichon
Dr. Daniel R. Peters
Dr. Shawn D. Thomas
1101 Freeport Rd
Pittsburgh PA 15238
(412) 782-0400 (*)

PLYMOUTH MTG

T. L. C. Laser Eye Centers
Dr. Irving M. Raber
Dr. Richard Tipperman
600 W Germantown Pike Cri Bldg
Plymouth Mtg PA 19462
(610) 940-3937 (*)

SCRANTON

Nei Ambulatory Surgery Ctr
200 Mifflin Ave
Scranton PA 18503
(570) 342-3145 (*)

SEWICKLEY

T. L. C. Laser Eye Centers
Suite 101
1606 Carmody Ct
Sewickley PA 15143
(724) 934-2020 (*)

STATE COLLEGE

Nittany Eye Associates
Ste. 100
428 Windmere Dr.
State College PA 16801
(814) 234-2015 (*)

(*) Handicap access.
ALT LANG: S-Spanish F-French
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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

TREVOSE

Dr. William F. Columbus
4626 Street Rd
Trevose PA 19053
(866) 600-3937 (*)

RHODE ISLAND

MIDDLETOWN

Dr. Stephen F. Sullivan
Dr. Kenneth Kenyon
73 Valley Road
Middletown RI 02842
(401) 847-1040 (*)

PROVIDENCE

T.L.C. Laser Eye Center
Ste 220
10 Orms St
Providence RI 02904
(401) 351-7036 (*)

SOUTH CAROLINA

CHARLESTON

Seltzer Laser Center
Ste D.
9304 Medical Plaza
Charleston SC 29406
(877) 768-2020

COLUMBIA

T.L.C. Laser Eye Center
Ste A.
945 Lake Murray Blvd
Columbia SC 29212
(877) 768-2020

GREENVILLE

T. L. C. Laser Eye Centers
Dr. David M. Donelson
Dr. Louis E. Probst
Dr. Harvard K. Riddle Jr.
Ste 140
30 Patewood Drive Bldg 1
Greenville SC 29615
(877) 768-2020 (*)

MOUNT PLEASANT

T.L.C. Laser Eye Center
Ste 403
721 Long Point Rd
Mount Pleasant SC 29464
(877) 768-2020 (*)

MYRTLE BEACH

Truvision Laser-Singleton Ey
350 Seaboard St
Myrtle Beach SC 29577
(877) 768-2020

SPARTANBURG

Westside Eye Center
Ste D.
1413 John B. White Sr. Blvd
Spartanburg SC 29306
(864) 542-1308 (*)

TENNESSEE

CHATTANOOGA

Pomerance Eye Center, PC
1801 Gunbarrel Road
Chattanooga TN 37421
(423) 855-6800 (*)

Southeast Eye Specialists
Ste 220
1949 Gunbarrel Rd
Chattanooga TN 37421
(888) 874-2020 (*)

Tru-Vision Laser
Ste A.
4926 Highway 58
Chattanooga TN 37416
(404) 264-0233 <d>

COOKEVILLE

Tennessee Lasik Asssociates
Ste 190
315 N. Washington Ave
Cookeville TN 38501
(877) 768-2020

HERMITAGE

Summit Eye Assocaites, PC
5410 Old Hickory Blvd
Hermitage TN 37076
(877) 768-2020

JOHNSON CITY

T. L. C. Laser Eye Centers
Dr. Nancy J. Alison
1019 W. Oakland Ave
Johnson City TN 37604
(423) 282-0002 (*)

KNOXVILLE

Tennessee Lasik Asssociates
Ste 3
9815 Cogdill Rd
Knoxville TN 37932
(877) 768-2020

MEMPHIS

Dr. Rolando Toyos
Ste 103
795 Ridgelake Blvd
Memphis TN 38119
(877) 768-2020

OAK RIDGE

T. L. C. Laser Center
Dr. Timothy P. Powers
90 Vermont Ave
Oak Ridge TN 37830
(865) 482-8894 (*)

TEXAS

AUSTIN

Dell Laser Consultants
901 Mo Pac Expressway South
Bldg 4
Austin TX 78746
(512) 347-0255 (*)

Eye Clinic Of Austin
Ste 140
3410 Far West Blvd
Austin TX 78731
(866) 327-2020

Lasik Plus
Dr. Stephen Whiteside
9705 Research Blvd
Austin TX 78759
(800) 525-8299 (*)

CORPUS CHRISTI

Dr. Ralph G. Berkeley
Dr. Erin A. Doe
Dr. Matthew B. McCauley
Dr. Brent R. McQueen
Dr. Regina L. Sun
Ste 318
5350 S. Staples
Corpus Christi TX 78411
(361) 992-1060 (*)

DALLAS

Dr. Linda L. Burk
Suite 300B
221 W. Colorado Blvd
Dallas TX 75208
(214) 987-2875 (*)

Dr. Linda L. Burk
Suite 300B
221 West Colorado Boulevard
Dallas TX 75208
(214) 987-2875 (*)

HOUSTON

Dr. Ralph G. Berkeley
Dr. Erin A. Doe
Dr. Matthew B. McCauley
Dr. Brent R. McQueen
Dr. Regina L. Sun
Ste 400
3100 Weslayan
Houston TX 77027
(713) 526-3937 (*)

Eye Excellence
Dr. Mary T. Green
Ste 2105
6624 Fannin
Houston TX 77030
(866) 327-2020 (*)

Lasik Plus
Dr. Federico L. Mattioli
Ste 325
3700 Buffalo Speedway
Houston TX 77098
(800) 525-8299 (*)

Dr. Samuel J. Yankelove
Suite 107
8800 Katy Freeway
Houston TX 77024
(713) 827-7666 (*)

KATY

Dr. Ralph G. Berkeley
Dr. Erin A. Doe
Dr. Matthew B. McCauley
Dr. Brent R. McQueen
Dr. Regina L. Sun
Ste 480
707 S. Fry Rd
Katy TX 77450
(281) 579-6777 (*)

LEWISVILLE

T. L. C. Laser Eye Centers
Suite 110
2601 S. Stemmons Freeway
Lewisville TX 75067
(866) 327-2020 (*)

MIDLAND

Turner Laser Center
Ste 3A
3001 W. Illinois
Midland TX 79701
(432) 580-0249 (*)

PALETSINE

Gold Eye Clinic
501 E. Kolstad St
Paletsine TX 75801
(903) 723-3250

PASADENA

Pasadena Eye Associates
Ste 280
3333 Bayshore Blvd
Pasadena TX 77504
(866) 327-2020

PLANO

Lasik Plus
Dr. Robert E. Smith
Ste 206
2108 Dallas Pkwy
Polo Towne Crossing
Plano TX 75093
(800) 525-8299

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K-Pakistan M-Mandarin

Vision Care Participating Network Providers

SAN ANGELO

Dr. Daniel M. Wilson
120 E. Beauregard
San Angelo TX 76903
(325) 658-1511 (*)

SAN ANTONIO

Dr. Philip L. Smith
1100 N. Main
San Antonio TX 78212
(210) 222-2154 (*)

Dr. Sebastian A. Mora
1327 Sw Military Drive
San Antonio TX 78221
(210) 924-5121 (*)

Dr. Joann M. Ray-Webster
Dr. Nader Iskander
Ste 101
7720 Jones Maltzburger
San Antonio TX 78216
(800) 525-8299

T. L. C. Laser Eye Centers
601 N.W. Loop 410
Pyramid Bldg
San Antonio TX 78216
(866) 327-2020 (*)

SOUTHLAKE

Dr. Robert P. Lehmann
1980 E. State Hwy 114
Southlake TX 76092
(817) 329-2700 (*) (S)

SUGARLAND

Lasik Plus
Dr. Federico L. Mattioli
Ste 1
16062 Sw Freeway
Sugarland TX 77479
(800) 525-8299 (*)

THE WOODLANDS

Dr. Ralph G. Berkeley
Dr. Erin A. Doe
Dr. Matthew B. McCauley
Dr. Brent R. McQueen
Dr. Regina L. Sun
Ste 125
9191 Pinecroft Dr
The Woodlands TX 77381
(281) 363-3443 (*)

UTAH

OGDEN

Mount Ogden Eye Care
4360 Washington Blvd
Ogden UT 84403
(801) 476-0494 (*)

PROVO

Excel Eye Center
1735 N. State St
Provo UT 84604
(801) 374-1818 (*)

SAINT GEORGE

Zion Eye Institute
1791 E. 280 N.
Saint George UT 84790
(435) 656-2020 (*)

SALT LAKE CITY

Lasik Plus
Dr. Sally B. Thompson
Ste 1
5241 South State St
Salt Lake City UT 84107
(800) 525-8299

T.L.C. Laser Eye Center
Ste 340
6440 S. Wasatch Blvd
Salt Lake City UT 84121
(877) 768-2020 (*)

VIRGINIA

ALEXANDRIA

Dr. Alfred Kronthal
6287 Franconia Rd
Alexandria VA 22310
(703) 971-7000 (*)

Lasik Plus
Dr. Walter N. Wills
Suite 100
1101 King Street
Alexandria VA 22314
(800) 525-8299 (*)

CHARLOTTESVILLE

Whitten Laser Eye
Dr. Edward L. Perraut Jr.
Dr. Mark E. Whitten
A. T.L.C Associate Center
675 Peter Jefferson Pkwy #130
Charlottesville VA 22911
(434) 817-5273 (*)

CHESAPEAKE

Lasik Plus
Dr. Quentin J. Franklin
732 Eden Way
Chesapeake VA 23322
(800) 525-8299

FAIRFAX

Dr. John C. Baldinger
Ste 101
3025 Hamaker Ct
Fairfax VA 22031
(703) 876-9630 (*) (S)

FALLS CHURCH

Dr. Tuan Q. Nguyen
6079 Arlington Blvd
Falls Church VA 22044
(703) 534-3331 (*)

GLEN ALLEN

Lasik Plus
Dr. Walter N. Wills
Suite 100
10571 Telegraph Road
Glen Allen VA 23059
(800) 525-8299

HAMPTON

Hampton Roads Eye Associates
Dr. Seth Oppenheim
Dr. Karen B. Shelton
Suite 1200
850 Enterprise Pkwy
Hampton VA 23666
(757) 838-4500 (*)

MC LEAN

Tlc Millennium Laser Center
Dr. Andrew E. Holzman
Dr. Edward L. Perraut Jr.
1750 Tysons Blvd,#120
Mc Lean VA 22102
(877) 768-2020 (*)

MCLEAN

Lasik Plus
Dr. Walter N. Wills
Ste 110
8280 Greensboro Dr
McLean VA 22102
(800) 525-8299

NORFOLK

Laser Optic Center II
5357 Henneman Dr
Norfolk VA 23513
(757) 340-8383

Verdi Eye Specialists
7312 Grandby St
Norfolk VA 23505
(877) 768-2020

RESTON

T. L. C. Laser Eye Centers
Dr. Edward L. Perraut Jr.
Dr. Mark E. Whitten
Suite 105
10790 Parkridge Blvd
Reston VA 20191
(877) 768-2020 (*)

RICHMOND

Dr. Akshay Dave
Dr. Deval D. Joshi
Ste 128
2010 Bremo Rd
Richmond VA 23226
(804) 285-0680 (*)

Dr. Garth Stevens
8700Stony Point Pkwy #120
Richmond VA 23235
(804) 330-9303 (*)

Dr. Perry W. Mullen
7229 Forest Ave
Highland Ii Building ,Ste 104
Richmond VA 23226
(804) 285-7307

Dr. Chris M. Petras
105 Twin Ridge Lane
Richmond VA 23235
(804) 320-8385 (*)

Virginia Eye Institute
Dr. Walter E. Bundy
Dr. Frank Larosa
Dr. Anthony D. Sakowski
Dr. Edmund W. Trice
(15% Maximum Discount)
400 Westhampton Station
Richmond VA 23226
(804) 287-4216 (*) (S)

Whitten Laser Eye
Dr. Edward L. Perraut Jr.
Dr. Mark E. Whitten
A. T.L.C Associate Center
2301 N. Parham Rd #3
Richmond VA 23229
(804) 527-5273 (*)

ROANOKE

T.L.C. Laser Eye Center
Ste 307
3800 Electric Rd
Roanoke VA 24018
(877) 768-2020

SALEM

Vistar Eye Center
10% Maximum Discount
438 W. Main St
Salem VA 24153
(540) 378-5276 (*)

TYSONS CORNER

Dr. Rajesh K. Rajpal
Ste 140
8180 Greensboro Dr
Tysons Corner VA 22102
(703) 827-5454 (*)

VIRGINIA BEACH

Dr. G. Peyton Neatrour
1201 First Colonial Rd
Virginia Beach VA 23454
(757) 425-5550

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<d> Dispenses eyewear only J-Japanese T-Cantonese K-Pakistan M-Mandarin

WILLIAMSBURG

Dr. Robert J. Cullom Jr.
Dr. Robert Cullom, Jr.
Ste 1300
120 Kings Way
Williamsburg VA 23185
(757) 345-1001 (*)

WINCHESTER

Dr. John A. Stefano
Ste 108
142 Linden Dr
Winchester VA 22601
(877) 768-2020 (*)

WASHINGTON

BELLEVUE

Lasik Plus
Dr. Floyd M. Cornell
Dr. Mark L. Nelson
Dr. Howard N. Straub
Suite B.
320 106 Ave Ne
Bellevue WA 98004
(800) 525-8299 (*)

OLYMPIA

Clarus Eye Centre
420 Lilly Rd, Ne
Olympia WA 98506
(360) 456-3200 (*)

SEATTLE

Dr. Sheldon Cowen
515 Minor Avenue Suite 160
Seattle WA 98104
(877) 768-2020

Dr. Thomas E. Gillette
1101 Madison Street Suite 600
Seattle WA 98104
(206) 215-2050

SPOKANE

The Laser Institute
Dr. Mark A. Kontos
Dr. Christoph W. Sturbaum
Ste 100
N1414 Houk Rd
Spokane WA 99216
(509) 928-8040 (*)

YAKIMA

Yakima Eye Care @ Fieldstone
Ste 100
506 N. 40 Ave
Yakima WA 98908
(800) 562-9708 (*)

WISCONSIN

BROOKFIELD

Lasik Plus
Dr. Mitchell A. Jackson
15455 W. Bluemound Rd
Brookfield WI 53005
(800) 525-8299

GREEN BAY

Baycare Clinic-Green Bay
2140 Velp Ave
Green Bay WI 54303
(920) 327-7070 (*)

Lasik Plus
Dr. Ron Allen
Ste 408
760 Willard Dr
Green Bay WI 54304
(800) 525-8299 (*)

MADISON

T. L. C. Laser Eye Centers
Dr. Louis E. Probst
2810 City View Dr
Madison WI 53718
(877) 768-2020 (*)

MENOMONIE

Wisconsin Vision Correction
2110 Us Highway 12
Menomonie WI 54751
(877) 768-2020

RACINE

Allen Eye Care
2722 Old Mill Dr
Racine WI 53405
(877) 768-2020

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Sample New York State Provider Contract

DAVISVISION®
SEE LIFE

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

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

RECITALS

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

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

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

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

I
PREAMBLE AND RECITALS

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

II
DEFINITIONS

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

.2 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a confirmation of eligibility number assigned by **DAVIS**, referencing a specific Member and Member's information; (b) a valid, **DAVIS**-assigned **PROVIDER** number;

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

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

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

.5 "**Generally Accepted Standards of Medical Practice**" means standards that are based upon: credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas and any other relevant factor as determined by statute(s) and/or regulation(s).

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

.7 "**Medical Assistance Program**" (hereinafter "MAP") means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States for Medical Assistance Programs, Section 1396 et seq., as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

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

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

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

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

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)
(i) be appropriate within generally accepted standards of practice;
(ii) be efficacious, as demonstrated by scientifically supported evidence;
(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and

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

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

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

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

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

.12 "**Medicare Advantage Member/Subscriber**" means an individual who is enrolled in and covered under a Medicare Advantage Program or any successor program(s) thereto regardless of the name(s) thereof. Dually eligible Medicare Advantage Subscribers are those individuals who are (i) eligible for Medicaid; and (ii) for whom the state is responsible for paying Medicare Part A and B cost sharing.

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

the name(s) thereof.

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

.15 "**Negative Balance**" means receipt of Copayment(s), Coinsurance(s) or other compensation by **PROVIDER** or Participating Provider which are in excess of the amounts that are due to **PROVIDER** or Participating Provider for Covered Services under this Agreement.

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

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

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

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

.20 "**Plan(s)**" means a health maintenance organization, corporation, trust fund, municipality, or other purchaser of vision care services that has entered into a Plan Contract with **DAVIS**.

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

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

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

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

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

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

III
SERVICES TO BE PERFORMED BY THE PROVIDER

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

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

(g) Should the display and/or frame(s) contained in the collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume the full cost of the display and/or the frame collection and will be required to reimburse **DAVIS** its/their fair market value.

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

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

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

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

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

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

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

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

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

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

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

IV
COMPENSATION

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

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

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

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

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

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

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

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

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

.4 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees **DAVIS**' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit plan, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation, remuneration or reimbursement from Members, person(s) acting on Member(s)' behalf, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, either now existing or hereinafter entered into between Member(s), or person(s) acting on Member(s)' behalf, and **PROVIDER**, which relate to liability for payment; shall survive termination of this Agreement regardless of the reason for termination; shall be construed to be for the benefit of the Member(s); and shall not be changed

without the approval of appropriate regulatory authorities, *it being understood that this hold harmless provision is in addition to the protections afforded to Members under Insurance Law Section 4307(d).*

.5 **Payment of Compensation**. Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable state's prompt pay statute, whichever is most restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment and Coinsurance collected or to be collected from the Member.

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

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

(a) Covered Services in General. For all Covered Services rendered by **PROVIDER** to a Member hereunder, ***PROVIDER*** *shall, within one hundred and twenty (120) days following the provision of Covered Services, submit to* ***DAVIS*** *a claim* which may be written, electronic or verbal, shall be approved as to form and content by **DAVIS,** and if applicable, shall be the standard claim form mandated by the State in which Covered Services were rendered. Failure of **PROVIDER** to submit a claim within one hundred and twenty (120) days following the provision of Covered Services will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER**. If **PROVIDER** is indebted to **DAVIS** for any reason including, but not limited to, Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

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

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

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

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

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

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

V
OBLIGATIONS OF PROVIDER

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

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

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

.1.3 as requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective

Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and

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

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

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

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

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

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

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

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements, including but not limited to:

Medicare, Medicare Advantage (and any successor program thereto), Medicaid, and MAP laws and regulations, CMS instructions and policies; agrees to audits and inspections by the CMS and/or its designees and shall cooperate, assist, and provide information as requested, and maintain records a minimum of ten (10) years; and agrees to comply with **DAVIS**' and Plan(s)' policies regarding provisional credentialing, credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, peer review, complaint, grievance resolution and appeals processes, comparative performance analysis, and enforcement and monitoring by appropriate government agencies, and activities necessary for the external accreditation of **DAVIS** and/or Plan(s), by the National Committee for Quality Assurance or any other similar organization selected by **DAVIS** and/or Plan(s).

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

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

.4 **Compliance with Laws, Regulations, and Ethical Standards**. During the Term of this Agreement, **PROVIDER** and **DAVIS** shall at all times comply with all applicable federal, state or municipal statutes or ordinances, including but not limited to, all applicable rules and regulations, all applicable federal and State tax laws, all applicable federal and State criminal laws, as well as the customary ethical standards of the appropriate professional society from which **PROVIDER** seeks advice and guidance or to which **PROVIDER** is subject to licensing and control. **PROVIDER** shall comply with all applicable laws and administrative requirements, including but not limited to, Medicaid laws and regulations, Medicare laws, CMS instructions and policies, **DAVIS**' and Plan(s)' credentialing policies, processes, utilization review, quality improvement, medical management, peer review, complaint and grievance resolution programs, systems and procedures. If at any time during the Term of this Agreement, **PROVIDER'**s license

to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall immediately notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as provided herein. **PROVIDER** agrees to cooperate with **DAVIS** in order that **DAVIS** may meet any requirements imposed on **DAVIS** by state and federal law, as amended, and all regulations issued pursuant thereto.

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

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

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

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

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

.7 **Cooperation with Plan Medical Directors**. **PROVIDER** understands contracting Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and in certain instances Plans will have the right to oversee and review the quality of

care administered to Members. **PROVIDER** agrees to cooperate with Plan(s)' medical directors in the medical directors' review of the quality of care administered to Members.

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** provisional credentialing, credentialing and re-credentialing policies and procedures and the provisional credentialing, credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees **PROVIDER** shall be duly licensed and certified under applicable State and federal statutes and regulations to provide the vision care services that are the subject of this Agreement, shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE), and shall participate in such programs of continuing education required by State regulatory and licensing authorities. Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform provisional credentialing, credentialing and re-credentialing of **PROVIDER** as required by **DAVIS,** Plan(s) or the CMS. Such documentation shall include, but shall not be limited to proof of: National Provider Identifier number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS**' sole option, the right to deny any professional participation in the Network or the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees at all times, and to the extent of his/her/its knowledge, **PROVIDER shall immediately notify DAVIS, in writing**, in the event **PROVIDER** suffers a suspension or termination of **PROVIDER**'s license or professional liability insurance coverage. **PROVIDER** shall: (a) devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s); (b) ensure vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices; and (c) abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

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

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

Participating Provider(s) regarding a non-emergent concern and to receive pre-recorded instructions with respect to the handling of an emergency.

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

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, the Plan(s) and the State and their respective agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which, in any manner may accrue against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees through **PROVIDER**'s intentional conduct, negligent acts or omissions, or the intentional conduct, negligent acts or omissions of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

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

.12 **Malpractice Insurance**. **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire Term of this Agreement, maintain a policy (or policies) of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants, employees, affiliates, independent contractors and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In addition, and in the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall, following the effective termination date of the foregoing policy, maintain "tail coverage" with the same liability limits. The foregoing policies shall not limit **PROVIDER**'s liability to indemnify the State or Enrollees of a Medical Assistance Program.

(a) **PROVIDER** shall cause his/her/its employed, affiliated, independent or

subcontracted Participating Provider(s) to substantially comply with Section V.12 above, and throughout the Term of this Agreement and upon **DAVIS**' request, **PROVIDER** shall provide evidence of such compliance to **DAVIS**.

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. **PROVIDER** shall comply with the "General Prohibitions Against Discrimination," 28 CFR §35.130 and similar regulations or guidelines that apply to the agencies with which Plan(s) contract. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the regulations implementing the Americans with Disabilities Act ("ADA"), 28 CFR §35.101 et seq., **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, economic status, health status (including but not limited to medical condition), medical history, genetic information, need for services, receipt of health care, evidence of insurability (including conditions arising out of acts of domestic violence), claims experience, or method of payment; agrees to adhere to 42 CFR §§422.110 and 422.502(h) as applicable and in conformity with all laws applicable to the receipt of Federal funds including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised DHHS LEP Guidance"); and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR §438.206(c)(2), **PROVIDER** and Participating Provider(s) agree Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and **PROVIDER** shall maintain written procedures as to interpretation and translation services for Members requiring such services. During the Term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee's or applicant's hire, tenure, terms, conditions, or privileges of employment due to such individual's race, color, religion, gender, disability, marital status or national origin.

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

.15 **Participation Criteria**. **PROVIDER** hereby warrants and represents **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of Federal funds; federal law designed to prevent or ameliorate fraud, waste, and

abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et. seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b), 42 CFR. §§422.504(h)(l), 423.505(h)(l)) and the HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **PROVIDER** hereby warrants and represents **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a federal health care program as described in Sections 1128B(b) and 1128B(f) of the Social Security Act, and all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier number, as applicable.

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

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

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

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

(a) Pursuant to 42 CFR §§422.504 and 423.505 and in accordance with the CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to safeguard and maintain, in an accurate and timely manner, contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agree to provide such information to **DAVIS,** to contracting

Plans, applicable state and federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a minimum of ten (10) years from the final date of the contract period or from the date of completion of any audit, or for such longer period of time provided for in 42 CFR §§422.504 and 423.505, or other applicable law, whichever is later. In the case of a minor Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, or for such longer period of time provided for in 42 CFR §§422.504, 423.505, or other applicable law, whichever is later. **PROVIDER** shall make available premises, physical facilities, equipment, records and any relevant information the CMS may require which pertains to Covered Services provided to Medicare Advantage Program Members. **PROVIDER** and Participating Provider(s) shall cooperate with any such review or audit by assisting in the identification and collection of any books, records, data, or clinical records, and shall make appropriate practitioner(s), employees, and involved parties available for interviews, as requested. Such records shall be truthful, reliable, accurate, complete, legible, and provided in the specified form. **PROVIDER** and Participating Provider(s) shall hold harmless and indemnify **DAVIS** and/or Plan(s) for any fines or penalties they may incur due to **PROVIDER**'s submission, or the submission by Participating Provider(s) of inaccurate or incomplete books and records.

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

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

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

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

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

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

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

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

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

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

VI
TERM OF THE AGREEMENT

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

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

VII
TERMINATION OF THE AGREEMENT

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

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

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

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

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

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

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

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

(v) a determination of fraud; and/or

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

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

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

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

(iii) a conviction of a felony;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agreement are not fully met or timely met; or

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

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

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents and/or accrediting standards. **PROVIDER** shall continue to provide Covered Services to such Member(s) and the Parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

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

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

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

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

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

.8 **Termination by the New York State Department of Insurance**. Should **DAVIS**' financial risk transfer agreement be terminated by the Superintendent of the New York State Department of Insurance (hereinafter referred to as the "Superintendent"), pursuant to the provisions set forth in 11NYCRR 101 Regulation 164 §101.4(a)(3), this Agreement shall be assignable on a prospective basis (without any obligation to pay any amounts owed to **PROVIDER** by **DAVIS**) to each insurer that entered into the financial risk transfer agreement with **DAVIS** for a period of time which is determined by the Commissioner of the New York State Department of Health, as respects entities certified pursuant to Article 44 of the New York State Public Health Law, or by the Superintendent as respects all other insurers, to be necessary in order to provide the services that the insurer is legally obligated to deliver to its subscribers. No such assignment shall exceed twelve (12) months from the date the financial risk transfer agreement is terminated by the Superintendent.

VIII
DOCUMENTATION AND AMENDMENT

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

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

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

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

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

.1 **Access to Records**. **PROVIDER** shall make all records related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

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

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

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

(b) consider the needs of the enrolled population;

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

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

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

.3 **Establishment of UR/QM Programs**. Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS**, in its sole and absolute

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

.4 **Grievance Procedures**. The grievance procedure set forth herein as **Attachment 1** shall be followed for the processing of any **PROVIDER** complaint regarding Covered Services. **PROVIDER** shall comply with and subject to **PROVIDER'**s rights of appeal be bound by such grievance procedure. From time to time should the grievance procedure require modification whether by **DAVIS** or Plan(s), it shall be modified in accordance with applicable regulations and Section V.3 "Compliance with Davis and Plan Rules" herein.

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

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

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

X
GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof will be settled by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the Parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorney fees and costs to the prevailing Party. Either Party may seek arbitration under Article 75 of the Civil Practice Laws and Rules for disputes regarding payment terms hereunder.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the Parties to it and to their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, neither Party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other Party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS**' assets.

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

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

.5 **Entire Agreement of the Parties**. This Agreement supersedes any and all agreements, either written or oral, between the Parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the Parties with respect to the rendering of Covered Services. Each Party to this Agreement acknowledges no representations, inducements, promises, or agreements, oral or otherwise, have been made by either Party, or anyone acting on behalf of either Party, which are not embodied herein, and no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing and signed by the Party to be charged.

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

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

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

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

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

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

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

.13 **Third Party Beneficiaries**.

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

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

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

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

-SIGNATURE PAGE TO FOLLOW-

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

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

PROVIDER:

Signature:_____
Print Name:_____
Print Title:_____
Print Date:_____
Print All Addresses Below [**complete addresses for all practice locations**]:
Address 1:_____
Address 2:_____
Address 3:_____
Address 4:_____
Address 5:_____

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

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

DAVIS VISION, INC.:

Signature: _____
Print Name:_____
Print Title:_____
Print Date:_____

[**For DAVIS use only**]

Effective Date:_____

[**For DAVIS use only**]

Notes:_____

[**For DAVIS use ONLY**]

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

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

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

RECITALS

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

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

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

WHEREAS, for the provision of vision care services on behalf of members of a Managed Care Organization, the terms and conditions of this Agreement shall be subject to approval by the New York State Department of Health.

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

I
PREAMBLE AND RECITALS

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

II
DEFINITIONS

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

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

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

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

.5 "**Generally Accepted Standards of Medical Practice**" means standards that are based upon: credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas and any other relevant factor as determined by statute(s) and/or regulation(s).

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

.7 "**Medical Assistance Program**" (hereinafter "MAP") means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States for Medical Assistance Programs, Section 1396 et seq., as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

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

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

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

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

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)
(i) be appropriate within generally accepted standards of practice;
(ii) be efficacious, as demonstrated by scientifically supported evidence;
(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and
(iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and

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

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

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

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

.12 "**Medicare Advantage Member/Subscriber**" means an individual who is enrolled in and covered under a Medicare Advantage Program or any successor program(s) thereto regardless of the name(s) thereof. Dually eligible Medicare Advantage Subscribers are those individuals who are (i) eligible for Medicaid; and (ii) for whom the state is responsible for paying Medicare Part A and B cost sharing.

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

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

.15 "**Negative Balance**" means receipt of Copayment(s), Coinsurance(s) or other compensation by **PROVIDER** or Participating Provider, which are in excess of the amounts that are due to **PROVIDER** or Participating Provider for Covered Services under this Agreement.

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

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

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

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

Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s). All obligations, terms, and conditions of this Agreement that are applicable to **PROVIDER** shall similarly be applicable to and binding upon Participating Provider(s) as defined herein.

.20 "**Plan(s)**" means a health maintenance organization, corporation, trust fund, municipality, or other purchaser of vision care services that has entered into a Plan Contract with **DAVIS**.

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

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

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

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

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

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

III
SERVICES TO BE PERFORMED BY THE PROVIDER

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

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

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

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

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

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

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

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

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

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

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

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

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

IV
COMPENSATION

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

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

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

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

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

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

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

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

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

.4 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees **DAVIS**' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit plan, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation, remuneration or reimbursement from Members, person(s) acting on Member(s)' behalf, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, either now existing or hereinafter entered into between Member(s), or person(s) acting on Member(s)' behalf, and **PROVIDER** which relate to liability for payment; shall survive termination of this Agreement regardless of the reason for termination; shall be construed to be for the benefit of the Member(s); and shall not be changed without the approval of appropriate regulatory authorities, *it being understood that this hold harmless provision is in addition to the protections afforded to Members under Insurance Law Section 4307(d).*

.5 **Payment of Compensation**. Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable state's prompt pay statute, whichever is most restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment and Coinsurance collected or to be collected from the Member.

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

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

(a) Covered Services in General. For all Covered Services rendered by **PROVIDER** to a Member hereunder, ***PROVIDER*** *shall, within one hundred and twenty (120) days following the provision of Covered Services, submit to* ***DAVIS*** *a claim* which may be written, electronic or verbal, shall be approved as to form and content by **DAVIS,** and if applicable, shall be the standard claim form mandated by the State in which Covered Services were rendered. Failure of **PROVIDER** to submit a claim within one hundred and twenty (120) days following the provision of Covered Services will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER**. If **PROVIDER** is indebted to **DAVIS** for any reason including, but not limited to, Overpayments, Negative Balances or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement

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

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

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

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

.8 **Negative Balance**. When a Negative Balance occurs, **DAVIS** has the right to offset future compensation owed to **PROVIDER** or Participating Provider with the amount owed to **DAVIS** and the right to bill **PROVIDER** or Participating Provider for such Negative Balance(s). **DAVIS** will automatically, when possible, apply the Negative Balance to other outstanding payables on **PROVIDER**'s account. In some instances it may be necessary for **DAVIS** to send an invoice to **PROVIDER** for outstanding Negative Balance(s). The **PROVIDER** is responsible to remit payment to **DAVIS** upon receipt of invoice. **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS**' network in accordance with the suspension and termination provisions set

forth in this Agreement. A Negative Balance shall not mean an Overpayment as defined herein.

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

V
OBLIGATIONS OF PROVIDER

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

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

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

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

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

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

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

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

Participating Provider(s) of inaccurate or incomplete books and records.

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

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

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

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

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

acknowledges and agrees **DAVIS** is accountable and responsible to the State MAP which shall, on an ongoing basis, monitor the performance of the Parties under this Agreement to ensure the performance of the Parties is consistent with the Plan Contract between **DAVIS** and the MCO and consistent with the contract between the State MAP and the MCO.

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

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

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

(a) **PROVIDER** shall safeguard all information about Members according to applicable State and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided due to or is obtained by or through **PROVIDER**'s performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is

provided under State and federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of **PROVIDER**'s obligations and the securement of **PROVIDER**'s rights under this Agreement.

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

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

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

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

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** provisional credentialing, credentialing and re-credentialing policies and procedures and the provisional credentialing, credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees **PROVIDER** shall be duly licensed and certified under applicable State and federal statutes and regulations to provide the vision care services that are the subject of this Agreement, shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE), and shall participate in such programs of continuing education required by State regulatory and licensing authorities. Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform provisional credentialing, credentialing and re-credentialing of **PROVIDER** as required by **DAVIS**, Plan(s), or the CMS. Such documentation shall include, but shall not be limited to, proof of: National Provider Identifier number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and

graduate education and professional background. **PROVIDER** agrees **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS**' sole option, the right to deny any professional participation in the Network or the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees at all times, and to the extent of his/her/its knowledge, **PROVIDER shall immediately notify DAVIS**, **in writing**, in the event **PROVIDER** suffers a suspension or termination of **PROVIDER**'s license or professional liability insurance coverage. **PROVIDER** shall: (a) devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s), (b) ensure vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices, and (c) abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

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

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

(a) **PROVIDER** agrees **PROVIDER** is subject to regular monitoring of his/her/its compliance with the appointment wait time (timely access) standards of 42 CFR §438.206(c)(1). As such **PROVIDER** agrees and understands corrective action shall be implemented should **PROVIDER** and/or Participating Provider(s) fail to comply with timely access standards and Plan(s) have the right to approve **DAVIS**' scheduling and administration standards. (b) **PROVIDER** agrees to provide **DAVIS** with ninety (90) calendar days notice if **PROVIDER** and/or Participating Provider shall (i) be unavailable to provide Covered Services to Members, (ii) move office location, (iii) change place of employment (iv) change employer, or (v) reduce capacity at an office location.

The ninety (90) calendar day notice shall, at a minimum, include the effective date of the change, the new tax identification number and a copy of the W-9 as applicable, the name of the new practice, the name of the contact person, the address, telephone and fax numbers and other such information as may materially differ from the most recently completed credentialing application submitted by **PROVIDER** and/or Participating Provider to **DAVIS**. Under no circumstance shall the provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER** and **DAVIS**.

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, the Plan(s) and the State and their respective agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which, in any manner may accrue against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees through **PROVIDER**'s intentional conduct, negligent acts or omissions, or the intentional conduct, negligent acts or omissions of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

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

.12 **Malpractice Insurance**. **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire Term of this Agreement, maintain a policy (or policies) of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants, employees, affiliates, independent contractors and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In addition, and in the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall, following the effective termination date of the foregoing policy, maintain "tail coverage" with the same liability limits. The foregoing policies shall not limit **PROVIDER**'s liability to indemnify the State or enrollees of a Medical Assistance Program.

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

.13 **New York State Department of Health**. To the extent this Agreement is implemented prior to approval of New York State Department of Health, the parties agree to incorporate into this Agreement any and all modifications required by the New York State Department of Health, or alternatively, to terminate this Agreement if so requested by the New York State Department of Health.

.14 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER**

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

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

.16 **Participation Criteria**. **PROVIDER** hereby warrants and represents **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program, including general provisions relating to non-discrimination, sexual harassment or fraud and abuse, as well as all applicable laws pertaining to the receipt of federal funds; federal law designed to prevent or ameliorate fraud, waste and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et. seq.) and the anti-kickback statute (42 U.S.C. §1320a-7b(b), 42 CFR §§422.504(h)(l), 423.505 (h)(l)) and the HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **PROVIDER** hereby warrants and represents **PROVIDER**, and all of **PROVIDER**'s employees,

affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a federal health care program as described in Sections 1128B(b) and 1128B(f) of the Social Security Act, and all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current National Provider Identifier number, as applicable.

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

(b) **PROVIDER** may not employ, contract with, or subcontract with an individual, or with an entity that employs, contracts with, or subcontracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. **PROVIDER** acknowledges and understands this Agreement shall automatically be terminated if **PROVIDER**, 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.

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

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

(a) Pursuant to 42 CFR §§422.504 and 423.505 and in accordance with the CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to safeguard and maintain, in an accurate and timely manner, contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agree to provide such information to **DAVIS,** to contracting Plans, to applicable state and federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a minimum of ten (10) years from the final

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

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

(c) **PROVIDER**'s obligations contained in Section V.18 herein shall survive termination of this Agreement.

.19 **Standard Clauses**. Attached to and expressly incorporated into this Agreement as **Appendix A**, are the "New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts" which are binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses (**Appendix A**) and any other part or provision of this Agreement, including but not limited to appendices, amendments, and exhibits, the Parties agree the provisions of the Standard Clauses shall prevail and control, except to the extent applicable law otherwise requires and/or to the extent a provision of this Agreement exceeds the minimum requirements of the Standard Clauses.

.20 **Prohibition on Use of Federal Funds for Lobbying**.

(a) **Prohibition of Use of Federal Funds for Lobbying**. The **PROVIDER** agrees, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the **PROVIDER** for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal contract, the making of any federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The **PROVIDER** agrees to complete and submit the "Certification Regarding Lobbying", **Appendix B** attached hereto and incorporated herein, if this Agreement exceeds $100,000.

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

(c) **Requirements of Subcontractors**. The **PROVIDER** shall include the provisions of this section in its subcontracts, including its Provider Agreements. For all subcontracts, including Provider Agreements, that exceed $100,000, the **PROVIDER** shall require the subcontractor, including any Participating Provider to certify and disclose accordingly to the Contractor.

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

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

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

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

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

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

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

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

VI
TERM OF THE AGREEMENT

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

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

VII
TERMINATION OF THE AGREEMENT

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

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

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

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

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

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

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

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

(v) a determination of fraud; and/or

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

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

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

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

(iii) a conviction of a felony;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date of this Agreement) at the rates for Covered Services attached hereto.

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents and/or accrediting standards. **PROVIDER** shall continue to provide Covered Services to such Member(s) and the Parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of the date of termination.

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

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

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

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

.7 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate the subject Agreement pursuant to Section VII.1 above, or should **PROVIDER** move office location, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Members under this Agreement, **PROVIDER** agrees to notify affected

said Members a minimum of thirty (30) days prior to the effective date of such action or termination.

.8 **Termination by the New York State Department of Insurance**. Should **DAVIS**' financial risk transfer agreement be terminated by the Superintendent of the New York State Department of Insurance (hereinafter referred to as the "Superintendent"), pursuant to the provisions set forth in 11NYCRR101 Regulation 164 §101.4(a)(3), this Agreement shall be assignable on a prospective basis (without any obligation to pay any amounts owed to **PROVIDER** by **DAVIS**) to each insurer that entered into the financial risk transfer agreement with **DAVIS** for a period of time which is determined by the Commissioner of the New York State Department of Health, as respects entities certified pursuant to Article 44 of the New York State Public Health Law, or by the Superintendent as respects all other insurers, to be necessary in order to provide the services that the insurer is legally obligated to deliver to its subscribers. No such assignment shall exceed twelve (12) months from the date the financial risk transfer agreement is terminated by the Superintendent.

VIII
DOCUMENTATION AND AMENDMENT

.1 **Amendment**. This Agreement may be amended by **DAVIS** with thirty (30) days advance written notice to **PROVIDER**. Notwithstanding the foregoing, this Agreement may also be amended by written consent of the Parties hereto. Any material amendment to this Agreement requires the approval of the New York State Department of Health. Any such amendment shall be submitted to the New York State Department of Health for approval at least thirty (30) days in advance of the anticipated effective date. Material amendments shall include but not be limited to:

(a) any change to a required contract or appendix provision;
(b) any change to or addition of a risk sharing arrangement other than the routine trending of fees or other reimbursement amounts;
(c) the addition of an exclusivity, most favored nation, or non-compete clause;
(d) any proposed sub-delegation/subcontracting of the existing contractual obligations of **PROVIDER** or **DAVIS VISION IPA, INC.**
(e) any proposed subcontracting of the statutory or regulatory responsibilities of an MCO; and
(f) any proposed revocation of approved delegations as set forth in (d) or (e) supra.

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

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

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

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

.1 **Access to Records**. **PROVIDER** shall make all records related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

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

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

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

(b) consider the needs of the enrolled population;

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

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

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

.3 **Establishment of UR/QM Programs**. Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER**

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

.4 **Grievance Procedures**. The grievance procedure set forth herein as **Attachment 1** shall be followed for the processing of any **PROVIDER** complaint regarding Covered Services. **PROVIDER** shall comply with and subject to **PROVIDER'**s rights of appeal be bound by such grievance procedure. From time to time should the grievance procedure require modification whether by **DAVIS** or Plan(s), it shall be modified in accordance with applicable regulations and Section V.3 "Compliance with Davis and Plan Rules" herein.

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

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

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

improvement are identified.

X
GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement or 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. In any such proceeding, the arbitrator(s) may award attorney fees and costs to the prevailing Party. Either Party may seek arbitration under Article 75 of the Civil Practice Laws and Rules for disputes regarding payment terms hereunder.

For any controversy or claim arising out of this Agreement as it relates to the provision of vision care services on behalf of eligible members of a Managed Care Organization, arbitration shall occur within the State of New York, and the Commissioner of the Department of Health shall be provided written notice of all issues going to arbitration or mediation. Copies of all arbitration or mediation decisions shall be provided to the Commissioner of the Department of Health. The Commissioner of the Department of Health is not bound by arbitration or mediation decisions.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the parties to it and to their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, neither Party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other Party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS**' assets.

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

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

.5 **Entire Agreement of the Parties**. This Agreement supersedes any and all agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the parties with respect to the rendering of Covered Services. Each Party to this Agreement acknowledges 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 and signed by the Party to be charged.

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

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

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

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

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

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

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

.13 **Third Party Beneficiaries**.

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

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

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

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

-SIGNATURE PAGE TO FOLLOW-

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

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

PROVIDER:

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

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

DAVIS VISION IPA, INC.:

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

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

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

Appendix A

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

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

A. Definitions For Purposes Of This Appendix

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

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

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

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk

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

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

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

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

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

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

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

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

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

$100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

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

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

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

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

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

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

C. Payment; Risk Arrangements

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

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

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

D. Records; Access

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

E. Termination and Transition

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

the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

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

F. Arbitration

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

G. Ipa-Specific Provisions

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

APPENDIX B

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

DATE: _____

TITLE:_____

ORGANIZATION:_____

NAME: (Please Print)_____

SIGNATURE: _____

ATTACHMENT 1

PROVIDER APPEAL POLICY

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

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

The appeal process is intended to:

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

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

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

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

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

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

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

ATTACHMENT 2

DAVIS VISION PARTICIPATING PROVIDER AGREEMENT FOR THE STATE OF NEW YORK

COMPENSATION

PROFESSIONAL FEES*

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

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

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

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

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Sample New York State Laser Provider Contract

DAVISVISION®
SEE LIFE

DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT
FOR LASER VISION CORRECTION SERVICES

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

RECITALS

WHEREAS, **DAVIS** has entered into or intends to enter into agreements (hereinafter "Plan Contract(s)") with health maintenance organizations, corporations, trust funds, municipalities, and other purchasers of vision care services (hereinafter "Plan(s)") and;

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

WHEREAS, the Parties desire to enter into this Agreement whereby **PROVIDER** agrees (upon satisfying all Network participation criteria) to provide on behalf of **DAVIS**, at a discounted rate, refractive surgery ("Refractive Surgery") to Members of Plans under Plan Contract with **DAVIS**; and

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

I
PREAMBLE AND RECITALS

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

II
DEFINITIONS

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

.2 "**Food and Drug Administration**" ("FDA") means a federal agency within the United States Department of Health and Human Services which regulates medical devices.

.3 "**Generally Accepted Standards of Medical Practice**" means standards that are based upon: credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas and any other relevant factor as determined by statute(s) and/or regulation(s).

.4 "**Medically Appropriate**" means vision care service(s) or treatment(s) which, as determined by **PROVIDER** a Member requires, and that are in accordance with Generally Accepted Standards of Medical Practice and adopted by **DAVIS.**

.5 "**Member**" means an individual and the eligible dependents of such an individual who is enrolled in or who has entered into contract with or on whose behalf a contract has been entered into with Plan(s), and who is entitled to receive Refractive Surgery.

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

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

.8 "**Plans**" means health maintenance organizations, corporations, trust funds, municipalities and/or other purchasers of vision care services that have entered into a Plan Contract(s) with **DAVIS**.

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

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

.11 "**State**" means the state in which **PROVIDER**'s practice is located or the state in which the **PROVIDER** renders Refractive Surgery service(s) to the Member.

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

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

III
SERVICES TO BE PERFORMED BY PROVIDER

.1 **Services**. **PROVIDER** shall provide all Medically Appropriate Refractive Surgery to Members within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Member(s) to ensure that it is Medically Appropriate. **PROVIDER** agrees and acknowledges that Refractive Surgery hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the Plan(s). Such Refractive Surgery shall be performed at a twenty-five percent (25%) discount off of **PROVIDER**'s Usual and Customary fee or five percent (5%) off any **PROVIDER**'s advertised, discounted fee, whichever is lower. Throughout the entire Term(s) of this Agreement, **PROVIDER** shall provide Refractive Surgery hereunder using only FDA-approved lasers and/or equipment and procedures.

.2 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s) covered under one or more of the Plans or in conflict with the terms of this Agreement. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the Americans with Disabilities Act, **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status, need for services, or method of payment; and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR 438.206(c)(2), **PROVIDER** and Participating Provider(s) agree that Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Further, **PROVIDER** understands that should any payments hereunder be, in whole or in part, from Federal funds **PROVIDER** is then subject to applicable laws related to the receipt of Federal funds, including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised DHHS LEP Guidance"). During the term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee's or applicant's hire, tenure, terms, conditions, or privileges of employment due to such individual's race, color, religion, gender, disability, marital status or national origin.

.3 **Open Clinical Dialogue**. Nothing contained herein shall preclude **PROVIDER** from engaging in open clinical dialogue with Members, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are covered Refractive Surgery 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 such person(s) to share information with Plan(s) and/or any regulatory agencies.

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

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

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

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

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

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

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

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

IV
COMPENSATION

.1 **Administrative Procedures**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of duties pursuant to this Agreement. Such procedures shall include but not be limited to the verification of patient eligibility, willingness to submit to an audit on the number of patients seen, and payments made to **DAVIS**, if any. **PROVIDER** recognizes that such administrative procedures may, from time to time, be amended by **DAVIS** and that such amended procedures shall be similarly binding on **PROVIDER**.

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

.3 **Payment of Compensation**. **PROVIDER** will be compensated either by the Member, by **DAVIS**, or by both parties subject to the Plan(s)' benefit program. If Plan benefit program provides for a discount only, **PROVIDER** shall seek compensation from the Member directly at the appropriate discounted rate. If Plan benefit program is partially reimbursed by **DAVIS**, **PROVIDER** shall seek compensation from **DAVIS**, up to the covered amount, the remainder of said compensation (if any) is to be paid by Member(s). If Member is covered under a Flex Spending Account, **PROVIDER** will be required to cooperate with **DAVIS** in submitting information to Plan(s) for Member reimbursement.

.4 **Negative Balance**. From time to time, **PROVIDER** may receive Copayments and Deductibles, which will afford **PROVIDER** with compensation amounts in excess of the amounts due to **PROVIDER** for providing Refractive Surgery services hereunder. Such receipts are hereinafter referred to as a "Negative Balance." When a Negative Balance arises, **DAVIS** shall have the right to offset future compensation owed to **PROVIDER** with the amount owed to **DAVIS**. At **DAVIS**' sole discretion, **DAVIS** may bill **PROVIDER** for a Negative Balance(s). **PROVIDER** shall be responsible to remit such Negative Balance to **DAVIS** within fifteen (15) days of receipt of invoice from **DAVIS**. Should payment not be received by **DAVIS** within the aforementioned timeframe, **DAVIS** retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate **PROVIDER** from further participation in **DAVIS**' network in accordance with the suspension and termination provisions set forth in this Agreement.

.5 **Plan Hold Harmless Provisions**. **PROVIDER** agrees that he/she/it shall look only to **DAVIS** and/or Member, as applicable, for compensation hereunder and shall hold harmless each Plan from any obligation to compensate **PROVIDER** for Refractive Surgery provided hereunder. This provision shall survive termination of this Agreement regardless of the reason for termination.

V
OBLIGATIONS OF PROVIDER

.1 **Compliance with DAVIS Rules**. **PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS** including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes that from time to time **DAVIS** may amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Refractive Surgery pursuant to this Agreement. **PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER**'s duties hereunder to Member. **PROVIDER** shall use its best efforts to ensure that Refractive Surgery services provided under this Agreement are of quality that is consistent with accepted professional practices. As applicable, **PROVIDER** agrees to abide by the standards established by **DAVIS**, including, but not limited to, standards relating to the utilization and quality of vision care services.

.2 **Compliance with Laws and Ethical Standards**. **PROVIDER** and **DAVIS** shall at all times during the term of this Agreement, comply with all applicable Federal, State or municipal statutes or ordinances, all applicable rules and regulations, including all applicable federal and State tax laws, as well as the ethical standards of the appropriate professional society from which **PROVIDER** seeks advice and guidance or to which **PROVIDER** is subject to licensing and control. If at any time during the term of this Agreement, **PROVIDER** shall have **PROVIDER**'s license to operate or to practice his/her/its profession suspended, conditioned or revoked, **PROVIDER** shall immediately notify **DAVIS** and this Agreement shall, except as otherwise provided herein, and without regard to a final adjudication of such suspension, conditioning or revocation, immediately terminate, and become null and void and of no further force or effect. **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.

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

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

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

.4 **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**

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

.6 **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**. **PROVIDER** agrees **PROVIDER** shall be duly licensed and certified under applicable State and federal statutes and regulations to provide the services that are the subject of this Agreement. **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform credentialing and re-credentialing of **PROVIDER** as required by **DAVIS** and Plan(s). Such documentation shall include, but shall not be limited to proof of: National Provider Identifier Number, licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees that **DAVIS** shall have the right to source verify the accuracy of all information

provided, and at **DAVIS**' sole option, the right to deny any professional participation privileges in the Network or the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees that at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall **immediately notify DAVIS in writing** in the event **PROVIDER** suffers a suspension or termination of license or of professional liability insurance coverage. **PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s). **PROVIDER** shall use best efforts to ensure 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** including, but not limited to, standards relating to the utilization and quality of vision care services.

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

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

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

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

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

against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees through **PROVIDER**'s intentional conduct, negligent acts or omissions, misfeasance or malfeasance, or through the intentional conduct, negligent acts or omissions, misfeasance or malfeasance of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

.10 **Malpractice Insurance**. Unless otherwise agreed upon, in writing, between **PROVIDER** and **DAVIS**, **PROVIDER** shall provide, at **PROVIDER**'s sole cost and expense, and throughout the entire term of this Agreement, 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 shall provide evidence of current insurance coverage to **DAVIS** if so requested.

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

.11 **Notice of Non-Compliance and Malpractice Actions**. **PROVIDER** shall notify **DAVIS** immediately, in writing, should it be in violation of any portion of Section V hereof. 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.

.12 **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 is intended for and may be inspected by prospective patients and others.

.13 **Record Retention**. **PROVIDER** agrees to maintain such records and provide such information to **DAVIS** and as may be required by law, 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 Refractive Surgery services and in the case of a minor who receives Refractive Surgery 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 this paragraph shall survive termination of this Agreement.

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

VI
TERM OF THE AGREEMENT

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

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

VII
TERMINATION OF THE AGREEMENT

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

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

(a) a failure by **PROVIDER** to maintain professional malpractice liability insurance as provided in Section V.10 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in V.2 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS**' rules and regulations as required in Section V.1 hereof;

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

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

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

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

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

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

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

<u>"Cause" for the purposes of suspension shall mean</u>:

(a) a failure by **PROVIDER** to maintain malpractice insurance coverage as provided in Section V.10 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section V.2 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section V.1 hereof;

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section IX.2 hereof;

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

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

.3 **Responsibility for Members at Termination**. In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall provide Refractive Surgery services to a Member entitled to such services from **PROVIDER** on the effective termination date of this Agreement until the services being rendered to the Member by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a patient), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such services by another practice. Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above, or should **PROVIDER** move office location, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to notify said Member(s) prior to the effective date of such action or termination.

VIII
DOCUMENTATION AND AMENDMENT

.1 **Amendment**. **DAVIS** may amend this Agreement (and any Exhibit) by providing **PROVIDER** with a written copy of the applicable portion of the amendment. If **PROVIDER** is unwilling to accept the amendment, **PROVIDER** may terminate this Agreement by giving **DAVIS** written notice of termination within fifteen (15) business days after receipt of the amendment, and such termination shall become effective ninety (90) calendar days after the expiration of this fifteen (15) business day period. If **PROVIDER** does not give **DAVIS** notice of termination within this fifteen (15) business day period, then the amendment will become effective thirty (30) calendar days after the original date of the amendment.

.2 **Documentation**. **DAVIS** shall provide **PROVIDER** with a copy of any document required by a contracting Plan which has been approved by **DAVIS** and which requires **PROVIDER's** signature. If **PROVIDER** does not execute and return said document within fifteen (15) business days of document receipt, or provide notification to **DAVIS** in accordance with Section VIII.1 hereof, **DAVIS** may execute said document as agent of **PROVIDER** and said document shall be deemed to be executed by **PROVIDER**.

.3 **Modification of Law, Rules, Regulations**. Notwithstanding anything herein to the contrary, should any applicable federal or State law(s) be amended and their implementing regulations, policy issuances and instructions be modified, no particular notice of amendment by **DAVIS** to **PROVIDER** shall be required. Such amended laws apply as of their respective effective dates and this Agreement shall automatically amend to conform to such changes without the necessity for executing written amendments. **DAVIS** shall however, employ best efforts to notify **PROVIDER** of such occurrences within a practicable timeframe.

IX
UTILIZATION REVIEW, QUALITY MANAGEMENT AND GRIEVANCE PROCEDURES

.1 **Access to Records**. As applicable, **PROVIDER** shall make all records 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.

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

.3 **Grievance Procedures**. A grievance procedure shall be established for the processing of any **PROVIDER** complaint regarding Refractive Surgery services hereunder. Such procedure will be established by **DAVIS** and contracting Plans, in their sole and absolute discretion. Subject to his/her/its rights of appeal, **PROVIDER** shall comply with and shall be bound by such grievance procedure.

X
GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement or to the breach thereof will be settled by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the Parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorneys' fees and costs to the prevailing Party.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the Parties to it and their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, neither Party may assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of the other Party, except that **DAVIS** may assign this Agreement to a controlled subsidiary or affiliate or to any successor to its business, by merger or consolidation, or to a purchaser of all or substantially all of **DAVIS**' assets.

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

.4 **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 Refractive Surgery 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 and signed by the Party to be charged.

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

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

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

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

.10 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through its participation with **DAVIS** regarding a Member, including, but not limited to, the Member's name, address and telephone number ("Member Information"), and all other "**DAVIS** trade secret information". For purposes of this Agreement, "**DAVIS** trade secret information" shall include, but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS**. **PROVIDER** shall

not disclose or use any Member Information or "**DAVIS** trade secret information" for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Member if Medically Appropriate for the proper treatment of such Member or upon the express, prior written permission of **DAVIS**, or of the Plan in which the Member is enrolled, or of the Member.

.11 **Severability**. Should any provision of this Agreement be held to be invalid, void or unenforceable by a court of competent jurisdiction or by applicable state or federal law and their implementing regulations, the remaining provisions of this Agreement will nevertheless continue in full force and effect. If any provision of this Agreement is held to be invalid, void, or unenforceable by any applicable regulatory body, or generally accepted industry and professional standards of practice, the remaining provisions will nevertheless continue in full force and effect.

.12 **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.

.13 **Use of Name**. **DAVIS** reserves the right to the control and to the use of its name(s) and all copyrights, symbols, trademarks or service marks presently existing or later established. **PROVIDER** shall not use **DAVIS'** or any Plan's name(s), tradename(s), trademark(s), symbol(s), logo(s), or service mark(s) without the prior, written authorization of **DAVIS** or such Plan. **DAVIS** may use the name, address, and telephone number of each individual **PROVIDER** (ophthalmologist) who is employed, affiliated subcontracted with, and/or who is within the control of **PROVIDER**.

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

SIGNATURE PAGE TO FOLLOW

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

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

PROVIDER:

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

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

DAVIS VISION, INC.:

Signature: _____
Print Name:_____
Print Title:_____
Date: _____

Effective Date:_____
[For DAVIS use ONLY]

Notes:_____
[For DAVIS use ONLY]

www.davisvision.com

PLAN OUTLINE

Philosophy

Provide high quality Laser Vision Correction services at reasonable discounts achieved by volume opportunities.

Services

- LASIK
- PRK

Fees/Discounts

- Usual and customary less 25% or advertised (discounted) fees less 5% (whichever is lower)
- No other group's discount fee may be lower

DAVISVISION®
SEE LIFE

Provider Manual 2010

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SECTION I
WELCOME TO DAVIS VISION

About The Manual

The policies and procedures in this manual apply to services rendered by providers to enrollees in benefit plans that are administered by Davis Vision. It is your responsibility to read and understand the policies and procedures in this manual. For questions about this manual, please contact Professional Affairs and Quality Management at 516-733-5365.

Davis Vision's Provider Relationship Statement

Providers play a crucial role in helping Davis Vision's mission of delivering integrated vision care solutions for the value-seeking customer/patient. Our relationship with physicians and providers is strengthened through timely communication, joint problem-solving and mutually beneficial financial arrangements. Relationships are designed to emphasize high-quality and cost-effective patient care.

Regulatory and Compliance

Providers are required to comply with all applicable laws and regulations. In addition, providers are required to comply with certain rules and regulations as contracted providers of Davis Vision because Davis Vision maintains licenses and certifications with state agencies.

Davis Vision and its designated agents have the right to audit provider books and records with regards to enrollees in benefit plans that are administered by Davis Vision.

Notice About Non-Discrimination

Davis Vision does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. In addition, Davis Vision complies with applicable anti-discrimination laws including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Providers may not discriminate against members based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin.

A. ABOUT DAVIS VISION

Davis Vision is a wholly owned subsidiary of HVHC Inc., a Highmark company, and has played a major role in providing quality vision care services since 1964. In addition to Davis Vision, HVHC Inc. owns New Jersey-based Viva International Group and Texas-based Eye Care Centers of America. Together these companies rank among the nation's largest vision companies. Davis Vision is distinguished from virtually every other vision care plan by its central laboratories, administrative systems, paid-in-full benefits and a professional quality improvement program.

Davis Vision provides vision care and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. The plan presently serves more than 55 million beneficiaries nationally through managed care organizations (HMOs and PPOs), insurance companies, governmental groups, corporations, union trust funds and third party administrators.

Corporate headquarters is located in Plainview, New York and Provider and Member Services operations are located in both Plainview and Latham, New York. Davis Vision operates three optical laboratories located in Philadelphia, Pennsylvania; Plainview, New York; and Las Vegas, Nevada. All laboratories have redundant equipment and systems, and have been designed to handle the production from the other laboratories in the event productive capacity is not available at any one of them. Davis Vision has over 800 employees dedicated to providing quality services to beneficiaries. The data center supporting Davis Vision's proprietary claims processing system is located in the Customer Relationship and Information Technology Center (CRITC) in Latham, New York.

Davis Vision's innovative vision benefit plans and services allow flexibility in the custom design of programs to meet specific client requirements. The broad spectrum of products includes, but is not limited to:

- **Comprehensive Vision Care:** Covers eye examination and materials at the frequency and benefit level chosen by the client.
- **Hybrid Programs:** Provides funded coverage for professional services with preferred pricing discounts on eyewear purchases.
- **Occupational Programs:** Provides specialty eyewear for computer use and OSHA-compliant safety eyewear.
- **Discount Programs:** Offers significant uniform discounts on both professional and material fees.
- **Eye Health and Wellness Programs®:** Provides clients and members access to our vision library and Eye Health and Wellness Web Site. Copies of Sightwire, a newsletter regarding eye care topics released six times a year, are available free of charge for clients to share with employees.

Davis Vision's provider network comprises nearly 32,000 providers (optometrists, ophthalmologists and retail centers) located in all fifty states, the District of Columbia, Puerto Rico, Guam, and Saipan. The network includes a wholly owned chain of proprietary vision centers located throughout upstate New York, Long Island, Central Pennsylvania, Massachusetts, New Hampshire and Rhode Island.

B. CLINICAL PRACTICE GUIDELINES

Davis Vision has adopted the Clinical Practice Guidelines of the American Optometric Association (AOA) and the American Academy of Ophthalmology (AAO). Providers may find a link to these guidelines on the Provider Portal of Davis Vision's Web site at **www.davisvision.com**. Hard copies of these guidelines are available by contacting the above associations directly.

C. RESEARCH

Davis Vision, a leader in vision care, continually reviews information that may lead to better vision care and the prevention of eye disease.

Davis Vision collects utilization trend data as an integral aspect of our Quality Improvement program. This data collection can include, but is not limited to:

- Dilated Fundus Examinations
- Pediatric care
- Safety eyewear use
- Medical eye care
- Medically necessary contact lenses

Patient and provider surveys are also conducted in order to improve care.

D. FRAUD, WASTE AND ABUSE

The activities of Davis Vision, its Associates and contracted providers must be carried out in accordance with applicable laws and Davis Vision policies and procedures. Federal and State laws define expectations on the submission of data, record keeping, access to records and the privacy of protected health information. Violations of laws may subject you to individual civil or criminal liability.

All inquiries and reports are confidential, subject to limitations imposed by law. Individuals may also make an anonymous report. Davis Vision policy prohibits retaliation against individuals who raise questions or concerns in good faith.

Davis Vision will undertake a reasonable investigation for any credible report of potential Waste, Fraud and/or Abuse and may refer the issue, as appropriate, to the Highmark Special Investigations Unit, CMS or law enforcement.

1. Definitions

Abuse: using wrongly or improperly

Examples:

- Excessive charges for services or supplies
- Billing for "free" services
- Breach of assignment agreements
- Improper billing practices, such as exceeding the limit charge, billing non-covered services as covered
- Misrepresenting services or dates of service.

Conspiracy: an agreement between two or more persons to perform together an illegal, wrongful or subversive act

Fraud: using intentional deception or misrepresentation for unlawful gain or unjust advantage

Examples:

- Billing for services or supplies that weren't provided
- Misrepresenting the diagnosis or prescription to ensure payment of materials or services
- Billing the medical carrier and Davis Vision for he same service
- Soliciting, offering or receiving a kickback, bribe or rebate
- An eligible provider billing for the services provided by a non-eligible provider or individual
- Loaning or using another person's member identification number (and/or card) to obtain services or materials

Medical Identity Theft: using another individual's medical insurance information to obtain medical treatment or services

Waste: using, consuming, spending or expending thoughtlessly or carelessly

2. The False Claims Act

- Prohibits knowingly presenting (or causing to be presented) to the Federal government a false or fraudulent claim for payment or approval.
- Prohibits knowingly making, using or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government
- Applies to claims made to Medicare Advantage Organizations
- Has been interpreted to mean that it is a potential violation of federal law if a provider makes little or no effort to validate the truth and accuracy of his/her statements, representations or claims or otherwise acts in a reckless manner as to the truth

3. Anti-Kickback Statute

Prohibits knowingly and willfully paying, offering, soliciting or receiving remuneration (anything of value):

- to induce a referral of a patient for items or services for which payment may be made, in whole or in part, under a Federal health care program; or
- in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item for which payment may be made in whole or in part under a Federal health care program
- There are certain exceptions specified in so-called "safe harbors" specified by law.

4. Contact Information

Anyone can contact the Anti-Fraud Hotline – Members, Providers, Groups, Brokers and Associates. For information and inquiries or to report potential misconduct, contact:

The Davis Vision Fraud, Waste and Abuse Unit

Toll-Free Hotline
24 hours a day 7 days a week
1-800-501-1491

Confidential U.S. Post Office Box
Davis Vision
P.O. Box 1416
Latham, NY 12110-1416

Confidential Fax
1-866-999-4640

email: antifraud@davisvision.com

E. CONFIDENTIALITY AND SECURITY OF INFORMATION

Davis Vision has established and maintains a HIPAA Privacy Office, under the direction of the Company's designated Chief Privacy Officer for Davis Vision strategic business units, including vision care and proprietary vision centers. The Privacy Office develops, obtains approval for, implements and monitors compliance with the necessary procedures and protocols that are required to assure full compliance with HIPAA Privacy Regulations.

The Privacy Office also audits compliance, investigates allegations or reports of privacy breaches and coordinates responses as appropriate and serves as liaison with other privacy offices.

Davis Vision has a moral, legal and professional obligation to protect the confidentiality of the patient's care record and personal information. Davis Vision's members are entitled to confidential, fair and respectful treatment of health information about themselves or family members. Davis Vision will abide by all applicable state and federal laws protecting patient confidentiality and the confidentiality of individual medical records. Davis Vision will not release any patient information without proper authorization from the patient and/or as required by law or judicial decree. It is our policy to ensure confidentiality of any health information submitted to, or by Davis Vision, which would identify the member or patient. All member/patient specific information will be considered confidential and is therefore protected. Member benefit and/or eligibility status, while confidential, is not considered protected.

Protected Health Information means any information or data that is created by or received by Davis Vision that would identify an individual and contains information regarding the past, present or future health status of that individual.

Eligibility information refers to information (written or verbally or electronically communicated) which indicates a member's eligibility for past, present or future services, as provided under the member's benefit plan. Eligibility information does not include protected health information.

Davis Vision participating providers agree to keep all protected member information confidential, and to:

- Prevent unauthorized access to member records.
- Place all Davis Vision member records in a secure location that will limit access to authorized personnel only.
- Identify the position and identity of authorized personnel who have access to patient care records.
- Retain patient and financial records in accordance with state and federal requirements.

Further, in those instances where Davis Vision needs to obtain patient-specific information from a provider or other healthcare entity it shall abide by its own confidentiality policy:

- Upon calling for patient information the Davis Vision associate will identify themselves by name, title and department.
- If further verification is required, Davis Vision will provide the request in writing or the entity may call the associate back.

Although the records are the property of the provider and/or Davis Vision, patients have the right to examine their records and to copy and/or clarify information contained in them. Accordingly, for the above listed reasons, members authorize the sharing of medical information about themselves and their dependents with Davis Vision and participating

providers. Davis Vision's Confidentiality Policy is available to any member, patient, provider or group upon request.

1. Disclosure of Information

Davis Vision shall not disclose any health information about a member received by or collected by Davis Vision unless disclosure is:

- Requested by the member, legal guardian or legal representative. Proper identification is required prior to release of information. Written authorization must be dated and signed within the appropriate time frame.
- For the purpose of an audit of Davis Vision's claim processing operations. Released information must be relevant to conducting the audit. Any outside agency reviewing information must agree to abide by Davis Vision's confidentiality policies.
- Reasonably necessary for Davis Vision to conduct an audit of utilization by provider.
- To an authorized, regulatory or accrediting agency conducting a survey and/or audit. The agency must agree to abide by Davis Vision's confidentiality policies.
- To a governmental authority or law enforcement agency while investigating or prosecuting the perpetration of fraud upon Davis Vision or a Davis Vision client.
- Reasonably necessary for the investigation of suspected fraud or abuse by a member or provider.
- To Davis Vision committees (such as Credentialing, Utilization Management, and Quality Improvement) that conduct peer review audits.
- In response to a court order.
- In response to a governmental authority for the intent purpose of verifying a member's eligibility for which the government is responsible.
- When otherwise authorized or required by federal, state or local laws.
- For the purposes of Treatment, Payment and Health Care Operations, Davis Vision will disclose the minimum necessary information to properly report encounter and claims history to a client.

Davis Vision will disclose eligibility information when:

- A member, member's legal spouse, member's dependent child(ren) or participating provider produces proper identification or eligibility documentation.
- A member or any listed plan beneficiary accesses the Interactive Voice Response system, speaks with a Member Service Representative or logs on to the Davis Vision web site and provides the appropriate member identification number.

SECTION II
RIGHTS AND RESPONSIBILITIES

A. PROFESSIONAL ETHICS

As a provider of vision care, Davis Vision promotes the guidelines of ethical behavior established by the American Optometric Association and the American Academy of Ophthalmology. These guidelines highlight Davis Vision's expectations for ethical behavior. All decisions regarding treatment will be determined solely on medical necessity and not on financial cost. The following guidelines are given prominence:

1. To hold the physical, emotional, social, health and visual welfare of all Davis Vision members uppermost at all times.
2. To ensure better care and services, and to provide these services with compassion, honesty, integrity and respect for the member's dignity.
3. To promote and hold in professional confidence all information concerning a patient, to use such information for the benefit of the patient, and to abide by all federal, state, and local regulatory agencies in maintaining this confidentiality.
4. To continually maintain and improve one's competency which includes technical ability, cognitive knowledge and ethical concerns for the member. Competence involves having the most current knowledge and understanding of vision care, enabling providers to make professionally appropriate and acceptable decisions in managing a member's care.
5. To provide care and services appropriate to the degree of education and training.
6. To consult with other health care professionals and refer patients, when appropriate.
7. To uphold the Davis Vision *Patient's Bill of Rights* (contained in Section D below). To obtain informed consent for all treatment, procedures and services. To communicate and educate patients and/or appropriate family members.
8. To inform Davis Vision of any physical, mental or emotional impairment that may impede your ability to provide appropriate patient care or to meet contractual obligations with Davis Vision.
9. To conduct oneself in an ethical and professional manner as described by the appropriate professional association and to comply with all federal, state and local regulations relating to the practice of one's profession.
10. To communicate with each member at an appropriate level of comprehension and/or in a language understood by the member, or to refer the member to Davis Vision for translation services.

11. To involve member and/or family members, when appropriate, in all treatment plans and decisions.

12. To resolve all conflicts involving treatment plans or, if unable to do so, to refer the member to Davis Vision, the member's applicable Plan or appropriate state agency for resolution.

13. To inform members of their right to view the policy and procedures for conflict resolution by contacting Davis Vision, their applicable Plan or appropriate state agency directly.

B. PROVIDER BILL OF RIGHTS

1. *Providers have the right* to compensation and payment for covered services provided to all Davis Vision members within the timeframe specified in the provider agreement specific to the jurisdiction within which they provide covered services.

2. *Providers have the right* to request prompt payment of all co-payments and/or deductibles from all Davis Vision members.

3. *Providers have the right* to request a copy of any document required by a contracting Plan, which has been approved by Davis Vision and requires a provider's signature.

4. *Providers have the right* to know that composition of the Utilization Review and Quality Management Committees include panel providers whenever appropriate. Providers have the right to provide feedback to Davis Vision on standards of care and clinical practice guidelines utilized by Davis Vision.

5. *Providers have the right* to voice any grievance on behalf of members or themselves regarding covered services.

6. *Providers have the right* to appeal decisions of Davis Vision without fear of reprisal.

7. *Providers have the right* to confidentiality of all credentialing information, subject to applicable local or state law as per the Participating Provider Agreement. Providers have the right to request access to their credentialing file to review information collected, to correct any erroneous information obtained during the credentialing process and to be informed of their status.

8. *Providers have the right* to confidentiality of their compensation arrangement with Davis Vision.

9. *Providers have the right* to discuss all treatment options with a member or, if applicable, with a member's designee, regardless of restrictions imposed by the vision care plan.

10. *Providers have the right* to prescribe, refer, and/or manage the care of patients based on their professional experience and judgment.

11. *Providers have the right* to receive all information needed to understand the benefit plans of members in their geographic area.

12. *Providers have the right* to know the qualifications of peers whose recommendations and/or decisions may differ from theirs or may affect their participation on the Davis Vision panel.

13. *Providers have the right* to make recommendations regarding quality of care, standards of care or clinical practice guidelines adopted or adapted by Davis Vision.

14. *Providers have the right* to be treated with respect and dignity regardless of their race, color, religion, gender, age, national origin, disability or sexual orientation.

15. *Practitioners in the State of Texas have the rig*ht to request all information necessary to determine that they are being compensated in accordance with Davis Vision's Participating Provider Agreement. The practitioner may make the request for information by any reasonable and verifiable means. The information provided will include a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees. Davis Vision will provide the required information by any reasonable method through which the practitioner can access the information including email, computer disks, paper or access to an electronic database no later than 30 days after receipt of request.

C. PROVIDER RESPONSIBILITIES

1. Providers are responsible to provide all medically appropriate covered services to participants within the scope of their license and to treat, manage, coordinate and monitor such care to each member.

2. Providers are responsible to maintain a service record and/or treatment record form for each member and to complete each form in accordance with Davis Vision's policy. Provider will hold such information confidential.

3. Providers may not differentiate or discriminate in the treatment of Davis Vision members 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 or health status. Providers will protect the rights of Davis Vision members (contained in Section D below).

4. Providers are responsible to be available to provide services to Davis Vision's members for medically appropriate urgent care. Information and instructions regarding emergency care shall be available twenty-four (24) hours per day, seven (7) days per week.

5. Providers are responsible to maintain malpractice insurance in the 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 or liability, or as otherwise required by state law.
6. Providers are responsible to comply with all credentialing and recredentialing requests in a timely manner.
7. Providers are responsible to notify Davis Vision immediately if their license has been suspended, restricted or limited in any way.
8. Providers are responsible to comply with all applicable federal, state or municipal statutes or ordinances and all applicable rules and regulations and the ethical standards of the appropriate professional society.
9. Providers are responsible to comply with all policies and procedures as described in the Provider Manual. Providers are responsible to maintain confidentiality of financial information from other providers but may discuss financial arrangements with Davis Vision's members.
10. Providers are responsible to comply with all utilization and quality improvement programs of Davis Vision and to submit requested documentation in a timely manner.
11. Providers are responsible for verifying Davis Vision's members' eligibility and obtaining authorization.
12. Providers are responsible for submitting all claims within sixty (60) days of the date services were provided.
13. Providers are responsible to inform Davis Vision's members of their financial responsibility prior to administering services.
14. Providers are responsible to inform Davis Vision when their offices will be closed for three (3) months or longer due to vacation, illness or other circumstances.

D. PATIENT BILL OF RIGHTS

Courtesy, dignity, confidentiality, communication and privacy are essential to services provided by Davis Vision. Davis Vision strives to ensure that all providers regard and uphold these rights:

1. *Patients have the right* to understand and use these rights. If for any reason patients do not understand the rights or require assistance, Davis Vision's staff will provide assistance. Patients, including the hearing and speech impaired, have the right to receive communications in a language and manner that is understood by the patient.

2. *Patients have the right* to receive treatment without discrimination as to race, color, religion, sex, age, national origin, disability, sexual orientation or source of payment.

3. *Patients have the right* to receive materials that clearly explain the scope of covered benefits, such as information regarding accessing covered benefits, including

requirements for prior authorization and accessing emergency or out-of-area services; cost-sharing features under the benefits plan and coverage exclusions. Patients are provided with a mechanism to access a directory of participating providers.

4. *Patients have the right* to expect continuity of care and to know in advance what appointment times and services are available in which locations.

5. *Patients have the right* to choose all plan services and options. When full service benefits are chosen, the provider agrees to accept the plan fees as payment in full. Where co-payments are applicable, patients have the right to an explanation of all such charges. Patients have the right to choose non-plan materials with the understanding that they are responsible for all applicable charges.

6. *Patients have the right* to be shown the Davis Vision Plan Collection and choose a frame from the Tower Collection (where applicable).

7. *Patients (and their families when appropriate) have the right* to know all options, therapies, treatments and services available to them regardless of any restrictions imposed by the vision care plan. Practitioners should not be deterred or constrained from presenting these options to the patient. The right entitles the patient access to information on services whose scope or frequency may exceed that which is allowed under the plan. Patients shall be informed of all professional fees prior to the provision of such services.

8. *Patients have the right* to receive considerate and respectful care in a clean and safe environment.

9. *Patients have the right* to know the name, position, and function of any office staff involved in care, and may refuse their treatment, examination or observation.

10. *Patients have the right* to know the names, qualifications and licenses of all providers involved with their care. If an optometrist is involved, they have the right to know whether the provider is certified to use diagnostic pharmaceutical agents and/or therapeutic pharmaceutical agents. If an ophthalmologist is providing care, they have the right to know whether the provider is board certified.

11. *Patients have the right* to receive complete information about their diagnosis, treatment and prognosis. *Patients have the right* to receive all the information needed to give informed consent for proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment. Patients are expected to provide all necessary information to providers to facilitate effective treatment. Patients are responsible for providing, to the best of their knowledge, accurate and complete information about their complaints, medical and family history, eye and vision history and any other pertinent information.

12. *Patients have the right* to refuse treatment and be told what effect this may have on their health.

13. *Patients have the right* to privacy while in the office and confidentiality of information and records regarding their care. Patients have the right that safeguards be adopted to protect their privacy and the confidentiality of all patient data gathered by Davis Vision participating providers. The release of protected information will be provided only to authorized agents and appropriate regulatory authorities.

14. *Patients have the right* to review, comment upon and request correction of health information on their medical record and obtain a copy of the medical record, for which the office may charge a reasonable fee. Patients cannot be denied a copy solely because they cannot afford to pay. The right allows patients to review, comment upon and request correction of health information on their medical record.

15. *Patients have the right* to receive the Davis Vision Privacy Practices Notice describing how their medical information may be used and disclosed and how they may gain access to this information as dictated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

16. *Patients have the right* to receive, without charge, a copy of their eyeglass prescription. Patients wearing contact lenses have the right to receive a copy of their contact lens prescription only after the lens fit has been confirmed as stated in the *Fairness to Contact Lens Consumers Act*. The prescription may contain an expiration date.

17. *Patients have the right* to receive an itemized bill and an explanation of all direct charges.

18. *Patients have the right* to be satisfied with the care and treatment provided. Patients have the right to voice their grievances, objections and dissatisfaction regarding the care and/or the cost of treatment of care received without the fear of reprisal. Patients have the right to appeal decisions initially unfavorable to their position. Patients have the right to a system that provides for the receipt and resolution of complaints and grievances in a timely manner.

19. *Patients have the right* to refuse to take part in any research or investigational studies.

20. *Patients in the Commonwealth of Virginia have the right* to obtain information on types of provider payment arrangements used to compensate providers for health care services rendered to enrollees.

E. PATIENT RESPONSIBILITIES

All patients are expected to provide information requested by practitioners providing their care. Patients will be informed of their responsibilities as described under Patients Rights Policy.

Patients are responsible for providing, to the best of their knowledge, accurate and complete information regarding the following:

- Present complaints.
- Medical history and any other significant events, including surgical history.
- Eye and vision history, social and family history.
- Current medications.
- Allergies and reactions.
- Any other pertinent information.

Additionally:

- Patients are responsible for reporting when they lack a clear understanding of a proposed course of action and what may be expected of them.
- Patients are responsible for following treatment recommendations, including using prescribed medications or treatments and reporting any factors that may prevent them from doing so.
- Patients are responsible for respecting the rights of others, including, but not limited to, other patients, staff and providers.
- Patients are responsible for assuring that the financial obligations associated with their care, including co-payments and fees for non-covered services, are met in a timely manner.
- Patients are responsible for notifying providers at the time an appointment is made that they are covered by a Davis Vision Plan.
- Patients are responsible for notifying providers at least 24 hours in advance when canceling any appointment.
- Patients are responsible to use the benefit in an honest manner.
- Patients should be aware that providers who care for them are not employees of Davis Vision and that Davis Vision does not control them.
- Patients are permitted to question providers about all treatment options and the provider's compensation arrangement with Davis Vision.
- Patients are responsible to ensure that their provider has received the proper authorization for services.
- Patients are responsible to report any concerns to Davis Vision at 1-800-584-1487.

SECTION III
CONTACTING DAVIS VISION

A. DAVIS VISION'S WEB SITE, www.DavisVision.com

As a participating provider in the Davis Vision network, you have instant access to complete information about patient eligibility and benefits, order and claim status, recent shipments and forms for your practice. You can also authorize, submit and track orders. If you have not yet created a login password, please call 1-800-77DAVIS (1-800-773-2847) and select option 3.

When you access the Provider Portal, the Home page displays a summary of your Practice Account Status including recent shipping history, work in progress and existing authorizations. It also displays links to important information such as repair/replacement policies, prior approval/medically necessary services request form, formularies, clinical practice guidelines, an electronic copy of the Provider Manual, etc. It also contains links to current and previously published Provider Newsletters.

Listed below are some of the main functions you can perform via the Provider Portal:

1. **Verify Member Eligibility**
   - From the Home page, enter the patient's ID# in the Member Accounts section.
     Result: Member Account page displays *Get Authorization* if member is currently eligible for services or *Not Eligible Until xx/xx/xxxx*.

2. **View Benefit Plans**
   - From the Member Account page, scroll down to *Member Forms*. For the Vision Plan Benefit Description, click on *View Form*.
     Result: Vision Care Plan Benefit Description displays.

3. **View Benefit Alerts**
   - New and updated benefits may be viewed by clicking on *View Benefit Alerts*.
     Result: All available Benefit Alerts for the timeframe indicated will display. Select the Alert you wish to view. (After one month, alerts are archived.)

4. **View or Print Service Record Form**
   - From the Member Account page, click on the patient's open authorization.
     Result: Authorization Detail page displays.
   - Click on *View Service Record Form*.
     Result: Service Record Form displays.

5. **Obtain An Authorization**
   - From the Member Account page, click *Get Authorization*.

Result: Get Authorization page displays current services for which the member is eligible.

- Select the type of authorization desired (exam & materials, exam only, materials only) and click *Get Authorization*.
  Result: Authorization Detail page displays authorization number, issue date, expiration date, applicable copayment, and the services authorized.

6. **Enter an Order**
   - From Authorization page, click *Enter Claim/Order*
     Result: Services Provided page displays.
   - Select the services you performed and click *Submit*.
     Result: Order is submitted.

7. **Track an Order**
   - From Order Tracking page, enter appropriate search parameters and click *Search*.
     Result: Orders matching search parameters are displayed.

8. **Place an Excel Advantage Order**
   - From the Home page, select the order type (frames, single vision lenses, contact lenses) and click Order Now.
     Result: Excel Advantage Order Entry page displays.
   - Select the Collection, Style, Color, Temple Length and Quantity. Click View Item Summary.
     Result: Order Summary page displays and allows you to either edit the item or add to your shopping cart.

B. INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

Providers may contact Davis Vision **24 hours a day** by calling the IVR at **1-800-77DAVIS (1-800-773-2847)**. You will be prompted to enter your provider number to gain access to the following capabilities:

- Verify member eligibility
- Obtain an authorization
- Obtain benefit information
- Determine copayments
- Request Service Record Forms
- Process claims for "Examination Only" services
- Place an order
- Track an order
- Obtain status of a claim
- Speak with a Member Service Representative

Member Service Representatives are available Monday through Friday 8:00 AM to 11:00 PM ET, Saturday 9:00 AM to 4:00 PM ET and Sunday 12:00 PM to 4:00 PM ET. Messages may be left after hours and will be returned the next business day.

C. CONTACT INFORMATION

In our ongoing efforts to provide the most prompt, correct information, we ask that you be prepared with your Davis Vision provider ID number when calling us.

Provider Web Site	To access our Web site, please go to: **www.davisvision.com** and enter your provider # and password. If you have not yet created a login password, please call: 1-800-77DAVIS (1-800-773-2847) and select option 3	• Verify eligibility/benefits • Request authorization for services • Place an order • Place an Excel Advantage order • Check order status • Check claim status • Review recent shipments • Review orders in progress • View formularies • View updates to benefit info • Download forms • Access important links: o Repair & Replacement Policy o Warranty Information o Clinical Practice Guidelines o Provider Bill of Rights o Patient's Bill of Rights o Provider Manual o Provider Newsletters
Provider IVR (Interactive Voice Response) System (Available 24 hours a day)	To access our IVR system, please call: **1-800-77DAVIS** **(1-800-773-2847)** and enter your provider #	• Verify eligibility/benefits • Request authorization for services • Place an order • Place an Excel Advantage order • Check order status • Check claim status • Request forms • Process claims for "examination only" services • Speak with a Member Service Representative
Provider Relations	To contact a Provider Relations Associate, please call: **1-800-933-9371**	• Place an order • Verify group discount information (for members with Affinity Discount plan)

Provider Recruiting Monday – Friday 8 a.m. – 6 p.m. (EST)	To contact a Provider Recruiting Associate, please call: **1-800-584-3140** or fax: **1-888-553-2847** or write: 159 Express Street P.O. Box 9104 Plainview, NY 11803	• Inquire about becoming a provider • Verify credentialing application status • Update address and office information
Utilization Review Monday – Friday 9 a.m. – 5 p.m. (EST)	To contact a Utilization Review Associate, please call: **1-800-328-4728, ext. 6811** or fax: **1-800-584-2329** or write: 159 Express Street P.O. Box 9104 Plainview, NY 11803	• Request prior approval for services outside regular eligibility cycle • Request prior approval for medically necessary contact lenses • Request Verification (Texas only)
Excel Advantage	To contact a Professional Field Consultant about the Excel Advantage Program, please email: **pfcdept@davisvision.com** or fax your request to: **1-888-281-4974**	• Place an Excel Advantage order
Excel Advantage (Billing)	To contact a Finance Associate about Excel Advantage billing, please call: **1-800-328-4728, ext. 6748** or write: 175 Express Street P.O. Box 9104 (U.S. Mail) Plainview, NY 11803	• Request Excel Advantage billing information.

Claims	To contact a Claims Associate, please call: **1-800-77DAVIS** **(1-800-773-2847)** or write: Vision Care Claims Unit P.O. Box 1501 (U.S. Mail) Latham, NY 12110	• Request expired voucher information • Request billing information • Request status of claim payment
Order Entry	To contact Order Entry, please call: **1-800-888-4321**	• Obtain warranty information • Track jobs • Place "examination only" order • Place other order • Advise Davis Vision of shipment received in error
Collections	To contact Collections, please call: **1-800-783-8031** or email: providerbilling@davisvision.com	• Inquire about provider statements • Inquire about negative balances • Make payment for negative balance • Obtain explanation of "balance forward"
Quality Assurance	To contact a Quality Assurance Associate, please call: **1-888-343-3470** or write: 711 Troy Schenectady Road Latham, New York 12110	• Submit an appeal • Submit a grievance on behalf of a member
Web Site Assistance	To obtain assistance with the Davis Vision website, please call: **1-800-943-5738**	

SECTION IV
THE VISION CARE BENEFIT

NOTE: *Davis Vision provides routine vision and eye care services to more than 55 million beneficiaries nationally through managed care organizations (HMOs and PPOs), insurance companies, governmental groups, corporations, union trust funds and third party administrators. Each group's benefit design is different and it is incumbent upon you to verify the type of benefits for which your patient is eligible.*

For detailed benefit information, please call Davis Vision at **(800-77-DAVIS)** for Provider Services or our Interactive Voice Response System, or visit our web site at **www.davisvision.com.**

A. MANAGED CARE PLANS

Davis Vision contracts with Managed Care Plans to provide basic routine vision care services for their members. Some managed care plans (such as HMOs) may require that patients first consult their Primary Care Physician (PCP) to determine whether the patient needs specialty care such as ophthalmologic services. If so, the PCP may need to obtain an authorization for the patient to seek care from a specialist.

When rendering or recommending diagnostic or therapeutic medical eye care services not included in the patient's routine eye care benefit administered by Davis Vision, participating providers must follow the protocol of the patient's medical plan, including coordination of care with the PCP when appropriate.

B. PRIMARY ROUTINE VISION CARE PRODUCTS

- **Affinity Discount Plans** offer significant discounts off professional services (e.g., eye examinations) and eyewear through a uniform schedule of maximum charges. Under Affinity Discount plans, providers utilize their own inventory, materials and laboratory services.

- **Hybrid Plans** offer funded coverage for professional services coupled with the Affinity Discount schedule on eyewear.

- **Comprehensive Vision Plans** cover eye examinations and eyewear and are typically categorized by one of three levels: Fashion, Designer, and Premier. Each of our plans are tailored to meet our clients' requests for benefit frequency, copayments and allowance levels.

  Generally, patients are limited to one pair of eyeglasses (or contact lenses in lieu of eyeglasses) per benefit cycle. Some plans may allow two pairs of eyeglasses; Davis Vision requires a 20% courtesy discounts that our participating providers extend to

patients who place an order for a second pair that is not covered by a patient's funded benefit.

All plan-supplied eyeglasses include an unconditional breakage warranty for one full year. Coverage for lost eyewear is not provided.

- **Occupational Plans** cover industrial safety and video display terminal (VDT)/computer eyewear. These programs can be offered on a stand-alone basis or in conjunction with the routine eye care benefit.

- **Eye Health & Wellness Program®** provides clients and members access to our vision library and Eye Health & Wellness Web Site. Copies of Sightwire, a newsletter regarding eye care topics released six times a year, are available free of charge for clients to share with employees.

C. COVERED ITEMS

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered and optional items. The basic vision care benefit consists of a routine eye examination (including dilation) and eyeglasses (lenses and frame) or contact lenses at a frequency chosen by the patient's group (typically once every 12 or 24 months). In addition, many groups make the benefit available annually for children below a specified age.

In most cases, the basic materials benefit includes:

- Almost every lens type
- All lens prescriptions
- Either plastic or glass lenses (for single vision, bifocal or trifocal)
- Oversized lenses
- All types of bifocals; however, the 28 or 35 mm. flat-top should be regarded as the standard bifocal whenever it can satisfy the patient's visual needs.
- Aphakic lenses (single vision and bifocal)
- Solid and gradient tinting of plastic lenses
- Contact lenses (in lieu of eyeglasses) (Formulary contained in Appendix)
- Most plans cover non-cosmetic contact lenses for conditions such as Keratoconus.

Most groups limit coverage to one (1) pair of Plan eyeglasses (lenses and frame) or one pair of contact lenses. Some groups allow two (2) pairs of eyeglasses (Distance Vision and Near Vision) in lieu of bifocals. Others allow multiple pairs without restriction.

D. NON-COVERED ITEMS

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered and optional items. Examples of services and materials which may not be included in the patient's Plan are:

- Medical treatment of eye disease or injury
- Visual therapy
- Special lens designs or coatings other than those described in the benefit plan
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Services not performed by licensed personnel
- Low vision aids and services
- Prosthetic devices and services
- Materials and services not specified in the benefit design
- Contact lenses and eyeglasses in the same benefit period
- Insurance of contact lenses

Providers must inform patients of all associated costs of non-covered items.

BEST PRACTICE

Complete the Davis Vision supplied Service Record Form, and obtain the patient's signature acknowledging he/she has been informed of all additional items and costs and agreeing to pay for such items.

E. OPTIONAL ITEMS

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered and optional items. Listed below are examples of services and materials which may be included in a group's benefit plan (with or without copayments):

- Premier Frames
- Occupational Vision Program
- Additional Pairs of Spectacles
- Contact Lenses
- Progressive Addition Lenses (Standard and Premium) (Plan Formularies contained in Appendix)
- Corning™ Photochromic (PGX) Lenses
- Anti-Reflective Coating (ARC) (Formulary contained in Appendix)
- Hi-Index Lenses
- Polarized Lenses
- Polycarbonate Lenses (included for dependent children and monocular patients)
- Ultraviolet Coating
- Blended Segment Lenses
- Plastic Photosensitive Lenses
- Mirror Coated Lenses

BEST PRACTICE

When a patient disregards your recommendation for polycarbonate lenses for visual safety and protection (due to activities that expose him/her to the risk of injury from flying objects or physical impact), be sure to use the "*Duty to Warn / Patient Rejection and Waiver Form*" found on the Provider Portal at www.davisvision.com (and in the Appendix of this Manual). Obtain your patient's signature acknowledging that he/she understands your recommendation and has decided to utilize an alternative material.

F. NON-PLAN ALLOWANCES

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered and optional items. Some benefit plans include a non-plan allowance to be used toward a patient's selection of non-plan frames and/or contact lenses. The amount of the non-plan allowance is subtracted from your usual and customary fee. Typically, the patient is responsible for the remaining balance less any courtesy discount.

When a patient selects a non-plan frame, the provider will receive one-half of the standard dispensing fees.

G. RESTRICTIONS RELATED TO SPLITTING BENEFITS

Some groups require members to obtain their eye examination and materials at the same visit (at the same location). Those members must order their eye wear during their visit for an eye examination. If they order their eye wear at a later date, the materials will not be covered. This is referred to as "splitting benefits," and individual group restrictions are clearly indicated on the patient's detailed Vision Plan Benefit Description and on the member's Service Record Form.

H. OCCUPATIONAL VISION BENEFIT (OPTIONAL COVERAGE)

NOTE: *When available, the Occupational Vision Benefit is restricted to the employee* ***only****.*

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered and optional items. It is your responsibility to verify eligibility and obtain an authorization, if necessary. Other restrictions may include limiting eligibility to:

- All employees
- Particular job functions
- Specific employees

Occupational Vision Benefits are available only at Davis Vision provider offices and materials must be ordered through the provider's assigned Davis Vision regional laboratory.

Safety glasses meet ANSI Z.87 requirements. If used, glass lenses will be chemically hardened in accordance with FDA 21 CFR part 801.

Three types of Occupational Benefits are offered:

1. **Standard Occupational Safety Benefit**

Patients with the standard Occupational Safety Benefit are entitled to a routine eye examination and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the patient. Patients may choose a standard frame and a safety frame. Safety lens tinting is limited to gray or pink with a maximum density of 30% and may be ordered **only** in plastic. The patient must place the order for the two sets of eyeglasses (dress pair and occupational pair) at the same time. Providers must submit orders to their assigned Davis Vision regional laboratory.

2. **Stand-Alone Occupational Benefit**

Patients with a Stand-Alone Occupational Benefit are entitled to a routine eye examination and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the patient. Patients may choose only a safety frame. Safety lens tinting is limited to gray or pink with a maximum density of 30% and may be ordered **only** in plastic. Providers must submit orders to their assigned Davis Vision regional laboratory.

3. **Video Display Terminal (VDT)**

Patients with a Video Display Terminal (VDT) Benefit are entitled to a routine eye examination including color vision testing, stereopsis and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the patient. VDT eyeglasses are prescribed for the patient specifically for VDT use. The VDT benefit is available in conjunction with a standard vision benefit (i.e., "dress" pair). To be eligible for the VDT eyeglass benefit, the patient's standard eyeglass prescription and the VDT prescription must differ in the following ways:

1. Prescription difference of at least 0.50 diopters
2. Different lens types, e.g. trifocal vs. bifocals
3. Segment height difference of at least 5mm

SECTION V
FEES, ELIGIBILITY & AUTHORIZATION

A. FEES

1. Examination Fees

Examination fees are determined by geographic location and level of service to be provided to beneficiaries and client groups. The examination fees are indicated on the patient's detailed Vision Plan Benefit Description which is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Fee information is also included on the patient's Service Record Form.

2. Dispensing Fees

Dispensing fees are determined based on geographic location and client group specifications. The dispensing fees are indicated on the patient's detailed Vision Plan Benefit Description which is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com).

Providers are paid 100% of the dispensing fee if the patient selects a Plan frame or has new lenses inserted into the patient's own frame. Providers are paid 50% of the dispensing fee if the patient selects a non-Plan frame.

3. Surfees

Surfees are an additional dispensing fee that may be paid to the provider when patients select upgrades or additional options. When applicable, such fees will be specified on the Service Record Form for each specific group.

4. Contact Lens Fitting Fees

Contact lens fitting fees are determined by the specific plan. The contact lens fitting fee is indicated on the patient's detailed Vision Plan Benefit Description which is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Fitting fee information is also included on the patient's Service Record Form.

5. Patient Copayments

Some plans require members to pay a copayment for specific services at the time of ordering. The copayment amounts are indicated on the patient's detailed Vision Plan Benefit Description which is available on the *Member Account* page of the Davis Vision

web site (www.davisvision.com). Copayment information is also included on the patient's Service Record Form.

It is your responsibility to collect all copayments at the time of ordering – not at the time of dispensing.

BEST PRACTICE

Record all plan copayments collected from your patient on the Davis Vision supplied Service Record Form, and obtain the patient's signature acknowledging he/she has been informed of all additional items and costs and agreeing to pay for such items.

6. Courtesy Discount

The Plan requires that participating providers extend members a courtesy discount when purchasing items not covered in the basic benefit. The minimum courtesy discount is 20% off the provider's usual and customary fees (or 10% off for disposable contact lenses). Courtesy discounts apply only to prescription eye wear.

7. Receipts

Patients are entitled to receipts for copayments and the purchase of additional items. They may be needed for tax reports, reimbursement requirements from other health coverage or personal records. Do not issue a receipt for the cost of services or materials for which the member has no personal financial responsibility (items included by their vision benefit).

8. Sales Tax

Depending on the state in which your practice is located, sales tax may be collected on:

- Eyewear that is dispensed / made by a provider
- Lens option copayments for retail locations
- Lens option copayments made by Davis Vision laboratory

9. Negative Balance

A negative balance is applied when a provider's office has collected copayments which exceed the amount Davis Vision is contracted to pay the office. If the office accumulates a positive balance the following month, that amount will be applied to the negative balance. If the provider has a negative balance two consecutive months, Davis Vision will send the provider a bill for the negative balance.

B. ELIGIBILITY AND AUTHORIZATION

*NOTE: Patients who have an Affinity Discount plan will not require an authorization, and therefore will not typically have an enrollment record within the Davis Vision administrative system. However, the group's discount plan information will be sent to you by Davis Vision. In the event this information is not on file, you may call **1-800-933-9371** to speak directly with a Provider Service Representative, who will help you verify the group's discount information.*

Davis Vision patients will be directed to call your office to schedule an appointment. At that time, you should verify the patient's current eligibility and request an authorization for the services being scheduled. After obtaining the patient's name, member identification number and the patient's birth date, follow one of the processes described below:

1. Via Web Site, www.DavisVision.com

Providers may access the Web site **24 hours a day**. To access your patient's account on the Web site, from the Home page, enter the patient's ID# in the Member Accounts section. The Member Account page will display either "Get Authorization" if the member is currently eligible for services or "Not Eligible Until xx/xx/xxxx."

If your patient is currently eligible for services, you may obtain an authorization. The system will display an authorization number. If your patient is not currently eligible for services, you will be notified of the reason (e.g., benefits already received within specified benefit cycle), which can be communicated to the patient. This process pertains only to the funded, Comprehensive and Hybrid vision benefits.

Some plans allow patients to obtain additional services between cycles. Please refer to the patient's detailed Benefit Description for additional information.

2. Via Interactive Voice Response System (IVR), 1-800-77DAVIS

Providers may access the IVR **24 hours a day**. When accessing the IVR, you will be prompted to enter your provider number. The IVR will then prompt you to enter the member's ID#. Once the member's identification has been verified, the IVR will enable you to obtain information about eligibility or to request an authorization for services.

3. Prior Approval Process

Some plans allow patients to obtain additional services between cycles with prior approval. In these cases, Davis Vision has specific criteria against which the patient's request is evaluated. It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination.

Complete the Prior Approval/Medically Necessary Services Request Form (on the Provider Portal under Important Links and contained in the Appendix to this Manual) and fax it to Davis Vision Utilization Review Department at **1-800-584-2329**. A Utilization Review Associate will review your request and will fax the determination back to you. Typically, Prior Approval requests are completed and faxed back to the provider within three (3) business days (unless a more stringent timeframe is imposed by State guidelines).

4. Service Record/Voucher Program Eligibility

Network providers are not responsible for determining eligibility in a Voucher Program. Only eligible persons receive vision benefit service record/vouchers Plan services should be provided only to the person name on the service record/voucher.

The benefit coverage for each member is indicated at the top of the service record/voucher in the Benefit Key section. The coverage varies between groups and sometimes within a group depending on patient type (member, spouse, child, retiree.)

Provider offices are responsible for verifying that service record/vouchers have not expired. The expiration date of the service record/voucher is generally indicated at the top of the service record/voucher. Members whose service record/voucher has expired are responsible to obtain a current one.

The major characteristics of the service record/voucher program are:

1. Only one service code is required on the service record/voucher claim form for each pair of eyeglasses provided by the Plan.

2. If allowed, members may receive the network (plan-provided) eye examination and still select non-plan frames or contact lenses. The patient pays charges for non-plan items, less any Plan allowance. Specific Plan allowances are found on group-specific service record/vouchers in the Benefit Key Section.

3. Fees and benefit levels may vary somewhat among groups due to contract periods, customary fee levels and coverage in the region. The Benefit Key at the top of all service record/vouchers contains the most current coverage and benefit information. It is specific to the patient whose name appears on the service record/voucher.

5. Concurrent Review Process

Because Davis Vision administers routine eye care services, it is unusual for a member to require continuing services. For these rare instances, Davis Vision may conduct concurrent review during the course of ongoing treatment.

Complete the Prior Approval/Medically Necessary Services Request Form (on the Provider Portal under Important Links and contained in the Appendix to this Manual) and fax it to Davis Vision Utilization Review Department at **1-800-584-2329**. A Utilization Review Associate will review your request and will fax the determination back to you. Typically, Davis Vision makes Concurrent Review determinations and provides notice of determination to the member, the member's designee and the health care provider by telephone and in writing within one (1) business day of receipt of necessary information.

If the member is currently receiving a requested service and Davis Vision denies the request for continued services, Davis Vision will mail the written notice of denial to the member at least ten (10) days prior to the effective date of the denial of authorization for continued services.

SECTION VI
ORDER ENTRY AND CLAIM SUBMISSION

A. OVERVIEW

All orders and/or claims must be telephoned, mailed or e-mailed to Davis Vision. The vast majority of claims received by Davis Vision via Web site (www.davisvision.com), IVR and phone (**1-800-77DAVIS**) are processed immediately upon receipt. Claims received via other methods such as fax and mailed paper claims are typically processed in the order they are received. This means that the oldest claims on hand at any given time are processed prior to more newly received claims. **Exceptions to this process include claims for states and clients with more stringent processing timeframes.**

B. ORDER ENTRY

1. Via www.davisvision.com

Davis Vision's **paperless program** enables order entry and claims processing to occur simultaneously when using the Web site.

Participating providers confirm member eligibility and benefit entitlement of the patient prior to delivering services. Once services have been rendered and the eyeglass/lens order needs to be submitted, the provider uses the Authorization Number to generate the order.

On orders for "Lenses Only", you **must** indicate that the patient's frame is to follow.

2. Via IVR System 1-800-77DAVIS

Orders may be processed through the IVR system by calling **1-800-77DAVIS (1-800-773-2847)**. The IVR will prompt you through the appropriate steps.

On orders for "Lenses Only", you **must** indicate that the patient's frame is to follow.

C. PROVIDER-SUPPLIED FRAMES OR PATIENTS' OWN FRAMES

When mailing a patient's own frame or a provider-supplied frame, please complete the Ship Back Form (see Appendix) with the invoice number generated when the lens order was placed. This will facilitate matching your order with the patient's frame when it is received. Be certain to enclose one copy of the Ship Back Form with the Frame. Include the following information:

- Member's name and identification number

- Invoice number that was generated when the order was placed
- Special instructions or explanation

Davis Vision will supply doctors with pre-paid, pre-printed shipping labels. Providers should send all returns to the assigned Davis Vision regional laboratory (laboratory addresses and telephone numbers are on the Ship Back Form).

To avoid unnecessary delays, forms should be complete and legible. Ship Back Labels have tracking numbers, which allow Davis Vision to trace all returns. Please retain a copy of the label for your records.

BEST PRACTICE

Mail patient-supplied and/or provider-supplied frames to Davis Vision as quickly as possible to avoid delays which negatively impact patient satisfaction.

D. CLAIM SUBMISSION

1. Clean Claim Definition

A clean in-network claim is defined as having the following data elements:

- a valid authorization number, referencing member and patient information
- a valid Davis Vision-assigned provider number
- the date of service
- the primary diagnosis code
- an indication as to whether or not dilation was performed
- description of services provided (examination, materials, etc.)
- all necessary prescription eyewear order information (if applicable)

A clean out-of-network claim is defined as having the following data elements:

- insured's valid ID number
- insured's name
- insured's insurance plan or program name
- patient name, birth date and sex
- patient's relationship to insured
- a valid Davis Vision provider number, if the benefit is assigned
- diagnosis/condition (including diagnosis code)
- procedures/services or supplies including days or units
- date of service
- itemized charges and total charge
- signature of the policyholder
- signature of physician or supplier

If a claim is received with the minimum required data elements as outlined above, the inclusion of additional claim elements cannot render a claim deficient or "unclean."

Should there be a change in any of the required data elements, Davis Vision will provide at least 60 days notice to all providers of any such change.

2. Unclean Claims

Upon receipt of a claim that does not contain all of the previously-defined clean claim data elements, Davis Vision will suspend the claim and request further information from the provider and/or member. Upon receipt of the requested information, the suspended claim is processed/paid. If no response is received within 60 calendar days from date of request, the claim is automatically denied because of failure to submit all required clean claim data elements.

3. Request for Additional Information from Participating Provider

If additional information is needed from a participating provider related to a clean claim, Davis Vision will send a written request within 30 days from date of receipt of claim detailing the specific clinical information required. The request will relate only to such information as Davis Vision can demonstrate is specific to the claim or the claim's related episode of care. Davis Vision will process the claim on or before the 15th day from date of receipt of the additional information. If no additional information was received, Davis Vision will process the claim based on the available information.

Davis Vision will not make more than one request for additional information as described above in connection with a claim.

4. Request for Additional Information from Other Sources

If additional information is needed from someone other than the participating provider who submitted the clean claim, Davis Vision will notify the participating provider within 30 days from date of receipt of claim of the name of the person from whom additional information is being requested. Davis Vision will process the claim on or before the 15th day from date of receipt of the additional information. If no additional information was received, Davis Vision will process the claim based on the available information.

5. In-Network Claims Processing

i. Via www.davisvision.com

Davis Vision's **paperless program** enables order entry and claims processing to occur simultaneously when using the Web site.

Participating providers confirm member eligibility and benefit entitlement of the patient prior to delivering services. During the authorization process, the provider enters the patient's ID number, name, procedure/service/supply and days/units. Upon successful entry of these elements, an Authorization Number (Eligibility Confirmation Number) is generated.

Once services have been rendered and the eyeglass/lens order needs to be submitted, the provider uses the Authorization Number to generate the claim/order. This significantly abbreviates the claim submission process.

ii. Via IVR System 1-800-77DAVIS

Claims for **examination only** services (no materials) may be processed through the IVR system by calling **1-800-77DAVIS (1-800-773-2847)**. The IVR will prompt you through the appropriate steps.

iii. Via Fax 1-800-933-9375

Providers who do not have Internet access may fax claims to 1-800-933-9375 (1-800-93-EYES-5).

Providers submitting Vouchers may not send them via fax. Vouchers must be submitted via mail.

iv. Via Mail

Providers who do not have Internet access and submitting claims or Vouchers may mail them to:

Vision Care Plan Processing Unit
P.O. Box 1525
Latham, New York 12110

A copy of the Voucher/Claim Form is included in the Appendix. You should submit the Voucher/Claim Form after the examination has been provided and the eyeglasses have been ordered. No other correspondence should be submitted with

the service record/vouchers. Please **do not mail** laboratory orders with the service record/vouchers.

It is essential that the form be filled out accurately and completely as described below:

- **Header:** The voucher number, member ID, patient name, date of birth, relationship to member, voucher issue date and expiration date are auto-generated when issued by the group. Vouchers are not transferrable to other family members and cannot be changed.. Be sure that the patient name on the voucher matches your patient's name. You are responsible for ensuring that the voucher has not expired. (If your patient has an expired voucher, instruct the member to request an extension by calling Member Services at 1-800-999-5431.)

  Benefits for which the member are eligible and the applicable copayments or non-plan allowances are clearly indicated. Special coverage and limitations are noted in the fields designated as *OTHER* and *PLEASE NOTE*.

- **Part 1:** In this section, please place a check mark next to the services provided and enter the amount paid rounded to the nearest dollar.

- **Part 2:** In this section, please enter information related to the Examiner and Dispenser (if different from the Examiner). Be sure to have the Examiner and Dispenser sign on the *Signature* line.

- **Part 3:** Please have the member or eligible dependent (or guardian for dependent children) sign and date the voucher before it is submitted for payment.

- **For Panel Doctors and Claims Processing Unit Use Only Section:** Please enter the provider's name and the provider number assigned by Davis Vision to you at the location where services were rendered. Enter the appropriate service code(s) from the Provider Procedure Codes included in the Appendix.
  - *Example:* Use Code **002** for Exam, Plan Single Vision Lenses, Plan Frame
  - *Example:* Use Code **N05** for Plan Bifocal Lenses, Plan Frame

- For option codes, enter the appropriate code(s) from the Option Codes included in the Appendix.
  - *Example:* Use Code **002-P** for Exam, Plan SV Lenses, Plan Frame, Photogrey (PGX)
  - *Example:* Use Code **005-A** for Exam, Plan BV Lenses Plan Frame, Polycarbonate Lenses

- If an occupational examination is provided (in conjunction with standard vision care benefit), and no need exists for occupational eyeglasses, enter the appropriate service code with prefix OE.
    - *Example:* Use Code OE-001 for Occupational Exam only.
    - *Example*: Use Code OE-005 for Occupational Exam, Plan BV Lenses, Plan Frame

- If an occupational examination is provided (in conjunction with standard vision care benefit) and reveals the need for occupational eyeglasses, enter two service codes.
    - Conventional eyeglasses: enter appropriate service code with OG prefix (e.g. OG-002).
    - Occupational eyeglasses: enter appropriate service code for lenses and frames with no exam (e.g. N05).
    - Typical billing would be OG-005, N02 or OG-002, N02.

- Also enter the date of service. The provider who performed the examination must sign the form.

6. Ancillary Medical Claims

A limited number of clients allow non-routine medical eye services to be billed to Davis Vision for payment. Davis Vision does not pre-authorize these services. The provider must submit all ancillary medical claims using a HCFA 1550 form to:

Vision Care Plan Processing Unit
P.O. Box 1525
Latham, New York 12110
Fax: 1-800-993-9375

SECTION VII
DOCTOR-PATIENT RELATIONS

A. NON-DISCRIMINATION

There should be no discrimination in making appointments. Plan participants should have the same hours available to them as private patients. Additionally, practitioners must not differentiate or discriminate as to the quality of service(s) delivered to patients because of a patient's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status, need for services, or method of payment.

B. CULTURAL SENSITIVITY

As established by your Participating Provider Agreement, you must provide covered services in a culturally competent manner to all Davis Vision patients, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

C. OPEN CLINICAL DIALOGUE

Davis Vision does not discourage practitioners from engaging in open clinical dialogue with their patients including, but not limited to, the discussion of all possible and applicable treatments, whether those treatments are covered services under the patient's benefit plan. Providers are not restricted from filing a complaint or making a report to an appropriate governmental body regarding policies and practices the provider believes may negatively impact the quality of or access to patient care, nor does Davis Vision prohibit or restrict a provider from advocating on behalf of the member for approval or coverage of a course of treatment.

D. BENEFIT ABUSE

If you suspect that a patient is misusing a plan benefit, please report your suspicions to Davis Vision at **1-800-77DAVIS**.

E. COORDINATION OF BENEFITS

In general, Davis Vision does not coordinate benefits with other insurance companies for in-network services. Since there are a few exceptions, please contact Member Services (through the IVR) at **1-800-77DAVIS** if the patient indicates he/she wants to coordinate benefits. If the patient is using his/her out-of-network benefits and has already submitted to the primary carrier, please ask the patient to attach the statement or explanation of benefits to the out-of-network claim form at time of submission to Davis Vision.

F. SCHEDULING AN APPOINTMENT

Routine appointments should be made available for members within 7-10 calendar days of request. Appointments for urgent conditions should be made available within 24-48 hours of request.

Davis Vision's members will contact your office directly to schedule an appointment. At that time you should obtain the member's name, identification number, patient's name (if different from member), date of birth and relationship to the member. At that time you should verify the patient's current eligibility via www.davisvision.com or the IVR at 1-800-77DAVIS. If your patient is not currently eligible for services, you should inform him/her of the next date of eligibility.

BEST PRACTICE
Remind patients to notify your office if they are unable to keep an appointment.

Patients should be reminded to bring identification at the time of the examination. Providers are not obligated to provide non-emergent services for members who fail to produce proper identification or members who are not eligible for services.

G. OBTAINING AN AUTHORIZATION

During the scheduling process or before the patient's appointment, verify the patient's current eligibility for services and request an authorization for services via www.davisvision.com or the IVR at 1-800-77DAVIS. While confirming patient eligibility, obtain an authorization for services. Once an authorization is obtained, print the Service Record Form (from the authorization) containing details of covered and non-covered services/options and place it in the patient's file. At the time of the patient's appointment, you should have him/her sign the Service Record Form to confirm his/her understanding of covered and non-covered services/options.

BEST PRACTICE
If you have a problem obtaining an authorization, call Davis Vision at 1-800-77DAVIS.
DO NOT SERVICE THE MEMBER WITHOUT AN AUTHORIZATION.

1. Authorizations for Services Requiring Prior Approval

Some plans allow patients to obtain services/options with Davis Vision's prior approval (e.g. additional lenses between eligibility cycles if patient has a qualifying prescription change.) In these cases, Davis Vision has specific criteria against which the patient's request is evaluated. To arrange for prior approval:

i. Print the *Prior Approval/Medically Necessary Services Request Form* on the Provider Portal at www.davisvision.com.
ii. Complete all applicable fields. (It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination.)
iii. Fax the completed form to Utilization Review at **1-800-584-2329**.

A Utilization Review Associate will review the request, document the determination on the request form and fax the request form back to you. Typically, Prior Approval requests are completed and faxed back to the provider within three (3) business days (unless a more stringent timeframe is imposed by State guidelines.)

2. Authorizations for Medically Necessary Contact Lenses

Definition: *Medically Appropriate/Medically Necessary Services describes vision care service(s) or treatment(s) that a provider, exercising his/her prudent, clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease, or its symptoms and that is in accordance with the "Generally Accepted Standards of Medical Practice"; and is clinically appropriate in terms of type, frequency extent site and duration; and is considered effective for the patient's illness, injury or disease; and is not primarily for the convenience of the patient or the provider; and is not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the patient's illness, injury or disease.*

Some plans include enhanced coverage for medically necessary contact lenses. Contact Lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

When you identify a need for medically necessary contact lenses, please complete the *Prior Approval/Medically Necessary Services Request Form* and fax the form to Utilization Review at **1-800-584-2329**. It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination. Your request will be reviewed by a licensed clinician to determine medical necessity. Individuals that conduct clinical reviews are available to discuss review determinations with the attending physician or ordering provider. If the original reviewer is not available, another clinician is available within one business day.

BEST PRACTICE

When completing the *Prior Approval/Medically Necessary Services Request Form*, be sure to include **both** your Professional Fees and Material Fees. Do not include routine exam fees.

If your request for medically necessary contact lenses is approved, Davis Vision will fax the authorization to your office utilizing the Request Form. This faxed authorization is your confirmation. The reviewer will send a copy of the authorization to Claims for manual processing.

Based on clinical practice guidelines of the American Optometric Association (AOA), contact lenses may be determined to be medically necessary and appropriate in the treatment of the following nine (9) conditions:

Keratoconus

- Diagnosis confirmed by keratometric readings and observations, Placido disc or corneal topography
- Best correctable visual acuity with spectacles of 20/40 or less in either eye
- At least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses
- Intact corneal epithelium
- Absence of corneal hydrops

Aphakia

- Aphakia in one or both eyes of congenital, surgical or traumatic etiology without implantation of an intraocular lens
- No corneal or vitreous opacities along the visual axis
- Intact macula
- Best correctable acuity of 20/100 or better
- Intact corneal epithelium

Anisometropia

- ≥ 4.00 diopters difference in prescription (spherical equivalent) between right and left eyes
- Best correctable acuity of 20/40 or better in the better eye
- Intact corneal epithelium

Aniseikonia

- Unequal image size between right and left eye resulting in intermittent or constant diplopia, suppression or binocular rivalry, or less than 100° steropsis
- Intact corneal epithelium

Pathological Myopia

- Myopia >8.00 diopters in one or both eyes
- Intact corneal epithelium

Aniridia

- Aniridia of congenital, surgical or traumatic etiology in one or both eyes

- Intact corneal epithelium

Corneal Disorders

- Any condition of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes
- Corneal opacification
- Intact corneal epithelium

Post-Traumatic Disorders

- Any condition of traumatic etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes
- Corneal opacification
- Intact corneal epithelium

Irregular Astigmatism

- ≥ 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90°, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles
- At least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses

H. THE OFFICE VISIT

Patients with appointments should not routinely be made to wait longer than one (1) hour.

By contractual agreement, Davis Vision's providers must comply with standards of care based on the guidelines of the American Academy of Ophthalmology and the American Optometric Association.

The office visit must include patient history, examination, discussion of examination results, provision of prescription for corrective eyewear, and dispensing of appropriate eyewear.

BEST PRACTICE

Have the member sign the Service Record Form (available from the member's authorization on www.davisvision.com) and place the signed copy in their file at EVERY visit.

1. Patient History

Patients are responsible for providing, to the best of their knowledge, accurate and complete information regarding:

- Present complaints

- Medical history and any other significant events, including surgical history
- Eye and vision history, social and family history
- Current medications
- Allergies and reactions
- Any other pertinent information

2. Examination

A comprehensive ocular assessment to evaluate the physiologic function and anatomic structure of the eye must be performed for all patients. All eye examinations must meet all existing state regulations. The general eye assessment should include, but is not limited to, the following:

- Assessment of current acuity, distance and near, using the member's present corrective lenses, if applicable
- External ocular evaluation including slit lamp examination
- Internal ocular examination*
- Tonometry
- Refraction – objective and subjective**
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields

* *A Dilated Fundus Examination must be included whenever professionally indicated.*
***Davis Vision does not cover refraction-only examinations. The refraction (CPT 92015) is considered part of the eye examination per the Participating Provider Agreement.*

In addition to those procedures performed as part of the conventional eye examination, contact lens fitting should include:

- Measurement of corneal curvatures
- Slit lamp examination of cornea
- The use of trial lenses if necessary
- One-on-one, hands-on instruction for insertion and removal of contact lenses
- Written instructions, upon delivery, for insertion and removal of contact lenses at home
- Follow-up visits necessary to check lens fit and corneal integrity

3. Provision of Prescription for Corrective Eyewear

In accordance with the rules and regulations of the Federal Trade Commission, a written eyeglass prescription must be issued to the patient upon completion of the examination if an ophthalmic correction is recommended. Patients wearing contact lenses must be provided

with a written contact lens prescription immediately after a contact lens fitting is performed (Federal Trade Commission's *Fairness to Contact Lens Consumers Act*). The contact lens prescription may contain an expiration date according to specific state law, but not less than one (1) year after the issue date of the prescription.

4. Dispensing Corrective Eyewear

Dispensing must be performed by duly certified and licensed personnel (if required by state regulation) and includes the following services:

- Frame selection - all appropriate plan frames will be shown and advice offered
- Fitting measurements - frame size, seg heights, etc.
- Ordering from central laboratories
- Verification of eyeglasses from laboratory for accuracy
- Adjusting eyeglasses for proper fit
- Follow-up adjustments

i. Glass Lenses for Children Under the Age of 18

Davis Vision does **NOT** fabricate glass lenses for children under the age of 18. Providers are strongly encouraged to supply Polycarbonate Lenses, which are provided at no cost for children under the age of 18. When a patient disregards your recommendation for polycarbonate lenses for children under age 18, obtain the patient's signature on the "*Duty to Warn / Patient Rejection and Waiver Form*" found in the Appendix and on the Provider Portal at www.davisvision.com.

The Davis Vision lab will hold all orders for glass lenses for children under the age of 18 until the signed *Duty to Warn Form* is faxed to **1-800-240-4413 Attn: Lab Verification**. The provider should retain a copy of the signed form in the patient's medical record.

ii. Frame Size Challenge:

If Davis Vision is unable to fit a patient's frame size from the "Exclusive Collection" of frames, the patient may choose a frame from an Approved Frame Manufacturer (refer to Appendix) with a maximum $40.00 wholesale cost. However, if Davis Vision is able to fit a patient's frame size, but the patient decides not to choose from the "Exclusive Collection" of frames, the frame will be considered a non-plan option if available through the patient's benefit design.

Please call the Order Entry Team at **1-800-888-4321** to place your order. Please include the name of the frame manufacturer, model number, color and size. The Order Entry Team will order the frame directly from the manufacturer and the eyeglasses will be fabricated in a Davis Vision lab. The provider's fee remains the same as if this were a plan frame being dispensed.

I. MEMBER APPEAL OF DENIED SERVICES

State-specific requirements regarding appeals are included in Sections 11-15.

If Davis Vision denies a request for services, the written adverse determination explains the reason for the denial (e.g. "not a covered benefit") and includes the member's appeal rights. In greater than 99% of all appeals, the member initiates the appeal. If your patient requests that you initiate an appeal on his/her behalf, please contact Quality Assurance at **1-888-343-3470** immediately to obtain details on timeframes for appeal submission. Individual groups and states have varying requirements and Quality Assurance will assist you with the appeal process.

Typically, appeals/complaints/grievances are acknowledged within 15 days and resolved within 30 days unless a group or State imposes a more stringent timeframe. The outcome of appeals/complaints/grievances is communicated in writing to the patient/member/provider.

J. REFERRING PATIENTS FOR ADDITIONAL SERVICES

When your patient requires a referral to another practitioner for routine vision services, such referral should be made to a qualified practitioner within the Davis Vision provider network. You must explain to your patient the reason for the referral and stress the importance of follow-up care, as well as possible consequences of failure to comply. Members have the right to refuse treatment.

If your recommendations exceed the limitations of the patient's benefit through Davis Vision, please instruct your patient to contact his/her medical carrier for further guidance. Please be sure that your patient has enough information about the reason for the referral so he/she can provide sufficient information to the medical carrier.

BEST PRACTICE

Although not required, it is helpful to give your patient written instructions about consulting another practitioner including possible additional tests to be conducted.

K. ARRANGEMENTS FOR PROLONGED ABSENCE/OFFICE CLOSING

If your office will be closed for three months or longer due to vacation, illness or other circumstances, please advise Davis Vision's Provider Recruiting Department by calling 1-800-584-3140. If possible, you should make arrangements with a colleague (in the Davis Vision network) to provide services for your patients during your absence.

If your office is closing permanently, please advise Davis Vision as soon as possible by calling Provider Recruiting at 1-800-584-3140. Under the terms of your Participating Provider Agreement, it is your responsibility to notify your Davis Vision patients prior to the effective date of your discontinuance from the Davis Vision network. Under these circumstances, if your

patients ask for copies of their records, you must provide them prior to the effective date of your discontinuance from the Davis Vision network.

L. EMERGENCY CARE PROVISIONS

As established in your Participating Provider Agreement, you must ensure that Davis Vision's patients have access to an answering service, a pager number and/or an answering machine 24 hours a day, 7 days per week. Each method of communication must contain information about the provider's office hours and contain pre-recorded instructions with respect to the handling of an emergency. Patients must also have an opportunity to leave a message regarding a non-emergent concern.

When a Davis Vision member is out of the service area and an emergency arises, if the member believes that an emergency medical condition exists or that a delay in services might compromise his/her health, the member is permitted to seek emergency care from a licensed health care practitioner or provider without obtaining prior approval from Davis Vision. Because Davis Vision provides routine vision care benefits, reimbursement for emergency services will be solely dependent upon whether the member is eligible for the benefit.

M. REFUSAL OF CARE

Davis Vision's patients who are of legal age have the right to refuse to comply with recommended treatment. The patient should inform you of his/her decision. It is your responsibility to inform the member of any potential consequences.

When a patient refuses the recommended course of treatment, you should document the patient record. Documentation should include your treatment recommendations, the patient's reasons for refusal, and potential consequences of non-compliance.

N. INVESTIGATIONAL STUDIES

Definition: *Investigational or experimental treatment is described by Davis Vision as an unapproved ocular diagnostic procedure warranted by the ocular health of the member and the subsequent diagnostic findings could alter the member's treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.*

Although Davis Vision does not participate in investigational studies, it does not prevent independent providers from participating in such studies. Services and care associated with investigational studies are funded separately by the sponsored research program. It is Davis Vision's policy that all participating providers who do participate in and conduct independent studies will:

- Inform the patient of the purpose of the study
- Inform the patient that he/she has the right to refuse to participate

- Inform the patient how collected data will be utilized
- Inform the patient of all associated risks and/or benefits
- Inform the patient of all associated costs
- Obtain written consent from the patient
- Ensure that all information will be kept confidential
- Provide patients with a written description of the study in a language and level understood by the member

Services performed, as part of an investigational study may not be billed under a Davis Vision program. It is the policy of Davis Vision that members have the right to refuse to participate in research and/or investigational studies.

O. TRANSFER OF PATIENT RECORDS

If a member requests that a provider transfer his/her patient care records to another provider, you are required to complete the transfer in a timely manner.

P. PRIOR APPROVAL

Prior approval or prospective review involves services that have not yet been rendered. All pre-service reviews are for non-urgent care as services and materials for urgent/emergency care are not covered under Davis Vision plans. Prior Approval Representatives are available during normal business hours, Monday through Friday, from 8:00 a.m. until 4:30 p.m. EST. Practitioners requesting prior approval of services complete a Prior Approval Form including, but not limited to, the following information:

- Member and/or patient's identification number
- Patient's name
- Diagnosis
- Requested service or procedure
- Justification

The practitioner faxes the completed form to Davis Vision's Prior Approval Department at (800) 584-2329. A Prior Approval Representative reviews the request for completeness and for medical necessity based on utilization review clinical criteria. The Prior Approval Representative refers all cases that do not meet clinical criteria for medical necessity to a clinical peer for review and determination. As part of the review, the practitioner may be contacted to discuss the case. Individuals that conduct peer clinical review are available to discuss review determinations with the attending physician or ordering provider. If the original peer reviewer is not available, another clinical peer is available within one business day.

All determinations are rendered within three (3) business days of receipt of a complete request, both verbally and in writing to both the member and the practitioner (unless a more stringent timeframe is imposed by State guidelines). If the request is incomplete, Davis Vision will request additional information within the initial three-business-day time frame. Davis Vision will allow

the member, member's designee and/or provider 45 calendar days to submit the requested additional information. If the requested information is not received within 45 calendar days, Davis Vision will issue a decision within 15 calendar days of the expiration of the 45-day time frame. Written denials based on medical necessity include, but are not limited to, the following information:

- Criteria utilized, including clinical rationale, if any, and documentation supporting the decision.
- Statement that the decision will be final and binding unless the member appeals in writing to the Quality Assurance/Patient Advocate Department within 45 days of the date of the notice of the decision.
- Name, position, phone number and department of person(s) responsible for the outcome.
- Appeal and Grievance Procedures

In cases where a client, plan or regulatory agency mandates a specific appeal process, Davis Vision will abide by that appeal process. In all other cases, Davis Vision's Member Appeals or Member Grievance Process will apply.

Q. CONCURRENT REVIEW

Concurrent review involves services that are currently being rendered. The practitioner is requesting that services continue or extend beyond what has already been approved or for additional services. In rare cases, Davis Vision may review certain services on a concurrent basis during the course of ongoing treatment. Practitioners complete the Prior Approval Form and fax it to the Prior Approval Department at (800) 584-2329.

All determinations are rendered within one (1) business day of receipt of necessary information but no later than 15 calendar days following the request, both verbally and in writing to both the member and the practitioner (unless a more stringent timeframe is posed by State guidelines). The written determination contains the following information:

- Number of extended services approved
- New total of approved services
- Date of onset
- Next review date
- Appeal and Grievance Procedures

R. RETROSPECTIVE REVIEW

Retrospective review involves services that have previously been rendered. Davis Vision does not conduct retrospective reviews for services covered under its plans. In rare instances, a retrospective review may be conducted:

- to determine medical necessity when a member or practitioner fails to obtain approval for services that require prior approval before services are rendered

- to determine medical necessity when a practitioner fails to obtain approval for services that require concurrent review before services continue beyond the approved timeframe
- to identify and refer potential quality of care/utilization issues

NOTE: A review initiated as the result of a notification or claim denial is considered an appeal.

If a service has been pre-authorized or approved by a Utilization Review Agent, the Utilization Review Agent shall not, pursuant to retrospective review, revise or modify the specific standards, criteria or procedures used for the utilization or review or procedures, treatments and services delivered to the insured during the same course of treatment.

S. MEMBER COMPLAINTS AND GRIEVANCES

Davis Vision provides routine vision care services to beneficiaries located in all fifty states, the District of Columbia, Puerto Rico and Guam. The generic complaint/appeal/grievance processes described below may not include state-specific requirements. Please refer to the Section 11-15 for some state requirements. For more complete information and guidance, call Davis Vision's Quality Assurance Department at ***1-888-343-3470.***

1. Adverse Determinations/Denials

Adverse determinations or denials can be divided into two categories:

- Benefit denials – a denial decision based on whether the member has a benefit for the service or product at the time the service or product is received.
- Medical necessity denials – a denial decision based on whether the product or service is medically necessary.

2. Benefit Denials

Routine vision and eye care services are limited to a frequency chosen by the client. Therefore, determinations are based solely on whether or not the member has an available benefit. No review is conducted to determine medical necessity.

Members have the right to voice a *complaint or grievance* about a benefit denial at any time and have the right to designate a representative to file on their behalf. Davis Vision will not retaliate or take any discriminatory action against any member as a result of filing a complaint or grievance. Davis Vision will provide members with a copy of the Grievance Resolution process upon request.

Members who call Customer Service about benefit denials are educated about the frequency with which they can obtain routine vision and eye care services.

3. Medical Necessity Denials

Some plans include enhanced coverage for medically necessary contact lenses. For plans offering enhanced coverage, Davis Vision reviews these requests to determine medical necessity based on the guidelines of the American Optometric Association.

Members have the right to appeal a medical necessity denial at any time and have the right to designate a representative to file on their behalf. Davis Vision will not retaliate or take any discriminatory action against any member as a result of filing an appeal. Davis Vision will provide members with a copy of the Grievance Resolution process upon request.

4. Appeal of Medical Necessity Denials

Davis Vision provides routine vision care services to beneficiaries located in all fifty states, the District of Columbia, Puerto Rico and Guam. The generic complaint/appeal/grievance processes described below may not include state-specific requirements. Please refer to Sections 11-15 for some state requirements. For more complete information and guidance, call Davis Vision's Quality Assurance Department at ***1-888-343-3470****.*

i. Appeal Level 1

The member, the member's representative or the health care provider may file an appeal verbally or in writing within 180 days after receipt of the adverse determination. The claimant may submit written comments, documents, records and other information relevant to the appeal. Within 15 days of receipt of the appeal of a medical necessity denial, Davis Vision will send a written acknowledgment to the member. If only a portion of such information is received, Davis Vision will request the missing information in writing within five (5) business days of receipt of the partial information. Davis Vision makes Standard Appeal determinations as fast as the member's condition requires and within 30 days of receipt of all necessary information. Davis Vision notifies the member, the member's designee and/or the health care provider in writing of the Appeal Determination within two (2) business days of the rendering of the determination. Davis Vision maintains an Expedited Appeal process for adverse determinations involving continued or extended health care services/procedures/treatments or additional services for a member undergoing a course of continued treatment prescribed by a health care provider, and for adverse determinations in which the health care provider believes an immediate Appeal is warranted.

ii. Appeal Level 2

Davis Vision maintains a single level Appeal process for Adverse Utilization Review Determinations. When requested by a client or required by state regulations, a second level of appeal will be available.

iii. External Review

Most states have developed an External Review Program designed to resolve disputes between health plans and consumers for services that were denied on the basis that they were not medically necessary. This process is regulated by the state in which the member resides.

For additional information about the availability of External Review, please contact Davis Vision's Quality Assurance Department at **1-888-343-3470**.

SECTION VIII
OPHTHALMIC MATERIALS AND LABORATORIES

A. SAMPLE FRAME COLLECTION

Davis Vision features a standardized Plan Collection of frames at select dispensing locations based upon geographic disbursement of membership. Davis Vision supplies a modern, stylish and compact frame display that contains samples of plan frames.

All Frames have color-coded tags which allow you to easily determine the appropriate frames to which the member is entitled. It is important to keep the color-coded tags on the frames as they indicate the frame collection level. The frame collection is tagged as follows:

Benefit Level	Color Code
Fashion	Yellow Tag
Designer	Red Tag
Premier	Blue Tag
Safety	Yellow, Red or Blue Tag

The cost of the sample frame collection and display is assumed by Davis Vision and remains the property of Davis Vision. Davis Vision retains the right to take possession of the Collection when a provider ceases to participate with the Plan and, with reasonable notice, at any other time. Providers assume full responsibility for the cost of any missing frames and will be required to reimburse Davis Vision for missing and unaccounted frames.

Frames supplied meet all standards outlined under the American National Standards Institute ANSI Z.80.5-1979.

B. LENSES

Only first quality lenses are supplied under the plans. All lenses are provided and workmanship performed in accordance with the American National Standards Institute ANSI Z80.1-1979. Glass ophthalmic lenses are chemically strengthened to achieve impact resistance in accordance with FDA Regulations 21CFR, Sub Part H, Section 801.410. All finished materials are quality assured prior to shipping.

Polycarbonate lenses are provided *at no extra cost* to all eligible dependent children (as defined by the Plan), patients with amblyopia, beneficiaries who are sighted in only one eye (i.e., monocular patients) and patients with prescriptions greater than + or (-) 6 diopters without additional dispensing fee to the provider. This policy is intended to provide maximum impact resistance and prevention of eye injuries for all eligible children and monocular patients requiring prescription eyewear.

C. CONTACT LENSES

To ensure maximum value for members, distinction may be made between new and existing contact lens wearers. This differentiation may affect the quantity of lenses supplied by the Plan and the professional fitting fee.

A New Wearer is defined as a member meeting one of the following criteria: (1) a patient who has never worn/been fitted for contact lenses in the past; (2) a patient who is new to your office (whether a new wearer or an existing wearer); and (3) a patient who has previously been fit with contact lenses in your office, but is now being fit with a significantly different type of contact lens.

New wearers will receive a comprehensive lens fitting and lenses according to Plan protocol. The provider will receive a first time fitting fee including any co-payment, if applicable, which includes payment for the additional steps required to determine the optimal lens type that provides maximum comfort and visual acuity for the patient.

An Existing Wearer is defined as a patient previously fit with contact lenses in your office who is now being fit with the same or similar type of contact lens.

Existing wearers will receive a reassessment fitting and lenses, according to Plan protocol. The provider will receive a fitting fee including any co-payment, if applicable, for this service.

Davis Vision's contact lens formulary makes various types of contact lenses available.

NOTE: This formulary is not always applicable to all groups. Please refer to the group-specific plan highlight sheet for complete contact lens information.

D. WARRANTY

NOTE: There are no exceptions to Davis Vision's generous warranty policy.

Davis Vision is committed to providing quality service and 100% customer satisfaction. All materials that are supplied by Davis Vision's wholly owned ophthalmic laboratories are covered under the following repair and replacement policies.

Coverage periods are based on the dates associated with the initial dispensing of eyewear. Any replacement materials that may be supplied will be covered for the remainder of the original coverage period.

Davis Vision may request the return of the original pair of eyeglasses, frames or lenses, including uncuts, prior to the processing of the redo order.

E. LENS COATINGS

NOTE: *Dispensing date is assumed to be 10 days after the date shipped from the Davis Vision laboratory.*

1. Scratch Protection Plan

Davis Vision will replace, within one year from original dispensing date*, spectacle lenses that have become scratched under normal usage, ONLY if the Scratch Resistance option was selected and paid by the patient at the time of the original order or if the option is covered in full within the group's vision care plan. This policy applies to ALL lens types and materials.

Whenever the Scratch Resistance option is selected and the applicable charge collected on any lens type or material at the time of the original order, your office will receive the corresponding additional dispensing fee (surfee) from Davis Vision. No surfee will apply if the Scratch Resistance option is covered in full under the group's benefit design.

BEST PRACTICE

If any of your Davis Vision patients have a history of mishandling their eyeglasses or if they are concerned about the possibility of developing scratches on the surfaces of their lenses, be sure to inform them of the potential benefit of selecting the Scratch Resistance option.

2. Anti-Reflective Coatings

For a period of one (1) year from the original date of dispensing, all lenses that have had an anti-reflective (AR) coating applied and which is peeling or crazing, will be replaced with new AR coated or uncoated lenses (member choice) of the same material, style and prescription, at no charge. NOTE: This ARC replacement policy does not cover scratches.

Davis Vision's ARC replacement policies/coverage periods may differ from other retail or manufacturers' policies. Davis Vision's adherence to the one (1) year period is based on the normal benefit coverage period, which would entitle a member to another exam and a whole new pair of eyewear each year, as opposed to the replacement of just lenses.

Scratched, AR coated lenses will be replaced, only if the scratch protection copay was paid or covered in full by the group's benefit plan design at the time of original order.

PATIENT CHANGES

NOTE: Dispensing date is assumed to be 10 days after the date shipped from the Davis Vision laboratory.

3. Frame Style, Lens Style and/or Lens Material

For a period of 30 calendar days from the original date of dispensing, your patient may return to you any pair of eyeglasses for changes to the Davis Vision Collection frame and/or lenses selected.

F. PROVIDER CHANGES

NOTE: Dispensing date is assumed to be 10 days after the date shipped from the Davis Vision laboratory.

1. Change of Prescription

To ensure that patients attain the best possible vision, Davis Vision providers may make any prescription changes necessary for a period of either 90 calendar days for eyeglasses or 30 calendar days for contact lenses from the original date of dispensing.

Non-Adaptation to Progressive Addition (No-Line Bifocal) Lenses

For a period of 60 calendar days from the original date of dispensing, progressive lenses may be returned for replacement with conventional single vision, bifocal or trifocal lenses.

*NOTE: Any member copayments associated with selection of the original progressive additional lenses will **not** be returned.*

G. PATIENT SUPPLIED FRAMES OR LENSES

Davis Vision also provides laboratory services for those orders where some portion of the materials are supplied by the patient. **We will not accept responsibility or liability for either frames and/or lenses supplied by the patient, including loss or damage.**

Davis Vision will make every effort to provide new lenses to a member's existing frame. However, should the member's existing frame break, it will be the member's responsibility to select another frame (either from the Davis Vision collection at prevailing copays, if applicable, or from the provider's selection) at the member's own expense.

BEST PRACTICE

When shipping a member's existing frame to Davis Vision, be sure to use the **Davis Vision** UPS shipping label which allows your shipment to be tracked.

H. PROVIDER SUPPLIED FRAMES

In the event Davis Vision damages or loses a new, provider-supplied frame, we will make every attempt to provide a replacement at no cost, without involvement of your office. If the frame cannot be replaced by us, Davis Vision will reimburse your office for the cost of the replacement frame, as originally invoiced to your office by the frame manufacturer or distributor. Davis Vision will not reimburse the retail price for the frame.

Please fax or email a copy of the invoice to Davis Vision for reimbursement. If the invoice is not available, Davis Vision's maximum reimbursement to you will be the Manufacturer's suggested wholesale price.

I. MATERIALS REPLACEMENT

NOTE: Dispensing date is assumed to be 10 days after the date shipped from the Davis Vision laboratory.

1. Breakage Warranty for Plan-Supplied Frames and/or Lenses

All eyeglasses provided by Davis Vision laboratories are warranted against breakage for one (1) year from the original date of dispensing. This applies to all spectacle lenses and Davis Vision Collection frames. If your materials should break within the warranty period, Davis Vision will supply replacement materials identical to those originally ordered.

2. Allergic Reaction to Plan-Supplied Frames

If your patient experiences an allergic reaction to plan-supplied frames within the first 90 calendar days from the original date of dispensing, Davis Vision will provide a new complete pair of eyeglasses in an alternative frame at no charge.

J. UNCUT LENS POLICIES

A one-time remake of uncuts, due to provider finishing errors, will be honored at no charge. All subsequent provider remakes on uncut orders will be billed through our Excel Advantage program. If not already on file, please provide your credit card information to the Excel Advantage Department in order to process your uncut remakes. If additional uncuts are to be supplied, Davis Vision will charge a fixed fee for each pair.

K. CONTACT LENSES

Contact lenses are covered under the individual manufacturer's warranty. Please contact the appropriate vendor.

L. WARRANTY CERTIFICATE

A Warranty Certificate will accompany all Plan materials (eyeglasses and lenses) covered under Davis Vision's warranty (according to the rules described herein). Please deliver the warranty certificate to the member whenever dispensing Plan eyeglasses.

M. LABORATORIES

Davis Vision maintains its own regional laboratories for the Plan vision care benefit. These laboratories have earned a commendable reputation in servicing third party plans. Each provider is assigned to a regional laboratory, depending upon geographic location of the office.

1. Laboratory Services

In establishing order procedures, Davis Vision's goals were to assure:

1. Maximum convenience for providers.
2. Uniform format requirements of the order processing data system.
3. Accuracy and speed in processing orders.
4. Prompt reimbursement for services rendered.

N. SHIPPING ERRORS

In the event you receive eyewear for a patient that you did not service, please call Davis Vision at **1-800-888-4321** immediately.

Davis Vision will make arrangements with an appropriate carrier to pick up the package from your office the following day.

O. RECEIVING YOUR ORDER

All eyewear shipped from a Davis Vision laboratory to your office should meet the following criteria upon receipt:

- Eyeglasses will have been cleaned, bench aligned and polished to be ready for dispensing upon receipt.
- Each patient's eyeglasses will be protected in an appropriate case.
- A warranty certificate will be enclosed in each case which is to be presented to the patient with the eyeglasses.
- A copy of the original laboratory invoice will be included with the finished eyeglasses (wrapped around the case). We suggest you retain this copy. If jobs are returned for changes, it is important that you enclose a copy of this form.

P. DELIVERY

Davis Vision will make every effort to promptly fill all Plan supplied ophthalmic material orders. Single vision stock orders will be shipped within one (1) to three (3) business days and multifocals within one (1) to five (5) business days.

SECTION IX
NETWORK MANAGEMENT AND PARTICIPATION

1. OVERVIEW

The purpose of Network Management is to provide structure and formal processes within which the organization evaluates the adequacy of the Davis Vision network, initiates recruiting efforts and affords all applicants fair process in compliance with the Health Care Quality Improvement Act of 1986. Davis Vision is responsible for maintaining a network of participating practitioners to deliver high quality patient are that is readily available and accessible to members.

2. COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE (CAQH)

Davis Vision is a member of the Council for Affordable Quality Healthcare (CAQH) and, as such, utilizes the CAQH Universal Credentialing DataSource (UCD) for gathering credentialing data for all the health care professionals.

CAQH is a not-for-profit alliance of more than 90 national, regional and local health plans and networks. CAQH's UCD employs many features that make a difference and improve the quality of health care professional data submitted via CAQH, such as:

- Automatic check for errors
- Only asks questions relative to the practice
- Allows physicians and other health care professionals to save a partially completed application and return later
- Enables common data on multiple health care professionals to be entered only once
- Assists in quickly locating contact information for colleges, medical schools and facilities

The CAQH process is available to health care professionals at no charge. Additionally, the process creates cost efficiencies by eliminating the time necessary to complete redundant credentialing applications for multiple health plans, reduces the need for costly credentialing software and minimizes paperwork by allowing health care professionals to make updates online. (Every four months, you will receive a request from CAQH to re-attest that all information in your application is current.)

We encourage physicians and other health care professionals to familiarize themselves with the CAQH Universal Credentialing DataSource prior to requesting consideration for inclusion in the Davis Vision network. Simply access the UCD demo at https://upd/caqh.org/OAS/ and click on **Overview**.

3. INITIAL CREDENTIALING PROCESS

NOTE: *Davis Vision's provider network is comprised of optometrists, ophthalmologists and opticians located in all fifty states, the District of Columbia, Puerto Rico, Guam, and Saipan. The generic credentialing process described below may not include state-specific requirements.*

The purpose of Davis Vision's Credentialing Program is to provide the framework and formal processes within which the organization evaluates potential providers and practitioners and re-evaluates participating providers and practitioners. Davis Vision is responsible for recruiting high quality practitioners and for ensuring that each one is qualified by training and experience to deliver high quality patient care that is readily available and accessible to members.

During the credentialing process, practitioners submit an application (Davis Vision, state-mandated or Universal Provider Datasource Form). A Data Entry associate reviews the application for completeness, accuracy and conflicting information. The associate transfers complete applications to Credentialing where an associate conducts primary source verification of education, licensure and board certification (if applicable) and queries the National Practitioner Data Bank-Healthcare Integrity and Protection Data Base, State Licensing Boards, the U.S. Treasury Office of Foreign Assets Control (OFAC), the Excluded parties List System (EPLS) and other appropriate databases when indicated. The associate queries the Federation of State Medical Boards (FSMB) regarding practitioners (ophthalmologists and MDs) at credentialing and recredentialing for all MDs. The associate confirms that the practitioner has submitted a copy of his/her DEA registration for every state in which the practitioner is licensed, where applicable. The associate reviews Medicare Opt-Out Reports supplied by part B carriers to determine if an applicant has declined remuneration from Medicare or Medicaid programs, thus preventing Davis Vision from including the applicant on any of Davis Vision's Medicare or Medicaid network panels.

NOTE: During the verification process, if credentialing information obtained from primary or secondary sources varies substantially from submitted information, the applicant is contacted by phone within 30 days of discovery and extended an opportunity to correct erroneous information via fax to a Credentialing associate within 10 business days with an explanation and supportive documentation.

The Credentialing associate verifies that no information will be more than 180 days old at the time of the Credentialing Committee review. The associate verifies that the practitioner's license and DEA registration will be in effect at the time of the credentialing decision, if applicable.

Davis Vision completes its review of the application and notifies the applicant in writing of the outcome or status within 90 days (unless more stringent timeframe is a state mandate) of receiving the complete application. Denial notifications advise an applicant the reason for the denial and afford the applicant an opportunity to correct erroneous information and appeal the decision based upon the erroneous information.

4. ONGOING MONITORING OF CREDENTIALS

Davis Vision monitors information related to its participating providers on an ongoing basis. Complaints involving potential quality of care issues are immediately forwarded to the Senior Vice President of Professional Affairs and Quality Management for review and guidance.

A designated Credentialing associate receives and monitors monthly notifications from CAQH listing cited practitioners. Because CAQH does not monitor Medicare Opt-Out or Office of Foreign Assets Control (OFAC) reports, or Excluded Parties Listing System (EPLS), Davis Vision monitors these sources monthly to ensure that Davis Vision participating providers are not among those providers cited. Although CAQH monitors the Office of Inspector General (OIG), Davis Vision additionally monitors this source monthly to ensure participating providers have not been excluded from Medicare/Medicaid programs.

If a Davis Vision provider is included in the CAQH citation notifications received during the month, the associate primary source verifies the information through NPDB-HIPDB or the entity that issued the license and documents all pertinent information. This information is reviewed by the Credentialing Committee at the next scheduled meeting. Potential actions taken by the Credentialing Committee might include, but are not limited to: continued follow up, site visit, medical record review, etc. However, if a serious incident is involved, the case is referred to the Senior Vice President for Professional Affairs and Quality Management for immediate review and action.

All practitioners and providers are required to notify Davis Vision within thirty (30) calendar days of any licensure sanctions (including probations or limitations, suspensions or terminations) by any other panel or third party program, all malpractice actions and any sanctions or changes in participation within the Medicare and Medicaid programs.

5. RECREDENTIALING PROCESS

NOTE: *Davis Vision's provider network is comprised of optometrists, ophthalmologists and opticians located in all fifty states, the District of Columbia, Puerto Rico, Guam, and Saipan. The generic credentialing process described below may not include state-specific requirements.*

Davis Vision's participating practitioners are recredentialed a minimum of once every three years, focusing on information subject to change during the time period since the practitioner was last credentialed.

Ninety (90) days before the recredentialing date, the Credentialing Department receives a report of all practitioners due for recredentialing. A notification letter is sent to each practitioner containing a list of documents to be submitted. Documents include:

- Supplemental Credentials Warranty or current state-specific Recredentialing Application
- Current State License(s)
- Current Malpractice Insurance Policy

- DEA Certificate (if applicable)
- Controlled Substance Registration (if applicable)
- Blank Patient Exam Form
- Copy of Board Certification (MD/DO Only)
- Hospital Affiliations (MD/DO Only)

The recredentialing process is similar to initial credentialing. In lieu of submitting a complete application, each practitioner must submit a signed Supplemental Credentials Warranty, which warrants that information provided in his/her original Davis Vision Provider Application is still correct and complete, a Universal Provider Datasource (UPD) form, or a state-mandated recredentialing application.

Providers who are registered with CAQH and who maintain a current UPD form are not required to mail updated information to Davis Vision. (However, some information must still be mailed to Davis Vision including, but not limited to, a signed contract.) The Credentialing Associate downloads the provider's application data from CAQH and uses that information to process the application.

Thirty days from the date of the initial notification letter, a second request is sent to any practitioners who have not yet submitted the recredentialing documentation. Thirty days from the date of the second request, a final request is sent to any practitioners who have not yet submitted the recredentialing documentation advising them that their participation with Davis Vision will be suspended on the last day of the month if documentation is not received.

Credentialing Department associates verify through primary or secondary source verification the information contained in all supporting documentation. (Refer to *Overview of Initial Credentialing Process* for information about verification sources.)

Davis Vision's recredentialing process includes a review of the practitioner's performance since initial credentialing. Performance indicators may include, but are not limited to, results of site visits and medical record review, member complaints and member satisfaction surveys.

The Credentialing Department associate verifies that no information (applications, supplemental warranties, signatures or primary or secondary source verification information) will be more than 180 days old at the time of the Credentialing Committee review. Questionable items or items that do not meet the screening criteria are documented and presented to the Credentialing Committee for discussion and/or individual consideration.

Completed recredentialing files are forwarded to the Credentialing Committee for review and final determination of network status. Practitioners/providers are notified of the results of the Credentialing Committee's determination.

<u>NOTE:</u> If additional information is required, the practitioner is contacted in writing within 10 business days of the Credentialing Committee's request and extended an opportunity to provide the additional information within 10 business days. (If the requested information is not received

within 10 business days, the Committee will consider the application voluntarily withdrawn.) If the Credentialing Committee has approved ***or*** *denied the application, the practitioner will be notified in writing within 60 calendar days of the decision. Denial notification advises the practitioner that he/she may correct erroneous information and may appeal the decision based upon the erroneous information. Upon request, Davis Vision will make available to the practitioner any information obtained during the credentialing process.*

The average time required for completion of a recredentialing application per practitioner is thirty (30) days from the time it is received in the Credentialing Department, but shall not exceed ninety (90) days.

6. PARTICIPATING PROVIDER AGREEMENT

As part of the Initial Credentialing and Recredentialing processes, you signed Davis Vision's Participating Provider Agreement. By signing this Agreement, you agreed to comply with numerous requirements including, but not limited to, the following:

- Provider agrees to be bound by all the provisions of the rules and regulations of Davis Vision as well as all applicable laws and administrative requirements of regulatory agencies.

- Provider agrees to abide by all Federal and State laws regarding confidentiality, including unauthorized uses or disclosures of patient information and personal health information.

- Provider agrees to provide an eye examination including, but not limited to, visual acuities, internal and external ocular examinations (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 or contact lenses according to Plan protocols.

- Provider agrees to ensure that members will have access to an answering service, a pager number and/or an answering machine 24 hours a day, seven (7) days per week.

- Provider agrees to comply with Davis Vision's eligibility system requirements and to obtain a valid confirmation of eligibility number prior to rendering services to any member.

- Provider agrees to observe the standards of care, quality improvement and grievance resolution protocols as set forth in this Provider Manual.

- Provider agrees to prepare and maintain patient records consistent with generally accepted standards and the requirements of Davis Vision. Copies of the Service Record Form will be completed for each individual to whom services are rendered, signed by both the doctor and the patient, and retained for a period of not less than ten (10) years (or per statutory/federal requirement, whichever is greater).

- Provider agrees to notify members in writing in advance of costs for which member is financially responsible before services are rendered.

- Provider agrees to accept the Plan's fees as payment in full (except for applicable plan co-payments) for the eye examination and dispensing of lenses and frames or contact lenses provided by the central laboratory. The client-specific fees will be applied for all billing, laboratory orders and allowances for non-plan items. The provider agrees not to assert any patient charge for covered items except for applicable co-payments or allowable amounts.

- Professional liability insurance will be maintained at a level equal to $1 million per occurrence/$3 million annual aggregate or the community standard.

- Provider agrees to maintain the Collection of Plan frames in accordance with the specifications in the Provider Agreement. Beneficiaries will be shown all suitable frame styles. The Collection, display, and other Plan materials will be returned to Davis Vision upon request.

- No claim for compensation for any covered services will be made against any participant. The vision care plan fee, as designated in the Plan outline, will be accepted as payment in full for the eye examination and dispensing of Plan lenses and frames, except when Plan co-payments apply.

- A courtesy discount of at least 20% off the provider's usual and customary fees (or 10% off for disposable contact lenses) will be extended to Plan beneficiaries for the purchase of materials not covered by the Plan.

- Provider agrees to indemnify and hold Davis Vision and its clients harmless from any damages or legal action arising out of the services provided under the terms and conditions of the Provider Agreement.

- Provider agrees to submit and maintain on file with Davis Vision a completed application, copies of their current state and CDS/DEA licenses, board certification and current malpractice policies, among other items as applicable.

- Provider will maintain in good standing all licenses required by law and must notify Davis Vision immediately of any action, which may adversely affect continuation of any applicable licenses. The provider must also notify Davis Vision of any pending malpractice claims or settlements made against them.

- Provider agrees to allow Davis Vision to conduct on-site office visitations and patient record reviews.

- Provider agrees to abide by the protocols and standards detailed in this manual.

7. PROFESSIONAL REVIEW ACTIONS

Davis Vision's Provider Agreements and the Provider Manual contain requirements for continued participation in the Davis Vision network. These requirements were developed to protect member health and welfare. Practitioners or providers who fail to comply with these requirements may be subject to professional review actions that affect network status. Practitioners being considered for a professional review action (termination, suspension, limitation of privileges) are referred to the Credentialing Committee for review and possible referral to the Peer Review Committee. Adverse determinations rendered by the Peer Review Committee are communicated to the practitioner or provider in writing including what action is being taken, the reason for the action, and a summary of the appeal rights and process.

> *EXCEPTION: Practitioners and providers will not be penalized, terminated or suspended from the network because they acted as an advocate for a member seeking appropriate covered services, or filed a complaint or an appeal, or requested a hearing or review.*

Practitioners who fail to return the recredentialing package are suspended in accordance with the notification in the "final request" letter. If these practitioners wish to appeal their suspension, they must submit a new credentialing application.

1. Termination Without Cause

Provider Agreements are effective for an initial term of twelve (12) months beginning on the Effective Date on the signature page of the agreement. After the initial twelve (12) month term has ended, the Provider Agreement may be terminated by either Davis Vision or the participating practitioner/provider without cause, upon 90 days prior, written notice. If Davis Vision terminates the agreement before the end of the initial term or for "cause", the provider can request a hearing before a panel within 30 days of receipt of the provider's request.

If the provider terminates the Provider Agreement without cause, or if an individual practitioner leaves the provider's practice or otherwise becomes unavailable to the members, the provider will notify those members prior to the effective date of the termination.

2. Termination for Cause

Davis Vision may terminate the Provider Agreement immediately for cause. "Cause" means:

- A suspension, revocation or conditioning of provider's license to operate or practice his/her profession.
- A suspension, or a history of suspension from Medicare or Medicaid or any other third party plan.
- Conduct by provider that endangers the health, safety, or welfare of members.
- Any other material breach of any obligation of the provider as detailed in the terms of the Provider Agreement.

- Conviction of a felony.
- Loss or suspension of a Drug Enforcement Administration (DEA) identification number.
- Voluntary surrender of the provider's license to practice in any state in which the practitioner serves as a Davis Vision provider while an investigation into the provider's competency to practice is taking place by that state's licensing authority.
- Bankruptcy of the provider.

Upon identification of a practitioner meeting any of the above criteria, his/her file is referred to the Credentialing Committee for immediate review. The Committee will report the outcome of the review to the Senior Vice President or Assistant Vice President of Professional Affairs. The Assistant Vice President of Professional Affairs will send a written notice to the practitioner by certified mail (with return receipt requested). The notice will indicate what action is being taken and the reason for the action. The notice advises the practitioner that he/she can send a written request to Davis Vision within 30 days of receipt of the notice for a hearing to modify or reverse the decision to terminate. Termination becomes effective immediately upon receipt of notice by the practitioner.

3. Suspension for Cause

Davis Vision may suspend the Provider Agreement for cause. "Cause" means:

- A failure by provider to maintain malpractice insurance coverage as required by the Provider Agreement
- A failure by provider to comply with applicable laws, rules, regulations, and ethical standards as required by the Provider Agreement
- A failure by provider to comply with Davis Vision rules and regulations as required by the Provider Agreement
- A failure by provider to comply with the utilization review and quality management procedures as required by the Provider Agreement
- A violation by provider of the non-solicitation covenant contained in the Provider Agreement whereby the provider agrees not to directly or indirectly engage in the practice of solicitation of members, plans or any employer of members without Davis Vision's prior written consent.

Upon identification of a practitioner meeting any of the above criteria, his/her file is referred to the Credentialing Committee for review. The Committee will report the outcome of the review to the Senior Vice President or Assistant Vice President of Professional Affairs. The Assistant Vice President of Professional Affairs will send a written notice to the practitioner by certified mail (with return receipt requested). The notice will indicate what action is being taken and the reason for the action and the date upon which the action becomes effective (at least 60 days from the date of the notice). The notice advises the practitioner that he/she can send a written request to Davis Vision within 30 days of receipt of the notice for a hearing to appeal the determination.

Davis Vision reserves the right to immediately suspend the Provider Agreement, pending investigation, of any participating practitioner who, in the opinion of the senior clinician, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. Davis Vision will investigate these instances on an expedited basis. Davis Vision's appeal process is available to the practitioner(s) involved in the investigation.

4. Right to Terminate or Limit Privileges for Non-Quality Issues

Davis Vision retains the right to terminate or limit the privileges of practitioners or providers based on non-quality issues, which may include, but are not limited to:

- Lack of Board Certification and TPA licensure.
- Excessive number of panel providers practicing in a geographic area.
- Failure to comply with the recredentialing process.
- Failure to comply with on-site and/or record reviews.

Upon identification of a practitioner meeting any of the above criteria, his/her file is referred to the Credentialing Committee for review. The Committee will report the outcome of the review to the Senior Vice President or Assistant Vice President of Professional Affairs. The Assistant Vice President of Professional Affairs will send a written notice to the practitioner by certified mail (with return receipt requested). The notice will indicate what action is being taken and the reason for the action and the date upon which the action becomes effective (at least 60 days from the date of the notice). The notice advises the practitioner that he/she can send a written request to Davis Vision within 30 days of receipt of the notice for a hearing to appeal the determination.

5. Credentialing Committee Review of Terminations

One or more members of the Credentialing Committee will review the proposed or potential termination of any practitioner or provider appropriately and will consider all applicable and available material (except for practitioners who fail to return the recredentialing package). Committee member(s) may, at his/her/their own discretion, request that the practitioner submit a written explanation of the issues under review or that the practitioner submit written responses to questions posed by the Committee. The Committee member(s) will report the outcome of the review with recommendations to the Senior Vice President or the Assistant Vice President of Professional Affairs.

The Senior Vice President or the Assistant Vice President of Professional Affairs will determine what action should be taken. Possible actions include, but are not limited to, sending an educational letter or continuing observation with the recommendation that the practitioner's participation in the network be restricted, suspended or terminated. If it is determined that a practitioner or provider should be suspended or terminated, the Assistant Vice President of Professional Affairs will send a written notice to the practitioner or provider by certified mail (with return receipt requested). The notice will indicate what action

is being taken, the reason for the action and the manner in which the practitioner or provider may appeal the decision and the date upon which the action becomes effective.

6. Practitioner or Provider Appeals

Davis Vision has an appeal process for instances in which it chooses to alter the conditions of practitioner participation based on issues of quality of care or service. The appeal process was developed with input from participating providers and is reviewed at least annually. It is available to all participating providers.

> *EXCEPTION: When a provider is terminated based on professional misconduct, or their conduct poses a threat of imminent harm to the health and safety of a member, or when their license limits their ability to fulfill their contractual obligations to Davis Vision, the provider forfeits the right to appeal the decision.*

To challenge a termination decision, a practitioner must send a written request to Davis Vision (at the address in the notice of action) for a hearing to modify or reverse a decision to terminate. The request must be sent by certified mail, return receipt requested and postmarked no later than thirty (30) days following receipt of the notice of action by the practitioner. This request serves as notification to Davis Vision that the practitioner wants to use the appeal process.

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

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

The written Request for Appeal must be mailed via certified, return receipt mail or insured overnight delivery to the following address:

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

Within thirty (30) days of receipt of the practitioner's request for a hearing, the Provider Appeal Committee will convene to hear the appeal. The Provider Appeal Committee is composed of one Regional Quality Assurance Representative, who is an active participating

practitioner, and at least two participating practitioners who were not involved in the initial determination. Practitioners are experienced in the peer review process. Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date and will advise of the practitioner of his/her right to be represented by an attorney or other person of his/her choice. This notice serves as notification to the practitioner that Davis Vision agrees to hear the practitioner's appeal. Failure to appear at the hearing will be deemed a waiver of the practitioner's right to appeal.

The practitioner may request additional time or may ask that the hearing be rescheduled. The request must be made in writing, sent by certified mail, return receipt requested, and must be received at Davis Vision at least ten (10) days before the scheduled hearing before the Provider Appeal Committee.

Any documentation to be presented by the practitioner at the hearing, including the names, addresses and credentials of any witnesses, if applicable, must be mailed to Davis Vision (at the address in the notice of action) by certified mail, return receipt requested, and must be received at least ten (10) days before the scheduled hearing date. At its discretion, the Provider Appeal Committee may or may not accept documentation or testimony of witnesses received after this date.

At the hearing, the practitioner will present his/her explanation as to why the decision for termination should be modified or reversed. The Director of Professional Services will present Davis Vision's position regarding the termination.

At the conclusion of the hearing, the Provider Appeal Committee will document its findings and recommendation. The Committee will forward their report to the Assistant Vice President of Professional Affairs and Quality Management within thirty (30) days of the hearing. The Assistant Vice President will consider the recommendation of the Provider Appeal Committee and make a final determination within fifteen (15) days. The Assistant Vice President will advise the practitioner of the final determination and will send him/her a copy of the Committee's report containing the specific reasons for the determination.

Decisions resulting in termination of a practitioner will be communicated in writing to the practitioner and will include notification that the termination is effective upon the practitioner's receipt of the notice. This decision involving the practitioner's participation in the Davis Vision network is final.

7. Reporting to Appropriate Authorities

All terminations related to professional competence or conduct, adversely affecting clinical privileges for a period longer than thirty (30) days, or related to the practitioner's voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation are reported within fifteen (15) days of termination to the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB), and the appropriate state licensing board(s). It is the responsibility of the Credentialing Department associates to

submit these reports via the IQRS application available through the NPDB website: www.npdb-hipdb.com. IQRS includes a draft report feature allowing for report data input and saving. In addition, the associate mails a copy of the report to the appropriate state licensing board.

SECTION X
QUALITY MANAGEMENT

A. OVERVIEW

The purpose of Davis Vision's Quality Management (QM) Program is to provide the framework and the formal processes within which the organization continually assesses and improves the quality of clinical care, safety and service provided to members. This includes the ongoing and systematic monitoring, analysis and evaluation of the accessibility and availability of vision care. This approach enables the organization to focus on opportunities for improving operational performance, health outcomes and member/practitioner/provider satisfaction.

B. ONSITE OFFICE REVIEW PROGRAM

A key element in assessing practitioner compliance with Davis Vision's requirements, regulatory mandates and accreditation standards is the Onsite Office Review Program. Office and record reviews are conducted by Regional Quality Assurance Representatives (RQARs) who are licensed optometrists or retired optometrists. Offices for review are selected according to the following criteria:

- Combination site visits and record reviews are scheduled once every three years for high-volume providers (e.g., providers who render care to at least 300 Davis Vision members annually).
- Record reviews (without a site visit) are conducted for providers who do not meet the high-volume provider criteria for a full onsite office review (e.g., providers who render care to fewer than 300 Davis Vision members annually).

Audit results are reported to Credentialing for inclusion in the provider's file and are considered by the Credentialing Committee when the provider's recredentialing file is presented for approval. Audit results are presented to the Quality Management Committee quarterly.

1. Office and Record Reviews

During a site visit, the RQAR reviewer evaluates the physical facilities for overall appearance, safety and cleanliness and evaluates equipment for overall condition and maintenance. Office staff may be interviewed regarding protocols for scheduling, dispensing and compliance with Davis Vision's policies and procedures, including safety and infection control practices. During the site visit, a sample of the provider's medical records is collected and examined. The RQAR reviewer evaluates the audit

results and reports the findings to the Assistant Vice President of Professional Affairs. Audit results are communicated to the provider in writing.

For providers who render care to fewer than 300 Davis Vision members annually, Davis Vision requests from the provider a sample of medical records from the total universe of plan patients. The medical records submitted are examined by a RQAR reviewer and the results are reported to the Assistant Vice President of Professional Affairs. Audit results are communicated to the provider in writing.

The audit tool located in the Appendix clearly identifies the components of the site visit and record review audits and the scoring methodology utilized by Davis Vision. The scoring threshold for site visits is 80% and for medical records is 65%. Providers scoring below 80% for the site visit and/or 65% for the medical record review must submit a written corrective action plan to Davis Vision which must be approved by the Assistant Vice President of Professional Affairs. Providers who score below 50% or whose corrective action plan is not approved by the Assistant Vice President are subject to a follow-up review (an additional site visit or a new sample of five records) in six months.

i. Commonly Accepted Guidelines for Medical Records

Adherence to the following commonly accepted guidelines is expected of all practitioners maintaining medical records:

- Medical records must be kept for individual patients in a secure area, away from patient access, but readily available to practitioners.
- Medical records must be legible and organized in a manner that allows for easy identification of patient name, date of birth, significant medical conditions, and allergies.
- The office must have policies in place for maintaining patient confidentiality in accordance with State and Federal laws.
- Practitioners must follow applicable professional and clinical guidelines for documenting care provided to patients.
- Date all entries, and identify the author and their credentials when applicable.
- Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The provider must also maintain a copy of the original entry.

Practitioners must retain patient medical records for a period of at least 10 years or the period required under applicable State and Federal laws.

ii. Medical Records Documentation

As reflected in the Medical Record Audit Tool contained in the Appendix, Davis Vision requires that the medical records for its members must include the following minimum documentation.

Patient Demographics:

- Patient name and date of birth on each page, or patient name and member ID number on each page
- Allergies to medication or other severe, potentially life-threatening allergic reactions (e.g., severe food allergies, latex, etc.)
- Address, phone number or other identifiers

Case (Medical) History:

- Chief complaint including recent changes in vision
- Relevant past eye, medical, and family history
- Relevant family ocular history
- Current medications
- Allergies to medication

Visual Acuity:

- Monocular
- Binocular
- Habitual
- Corrected
- Distance
- Near

Eye Health:

- External and internal structures of the eye
- Gross Visual Fields
- Pupil
- Intraocular pressure
- Dilated fundus examination, when indicated

Refraction:

- Objective
- Subjective
- Distance
- Near accommodative evaluation

Binocular Function:

- Distance phoria
- Near phoria,

- Ocular motility

Assessment/Management:

- Examination results including diagnosis and clinical recommendations and prescription
- Patient education and recommendation for follow-up care, if appropriate
- Referral to specialist or Primary Care Physician

Other:

- Printed name and signature of the examining doctor
- Exact lenses and frames and/or contact lenses dispensed
- Record must be legible
- Include the patient's Service Record Form in the medical record when applicable (including patient's agreement to pay for services not covered by the benefit plan)

Refractive surgeons must include in their documentation appropriate pre- and post-operative clinical notes.

C. INSTRUMENTATION AND EQUIPMENT

Each participating provider office must include the following instrumentation and equipment to administer high quality and comprehensive examinations:

- Examination Chair
- Instrument Stand
- Acuity Chart/Slides/Cards
- Ophthalmoscope
- Retinoscope/autorefractor
- Phoropter
- Tonometer
- Trial Lens Set
- Trial Frame
- Lensometer
- Keratometer
- Biomicroscope
- Field Testing Equipment
- Color Vision Test
- Stereopsis Test
- Binocular Indirect Ophthalmoscope with appropriate lens

All instrumentation must be well maintained, properly calibrated and in good working order. Infection control measures must be incorporated into the maintenance of all equipment.

D. UNSCHEDULED OFFICE VISITS

Davis Vision retains the right to visit any participating provider's office at any time and without prior notice. Reasons for an unscheduled office visit may include, but are not limited to, member complaints, failure of the practitioner to implement or comply with a corrective action plan, or failure of the practitioner to respond to requests for information.

As established in the Participating Provider Agreement, you are required to provide us with copies of medical records for our members within a reasonable time period following our request for the records.

E. MEMBER SATISFACTION

The purpose of Davis Vision's comprehensive member satisfaction program is to:

- Determine overall member perception of the vision care plan.
- Identify aspects of the program in which members would recommend a change.
- Identify practitioners on the panel who are not providing courteous and high quality services to members.
- Identify elements of the system which may be causing delays in the provision of care.
- Provide members with the opportunity to offer both positive and critical feedback
- Offer members the opportunity to ask questions regarding the program.
- Provide feedback to the practitioners on their patients' opinions about their care.
- Provide feedback to the laboratory on the patients' opinions about their services and materials.
- Provide feedback to the program's sponsor group on the assessment of the benefit by their constituents.

Patients' attitudes and perceptions are the fundamental component of quality improvement that is why Davis Vision members have the right to access and express their opinions and concerns. Patients obtaining services have the opportunity to complete a patient satisfaction survey to express their views concerning the quality of services rendered. This survey instrument is designed to elicit the patient's opinion on access to care, treatment by the professional staff and satisfaction with the examination and prescriptive eyewear.

Survey responses are evaluated and, if necessary, follow-up action is taken promptly. Davis Vision consistently achieves satisfaction rates of over 98%. Those surveyed who indicate less than total satisfaction are contacted individually to ensure 100% satisfaction. If appropriate, participating providers are asked to respond to concerns raised by their patients.

Davis Vision conducts statistical analysis on aggregate results. Semiannually, the RQARs provide comparative statistics to provider offices whose patients completed and returned at least ten (10) surveys. Survey results are shared with the Director of Professional Services, the Quality Improvement Committee and are used during the recredentialing process.

F. PRACTITIONER SATISFACTION

The Provider Satisfaction Survey establishes a platform for open communication and creates a better partnership between Davis Vision and its participating providers. The opinions, ideas and suggestions of Davis Vision's participating providers are as important as those of Davis Vision's members. At least annually, Davis Vision sends participating providers a Provider

Satisfaction Survey that addresses topics such as laboratory services, administrative processes and reimbursement. Responses are scanned and evaluated. Aggregate results are presented to the Quality Improvement Committee. The Committee discusses issues and concerns expressed by the providers, focusing on challenging trends or dissatisfaction.

As a result of comments in the Provider Satisfaction Survey, Davis Vision may take action including, but not limited to:

- Referring a topic to the Opportunities Committee, or other appropriate committee
- Referring a survey to a Professional Field Consultant or Regional Quality Assurance Representative for a site visit

SECTION XI
MARYLAND ADDENDUM

This Addendum is applicable to providers in the State of Maryland with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of Maryland.

The following requirements and processes supersede those in the Davis Vision Provider Manual.

MARYLAND STATE
MEMBER GRIEVANCE AND COMPLAINT PROCESS

DEFINITIONS

"Adverse Decision" means a utilization review determination that a proposed or delivered health care service which would otherwise be covered under the member's contract is or was not medically necessary, appropriate, or efficient and may result in non-coverage of the health care service. Adverse decision does not include a decision concerning a person's status as a member.

"Company" or "Davis Vision" shall refer to Davis Vision, Incorporated.

"Complaint" means a protest filed with the Maryland Insurance Commissioner involving an adverse decision, grievance decision or an appeal concerning a member.

"Emergency Case" means a case involving an adverse decision for which an expedited review is required if:

a) the adverse decision is rendered for health care services that are proposed but have not been delivered; and
b) the services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

"Filing Date" means the earlier of:
a) 5 days after date of mailing; or
b) the date of receipt.

"Grievance" means a written protest filed by a member or a health care provider on behalf of a member through this internal grievance process regarding an adverse decision

concerning the member. A grievance does not include a verbal request for reconsideration of a utilization review determination.

"Grievance Decision" means a final determination that arises from a grievance filed with the Company under its internal grievance process regarding an adverse decision concerning a patient.

"Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in Maryland that is governed by Title 15, Subtitle 10A of the Insurance Article of the Maryland Annotated Code.

STANDARD GRIEVANCE

The member, or a health care provider acting on the member's behalf, may file a grievance regarding an adverse decision. The member or health care provider acting on the member's behalf must file a grievance within one hundred and eighty (180) days after the member receives the adverse decision.

Grievances must be made in writing to Davis Vision. A written grievance may be made in one of two ways:

- It may be mailed to:
  Davis Vision, Inc.
  P.O. Box 791
  Latham, New York 12110
  Attention: Quality Assurance
- It may be sent via email:
  Log onto our website:
  www.davisvision.com
  Click on "Contact" (at very bottom of screen)
  Click on "To send an email, click here"

Members may call Davis Vision toll free at **1 (800) 999-5431** twenty-four (24) hours a day seven days a week to voice concerns and complaints. A Davis Vision Associate will attempt to resolve verbal complaints or concerns. However, voicing a complaint or concern verbally does not constitute the filing of a formal grievance under this internal grievance process.

Upon receipt of a grievance, a Quality Assurance Associate documents the grievance in the member's file and reviews the grievance to determine whether there is sufficient information to complete the internal grievance process. If not, Davis Vision will provide verbal and/or written notification within five (5) business days to the member or health care provider who filed the grievance on behalf of the member. The notification will include an offer to assist the member and health care provider in gathering the necessary information without delay.

If there is sufficient information to complete the internal grievance process, Davis Vision will provide written acknowledgment of the filing of the Grievance to the member and or the health care provider within 15 days of receipt of the Grievance. The written

acknowledgment includes (1) a statement that the member has the right to designate a representative to participate in the process on his/her behalf, (2) the Associate's name and telephone number, and (3) the timeframe for a Grievance determination.

Standard Grievances are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the Initial Adverse Determination and who is not a subordinate of the initial reviewer.

Davis Vision makes Standard Grievance Determinations and provides verbal notification to the member, the member's designee and/or the health care provider as fast as the member's condition requires and within 30 business days of receipt of the request for pre-service requests or within 45 business days of receipt of the request for retrospective requests, unless Davis Vision and the member or health care provider mutually agree that a further extension of the time limit (maximum of 30 business days) would be in the member's best interest. Written notice will be sent to the member, the member's designee and the health care provider within five (5) business days after the decision has been verbally communicated.

A member or a health care provider may file a complaint with the State Insurance Commissioner if the member or health care provider does not receive a Grievance Determination from Davis Vision on or before the 30th business day on which the grievance was filed for pre-service requests or on or before the 45th business day on which the grievance was filed for retrospective requests.

The notice of grievance decision will include:

- Detailed statement in clear, understandable language the specific factual bases for Davis Vision's decision;
- Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based, without using only generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary;"
- The name, business address, and business telephone number of the designated Davis Vision Associate who has responsibility for the internal grievance process;
- Statement that the member, or provider on behalf of the member, has the right to file a complaint with the State Insurance Commissioner within 30 business days of receipt of the Grievance Determination.
- The Commissioner's address, telephone number, and facsimile number.
- **"THERE IS HELP TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.** You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division Monday-Friday from 9 a.m. to 4:30 p.m. by telephone in Maryland at 1-877-261-8807 or by fax at 410-576-6571 or in writing Office of the Attorney General, Consumer Protection Division, Health Education and Advocacy Unit, 200 St. Paul Place, Baltimore, MD 21202-2021. You may also file your dispute online by accessing the Health Education Advocacy Unit at

http://www.oag.state.md.us/Consumer/HEAUrelform.htm

The Health Advocacy Unit can help you and your health care provider prepare a grievance to file under the carrier's internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process. Additionally, you may file a complaint with the Maryland Insurance Administration, without having to first file a grievance with the plan, if: (1) the plan has denied authorization for a health care service not yet provided to you, and (2) you or your provider can show a compelling reason to file a complaint, including that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN YOUR CERTIFICATE OF COVERAGE."

EXPEDITED GRIEVANCE

Davis Vision maintains an Expedited Grievance process for adverse determinations involving a situation where the standard timeframes could result in loss of life, serious impairment to a bodily function or serious dysfunction of a bodily organ. This Expedited Grievance process includes mechanisms that facilitate resolution of the Grievance including, but not limited to, the sharing of information from the member's health care provider and Davis Vision by telephone or fax.

Expedited Grievances are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the Initial Adverse Determination and who is not a subordinate of the initial reviewer.

Davis Vision makes Expedited Grievance Determinations and provides notice of determination to the member, the member's designee and the health care provider by telephone as fast as the member's condition requires, but in no event more than 24 hours after receipt of the request. Written notice will be sent to the member, the member's designee and the health care provider within one (1) calendar day after the decision has been verbally communicated. The written Expedited Grievance Determination will contain the same information as the Standard Grievance Determination, described above.

If the Expedited Grievance does not resolve the difference of opinion, the member, the member's designee and/or the health care provider may file a complaint with the State Insurance Commissioner.

A member or a health care provider may file a complaint with the Commissioner if the member or health care provider does not receive an Expedited Grievance Determination from Davis Vision within 24 hours after the grievance was filed.

FILING COMPLAINTS WITH THE INSURANCE COMMISSIONER

The internal grievance process must be exhausted prior to filing a complaint with the Commissioner **unless** the member or health care provider can provide sufficient

information and supporting documentation in the complaint that demonstrates a compelling reason to file with the Commissioner prior to completing the internal procedures. The demonstration of a compelling reason includes a showing that the potential delay in the receipt of a health care service until after the member or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ. In a case involving a post-service denial, there is no compelling reason to allow a member or a health care provider on behalf of a member to file a complaint without first exhausting the internal grievance process of the Company.

SECTION XII
NEW JERSEY ADDENDUM

This Addendum is applicable to providers in the State of New Jersey with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of New Jersey. Depending on the contractual relationship with the New Jersey managed care organization ("NJ-MCO"), Davis Vision may or may not be delegated for member complaints and appeals. Please contact Davis Vision Provider Services at ***1-800-933-9371*** *for specific member and delegation information*

The following requirements and processes supersede those in the Davis Vision Provider Manual.

- NJ FamilyCare/Medicaid members do not pay a fee for vision care. NJ FamilyCare C members pay a $5 personal contribution to care (PCC). NJ FamilyCare D members pay a $5 co-pay for optometrist visits. (I, 3)

- For providers in the State of New Jersey, if Davis Vision terminates the Provider Agreement before the end of the initial term (12 months beginning on the Effective Date on the signature page of the Agreement) or for "cause", the provider can request in writing a hearing within 10 business days following the date of receipt of notice of termination. Davis Vision will hold a hearing within 30 days following receipt of a written request for a hearing by a terminated health care professional before a panel appointed by Davis Vision. (IV, 11)

- For providers in the State of New Jersey, if the provider terminates the Provider Agreement without cause, or if an individual practitioner leaves the provider's practice or otherwise becomes unavailable to the members, the provider will notify those members receiving a current course of treatment at least 30 business days prior to the effective date of the termination. (IV, 11)

- Davis Vision will notify the New Jersey managed care organization ("NJ-MCO") upon notification that a provider or subcontractor will be suspended, terminated or voluntarily withdrawn from participation in the Davis Vision network, to allow the NJ-MCO to notify DMAHS at least 45 days prior to the effective date of the action.. If the termination was "for cause," Davis Vision's notice to the **NJ-MCO** will include the reasons for the termination. (IV, 12)

    1. Provider resource consumption patterns will not constitute "cause" unless Davis Vision can demonstrate it has in place a risk-adjustment system that takes into account enrollee health-related differences when comparing across providers.

2. Davis Vision will assure immediate coverage by a provider of the same specialty, expertise, or service provision and will provide the **NJ-MCO** with a copy of the new contract with a replacement provider upon execution, to allow the **NJ-MCO** to submit same to DMAHS 45 days prior to the effective date.

3. Upon request, Davis Vision will provide the **NJ-MCO** with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts, to allow the **NJ-MC**O to submit same to DMAHS.

- For providers in the State of New Jersey, the Attestation section of the Credentialing Application must indicate whether the applicant has any history of chemical dependency/ substance abuse. (VII, 7)

- For providers in the State of New Jersey, if Davis Vision's Credentialing Committee recommends termination of a provider from the network, the written notification to the provider will include the requirement that the provider must notify those affected members receiving a current course of treatment at least 30 business days prior to the effective date of the termination. (VII, 13)

- At the conclusion of the Provider Appeal Process, if the outcome results in the termination of the provider, the written notification to the provider will include the requirement that the provider must notify those affected members at least 30 business days prior to the effective date of the termination and the provider's termination is effective 45 days from the date of the notification. (VII, 14)

- NJ FamilyCare/Medicaid members should never be charged for copying medical records. (VIII, 3)

- NJ FamilyCare/Medicaid members are not charged for missed appointments. Davis Vision will request that all members notify providers at least 24 hours in advance when canceling any appointment. (VIII, 5)

- **Investigational Studies:**
  NOTE: *Davis Vision provides routine vision and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. Davis Vision does not provide or manufacture life-saving equipment, nor does Davis Vision authorize or provide medical treatment (emergency or routine).*
  NJ FamilyCare/Medicaid members who are qualified to participate in an approved clinical trial will not be denied participation in the clinical trial by Davis Vision, will not be denied coverage by Davis Vision of routine costs for items and services furnished in connection with participation in the trial, will not be discriminated against by Davis Vision on the basis of the enrollee's participation in such trial. (Davis Vision will provide payment for routine patient costs as available through the member's benefit design, but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.) (VIII, 12)

- A "qualified" enrollee means an enrollee under Davis Vision's coverage who meets the following conditions:
    1. The enrollee has a life-threatening or serious illness for which no standard treatment is effective;
    2. The enrollee is eligible to participate in an approved clinical trial with respect to treatment of such illness;
    3. The enrollee and the referring physician conclude that the enrollee's participation in such trial would be appropriate; and
    4. The enrollee's participation in the trial offers potential for significant clinical benefit for the enrollee.

- An "approved clinical trial" means a clinical research study or clinical investigation that meets the following requirements:
    1. The trial is approved and funded by one or more of the following:
        - The National Institutes of Health
        - A cooperative group or center of the National Institutes of Health
        - The Department of Veterans Affairs
        - The Department of Defense
        - The Food and Drug Administration, in the form of an investigational new drug (IND) exemption
    2. The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training.
    3. There is no alternative non-investigational therapy that is clearly superior.
    4. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as effective as the non-investigational alternative.

- For providers in the State of New Jersey servicing NJ FamilyCare/Medicaid members, medically necessary services are services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of service that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific

community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this manual. (VIII, 14)

- **Appeals:**
  An enrollee, and any provider acting on behalf of the enrollee with the enrollee's consent (enrollee's consent is not required in the case of a deceased patient, or when an enrollee has relocated and cannot be found), may appeal any UM decision resulting in a denial, termination, or other limitation in the coverage and access to health care services. Such enrollees and providers will be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process.

  Action means, at a minimum, any of the following:
    - An adverse determination under a utilization review program;
    - Denial of access to specialty and other care;
    - Denial of continuation of care;
    - Denial of a choice of provider;
    - Denial of coverage of routine patient costs in connection with an approved clinical trial;
    - Denial of access to needed drugs;
    - The imposition of arbitrary limitation on medically necessary services;
    - Denial in whole or in part, of payment for a benefit;
    - Denial or limited authorization of a requested service, including the type or level of services;
    - The reduction, suspension, or termination of a previously authorized service;
    - Failure to provide services in a timely manner;
    - Denial of a service based on lack of medical necessity.

  For your information and to enable you to advise your patients about their appeal rights, please refer to the following description of the NJ Appeals Process. The instructions include the 60-day time limit for members, or providers acting on behalf of members, with the member's written consent, to file an appeal.

  The appeal process for NJ FamilyCare/Medicaid members consists of an informal internal review (Level 1 Appeal), a formal internal review (Level 2 Appeal) and a formal external review (Level 3 Appeal) by an independent utilization review organization under the DOBI and/or the Medicaid Fair Hearing process. Medicaid/NJ FamilyCare A members and certain NJ FamilyCare D members may access the Fair Hearing process. Other NJ FamilyCare members, by federal rule, do not have access to the Medicaid Fair Hearing process.

  1. Level 1 Appeals will be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event will exceed 72 hours in the

case of appeals from determinations regarding urgent or emergency care, and five (5) business days in the case of all other appeals. If the appeal is not resolved to the satisfaction of the member at this level, the **NJ MCO** will provide the member and/or the provider with a written explanation of his or her right to proceed to a Level 2 Appeal, including the applicable time limits, if any, for making the appeal and to whom the appeal should be addressed.

2. Level 2 Appeals are available to any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the Level 1 Appeal, will have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the **NJ MCO** who have not been involved in the utilization management determination at issue. The members of the appeal panel will include practitioners who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. All Level 2 Appeals are acknowledged by the **NJ MCO** in writing to the member or provider filing the appeal within 10 business days of receipt. All Level 2 Appeals will be concluded as soon as possible after receipt by the **NJ MCO** in accordance with the medical exigencies of the case, which in no event will exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care and, except in the case of a situation in which the **NJ MCO** must extend the timeframe by an additional 14 calendar days, 20 business days in the case of all other appeals. The **NJ MCO** may extend the timeframes by up to 14 calendar if the member requests the extension or the **NJ MCO** shows (to the DMAHS' satisfaction upon its request) that there is need for additional information and how the delay is in the member's interest. If the Level 2 Appeal is denied, the **NJ MCO** will provide the member and/or provider with written notification of the denial and the reasons for the denial together with a written notification of his or her right to proceed to an external Level 3 Appeal. This notification will include specific instructions as to how the member and/or provider may arrange for an external appeal and will include any forms required to initiate such an appeal. In the event the **NJ MCO** fails to comply with any of the previously mentioned timeframes, or if the **NJ MC**O waives its right to an internal review of the appeal, then the member and/or provider will be relieved of his or her obligation to complete the internal review process and may, at his or her option, proceed directly to the external appeals process.

3. The external appeal process (Level 3 Appeal) is available to any member and any provider acting on behalf of a member with the member's written consent who is dissatisfied with the results of the internal appeal process. To initiate an external appeal, the member and/or provider will, within 60 days from receipt of the written determination of the Level 2 Appeal, file a written request with the Department of Banking and Insurance on a form automatically provided to the member.

- **NJ Credentialing Requirements**
  The initial credentialing process obtains and reviews verification of the following information, at a minimum:
    - the practitioner holds a current valid license to practice;
    - valid DEA or CDS certificate, as applicable;
    - graduation from medical school and completion of a residency, or other post-graduate training, as applicable;
    - work history;
    - professional liability claims history;
    - good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)
    - the practitioners hold current, adequate malpractice insurance according to the plan's policy;
    - any revocation or suspension of a State license or DEA number;
    - any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and
    - any censure by the State or County Medical Association.

  Davis Vision requests information on the practitioner from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate professional licensing board, depending on the provider type.

  The application process includes a statement by the applicant regarding:
    - any physical or mental health problems that may affect current ability to provide health care;
    - any history of chemical dependency/substance abuse;
    - history of loss of license and/or felony convictions;
    - history of loss or limitation of hospital privileges or disciplinary activity; and
    - an attestation to correctness/completeness of the applications.

- **NJ Recredentialing Requirements**
  The recredentialing process is implemented every three years and includes review of data from:
    - member complaints;
    - results of quality reviews;
    - performance indicators;
    - utilization management and;
    - reverifications of hospital privileges and current licensure.

SECTION XIII
PENNSYLVANIA ADDENDUM

This Addendum is applicable to providers in the Commonwealth of Pennsylvania with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the Commonwealth of Pennsylvania.

The following requirements and processes supersede those in the Davis Vision Provider Manual.

- Davis Vision makes Prior Approval Review determinations and provides notice of determination to PA HealthChoices/Medicaid members, the members' designee and the health care provider as fast as the member's condition requires and within two (2) business days from receipt of necessary information. A written or electronic confirmation of the decision is given within two (2) business days of communicating the decision.
- If a request for Prior Approval Review does not include sufficient information for Davis Vision to make a determination, Davis Vision will request the required information within 48 hours of the request for service.
- Davis Vision makes Concurrent Review determinations and provides notice of determination to PA HealthChoices/Medicaid members, the members' designee and the health care provider within one (1) business day of receipt of necessary information. A written or electronic confirmation of the decision is given within one (1) business day of communicating the decision.
- Davis Vision recognizes the DPW medical necessity definition as follows:
    - A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:
        - The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability
        - The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
        - The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.
- For members under the age of 21 and covered under the MA Program, requests for services that exceed benefit limits will be subjected to additional review for medical necessity. These reviews will be conducted by a licensed clinician and require MD to MD discussion, or documentation of attempts to reach the prescribing physician for discussion.

PENNSYLVANIA MANAGED CARE
MEMBER COMPLAINT AND GRIEVANCE PROCESSES

Davis Vision maintains complaint and grievance processes, each involving two (2) levels of review. A Member or a vision care Provider may contact the Pennsylvania Department of Health ("Department of Health") to complain that Davis Vision's administrative processes or time frames are being applied in such a manner as to discourage or disadvantage the Member or vision care Provider in utilizing the complaint and grievance processes. Referral of the allegations to the Department of Health will not operate to delay the processing of the complaint or grievance review. (Refer to Sections below for the process by which a member may give a provider written consent to file a grievance on his/her behalf.)

At any time during the internal complaint or grievance process, a Member may choose to designate an authorized representative to participate in the complaint or grievance process on his/her behalf. The Member or the Member's authorized representative shall notify Davis Vision, in writing, of the designation. Davis Vision reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

For purposes of the complaint and grievance processes, Member includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf.

At any time during the internal complaint or grievance process, at the request of the Member, Davis Vision will appoint a person from its Quality Assurance Department to assist the Member, at no charge, in preparing the complaint or grievance. The Davis Vision employee made available will not have participated in any previous decisions to deny coverage for the issue in dispute.

At any time during the internal complaint or grievance process, a Member may contact the Davis Vision Quality Assurance/Patient Advocate Department at 1-888-343-3470 to inquire about the filing or status of a complaint or grievance.

1. Complaint Process

a. Internal Complaint Process

Davis Vision maintains a complaint process for the resolution of disputes or objections by a Member regarding a Network Provider or the coverage (including contract exclusions and non-covered benefits), operations or management policies of Davis Vision, delivery of services and the breach or termination of the Agreement. A complaint does not include a grievance.

Members have the right to have complaints internally reviewed through the two (2) level process described in this Internal Complaint Process.

Members must exhaust this two (2) level process before seeking further administrative review of a complaint by the Department of Health or Pennsylvania Insurance Department. Except in the case of a Second Level Review involving the denial of a Pre-service Claim, the entire two (2) level process described below is mandatory and must be exhausted before a Member is permitted to institute such action at law or in equity in a court of competent jurisdiction as may be appropriate.

i. Initial Review

1. The Member's initial complaint shall be directed to the Quality Assurance Department. This complaint, which may be oral or in written form, must be submitted within 180 days from the date of the Member's receipt of the notification of an adverse decision or the occurrence of the issue which is the subject of the complaint. Within five (5) business days of receipt of the complaint, Davis Vision will provide written confirmation to the Member and/or the Member's designated representative that the request has been received, and that Davis Vision has classified it as a complaint for purposes of internal review. If a Member disagrees with Davis Vision's classification of a request for an internal review, he/she may directly contact the Department of Health for consideration and intervention with Davis Vision in regards to the classification that has been made.
2. The Member, upon request to Davis Vision, may review all documents, records and other information relevant to the complaint and shall have the right to submit any written comments, documents, records, information, data or other material in support of the complaint. The initial level complaint review will be performed by an Initial Review Committee which shall include one (1) or more employees of Davis Vision. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Member's complaint.
3. In rendering a decision on the complaint, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Davis Vision. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the complaint.
4. Each complaint will be promptly investigated and a decision rendered within the following time frames:
    a. When the complaint involves a non-urgent care Pre-service Claim, within a reasonable period of time

appropriate to the medical circumstances not to exceed 30 days following receipt of the complaint;

b. When the complaint involves a Post-service Claim, within a reasonable period of time not to exceed 30 days following receipt of the complaint.

5. Davis Vision will provide written notification to the Member and/or the Member's designated representative of its decision within five (5) business days of the decision, not to exceed 30 days from Davis Vision's receipt of the Member's complaint. All notifications shall include, among other items, the specific reason or reasons for the decision, the procedure for appealing the decision, a statement that the member may appeal the decision within 45 days from date of notification and, in the case of a complaint involving the denial of a Pre-service Claim, a statement regarding the right of the Member to pursue legal action.

ii. Second Level Review

1. If the Member is dissatisfied with the decision following the initial review of his/her complaint, including a non-urgent care Pre-service Claim or Post-service Claim complaint, he/she may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date an adverse decision is received and may include any written information from the Member or any party in interest. Upon receipt of the request for the second level review, Davis Vision will send the Member and the Member's representative an explanation of the procedures to be followed during the second level review, including the Member's right to request the aid of a Davis Vision employee, who did not participate in previous decisions to deny coverage for the issue in dispute, at no charge, in preparing the Member's second level complaint; and notification that the Member and the Member's representative have the right to appear before the Second Level Review Committee and that Davis Vision will provide the Member and the Member's representative with 15 days advance written notice of the time scheduled for that review. The Second Level Review Committee shall be comprised of three (3) individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one (1) individual of the committee will not be an employee of Davis Vision or of any Davis Vision related subsidiary or affiliate. When arranging the hearing, Davis Vision will notify the member in writing of the hearing procedures and rights at

such hearing, including the right of the member to be present at the review. If a member cannot appear in person at the second level review, Davis Vision shall provide the member the opportunity to communicate with the Committee by telephone or other appropriate means.

2. Attendance at the second level review will be limited to members of the review committee; the Member or the Member's representatives, including any legal representative or attendant necessary for the Member to participate in or understand the proceedings, or both; the Member's provider if the Member consents to the provider being present; applicable witnesses; and appropriate representatives of Davis Vision. Persons attending the second level review and their respective roles at the review will be identified for the enrollee. The second level review will be informal and impartial to avoid intimidating the Member or the Member's representative. The committee members will not discuss the case to be reviewed prior to the second level review meeting. Committee members who are unable to attend the review meeting may vote if they actively participate in the review meeting by telephone or videoconference. If additional information is introduced at the review meeting, it will be provided to committee members participating by telephone or videoconference for review prior to the vote. Depending on the issue under review, Davis Vision may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney representing the committee will not argue the Davis Vision's position or represent Davis Vision or its staff. The committee may question the enrollee, the enrollee's representative and Davis Vision employees representing the plan's position. The committee will base its decision solely upon the materials and testimony presented at the review meeting. The proceedings of the second level review committee, including the comments of the Member or the Member's representative, will be recorded electronically and maintained as part of the complaint record.
3. The hearing will be held and a decision will be made within 30 days of Davis Vision's receipt of the Member's request for review. This applies to both the voluntary second level review of a non-urgent care Pre-service Claim complaint and the mandatory second level review of a Post-service Claim complaint.
4. Davis Vision will provide written notification of its decision within five (5) business days of the decision, not to exceed 30 days from Davis Vision's receipt of the Member's request for

review. All notifications shall include, among other items, the specific reason or reasons for the decision, the procedure and timeframes for appealing the decision (including addresses and telephone numbers for the Department of Health and Pennsylvania Insurance Department) and, in the case of a complaint involving the denial of a Post-service Claim, a statement regarding the right of the Member to pursue legal action.

b. Appeal of Complaint

A Member will have fifteen (15) days from the receipt of the notice of the decision of the Second Level Review Committee to appeal the decision to the Department of Health or the Pennsylvania Insurance Department, as appropriate depending on the nature of the dispute. The appeal shall be in writing unless the Member requests to file the appeal in an alternative format.

Appeals may be filed at the following addresses:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120

Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Bldg.
Harrisburg, PA 17120
717-787-5193, Toll Free 888-466-2787
Fax 717-705-0947
PA AT&T relay service 800-654-5984

All records from the initial review and the second level review shall be forwarded to the Department of Health or the Pennsylvania Insurance Department, as appropriate. The Member, the vision care Provider or Davis Vision, may submit additional material related to the complaint. Each shall provide to the other, copies of additional documents provided. The Member may be represented by an attorney or other individual before the appropriate Department.

2. Grievance Process

a. Internal Grievance Process

Davis Vision maintains an internal grievance process by which a Member, the Member's designated representative or a vision care Provider, with the written consent of the Member, shall be able to file a grievance regarding the denial of payment for a vision care service on the basis of Medical Necessity and Appropriateness.

A grievance may be filed regarding a decision that:

(a) Disapproves full or partial payment for a requested vision care service;

(b) Approves the provision of a requested vision care service for a lesser scope or duration than requested; or
(c) Disapproves payment for the provision of a requested vision care service but approves payment for the provision of an alternative vision care service. A grievance does not include a complaint.

Members have the right to have grievances internally reviewed through the two (2) level process described in this Internal Grievance Process.

Members must exhaust this two (2) level appeal process before seeking further review of a grievance by an independent external review organization assigned by the Department of Health. Except in the case of a Second Level Review involving the denial of a Pre-service Claim, the entire two (2) level process described below is mandatory and must be exhausted before a Member is permitted to institute such action at law or in equity in a court of competent jurisdiction as may be appropriate.

Vision Care Provider Initiated Grievances

A vision care Provider may, with the written consent of an enrollee or the enrollee's legal representative, file a written grievance. This consent may be obtained by the Provider at the time of treatment. However, the Provider may not require this consent as a condition of providing a health care service. Written consent must include:

- Name and address of the Member and the Policy Holder, if they are different, the Member's date of birth and identification number.
- If the Member is a minor or is legally incompetent, the name, address and relationship to the Member of the person who signs the consent for the Member.
- The Provider's name, address and provider I.D. number as assigned by Davis Vision.
- Davis Vision's name and address, as the plan to which the grievance will be submitted.
- An explanation of the specific service for which coverage was provided or denied to the enrollee for which the consent will apply.
- The following statements:
    - The Member or the Member's representative may not submit a grievance concerning the services listed in this consent form unless the Member or the Member's legal representative rescinds this consent in writing. The Member or the Member's legal representative has the right to rescind consent at any time during the grievance process.
    - The consent of the Member or the Member's legal representative shall be automatically rescinded if the Provider fails to file a

grievance or fails to continue to prosecute the grievance through the second level review process.

- The Member or the Member's legal representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form and has had it explained to his/her satisfaction. The Member or the Member's legal representative understands the information in the consent form.

- The dated signature of the Member or the Member's legal representative and the dated signature of a witness.

The Member or the Member's legal representative may rescind consent to a vision care Provider to file a grievance on behalf of the Member at any time during the grievance process. If the Member or the Member's legal representative rescinds consent, the Member or the Member's legal representative may continue with the grievance at the point at which consent was rescinded. The Member or the Member's legal representative may not file a separate grievance. A Member or the Member's legal representative who has filed a grievance may, at any time during the grievance process, choose to provide consent to a vision care Provider to continue with the grievance instead of the Member or the Member's legal representative.

The Provider having obtained consent from the Member or the Member's legal representative to file a grievance, shall have ten (10) days from receipt of the initial, standard written adverse determination and any decision notification letter from a first, second or external review upholding Davis Vision's decision to notify the Member or the Member's legal representative of its intention not to pursue a grievance.

Once the Provider has assumed responsibility for filing a grievance, he/she may not bill the Member or the Member's representative for services provided that are the subject of the grievance until the external grievance review has been completed or the Member or the Member's legal representative rescinds consent for the Provider to pursue the grievance. If the Provider chooses never to bill the Member or the Member's representative for the services provided that are the subject of the grievance, the Provider may withdraw the grievance with notice to the Member and the Member's representative. If the Provider elects to appeal the adverse decision of an external review agent to a court of competent jurisdiction, he/she may not may not bill the Member or the Member's representative for services provided that are the subject of the grievance until a final decision is rendered or the Provider withdraws the appeal.

i. Initial Review

NOTE: Davis Vision will provide an expedited review if written certification is received from the Member's physician.

The Member's initial grievance must be submitted in writing (or communicated orally under special circumstances) within one hundred-eighty (180) days from the Member's receipt of the notification of an adverse decision or occurrence of the issue which is the subject of the grievance and shall be directed to the Quality Assurance Department.

Within five (5) business days of receipt of the grievance, Davis Vision will provide written confirmation to the Member, the Member's designated representative and the vision care Provider including, but not limited to, the following information:

- That the request has been received
- That Davis Vision has classified it as a grievance for purposes of internal review. If the Member disagrees with Davis Vision's classification of a request for an internal review, he/she may directly contact the Department of Health for consideration and intervention with Davis Vision in regards to the classification that has been made.
- That the Member, the Member's designated representative or the vision care Provider may request the aid of a Davis Vision employee, at no charge, in preparing the grievance
- That the Member, the Member's designated representative or vision care Provider, upon request to Davis Vision, may review documents, records and other information relevant to the grievance and shall have the right to submit any written comments, documents, records, information, data or other material in support of the grievance.

The initial level grievance review will be performed by an Initial Review Committee which shall include one (1) or more individuals selected by Davis Vision at least one (1) of whom is a licensed Physician in the same or similar specialty as that which would typically manage or consult on the health care service in question. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision relating to the Member's grievance. The Member or the vision care Provider may specify the remedy or corrective action being sought.

In rendering a decision on the grievance, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Davis Vision. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the grievance.

Each grievance will be promptly evaluated and a decision rendered within the following time frames:

When the grievance involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the grievance; or
When the grievance involves a Post-service Claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the grievance.

Davis Vision will provide written notification to the Member, the Member's designated representative and/or the health care provider of its decision (upheld or overturned) within five (5) business days of the decision, not to exceed thirty (30) days from Davis Vision's receipt of the Member's grievance. All notifications shall include, among other items, the specific reason or reasons for the decision including clinical rationale, the procedure for appealing the decision, a statement that the member may appeal the decision within 45 days from date of notification and, in the case of a grievance involving the denial of a Pre-service Claim, a statement regarding the right of the Member to pursue legal action.

ii. Second Level Review

If the Member is dissatisfied with the decision (upheld or overturned) following the initial review of his/her grievance, including a non-urgent care Pre-service Claim or Post-service Claim grievance, he/she may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed by the Second Level Review Committee must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date an adverse decision is received and may include any written information from the Member or healthcare Provider.

Within five (5) business days of receipt of the request for second level review, Davis Vision will provide written confirmation to the Member, the Member's designated representative and/or the vision care Provider including, but not limited to, the following information:

- That the request has been received
- An explanation of the second level review process
- That the Member, the Member's designated representative or the vision care Provider may request the aid of a Davis Vision employee, who did not participate in the previous decisions to

deny coverage for the issue in dispute, at no charge, in preparing the Member's second level complaint

- That the Member, the Member's designated representative or vision care Provider, upon request to Davis Vision, may review documents, records and other information relevant to the grievance and shall have the right to submit any written comments, documents, records, information, data or other material in support of the grievance.
- That the Member and the Member's designated representative have the right to appear before the Second Level Review Committee and that Davis Vision will provide the Member and the Member's representative with 15 days advance written notice of the time scheduled for that review.

The Second Level Review Committee shall be comprised of three (3) individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one (1) individual of the committee will not be an employee of Davis Vision or of any Davis Vision related subsidiary or affiliate. The Committee will include a licensed Physician in the same or similar specialty as that which would typically manage or consult on the health care service in question. When arranging the hearing, Davis Vision will notify the Member, the Member's designated representative and/or the health care provider in writing of the hearing procedures and rights at such hearing, including the right of the member to be present at the review. If a member cannot appear in person at the second level review, Davis Vision shall provide the member the opportunity to communicate with the Committee by telephone or other appropriate means.

Attendance at the second level review will be limited to members of the review committee; the Member or the Member's representatives, including any legal representative or attendant necessary for the Member to participate in or understand the proceedings, or both; the Member's provider if the Member consents to the provider being present; applicable witnesses; and appropriate representatives of Davis Vision. Persons attending the second level review and their respective roles at the review will be identified for the enrollee. The second level review will be informal and impartial to avoid intimidating the Member or the Member's representative. The committee members will not discuss the case to be reviewed prior to the second level review meeting. Committee members who are unable to attend the review meeting may vote if they actively participate in the review meeting by telephone or videoconference. If additional information is introduced at the review meeting, it will be provided to committee members participating by telephone or videoconference for review prior to the

vote. Depending on the issue under review, Davis Vision may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney representing the committee will not argue the Davis Vision's position or represent Davis Vision or its staff. The committee may question the enrollee, the enrollee's representative and Davis Vision employees representing the plan's position. The committee will base its decision solely upon the materials and testimony presented at the review meeting. The committee will not base its decision upon any document obtained on behalf of Davis Vision which sets out medical policies, standards or opinions or specifies opinions supporting Davis Vision's decision unless the plan also makes available for questioning by the review committee and/or the Member an individual, selected by Davis Vision, who is familiar with the policies, standards and opinions contained in the document. The proceedings of the second level review committee, including the comments of the Member or the Member's representative, will be recorded electronically and maintained as part of the complaint record.

The hearing will be held and a decision will be made within thirty (30) days of Davis Vision's receipt of the Member's request for review. This applies to both the voluntary second level review of a non-urgent care Pre-service Claim grievance and the mandatory second level review of a Post-service Claim grievance.

Davis Vision will provide written notification to the Member, the Member's designated representative and/or the health care provider of its decision (upheld or overturned) within five (5) business days of the decision, not to exceed thirty (30) days from Davis Vision's receipt of the Member's request for review. All notifications shall include, among other items, the specific reason or reasons for the decision including clinical rationale, the procedure and timeframes for requesting an external grievance review and, in the case of a grievance involving the denial of a Post-service Claim, a statement regarding the right of the Member to pursue legal action.

iii. External Grievance Process

A Member, the Member's designated representative or a vision care Provider, with the written consent of the Member, may request an external review of a denial of a second level grievance within fifteen (15) days from the receipt of the notification of the decision of the Second Level Review Committee. The appeal can be filed by submitting a request for an external grievance to Davis Vision. The Member should include any material justification and all reasonably

necessary supporting information as part of the external grievance filing.

Within five (5) business days of receiving the external grievance, Davis Vision will notify the Department of Health, the Member, the Member's designated representative or the healthcare Provider, as appropriate, that a request for an external grievance review has been filed. Davis Vision's notification to the Department of Health shall include a request for assignment of a Certified Utilization Review Entity (CRE). Davis Vision shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the CRE conducting the external grievance within fifteen (15) days of the receipt of notice that the external grievance was filed. Within this same period, Davis Vision shall provide the Member, the Member's designated representative or the vision care Provider with a list of documents forwarded to the CRE for the external review. The Member, the Member's designated representative or the vision care Provider may supply additional written information, with copies to Davis Vision, to the CRE for consideration on the external review within fifteen (15) days of receipt of notice that the external grievance was filed.

The external grievance process will be conducted by a CRE selected by the Department of Health. The Department of Health will notify the Member or the vision care Provider, and Davis Vision of the name, address and telephone number of the CRE assigned within two (2) business days following receipt of the request for assignment. If the Department of Health fails to select a CRE within two (2) business days of receiving the request, Davis Vision has the right to designate and notify a CRE to conduct the external review. Each party has seven (7) business days from the date on the notice of assignment of the CRE to object orally or in writing to the Department based on conflict of interest. The objecting party may request the assignment of another CRE. Again, each party has seven (7) business days from the date on the notice of assignment of the CRT to object orally or in writing to the Department based on conflict of interest. The objecting party may request the assignment of another CRE. If either party objects to the second CRE assigned, the 60-day time period allowed for the CRE's review will be calculated from the date on which the CRE is accepted by both parties. The CRE conducting the external grievance shall review all the information considered in reaching any prior decisions to deny payment for the vision care service and any other written submission by the Member or the vision care Provider.

Within sixty (60) days of the filing of the external grievance, the CRE conducting the external grievance shall issue a written notification of the decision to the Department, Davis Vision, the Member, the Member's representative or the vision care Provider, including the basis and clinical rationale for the decision.

The external grievance decision may be appealed to a court of competent jurisdiction within sixty (60) days of receipt of the notification of the external grievance decision. Davis Vision shall authorize any vision care service or pay a claim determined to be Medically Necessary and Appropriate based on the decision of the CRE regardless of whether an appeal to a court of competent jurisdiction has been filed.

iv. Expedited Review Process

Davis Vision maintains an Expedited Review Process that is available to Members if the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Standard Review Process.

The Member, the member's representative or a vision care Provider, with the written consent of the Member, may request an Expedited Review at any stage of the review process by providing Davis Vision with written certification from the Member's physician that the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Standard Review Process. The certification shall include a clinical rationale and facts to support the physician's opinion. Davis Vision will accept the physician's certification and provide an Expedited Review.

Upon receipt of the request for an Expedited Review accompanied by written certification from the Member's physician, Davis Vision will contact the member by telephone within 12 hours to:

- Acknowledge receipt of the request for an Expedited Review
- Advise the Member of his/her right to participate in the Expedited Review
- Determine whether the Member wishes to participate in the Expedited Review by telephone conference call
- Advise the Member of the proposed time and date of the review. (Adjustments in the time and date of the review may be made to reasonably accommodate the member's participation.)

Attendance at the expedited review will be limited to members of the review committee; the Member or the Member's representatives, including any legal representative or attendant necessary for the

Member to participate in or understand the proceedings, or both; the Member's provider if the Member consents to the provider being present; applicable witnesses; and appropriate representatives of Davis Vision. Persons attending the expedited review and their respective roles at the review will be identified for the enrollee. The expedited review will be informal and impartial to avoid intimidating the Member or the Member's representative. The committee members will not discuss the case to be reviewed prior to the expedited review meeting. If additional information is introduced at the review meeting, it will be provided to committee members participating by telephone for review prior to the vote. Depending on the issue under review, Davis Vision may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney representing the committee will not argue the Davis Vision's position or represent Davis Vision or its staff. The committee may question the enrollee, the enrollee's representative and Davis Vision employees representing the plan's position. The committee will base its decision solely upon the materials and testimony presented at the review meeting. The committee will not base its decision upon any document obtained on behalf of Davis Vision which sets out medical policies, standards or opinions or specifies opinions supporting Davis Vision's decision unless the plan also makes available for questioning by the review committee and/or the Member an individual, selected by Davis Vision, who is familiar with the policies, standards and opinions contained in the document. The proceedings of the expedited review committee, including the comments of the Member or the Member's representative, will be recorded electronically and maintained as part of the complaint record.

The hearing will be held and a decision will be issued within 48 hours of receipt of the Member's request for an Expedited Review accompanied by written certification from the Member's physician. Notification to the Member shall state the basis for the decision, including any clinical rationale and the procedure for obtaining an Expedited External Review. Within 24 hours of receipt of a Member's request for an Expedited External Review, Davis Vision shall submit a request for an Expedited External Review to the Department by fax and telephone.

When the Department has assigned a CRE, Davis Vision will transfer a copy of the case file to the CRE for receipt on the next business day and the CRE shall have 2 business days to issue a decision.

SECTION XIV
TEXAS ADDENDUM

*This Addendum is applicable to providers in the State of Texas with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of Texas. Depending on the contractual relationship with the Texas managed care organization, Davis Vision may or may not be delegated for member complaints and appeals. Please contact Davis Vision Provider Services at **1-800-933-9371** for specific member and delegation information*

The following requirements and processes supersede those in the Davis Vision Provider Manual.

- Claims must be filed not later than the 95th day after services are rendered for both contracted and out-of-network providers. The provider forfeits the right to payment if the claim is not filed in 95 days, unless failure to comply is the result of a catastrophic event.
- A physician or provider may not submit a duplicate claim before the 46th day for paper-filed claims or before the 31st day for electronically-filed claims after the original submission.
- Providers must notify Davis Vision of a claim underpayment within 270 days of the date of partial payment.
- In accordance with Title 28 of the Texas Administrative Code Section 19.1724, Davis Vision is required to offer Davis Vision contracted providers in Texas the option to submit a "verification" as defined as follows: "A guarantee that an HMO (or HMO's delegate) or preferred provider carrier will pay for proposed medical care or health care services rendered within the required timeframe to the patient for whom the services are proposed."

  Please call the Davis Vision Interactive Voice Response (IVR) System at **1-800-77DAVIS** and follow the prompts to reach the Verification prompt. Provide the following data elements for all verifications:
  - Patient name
  - Member ID number
  - Patient date of birth
  - Name of member
  - Patient's relationship to the member
  - Diagnosis code
  - Proposed procedures or materials
  - Place of service
  - Proposed date of service
  - Group code (Davis Vision group code or prefix code)
  - Other carrier information – if available

- Provider name and Davis Vision Provider Number

SECTION XV
VIRGINIA ADDENDUM

This Addendum is applicable to providers in the State of Virginia with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of Virginia.

The following requirements and processes supersede those in the Davis Vision Provider Manual.

VIRGINIA MANAGED CARE
MEMBER COMPLAINT AND APPEALS PROCESS

DEFINITIONS (per Code of Virginia §32.1-137.7 and 12VAC5-408.10)

"Adverse Decision" means a utilization review determination by the utilization review entity that a health service rendered, or proposed to be rendered, was or is not *medically necessary*, when such determination may result in non-coverage of the health service or health services.

"Appeal" means a formal request by a *covered person* or a provider on behalf of a covered person or reconsideration of a decision, such as a final *adverse decision*, a benefit payment, a denial of coverage, or a reimbursement for service.

"Commission" means the Virginia State Corporation Commission.

"Complaint" means a written communication from a *covered person* primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including claims payments, the handling or reimbursement for such services, or any other matter pertaining to the *covered person's* contractual relationship with the managed care health insurance plan

"Covered Person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Emergency Medical Condition" is defined as the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the *covered person's* health in serious jeopardy. It also involves a health condition or illness that, if not treated within

the time frame allotted for a standard review, would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the covered person's health in serious jeopardy.

"Final Adverse Decision" means a *utilization review* determination made by a physician advisor or peer of the *treating health care provider* in reconsideration of an *adverse decision*, and upon which a provider or patient may base an *appeal*.

"Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Treating Health Care Provider" or "Provider" means a licensed health care provider who renders or proposes to render health care services to a *covered person*.

"Utilization Review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person.

"Utilization Review Entity" or "Entity" means a person or entity performing utilization review.

MEDICAL NECESSITY DETERMINATION

Davis Vision contracted providers who identify a need for services requiring a medical necessity determination complete and fax a Prior Approval Form to Davis Vision including, but not limited to, the patient's identification number, the patient's name, diagnosis, requested service or procedure and justification. A Utilization Review Associate reviews the request for completeness. If additional information is required to make the determination, the Utilization Review Associate notifies the provider verbally and/or in writing.

A licensed clinician reviews the request and all supporting documentation. With the exception of retrospective reviews, Davis Vision makes a reasonable attempt to communicate an initial adverse recommendation to the health care provider prior to the issuance of an adverse decision. Davis Vision shall accept additional information from the health care provider by telephone, fax machine or otherwise, prior to the issuance of an adverse determination.

A licensed clinician makes a determination no later than two (2) business days after receipt of all information necessary to complete the review. Davis Vision provides notice of determination to the member, the member's representative and the health care provider

by telephone and in writing as fast as the member's condition requires and within two (2) business days from receipt of necessary information. Notification of adverse determinations includes instructions for the health care provider to seek reconsideration of the adverse determination including the name, address and phone number of the person responsible for making the adverse determination. Notification also includes the criteria relied upon for the decision, the clinical reason for the adverse decision, a statement advising the covered person of his/her right to pursue an appeal and a description of the appeal process including, but not limited to, time limits, addresses and telephone and fax numbers.

INFORMAL RECONSIDERATION

Reconsideration of any adverse decision may be requested by the provider on behalf of the covered person. A decision on reconsideration shall be made by a licensed clinician. Davis Vision shall notify the treating provider on behalf of the covered person of the reconsideration determination in writing within ten (10) business days of receipt of the request for reconsideration. Notification of the final adverse determination shall include, but is not limited to, the criteria used, the clinical reason for the adverse decision and the opportunity for an appeal.

EXPEDITED APPEAL

If the treating provider determines that the regular appeals process would delay the rendering of health care in a manner that would be detrimental to the health of the patient, Davis Vision shall handle the appeal on an expedited basis. An expedited appeal decision may be further appealed through the standard appeal process unless all material information and documentation were reasonably available to the provider and Davis Vision at the time of the expedited appeal and the reviewer was a peer of the patient's provider.

Expedited appeals are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination. The decision on an expedited appeal shall be made no later than one (1) business day after receipt of all necessary information.

If the review of an expedited appeal results in an adverse determination, Davis Vision shall take the following actions immediately:

- Notify the member, the member's representative and the provider of the decision by telephone, facsimile or electronic mail
- Notify the member that he/she has the right to file a request for an expedited appeal with the Bureau of Insurance.
- Follow-up the above notification within 24 hours with a written notice to the member and the treating provider informing them of the right to appeal the decision to the Bureau of Insurance and providing them with the appropriate forms for filing the appeal.

APPEAL OF FINAL ADVERSE DETERMINATION

Davis Vision maintains an appeals process, including a process for expedited appeals, to review any final adverse decision. The covered person, the covered person's representative or a health care provider acting on the covered person's behalf may request an appeal within 180 calendar days after receipt by the covered person of the initial adverse determination.

Appeals may be made in writing, or by telephone, to Davis Vision as follows:

Davis Vision, Inc.
Quality Assurance Department
P.O. Box 791
Latham, NY 12110
Telephone: 1-888-377-0914
TTY/TDD: 1-800-523-2847
Fax: 1-888-343-3475
Email: www.davisvision.com

Davis Vision provides written acknowledgment of the filing of the appeal to the covered person, the covered person's representative and/or the health care provider within fifteen (15) business days after receipt of the appeal.

Appeals are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination. Davis Vision makes appeal determinations and provides written notification to the covered person, the covered person's representative and/or the health care provider as fast as the member's condition requires and within 60 calendar days of receipt of required documentation.

The written decision includes the criteria used and the clinical reason for the decision. If the appeal process results in an adverse determination, the notification includes a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance, procedures for making such an appeal, and the binding nature and effect of such an appeal.

No covered person who exercises the right to file an appeal shall be subject to disenrollment or otherwise penalized due to the filing of an appeal.

REGISTERING A COMPLAINT OR GRIEVANCE

Davis Vision maintains a system for the resolution of complaints brought by covered persons, or by providers acting on behalf of a covered person and with the covered person's consent, including complaints regarding availability, delivery or quality of

health care services, or any other matter pertaining to the covered person's contractual relationship with the managed care health insurance plan licensee.

Complaints may be made in writing, or by telephone, to Davis Vision as follows:

Davis Vision, Inc.
Quality Assurance Department
P.O. Box 791
Latham, NY 12110
Toll free Telephone: 1-800-584-1487
TTY/TDD: 1-800-523-2847
Fax: 1-888-343-3475
Email: www.davisvision.com

Davis Vision's toll free number, **1-800-584-1487**, is available 24 hours a day, 7 days a week, for covered persons or providers to voice complaints and concerns. A Davis Vision Associate will attempt to resolve verbal complaints or concerns at time of the initial telephone call. Unresolved complaints or concerns are referred to the Quality Assurance Department where they are documented. At any time, a complainant may request that a formal complaint be registered.

Timelines for responding to complaints shall accommodate clinical urgency and shall not exceed 30 calendar days from receipt of the complaint. Resolution of complaints shall not exceed 60 calendar days from date of receipt of the complaint.

No covered person who exercises the right to file a complaint shall be subject to disenrollment or otherwise penalized due to the filing of a complaint.

ASSISTANCE WITH APPEALS AND COMPLAINTS

Covered persons may contact the Office of the Managed Care Ombudsman at the following address and telephone number to help with appeals and complaints:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll free Telephone: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
TDD/Voice: 804-371-9206
Fax: 804-371-9944
E-mail: ombudsman@scc.virginia.gov

EXTERNAL APPEALS - The Virginia Bureau of Insurance

The Virginia Bureau of Insurance maintains an External Appeal process to review final adverse determinations made on the basis of medical necessity or

experimental/investigational procedures. A covered person or a provider acting on behalf of a covered person ("appellant") may appeal to the Bureau of Insurance ("Bureau") for review of any final adverse decision which meets the following criteria:

- The covered person must be covered by an eligible insurance plan, which disqualifies self-funded ERISA plans, Medicare and Medicaid. Also, persons covered by federal employee health plans are not eligible to file appeals for External Review with the Bureau.
- The covered person must have exhausted all internal appeals available through the managed care health insurance plan.
- The covered person must have been denied coverage because it was determined the care was not medically necessary or involved experimental or investigative procedures.
- The covered person must file for an External Review within 30 days of the final decision to deny coverage.
- The covered person's claim must exceed $300.00. There is a $50.00 filing fee with any appeal. This fee may be waived based on financial hardship.

An appellant may request an Expedited External Review for situations involving an emergency medical condition. The Bureau shall make a determination as to whether an expedited review is warranted. If an expedited review is denied, the appellant shall be advised to use the managed care health insurance plan's internal appeal process.

If the External Appeal is accepted, the Bureau shall ask an independent healthcare review organization that is not affiliated with the covered person's managed care health insurance plan to conduct a review of the appeal. The review organization shall obtain medical information pertinent to the appeal from the covered person, the health care provider and the managed care health insurance plan. The review organization shall make a written recommendation to the Commissioner of Insurance who shall review the recommendation to ensure that it is not arbitrary or capricious. The Commissioner shall then issue a written ruling that will uphold, reverse or modify the decision made by the managed care health insurance plan. That ruling is binding and cannot be appealed.

SECTION XVI
APPENDIX

Anti Reflective Coating Formulary

Approved Frame Manufacturers

Contact Lens Collection

Duty to Warn/Patient Rejection and Waiver Form

Lab Shipback Forms

Medical Record Review Tool

Prior Approval/Medically Necessary Services Request Form

Progressive Addition (PAL) and Intermediate Lens Formulary

Proivder Claim Payment Appeal Policy

Provider Office Review Tool

Provider Procedure and Option Codes

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Anti-Reflective Coating (ARC)

The 3 categories are Standard, Premium, and Ultra. Standard being the lowest copayment, Premium next, then Ultra being at the highest copayment. The patient charge, provider reimbursement, or additional dispensing fee (surfee) for any of the category differs and is indicated on the group specified Service Record Form or Personalized Service Record Form, and the plan outline.

The table below indicates the various AR coatings included in each category. *Please note: Not all AR coatings are available on all lens style / material combinations".*

STANDARD ARC

Standard AEGIS
Carl Zeiss BLUE (Super) ET®
Carl Zeiss GOLD ET®
Essilor REFLECTION FREE®

PREMIUM ARC

Essilor CRIZAL™
Carl Zeiss CARAT BLUE®
Carl Zeiss CARAT GOLD®

ULTRA ARC

Essilor CRIZAL SUN™
Crizal AVANCE™ with Scotchgard™
Carl Zeiss CARAT ADVANTAGE BLUE®
Carl Zeiss CARAT ADVANTAGE GOLD®
Carl Zeiss TEFLON®

These Formularies are subject to change at any time. Please visit the Davis Vision website at www.davisvision.com for the current Formularies.

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Approved Frame Manufacturers

(Please select up to a $49.00 Wholesale cost)
(Special fit circumstances up to $40.00 Wholesale cost)

A & A Optical	**I Deal Optics**	**Safilo**
Artcarft	**Kenmark**	**Signature Eyewear**
Aspex	**L'Amy**	**Silhouette**
Avalon	**Liberty**	**Silver Dollar**
B. Robinson/Magazine	**Lido West**	**Smilen**
Britalia	**Limited Edition**	**TMS Titmus (Sperian)**
Cadillac Eyewear	**Luxottica**	**Tura**
Capri	**Marchon**	**Value Eyewear**
Charmont	**Marcolin**	**Viva**
Clear Vision	**Mcgee Group**	**Windson Eye**
Colors in Optics	**Modern Optical**	**Zimco**
Contienental	**Neo Style**	**Zyloware**
Eastern States	**New Millenium**	
Europa	**Nouveau**	
Eyedeals	**On-Guard Safety**	
Eyewear Designs	**Optimate**	
Eye Q Eyewear	**Optio vision**	
Hart Specialties	**REM Eyewear**	
Hilico	**Revolution**	

Davis Vision can special order any of the above frame selections.

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CONTACT LENS COLLECTION

Type	Lens	Manufacturer
D	Soflens 38 (6 Pk)	Bausch & Lomb®
D	Clear Site (1-Day 30 Pack)	Cooper/OSI
D	Focus Dailies - 30 Pk	CIBA Vision®
D	O2 Optix	CIBA Vision®
D	Cooper Clear FW	Cooper/OSI
D	Biomedics XC (Silicon Hydrogel)	Cooper/OSI
D	Encore Premium	Cooper/OSI
D	Acuvue	Johnson & Johnson
D	Acuvue 2	Johnson & Johnson
D	Acuvue Advance	Johnson & Johnson
D	1-Day Acuvue	Johnson & Johnson
D	Biomedics 38	Cooper/OSI
D	Biomedics 55	Cooper/OSI
D	Freshlook LT	CIBA Vision®
PR	Purevision (Silicon Hydrogel)	Bausch & Lomb®
PR	Proclear Compatibles	Cooper/OSI
PR	Frequency 38	Cooper/OSI
PR	Frequency 55	Cooper/OSI

The above list may be updated from time to time without prior notice. Please check your plan materials (provider outline and service record form) for specific benefit and copayment information (as certain contact lenses may be available with a copayment and that copayment may vary by lens type based on plan design) and for the dispensing amount.

KEY: D - Disposable PR - Planned Replacement

These Collections are subject to change at any time. Please visit the Davis Vision website at www.davisvision.com for the current Formularies.

Duty to Warn / Patient Rejection and Waiver Form

Proper selection and use of eyewear is critical to your eye safety. If your occupational, sports, or other activities expose you to the risk of flying objects or physical impact, you eye safety may require the use of special spectacle lens materials. For tasks which require impact protection, polycarbonate lenses should be used. Of all materials that spectacle lenses may be fabricated from, polycarbonate lenses are the most impact resistant.

I understand that my doctor / dispenser has recommended polycarbonate lenses for my visual safety and protection. I hereby acknowledge that I have voluntarily, and with full knowledge of the possible consequences of my selection, decided to utilize an alternative material for my eyewear. I am ordering lenses made of

[ ] CR39 Plastic
[ ] Glass
[ ] High Index Plastic

Polycarbonate lenses were recommended by doctor / dispenser for the following reason(s):

_____

_____

_____

_____

_____ _____

Patient Signature *Date*

_____

Signature of Parent/Guardian (if applicable)

_____

Signature of Witness

Fax completed form to:
Davis Vision Lab Research / Redo Team
Fax Number: 1-800-240-4413

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SHIP-BACK INFORMATION
TO ACCOMPANY ITEMS SENT TO LABORATORY

520 AIRPORT ROAD
SUITE A-5
ALBUQUERQUE, NM 87121
(FAX) 1-505-833-3520

170 EXPRESS STREET
PLAINVIEW NY 11803
1-800-888-4321
(FAX) 1-800-933-9375

3805 WEST CHESTER PIKE
BUILDING D, SUITE 150
NEWTOWN SQUARE, PA
19073
1-800-836-2082
(FAX) 215-937-0649

5555 BADURA AVE STE. 160
LAS VEGAS, NV 89118
1-800-393-7919
(FAX) 1-702-270-7805

Todays Date:			
From:			
Patient:			

FOR NON-PLAN FRAME ORDERS

From:	MANUFACTURER	STYLE	SIZE
Reference:	DATE OF ORDER	INVOICE#	COLOR

FOR EYEGLASS RETURNS

ORIGINAL ORDER DATE:	DATE OF ORDER	INVOICE#	
TYPE RETURNED (check one)	UNDISPENSED	DISPENSED	WARRANTY

DETAILS: PLEASE DESCRIBE REASONS FOR RETURN OF EYEWEAR BELOW:

(FOR LABORATORY USE ONLY)

LSF20101215

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SHIP-BACK INFORMATION
TO ACCOMPANY ITEMS SENT TO LABORATORY

520 AIRPORT ROAD
SUITE A-5
ALBUQUERQUE, NM 87121
(FAX) 1-505-833-3520

170 EXPRESS STREET
PLAINVIEW NY 11803
1-800-888-4321
(FAX) 1-800-933-9375

3805 WEST CHESTER PIKE
BUILDING D, SUITE 150
NEWTOWN SQUARE, PA
19073
1-800-836-2082
(FAX) 215-937-0649

5555 BADURA AVE STE. 160
LAS VEGAS, NV 89118
1-800-393-7919
(FAX) 1-702-270-7805

Todays Date:
From:
Patient:
FOR NON-PLAN FRAME ORDERS
From: MANUFACTURER STYLE SIZE
Reference: DATE OF ORDER INVOICE# COLOR
FOR EYEGLASS RETURNS
ORIGINAL ORDER DATE: DATE OF ORDER INVOICE#
TYPE RETURNED (check one) UNDISPENSED DISPENSED WARRANTY
DETAILS: PLEASE DESCRIBE REASONS FOR RETURN OF EYEWEAR BELOW:
(FOR LABORATORY USE ONLY)
LSF20101215

Provider Name: **Provider Number:** **DATE**

RQAR:

PRINT NAME

	I Demographics (8)			II Case History (14)				III Habitual VA (4)		IV Eye Health (30)						V Refraction (20)					VI Binoc Function (8)				VII Assessment / Mgt (10)		VIII Other (6)		
Chart Identification	**Adult/Child/Special**	**Form (4)**	**Demographics (4)**	**CC (4)**	**EH (4)**	**MH (4)**	**FH (2)**	**Distance (2)**	**Near (2)**	**External (8)**	**Internal (8)**	**Visual Field (2)**	**Pupil (3)**	**Tonometry (4)**	**Dilation (5)**	**Objective (4)**	**Subjective (8)**	**Distance VA (2)**	**Near Refraction (4)**	**Near VA (2)**	**Ocular Motility (2)**	**NPC (2)**	**Near Phorias (2)**	**Distance Phorias (2)**	**Diagnosis/Assessment (5)**	**Education / Plan (5)**	**Dr. Signature (3)**	**Legibility (3)**	**TOTALS**
1.																													
2.																													
3.																													
4.																													
5.																													
6.																													
7.																													
8.																													
9.																													
10.																													
Numerical Totals	**X**																												**XXXXX**
Numerical average	**X**																												

Observations & Comments:

ADD SEPARATE SHEET FOR ADDITIONAL COMMENTS:

For Office Use Only:

Site Visit **I** **II** **III**

Record Review **I** **II** **III**

Auditors Signature

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Progressive Addition (PAL) and Intermediate Lens Formulary

In order to best support each practitioner's professional judgment in providing the ideal PAL design for an individual patient's needs, Davis Vision has implemented a 2-tier progressive lens formulary for most groups. Under this formulary, members may receive either Standard or Premium progressive lens designs. The patient charge for either category may differ and is indicated on the group specified Service Record Form or Personalized Service Record Form. A listing of all progressive lens designs in each category is represented in the following table:

STANDARD PROGRESSIVE STYLES

Short Corridor:

AO Compact
AO Compact Ultra
Armorlite Navigator Short
Vision Ease Outlook
Vision Ease Tegra Outlook

Traditional Corridor:

Armorlite Navigator
Essilor Adaptar
Essilor Natural
Hoya GPWide
Sola Instinctive
KbCo Fusion II
Sola VIP / VIP Gold
X-Cel Freedom ID
Younger Image

PREMIUM PROGRESSIVE STYLES

Short Corridor:

Armorlite Kodak Concise
Armorlite Kodak - Precise Short
Essilor Smallfit
Hoya Summit CD
Seiko Proceed III
Varilux Ellipse
Varilux Physio Short
Zeiss GT2 Short

Traditional Corridor:

AO Easy
Armorlite Kodak Precise
Essilor Accolade
Essilor Ovation
Hoya Summit ECP
Seiko Proceed II
Sola SolaMax
Sola SolaOne
Varilux Comfort (New Design)
Varilux Physio
Vision Ease Illumina
Zeiss GT2

INTERMEDIATE LENS STYLES

For task specific uses such as computer vision

AO Sola Access
Hoya Tact
Zeiss Gradal RD
Zeiss Business

Please note: If your patient cannot successfully adapt to progressive lenses within 60 days, standard bifocals will be remade without any cost to the member. However, co-payments or patient charges (if any) will not be refunded to the patient.

These formularies are subject to change at any time.

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Received by Davis Vision

PRIOR APPROVAL / MEDICALLY NECESSARY SERVICES REQUEST FORM

Submit To: Toll Free Fax 1-800-584-2329 Questions? Call: 1-800-328-4728 x6811

IMPORTANT: PLEASE VERIFY MEMBER BENEFIT PRIOR TO SUBMITTING REQUEST.

Patient Information

Patient Name (Please Print)		Member/Patient ID Number
Patient Date of Birth	New Patient Yes ☐ No ☐	Group/Employer Name

Provider Information

Provider Name (Please Print)	Provider Panel Number	Today's Date
Provider Telephone Number	Provider Fax Number	

Services Requested

Exam Only ☐	Contact Lens Evaluation ☐	Keratoconus ☐	Progressive Myopia ☐
Exam & Eyeglasses ☐	Contact Lenses ☐	Aphakia/Post Cataract ☐	Pathological Myopia ☐
Eyeglasses Only ☐	Low Vision Evaluation ☐	Anisometropia ☐	Diabetes ☐
Repair/Replace ☐	Low Vision Aids ☐		Other _____
	Additional Exam ☐		

Diagnosis/Reason for Services

Provider Comments **Supporting Documents Attached** ☐

Prescription Information **Fees (Information Required)**

Rx Eyeglasses	OD OS	VA OD VA OS	Professional Fee $_____
Contact Lenses	OD OS	VA OD VA OS	Material Fee $_____ Contact Lenses ☐ Low Vision Aids ☐ Eyeglasses ☐

BOTH OLD AND NEW PRESCRIPTION MUST BE COMPLETED BELOW FOR REQUESTS RELATED TO SIGNIFICANT CHANGES IN RX.

Old Rx	OD OS	**New Rx**	OD OS

FOR DAVIS VISION USE ONLY – DO NOT WRITE BELOW THIS AREA

Approved Date	Auth No./Benefit	Denied Date	Reviewed By: Signature
Comments:			
Additional Information Required		Date Requested	Date Received

PROVIDER CLAIM PAYMENT APPEAL POLICY

Davis Vision affords providers the opportunity to a written appeals process for disputes related to payment of claims, other than those based upon utilization management determinations. The appeals process requires direct communication between any provider and Davis Vision and does not require any action by the enrollee.

Providers have the right to file an appeal to any claim decision at any time. Davis Vision will not retaliate or take any discriminatory action against any provider as a result of filing a complaint, grievance or appeal.

The appeal process is intended to:

- provide a mechanism for all providers to dispute billing or payment concerns and to have those concerns addressed in a satisfying and timely manner.
- be easily accessible to providers
- provide prompt, fair and full investigation and resolution of appeals
- meet the criteria/requirements set forth by regulatory and accrediting bodies.

A written appeal from a participating or non-participating provider is considered a formal request for a review related to any adverse payment or billing determination rendered by Davis Vision.

An appeal can arise from and includes, but is not limited to, the dispute of claim issues such as reimbursement, timeliness and resubmission. In addition, providers may file an appeal regarding:

- obtaining a prompt authorization
- dissatisfaction with Davis Vision's policies and procedures
- lost of incomplete claim forms or electronic submissions
- requests for additional explanation as to services or treatment
- inappropriate or unapproved referrals initiated by any provider
- or any other reason for a billing dispute.

All claim appeals must be submitted in writing and received within 90 calendar days following receipt of the initial claim determination.

To file a claim appeal, a provider should mail all of the above-mentioned information to:

Davis Vision
Provider Appeals – Quality Assurance
P.O. Box 791
Latham, NY 12110

Appeal determinations, including written notification, shall be completed within thirty (30) calendar days from receipt of the request.

Providers Practicing in the State of New Jersey

A provider should submit all of the following information when filing an initial claim appeal and *must submit the appeal request on the appropriate appeal form created by the New Jersey Department of Banking and Insurance:*

- name and address of the Provider
- Professional Provider's Tax Payer Identification Number or an Institutional Provider's Medicaid Provider Number, as applicable
- the Member/Covered Person/s name
- the date(s) of service for the specific claim in question
- a letter or other writing, clearly denoted as a Provider Claim Determination Appeal, which includes a description regarding the claim in question
- a copy of any and all prior Explanation of Benefits forms or correspondence issued by Davis Vision supporting its Claims Payment Determination

- a copy of any and all documentation demonstrating proof of a claim submission
- the specific basis or rationale for the claim appeal
- the specific remedy or relief sought and if the amount due on the claim is questioned, the specific amount the provider believes is due and the basis, rationale and supporting documentation for such view.

Other documentation that supports the rationale for the claim appeal, if necessary, include:

- payment vouchers
- claim records
- prior correspondence
- print outs of electronic claims systems transactions
- any other documentation necessary to adequately support the rationale for the Claim Appeal

To file a claim appeal, a provider should mail all of the above-mentioned information to the address listed below.

Davis Vision
Provider Appeals – Quality Assurance
P.O. Box 791
Latham, NY 12110

Appeal determinations, including the written notification, shall be completed within thirty (30) calendar days from the receipt of the request.

The Department of Banking and Insurance has established a binding and non-appealable external ADR mechanism that involves arbitration, and in some cases, mediation, for providers who remain dissatisfied following their pursuit of an appeal through the initial claim appeals process. These mechanisms are described below:

Upon determination of the initial appeal, providers may appeal all adverse determinations through an independent, binding ADR process. Arbitration must be initiated on or before the 90th calendar day following receipt of the determination of an appeal. Disputes must be in the amount of $1000 or more. Providers and healthcare professionals must aggregate claims to reach the $1000 minimum under circumstances in which the same claim issue is involved.

Providers may initiate the above binding and non-appealable external ADR review of an adverse decision of a provider claim appeal after the initial appeal review, by filing a request for external ADR review, with the written findings from the initial appeal determination within ninety (90) calendar days from the date of the written decision to the following address:

Davis Vision
Provider Appeals – Quality Assurance
P.O. Box 791
Latham, NY 12110

All external ADR appeal requests must be submitted on the applicable appeal form created by the Department of Banking and Insurance. The ADR arbitrator is subject to change. Proceedings under such external ADR mechanism, including the method of selecting the mediator or arbitrator that will mediate or arbitrate the case shall be in accordance with the rules followed by the ADR organization.

The arbitrator's decision shall be issued on or before the 30th calendar day from receipt of the appeal form and all necessary documentation for the arbitrator to complete the review.

The decision of the independent arbitrator shall be binding and non-appealable. If the arbitrator results are made against the payer, the claim must be adjudicated with accrued interest at the rate of 12% per annum, on or before the tenth business day following the issuance of the arbitrator's determination.

Provider Office Review

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TOTAL SCORE:

Provider No. **Provider Name:** **Office Manager:** **Phone#:**

Address: **City:** **State:**

Initial Date: **RQAR:** **Follow-up Visit:** **QOC Visit:**

Practice Type: Solo: **Partnership:** **Group:** **Optical:** **Ophthalmology:**

Resources: Facilities/Personnel (35 Points)	Points	Score	Comments
Reception & Waiting Area:			
Adequate Space and Seating	3		
Cleanliness and Ventilation	2		
Handicap Access	1		
Examining Rooms:			
Adequate Space and Seating	3		
Cleanliness and Ventilation	2		
Hand Washing Facilities	1		
Privacy of Examination	2		
Dispensing Area:			
Adequate Space and Seating	3		
Cleanliness	2		
Location Davis Vision Tower	1		
Other Patient Care Exam Rooms:			
Contact Lens/Pre Testing	1		
Visual Fields/Vision Training	1		
Additional Testing/Laboratory	1		
Consultation Room	1		
Rest Rooms:			
Sanitary/Adequately Supplied	3		
Safety:			
Smoke Alarms/Extinguishers	1		
Exit Sign Clearly Visible	1		
Evacuation Plan	1		
Emergency Kit	1		
Personnel:			
Identifying Tag (Licensed Personnel)	1		
Appearances	2		
Licenses Displayed	1		

Provider Office Review

Equipment (40 Points)	Point	Score	Comments
Examination Chair	3		
Instrument Stand	2		
Projector Chart/Slides	2		
Near Point Cards	2		
Direct Ophthalmoscopy	2		
Binocular Indirect Ophthalmoscope	3		
Retinoscope/Auto	3		
Phoropter	2		
Tonometer/Type	2		
Trial Lens Set	2		
Lensometer	2		
Keratometer	2		
Biomicroscope	3		
Contact Lens Kit	2		
Visual Field	3		
Color Vision Test	2		
Imaging Instrumention HRT/GDX	1		
Other	2		
Infection Control (7 Points)			
Alcohol, Gel, Solution, Disinfection	2		
Drugs (Check Expiration dates)	2		
Contact Lens & Solutions (Check Expiration Date)	2		
Medications Adequately Stored	1		
Accessibility (5 Points)			
Wait Time (45 Minutes or Less)	1		
Exam Availability (at Least 12 hours per week)	1		
Patients Obtain Appointment within 2 Weeks	1		
Protocol Missed Appointment (Charts noted, Patient called)	1		
Emergency/After Hours Protocol (e.g. Answering Machine)	1		
Medical Records/Privacy (13 Points)			
Records Stored in a Secure and Confidential Area	2		
Patient Name or ID on Chart Pages	1		
Doctors' Name or ID on Chart Pages	1		
All Entries Dated	1		
Records Legible to Others	1		
Place to Document Allergies	1		
Place to Document Medications	1		
Place to Document Med/Eye History	1		
All Items Secured in Chart	1		
HIPAA Requirments Written Policy use/Disclousure of PHI	1		
Designated Compliance Office	1		
Cooperation of Office Personnel	1		

Davis Vision
Provider Procedure Codes

Procedure Code	Description
CL01	Contact Lens Evaluation
CL02	Contact Lens Evaluation; Fitting (New Patient)
CL03	Contact Lens Evaluation; Re-Fit (Existing Wearer)
CL04	Contact Lens Evaluation; Fitting Toric (New Patient)
CL05	Contact Lens Evaluation; Re-Fit Toric (Existing Wearer)
CL12	Daily Wear Contact Lens Fitting (New Wearer)
CL13	Daily Wear Contact Lens Re-Fitting (Existing Wearer)
CL14	Toric Daily Wear Contact Lens Fitting (New Wearer)
CL15	Toric Daily Wear Contact Lens Re-Fitting (Existing Wearer)
CL16	Disposable Contact Lens Fitting (New Wearer)
CL17	Disposable Contact Lens Re-Fitting (Existing Wearer)
CL18	Toric Disposable Contact Lens Fitting (New Wearer)
CL19	Toric Disposable Contact Lens Re-Fitting (Existing Wearer)
92310	Daily Wear Contact Lens Fitting
S0592	Extended Wear Contact Lens Fitting
001	Examination Only
002	Exam, Plan Single Vision Lenses, Plan Frame
003	Exam, Plan Single Vision Lenses, Practioners Frame
004	Exam, Plan Single Vision Lenses, Own Frame
005	Exam, Plan Bifocal Lenses, Plan Frame
006	Exam, Plan Bifocal Lenses, Practioners Frame
007	Exam, Plan Bifocal Lenses, Own Frame
008	Exam, Plan Trifocal Lenses, Plan Frame
009	Exam, Plan Trifocal Lenses, Practioners Frame
010	Exam, Plan Trifocal Lenses, Own Frame
011	Exam, Practioners Single Vision Lenses, Plan Frame
012	Exam, Practioners Bifocal Lenses, Plan Frame
013	Exam, Practioners Trifocal Lenses, Plan Frame
014	Exam, Practioners Aphakic Single Vision Lenses, Plan Frame
015	Exam, Practioners Aphakic Bifocal Lenses, Plan Frame
016	Exam, Practioners Single Vision Lenses, Practioners Frame
017	Exam, Practioners Bifocal Lenses, Practioners Frame
018	Exam, Practioners Trifocal Lenses, Practioners Frame
019	Exam, Practioners Aphakic Single Vision Lenses, Practioners Frame
020	Exam, Practioners Aphakic Bifocal Lenses, Practioners Frame
021	Exam, Practioners Contact Lenses (no definition of the type)
022	Exam, Practioners Medically Necessary Contacts
023	Exam, Plan Contact Lenses
024	Exam, Plan Frame
025	Exam, Practioners Soft Contact Lenses
026	Exam, Practioners Hard Contact Lenses
027	Exam, Practioners Toric Contact Lenses
028	Exam, Practioners Rigid Gas Permeable Contact Lenses
029	Exam, Practioners Frame
030	Exam, Plan Disposable Contact Lenses

031	Exam, Plan Premium Disposable Contact Lenses
032	Exam, Plan Single Vision Lenses Safety Complete
034	Exam, Plan Single Vision Lenses Safety Lenses
035	Exam, Plan Bifocal Lenses Safety Complete
037	Exam, Plan Bifocal Lenses Safety Lenses
038	Exam, Plan Trifocal Lenses Safety Complete
039	Exam, Plan Trifocal Lenses Safety Lenses
046	Exam, Practioners Bifocal Contact Lenses
N02	Plan Single Vision Lenses, Plan Frame
N03	Plan Single Vision Lenses, Practioners Frame
N04	Plan Single Vision Lenses, Own Frame
N05	Plan Bifocal Lenses, Plan Frame
N06	Plan Bifocal Lenses, Practioners Frame
N07	Plan Bifocal Lenses, Own Frame
N08	Plan Trifocal Lenses, Plan Frame
N09	Plan Trifocal Lenses, Practioners Frame
N10	Plan Trifocal Lenses, Own Frame
N11	Practioners Single Vision Lenses, Plan Frame
N12	Practioners Bifocal Lenses, Plan Frame
N13	Practioners Trifocal Lenses, Plan Frame
N14	Practioners Aphakic Single Vision Lenses, Plan Frame
N15	Practioners Aphakic Bifocal Lenses, Plan Frame
N16	Practioners Single Vision Lenses, Practioners Frame
N17	Practioners Bifocal Lenses, Practioners Frame
N18	Practioners Trifocal Lenses, Practioners Frame
N19	Practioners Aphakic Single Vision Lenses, Practioners Frame
N20	Practioners Aphakic Bifocal Lenses, Practioners Frame
N21	Practioners Contact Lenses
N22	Practioners Medically Necessary Contact Lenses
N23	Plan Contact Lenses
N24	Plan Frame, Member Lenses
N25	Practioners Soft Contact Lenses
N26	Practioners Hard Contact Lenses
N27	Practioners Toric Contact Lenses
N28	Practioners Rigid Gas Permeable Contact Lenses
N29	Practioners Frame
N30	Plan Disposable Contact Lenses
N31	Plan Premium Disposable Contact Lenses
N32	Safety Single Vision Lenses, Safety Frame
N34	Safety Single Vision Lenses, Own Frame
N35	Safety Bifocal Lenses, Safety Frame
N37	Safety Bifocal Lenses, Own Frame
N38	Safety Trifocal Lenses, Safety Frame
N39	Safety Trifocal Lenses, Own Frame
N46	Practioners Bifocal Contact Lenses
MN11	Practioners Single Vision Lenses, Own Frame
MN12	Practioners Bifocal Lenses, Own Frame
MN13	Practioners Trifocal Lenses, Own Frame
MN14	Practioners Aphakic Single Vision Lenses, Own Frame
MN15	Practioners Aphakic Bifocal Lenses, Own Frame
M011	Exam, Practioners Single Vision Lenses, Own Frame

M012	Exam, Practioners Bifocal Lenses, Own Frame
M013	Exam, Practioners Trifocal Lenses, Own Frame
M014	Exam, Practioners Aphakic Single Vision Lenses, Own Frame
M015	Exam, Practioners Aphakic Bifocal Lenses, Own Frame
R01	Refractive Exam Only
R02	Refractive Exam, Plan Single Vision Lenses, Plan Frame
R03	Refractive Exam, Plan Single Vision Lenses, Practioners Frame
R04	Refractive Exam, Plan Single Vision Lenses, Own Frame
R05	Refractive Exam, Plan Bifocal Lenses, Plan Frame
R06	Refractive Exam, Plan Bifocal Lenses, Practioners Frame
R07	Refractive Exam, Plan Bifocal Lenses, Own Frame
R08	Refractive Exam, Plan Trifocal Lenses, Plan Frame
R09	Refractive Exam, Plan Trifocal Lenses, Practioners Frame
R10	Refractive Exam, Plan Trifocal Lenses, Own Frame
R11	Refractive Exam, Practioners Single Vision Lenses, Plan Frame
R12	Refractive Exam, Practioners Bifocal Lenses, Plan Frame
R13	Refractive Exam, Practioners Trifocal Lenses, Plan Frame
R14	Refractive Exam, Practioners Aphakic Single Vision Lenses, Plan Frame
R15	Refractive Exam, Practioners Aphakic Bifocal Lenses, Plan Frame
R16	Refractive Exam, Practioners Single Vision Lenses, Practioners Frame
R17	Refractive Exam, Practioners Bifocal Lenses, Practioners Frame
R18	Refractive Exam, Practioners Trifocal Lenses, Practioners Frame
R19	Refractive Exam, Practioners Aphakic Single Vision Lenses, Practioners Frame
R20	Refractive Exam, Practioners Aphakic Bifocal Lenses, Practioners Frame
R21	Refractive Exam, Practioners Contact Lenses
R22	Refractive Exam, Medically Necessary Contact Lenses
R23	Refractive Exam, Plan Contact Lenses
R24	Refractive Exam, Plan Frame
R29	Refractive Exam, Practioners Frame
R30	Refractive Exam, Plan Disposable Contact Lenses
R31	Refractive Exam, Plan Premium Disposable Contact Lenses
R32	Refractive Exam, Safety Single Vision Lenses, Safety Frame
R34	Refractive Exam, Safety Single Vision Lenses, Own Frame
R35	Refractive Exam, Safety Bifocal Lenses, Safety Frame
R37	Refractive Exam, Safety Bifocal Lenses, Own Frame
R38	Refractive Exam, Safety Trifocal Lenses, Safety Frame
R39	Refractive Exam, Safety Trifocal Lenses, Own Frame
S0500	Exam, Practioners Disposable Contact Lenses
SN500	Practioners Disposable Contact Lenses
E2400	Exam, Practioners Supplied Soft Contact Lenses
N2400	Practioners Supplied Soft Contact Lenses
E2500	Exam, Plan (Practioners Supplied) Hard Contact Lenses
N2500	Plan (Practioners Supplied) Hard Contact Lenses
E2600	Exam, Practioners Supplied Extended Contact Lenses
N2600	Practioners Supplied Extended Contact Lenses
NONS0500	Exam, Practioners, Non Disposable Contact Lenses
NONSN500	Practioners, Non Disposable Contact Lenses

Davis Vision
Option Codes

F	Premier Frame
D	Designer/Metal Frames
L	Fashion Frame
S	Scratch Resistant Coating
P	Photogrey (PGX)
R	Anti Reflective Coating (Standard)
U	Ultraviolet Coating
I	Standard Progressive Lenses
@	Premium Progressive Lenses
A	Polycarbonate Lenses
B	Double Segment Bifocal Lenses
E	Blended Invisible Bifocal Lenses
G	Polarized Lenses
H	High Index Plastic Lenses
T	Tinting (Plastic Gradient)
Q	Plastic Photosensitive Lenses
C	Color Coating
V	Edge Treatment
$	Intermediate Lenses
Y	Blended Myodisc
%	Quadrifocals
J	High Index Glass
M	Mirror Coating
K	Didymium Single Vision Lenses
O	Rose Tint (Plastic)
N	Didymium Multifocal Lenses
W	Premium Anti Reflective Coating
Z	Ultra Anti Reflective Coating
+	Tinting (Plastic Solid)
-	Tinting (Glass)
=	Executive Multifocal
*	Rose Tint (Glass)
#	Colorcoating (Gradient)
<	High Index Plastic (Under 1.6 Center)
(	High Index Glass (Under 1.6 Center)
>	Oversize Lenses

PROVIDER
NETWORK NEWS

WINTER 2010

Inside…

idealChoice:

Our Best Provider Plan Ever!

We see you. We hear you!

We are pleased to extend this exclusive opportunity to participate as a Davis Vision idealChoice plan provider! To meet the continuing growth of our client base, we designed the idealChoice plan to enhance our 30,000-strong Preferred Provider Organization. The idealChoice plan is designed to increase reimbursements to providers who are currently utilizing the Davis Vision laboratories.

We expect to offer idealChoice to employer groups in 2011. Existing Davis Vision providers utilizing the Davis Vision laboratories will be automatically enrolled in the idealChoice plan and receive higher reimbursements for groups sold under the idealChoice plans in 2011.

Plan benefits include free form progressive lens options included in the plan design and a broad range of quality lens types and coatings, as you determine. We will offer easy administration with Online Benefit Alert! providing access to group changes or additions, benefit plan information and payment reimbursement information.

idealChoice offers:

- **Higher provider reimbursements**
- **Higher dispensing fees on all plan frames**
- **Expanded selection of lens options (free-form, digital progressives) with higher dispensing fees**
- **In-network claims paid weekly**
- **Easier-to-understand Explanation of Payments ONLINE**

Eye Health & Wellness: See Better. See

Vision problems are now the second most prevalent health issue in the U.S., affecting over 120 million Americans.[1] They impose a heavy financial burden on employers, accounting for a whopping $8 billion in sick days, medical bills and lost productivity per year. In fact, employers spend more on vision and eye disease annually than on breast cancer, lung cancer or HIV.[2]

Davis Vision's Eye Health Connection℠ Program is dedicated to promoting better health among our members and lowering overall medical costs.

Healthy eyes help ensure healthy lives. That's why our Eye Health Connection Program prompts members to receive a regular comprehensive eye exam including dilation for early diagnosis of sight-threatening eye diseases, some of which have no symptoms.

This exam is not only critical to maintaining eye health; it also often provides the first indication of a chronic systemic disease, such as diabetes or hypertension, that can lead to more critical complications and higher costs if left untreated. Early diagnosis and treatment are essential to preventing such complications. A recent study found that spotting signs of diabetes, hypertension and high cholesterol through eye exams ultimately saved between $204,000 and $968,000 for each of five companies examined.[3]

Targeted Care Management

The most effective health and wellness programs are the ones most specifically targeted to individual members' health care needs. Davis Vision is well positioned to successfully administer such a program. We modified our new corporate-wide computer operating platform in order to expand disease management capabilities to meet the needs of as many members as possible.

What makes our program different from others is that our system capabilities extend further than tracking members with diabetes. We are also able to track members diagnosed with glaucoma, cataracts and age-related macular degeneration. This places Davis Vision in a position to facilitate more specifically targeted patient care.

Our goal is to elevate the level of benefits offered to members living with eye disease so that their quality of life is positively impacted. To that end, our Eye Health Connection Program provides greater frequency of dilated eye exams to members affected by the four leading eye conditions that lead to vision loss or blindness: diabetic retinopathy, glaucoma, cataracts and age-related macular degeneration.

We also have the flexibility to offer expanded eyewear coverage for those members. (See chart on next page.) This serves to motivate the member to return for routine eye care.

Wellness Programs Boost Health & Savings

Nearly 60% of the U.S. population over 18 has at least one chronic health condition.[4] What does that mean for the employer? It means that over half of its employees likely have a chronic health problem. Because the rate of chronic disease—which now accounts for 85% of overall health care spending—is expected to increase, it also means that health care costs will continue to rise.[5]

That trend could be slowed by improving prevention, early intervention and disease management. A current report estimates that these measures could avert 40.2 million cases of chronic conditions and save $1.1 trillion by 2023.[6] Many companies are fostering such improvements by offering health and wellness and disease management programs to their employees.

Davis Vision's Eye Health Connection℠ Program is dedicated to promoting better health among our members and lowering overall medical costs.

Communication Intensive Program

Our Eye Health Connection Program is communication intensive! Davis Vision distributes customized communications to targeted members throughout the year to encourage regular eye exams. An online vision wellness library and resource center, part of Davis Vision's Eye Health Connection Program, helps members learn more about the importance of eye exams and about the diseases and conditions that an eye exam can diagnose.

Before benefit plan implementation, the member's eye care provider is notified of his or her unique vision benefit coverage enhancements under our program, as well as specific care and encounter reporting requirements. Periodic exam reminder letters and health educational materials sent to patients enable them to become partners in their health.

Primary Care Physician (PCP) notification forms are available for providers to share exam results with a member's PCP. We share member health data with designated health partners, such as a medical carrier, medical management group or pharmacy, in compliance with HIPAA regulations.

Davis Vision's sophisticated administrative system, coupled with our dedication to helping members plan for their eye care, has resulted in an eye health and wellness program with proven results! Visits to eye care providers by members in our Diabetic Outreach Program are 60% higher than for non-diabetic members, resulting in healthier eyes and ultimately lower overall medical costs.

How the System Works

We have expanded our capabilities to include:

- Identification and flagging of members with diabetes, glaucoma, cataracts or macular degeneration by claim-submitted diagnoses.
- Authorization of additional benefits based on diagnosis.
- Handling of multiple benefit levels within any member employee's family.
- Sending customized disease-focused communications to members.
- Provision of consistent and highly specific encounter data reporting. We can work with a client's pharmacy, disease management or medical carrier to flag an affected member and share data with appropriate health plan partners.

Disease	Davis Vision Eye Health Connection℠ Enhanced Benefits
Diabetes: 5.5 million Americans have diabetic retinopathy.[1] Yet one-fourth of the 23.6 million Americans with diabetes remain undiagnosed, putting them at risk for vision loss.[2]	• 2 examinations per benefit cycle at standard plan copay (if applicable) • New lenses after each exam with qualifying prescription change[4] • Polycarbonate lenses at no charge
Glaucoma: About 2.3 million Americans over age 40 have been diagnosed. An additional 2 million do not yet know they have it.[3]	• 2 exams per benefit cycle at standard plan copay (if applicable) • New lenses after each exam with qualifying prescription change[4]
Cataracts: More than 22 million Americans have cataracts. Over half of all Americans have cataracts by the time they are 80 years old.[3]	• 2 exams per benefit cycle at standard plan copay (if applicable) • New lenses after each exam with qualifying prescription change[4] • Transitions™ lenses at no charge • Standard Progressive lenses at no charge
Macular Degeneration: AMD currently affects the vision of more than 2 million Americans over age 50.[1]	• 2 exams per benefit cycle at standard plan copay (if applicable) • New lenses after each exam with qualifying prescription change[4] • Transitions™ lenses at no charge • Enhanced Low Vision allowances ($2,000 lifetime limit for Low Vision aids)

[1]Prevent Blindness America | [2]American Diabetes Association | [3]NIH Medline Plus | [4]+/- 0.50 diopter change in power or ≥ 10 degree change in axis

Sources:
[1] The Vision Council: "Vision in Business," 2007 | [2] Ibid. | [3] Employee Benefit News: "The Eyes Have it," April 15, 2010
[4] Center for Studying Health System Change: "Rising Rates of Chronic Health Conditions: What Can Be Done," July 31, 2008 | [5]HealthReform.gov Web site: "Health Reform Quiz," 2010
[6] Milkin Institute: "An Unhealthy America," 2004

Credentialing Corner

Are You Due for Recredentialing?

At least once every 36 months, you must submit recredentialing documentation in order to maintain your active standing as a Davis Vision provider. Here is what you need to know about the process.

Notification

You will receive a request for your recredentialing documentation 90 days, 60 days and 30 days prior to your recredentialing month.

Process

- If you are registered with the Council for Affordable Quality Healthcare (CAQH), your responsibility is to ensure that your documents are current with CAQH, provide Davis Vision with your CAQH ID number and complete/submit a new Davis Vision Provider Agreement.
- If you are not registered with CAQH, your responsibility is to complete/submit a recredentialing application, a new Davis Vision Provider Agreement and your current documents directly to Davis Vision, as outlined in the request for recredentialing documentation.

Due Date

There is no specific due date for documentation, but it is important to respond in a timely manner to requests for recredentialing information. The risk of suspension increases if the provider submits documentation after the last day of the month before documentation is due!

If you are suspended, you will not be able to obtain authorizations, see patients or submit claims until you are credentialed as a "new" provider and approved by the Credentialing Committee, which can take up to a couple of weeks.

Help Us Help You!

Top reasons why your recredentialing application process may be delayed:

1. Work history information is incomplete. Be sure to include the past five years of your work history, up to and including your present position. You must include beginning and ending months and years, as well as a written explanation of any work history gaps of 30 days or more.
2. Your professional liability policy is not clear. Your policy must include either your name or the name of the group used in your office application. It must clearly outline your professional liability limits (a minimum of $1 million per occurrence and a $3 million aggregate is required).
3. Your CAQH application is not up-to-date and/or documentation is not current. You must re-attest every 120 days at **www.upd.caqh.org/oas** and fax updated documentation as needed.
4. Your Davis Vision Provider Agreement is not submitted with the application, or is incomplete. You must sign, date and include practice locations on all signature pages. Your application will not be processed without a provider agreement.

CAQH Saves Time and Money!

The Council for Affordable Quality Healthcare (CAQH) is an online service to complete your credentialing and recredentialing applications.

- Enter data once, and you may never need to fill out credentialing applications again!
- Re-attest in minutes.
- Register today at www.caqh.org.

If you have any questions, please do not hesitate to contact Davis Vision's Credentialing Department!

DAVIS VISION

Credentialing Department

Phone: 800.328.4728

Fax: 800.350.1516

Community Outreach

Davis Vision's Push for Literacy

Davis Vision's Focus on America® program kicked off its national literacy initiative at Queens Library in New York this fall to raise awareness of the connection between healthy vision, reading and academic success. That message was reinforced in a radio appearance by Dr. Dan Levy, Davis Vision's Assistant Vice President of Professional Affairs, on WBLI and WBAB radio in the New York metro area.

As part of the literacy campaign, uninsured and underinsured children in communities across the nation will receive free vision services, free books and education on proper eye care. Next year, 26 of Davis Vision's 52 free screenings will be held in libraries, where children will be encouraged to get their first library card.

"Through this partnership with Davis Vision that contributes to better vision care, our young customers have a better chance to access books, develop a love of learning and further their education," said Jennifer Manley, Director of Government and Community Affairs, Queens Library.

At non-library vision screenings, books may be donated or "swapped" to keep the literacy component relevant at all events. Partners in the "Bring a Book. Get a Book. See a Book" campaign include Transitions® Optical's Bess the Book Bus, the American Literacy Corp. and libraries around the country.

"Our literacy initiative is not just about promoting academic success; we want kids to develop a love of reading," said Laura Dyer, Davis Vision's Assistant Vice President of Community Relations. "Since 80 percent of learning takes place visually, proper vision care during childhood is imperative, and it is crucial to reading and writing."

Davis Vision gave free screenings and sunglasses to kids at its literacy campaign kickoff event in September at Queens Library in New York.

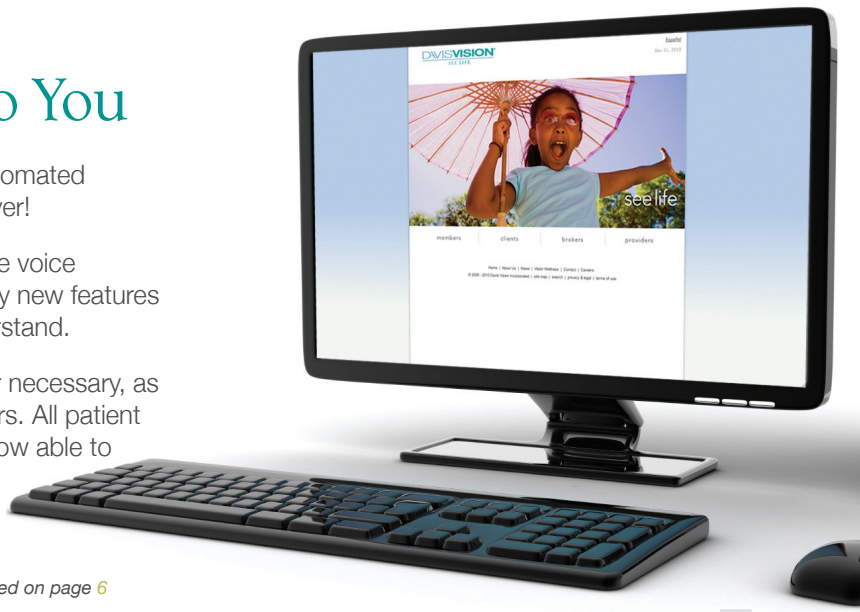
Technology Update

Streamlining Our Service to You

Our new corporate-wide CVX computer platform enables automated phone and Web communications to be more efficient than ever!

Last year Davis Vision completed the rollout of new interactive voice response (IVR) phone technology. We have since added many new features that have made the IVR system even easier to use and understand.

First, punching in member identification numbers is no longer necessary, as our system now has the ability to understand spoken numbers. All patient service submenus have been revamped, and providers are now able to learn a patient's future date of eligibility for exam services. Because the system is self-service, users are prevented from accidentally or inappropriately exiting the system.



continued on page 6

Streamlining Our Service to You continued from page 5

Routine authorizations are supported exclusively through the IVR as well as the Web site.

Our new CVX computer platform serves as the foundation for continued improvements to the efficiency of provider self-service.

Look for the following additional IVR upgrades in the months to come:

- Inclusion of lab order status information.
- Directed speech deployment using key words.
- Indication of future eligibility for all services.
- Ability to present a message for discount groups.
- Ability to issue an authorization retroactively.
- Inclusion of information about copay amounts.
- Ability to perform "change" or "replace" authorizations via the provider IVR and Web site.

All these features result in a more streamlined call flow with added functionality that will greatly enhance your experience with the IVR phone system.

We encourage you to make use of the automated technologies available to providers, including fast and efficient Web processing capabilities along with the new IVR system. If you are not yet registered to use the Davis Vision Web site, visit us at **https://idoc.davisvision.com/davis/providernew/login.asp.**

Professional Affairs

Who Are RQARs? And What Are They Doing in Your Office?

Has a Davis Vision representative visited your practice lately? Our national team of provider liaisons includes 36 Regional Quality Assurance Representatives (RQARs), who lead Davis Vision's onsite office Review Program. All are licensed or retired optometrists.

The Review Program is a key element in assessing practitioner compliance with Davis Vision's requirements, regulatory mandates and accreditation standards. Combination site visits and record reviews are scheduled once every two years for high-volume providers, those who see at least 300 Davis Vision members annually. For providers who see fewer than 300 Davis Vision members per year, record reviews are conducted every two years instead of a site visit.

During a site visit, the RQAR evaluates physical facilities for overall appearance, safety and cleanliness, and evaluates equipment for overall condition and maintenance. Your office staff may be interviewed regarding protocols for scheduling, dispensing and compliance with Davis Vision's policies and procedures, including safety and infection control practices.

A sample of the provider's examination records is collected and reviewed. The RQAR evaluates the audit results and reports the findings to the Assistant Vice President of Professional Affairs. Results are communicated to the provider in writing.

Review results are reported to Davis Vision's Quality Assurance Department and are placed in the provider's recredentialing file. The results are then considered by the Credentialing Committee when the provider's file is presented for approval. They are also presented to the Quality Management Committee quarterly.

If areas of concern are noted, the provider must submit to Davis Vision a written corrective action plan, which must be approved by the Assistant Vice President of Professional Affairs. Follow-up actions may include an additional site visit or review of a new sample of records in six months.

LASIK Ads Must Warn Consumers of Risks

Those who promote LASIK eye surgery must ensure that their advertisements tell consumers about its possible risks and limitations. Ads that do not convey the necessary warnings and precautions are deceptive, said the Food and Drug Administration (FDA) in a letter to eye care professionals.

The FDA has received complaints from LASIK patients that ads for the procedure failed to inform them of the risks involved. During a public meeting held by the agency, many patients reported having experienced unexpected blurriness, double vision, depression and other problems after undergoing LASIK.

"Advertising and promotional materials for FDA-approved lasers used during LASIK procedures must be truthful, properly substantiated and not misleading," wrote Timothy Ulatowski, head of the Office of Compliance for the FDA's Center for Devices and Radiological Health. The letter also explained that in determining whether an ad is misleading, the FDA takes into account the extent to which it fails to reveal facts related to consequences of the surgery.

The FDA's letter spares LASIK-related companies, which could have been hurt by stricter action, including device makers Abbott Laboratories' unit Abbott Medical Optics Inc, Alcon Inc. and Bausch & Lomb, as well as clinics such as TLC Vision Corp and LCA Vision Inc.

The FDA splits oversight of LASIK advertising with the Federal Trade Commission. If the FDA deems LASIK advertising misleading, it can issue warning letters as well as take stronger action, such as imposing fines or making referrals for criminal investigation.

About 8 million Americans have undergone the procedure since it was approved in 1998, according to Lasik Surgery News. A weak U.S. economy has already reduced demand for the elective surgery, which is not covered by most health insurers.

Submit Remake Orders Online!

Davis Vision is delighted to offer providers the ability to submit remake orders online. This functionality is available where no changes to the original order are required. This new feature will save your business time and speed delivery by enabling you to electronically submit your remake orders any time.

Visit www.davisvision.com today! You will be able to submit remake orders for:

- Incorrect lens power
- Frame warranties
- Lens warranties
- Cosmetic defects

The Customer Service Contact Center will still be available to place remake orders for reasons that are not listed above.

Please be advised that all remakes are subject to warranty periods. Davis Vision will request orders to be returned under specific circumstances. Additionally, Davis Vision reserves the right to review all remake orders and to disable the remake function available on the Web site.

DAVISVISION®
SEE LIFE

PROVIDER
NETWORK NEWS

AUTUMN 2010

Inside...

How Will Health Care Reform Affect Managed Vision?

Many eye care providers are wondering how the new health care reform legislation will affect the ways they do business with patients and managed vision care companies. Since passage of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), Davis Vision has begun a full assessment of how managed vision care may be impacted.

While most provisions of the bill go into effect Jan. 1, 2014, some reforms take effect sooner. Following are some key points of the legislation as it now stands, along with questions and answers.

Adult children up to the age of 26 will be allowed to stay on their parents' group health plan, beginning in plan years on or after Sept. 23, 2010.

How will these changes pertain to stand-alone vision benefits?

The new rules apply uniformly to group health plans and health insurance issuers regulated by the Employee Retirement Income Security Act and the Public Health Service Act. Like many limited-scope benefit plans, stand-alone vision plans do not fall within the meaning of such regulated entities and thus are not subject to this requirement. In general, stand-alone vision plans will remain the same, although they may become affected as various agencies begin to implement the reforms under new regulatory frameworks.

Fully insured vision plans governed under state insurance laws must continue to follow state regulations where dependent coverage for ancillary, non-medical services is mandated.

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SEE LIFE

The PPACA requires all plans that are subject to the provision of essential health benefits to offer pediatric vision care.

What are considered essential health benefits?

All qualifying health plans under the PPACA must arrange for the provision of essential health benefits. A list of essential health benefits will be defined by the Secretary of the Department of Health & Human Services (HHS) in forthcoming regulations.

Although pediatric vision care services are currently within the scope of such essential health benefits, the HHS has not yet

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Benefit Alert!

Davis Vision is excited to announce our new online feature: Benefit Alert!

With Benefit Alert, providers have easy access to:

- Group changes or additions. No more individual mailings to your office. All new alerts are posted for one month, then archived.
- Service Record Forms.
- Provider Payment Reimbursement. Detailed payment information, including the patient's out-of-pocket expense, is displayed on the summary screen after each order/claim is placed online.

We are sure you will find these new features a valuable time saver. If you have not yet created your log-in password and customized your provider home page, it is important to contact our **Internet Team** at **1-800-773-2847** (select option 3 from the main menu) so that you may access this information.

Credentialing Corner

Davis Vision Re-certifies with NCQA

Davis Vision successfully completed its 2010 National Committee for Quality Assurance (NCQA) certification in provider credentialing, receiving an overall score of 100 out of 100 points. The NCQA, a private, non-profit organization, is regarded as the premier source of information regarding health care quality, enabling consumers and employers to make more informed decisions.

NCQA requires recertification every two years, and conducts a thorough review process (including a site visit and an audit) to assess a company's continued adherence to quality standards. We first achieved certification in 2004 and have diligently maintained it ever since.

Are You Current with CAQH?

Many providers enjoy the convenience of using the Council for Affordable Quality Healthcare (CAQH) online service to complete their credentialing and re-credentialing applications. Did you know that you are required to update your information regularly?

Every four months, you will receive a request from the CAQH to re-attest that all information in your application is current. Spending approximately five minutes every 120 days reviewing your application will save you hours in the long run on unnecessary phone calls and faxes! Avoid delays in processing your application by filling out forms and submitting licenses correctly:

Work History: You are required to document five years of work history, including beginning and ending month/year for each position, including your current position. Any work history gaps of 30 days or more must be documented.

Professional Liability Insurance: The form must clearly state "professional liability" and include your name, policy number, effective/expiration dates and minimum limits of $1 million per occurrence and $3 million aggregate.

Licenses: You are required to submit all current licenses, including State Licenses, DEA Certificates and Controlled Substance Registrations (if applicable)

At re-attestation, you should also review all previously submitted documentation such as CV, licenses, malpractice insurance and Board Certificate to ensure all documents have not expired. To learn more about CAQH, visit http://www.caqh.org/ucd.php.

Boston Area Optometrist Named Davis Vision's Provider of the Year

Dr. Irwin Nathanson, a general and pediatric optometrist practicing in Danvers, Mass., was named Davis Vision's 2010 Provider of the Year. Dr. Nathanson accepted the award from Dr. Daniel Levy, Davis Vision's Assistant Vice President of Professional Affairs, who drove to Danvers to personally deliver the prize in early April.

Based on specific measures of excellence, Dr. Nathanson's dedication to high standards and exceptional quality of care earned him the top honor among providers in Davis Vision's national network. Ranking criteria included both patient satisfaction surveys and site visits conducted by Davis Vision's Quality Assurance Program.

> "Dr. Nathanson has demonstrated an exceptionally high level of care for all of his patients"
>
> - Dr. Joseph Wende, Senior Vice President Professional Affairs | Quality Management

"It is quite an honor to receive this award from Davis Vision," said Dr. Nathanson. "All patients in my office are treated equally, and I believe it is a privilege to be able to help all patients achieve the best vision they can have."

Dr. Levy presented Dr. Nathanson with an award plaque; a Volk Super Field lens; a Reichert IOPac® handheld pachymeter; and a trip for two to Vision Expo West in Las Vegas this October. Dr. Nathanson also received a commendation by the House of Representatives of the State of Massachusetts and congratulations from the Mayor of Peabody for his outstanding service to the community.

A Davis Vision provider since the early 1980s, Dr. Nathanson has been practicing for over 35 years and is a member of the New York Children's Vision Coalition. He served as Associate Professor of Optometry at the New England College of Optometry, his alma mater, for 21 years. Dr. Nathanson has written extensively about vision therapy and vision development for professional journals. In addition to his professional accomplishments, Dr. Nathanson is heavily involved with the community.

"Dr. Nathanson has demonstrated an exceptionally high level of care for all of his patients, with the philosophy that each patient deserves the best and should be treated equally," said Davis Vision's Dr. Joseph Wende. "We are pleased to honor him as Davis Vision's Provider of the Year."

In addition to Dr. Nathanson, 24 other vision care providers across the nation were recognized for outstanding performance in Davis Vision's second annual provider recognition program.

Dr. Daniel Levy, Davis Vision's Assistant Vice President of Professional Affairs (left), presents Dr. Irwin Nathanson with a plaque in honor of his 2010 Provider of the Year Award.

Community Outreach

Frame Donation Benefits New Mexico Opticianry School

The Southwestern Indian Polytechnic Institute (SIPI) of Albuquerque, NM, has the area's only dedicated Opticianry program that not only trains students to enter the field of Opticianry, but also provides affordable eye care to the Albuquerque community. In an effort to help SIPI further its mission, Davis Vision donated 4,000 eyeglass frames earlier this year.

"This is the largest donation the vision program has ever received, and we anticipate that this donation is going to help us for the next five years," said Samuel Henderson, Coordinator Instructor for Vision Care Technology at SIPI. "We're going to work with the Lions Club and different tribes in New Mexico and the Southwest area to help them provide affordable eye care."

Davis Vision's donated frames will be used for laboratory and dispensing classes in SIPI's Opticianry program and for children and the elderly with limited resources. Frames will be provided for free and lenses for a minimal cost.

Students and teachers from the Southwestern Indian Polytechnic Institute's Vision Care Technology program welcome Tom Davis, Davis Vision's Executive Vice President/Chief Marketing Officer (second from right) to their school.

HITECH Act of 2009

New Legislation Adds Patient Privacy Regulations

One of the most important changes in health care regulatory requirements is the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was signed into law as part of the American Recovery and Reinvestment Act of 2009 (ARRA). Enforcement began in February 2010.

The purpose of the HITECH Act is to increase the use of electronic health records by physicians and hospitals. This act requires the government to develop standards that allow for the nationwide electronic exchange and use of health information.

The government will invest $20 billion in health information technology infrastructure. At the same time, privacy and security laws will be strengthened to protect identifiable health information from misuse.

Health care providers face some difficult challenges when it comes to information security due to the increased number of federal regulations under HITECH. The Act adds security breach notification requirements, implements new data security standards for electronic health records and expands security and privacy provisions previously addressed in the Health Insurance Portability and Accountability Act (HIPAA).

A significant change is an increase in the monetary, civil and criminal liability penalties for noncompliance for both individuals and corporations. The HITECH Act extends security and privacy rules to business associates, holding them to the same standards as HIPAA-covered entities.

It is increasingly important for health care providers to keep abreast of state and federal legislation that protects patient information.

For more information about the HITECH Act of 2009, log on to http://waysandmeans.house.gov.

Davis Vision Sends Hope to Poorest Areas

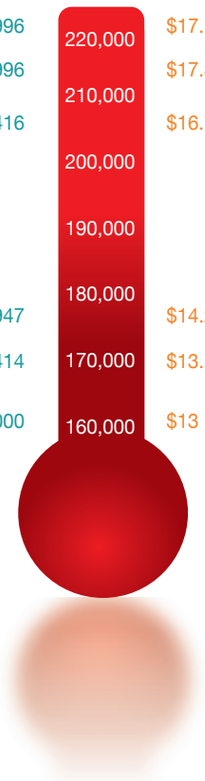
Davis Vision's Sight from America℠ program is helping to improve the lives of thousands around the world by restoring their eyesight. This program provides frames to developing countries for use in eye care clinics, schools, orphanages and refugee camps. All donated Davis Vision frames are fitted with prescription lenses for each patient.

Davis Vision's community outreach programs have provided $17.7 million in free eye care over an 18-month period.

Jeffrey Marshall, O.D. (right), President of VOSH-Indiana, accepts a frame donation from Tom Davis, Executive Vice President and Chief Marketing Officer of Davis Vision.

Davis Vision Eyewear Donations

As of...	Total Pairs of Eyewear	Total Retail Value
June 2010	220,996	$17.7 mil.
May 2010	215,996	$17.3 mil.
March 2010	208,416	$16.7 mil.
Feb. 2010	176,947	$14.2 mil.
Jan. 2010	170,414	$13.7 mil.
2009	162,000	$13 mil.



Lab Spotlight

New Scratch Protection Plan

For the first time in many years, Davis Vision has updated our materials repair and replacement policies. Our new Scratch Protection Plan (SPP) was introduced in January 2010.

Previously, the copay for the scratch-coating option available to most patients covered both the coating and the associated warranty. It was applicable only to plastic single-vision and non-progressive lenses, as polycarbonate, high-index and most progressive lenses already came scratch-coated from the manufacturer. However, lens replacements were provided on all scratch-coated product, regardless of whether a copay had been paid or not. As a result, there was a significant, unwarranted cost to Davis Vision and our providers.

In January, Davis Vision began to automatically provide scratch-coated lenses on all orders at no charge to the member. This change provided immediate access to better materials for all members and had a small but positive effect on return and internal spoilage rates.

The SPP copay (typically $20 for single-vision, $40 for multi-focal) now covers only the scratch warranty and can be applied to all lenses, providing your office with an additional revenue opportunity. This copay more appropriately covers the warranty costs incurred when replacement becomes necessary. It applies to all new groups and existing groups upon renewal. Check Service Record Forms for details.

New Castle, PA, Provider Orders Online and Wins Trip to "Big Game" in Miami!

Dr. Candice Macri (left), a New Castle, PA, native, and her cousin, Lynn Pitzer, take in the electrifying pre-game atmosphere on February 7, 2010, in Sun Life Stadium at "The Big Game" in Miami. Dr. Macri received two round-trip flights, game tickets and hotel accommodations as the winner of Davis Vision's "Order Online to Win" promotion, launched as an incentive for network providers to place eyewear orders online.

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issued a final regulation defining "pediatric vision care." We are unaware of the extent to which vision care services must be offered to pediatric patients.

In the bill, what age range is defined under pediatric vision care?

The PPACA does not define the age range for a child to be considered a pediatric patient. A child is presumed to be a pediatric patient if he or she is under age 21, though the final rules may alter such interpretation. Existing interpretation for such age is merely speculative based on several federal legislations pertaining to varying pediatric services.

The new bill includes a provision for "preventive and wellness services and chronic disease management."

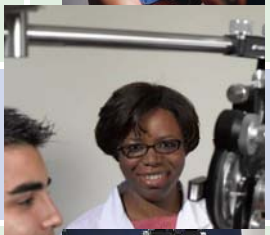
What types of services will this cover for adults?

For adults, essential benefits include preventive and wellness services and chronic disease management programs that are rated A or B by the U.S. Preventive Services Task Force. Examples include cancer, heart disease, diabetes, hypertension and abnormal cholesterol levels. While no specific eye disease has been rated A or B, the definition of "preventive and wellness services and chronic disease management" in forthcoming regulations may or may not include routine vision care.

Because the contribution of regular eye exams to a patient's overall health is well documented, Davis Vision has been a vocal advocate in the health care debate for insuring the inclusion of routine vision care services across all populations as an integral component of preventive care and wellness services.

Member Benefit Encounter

Paperless administration or the ability to work with partner's existing I.D. cards!

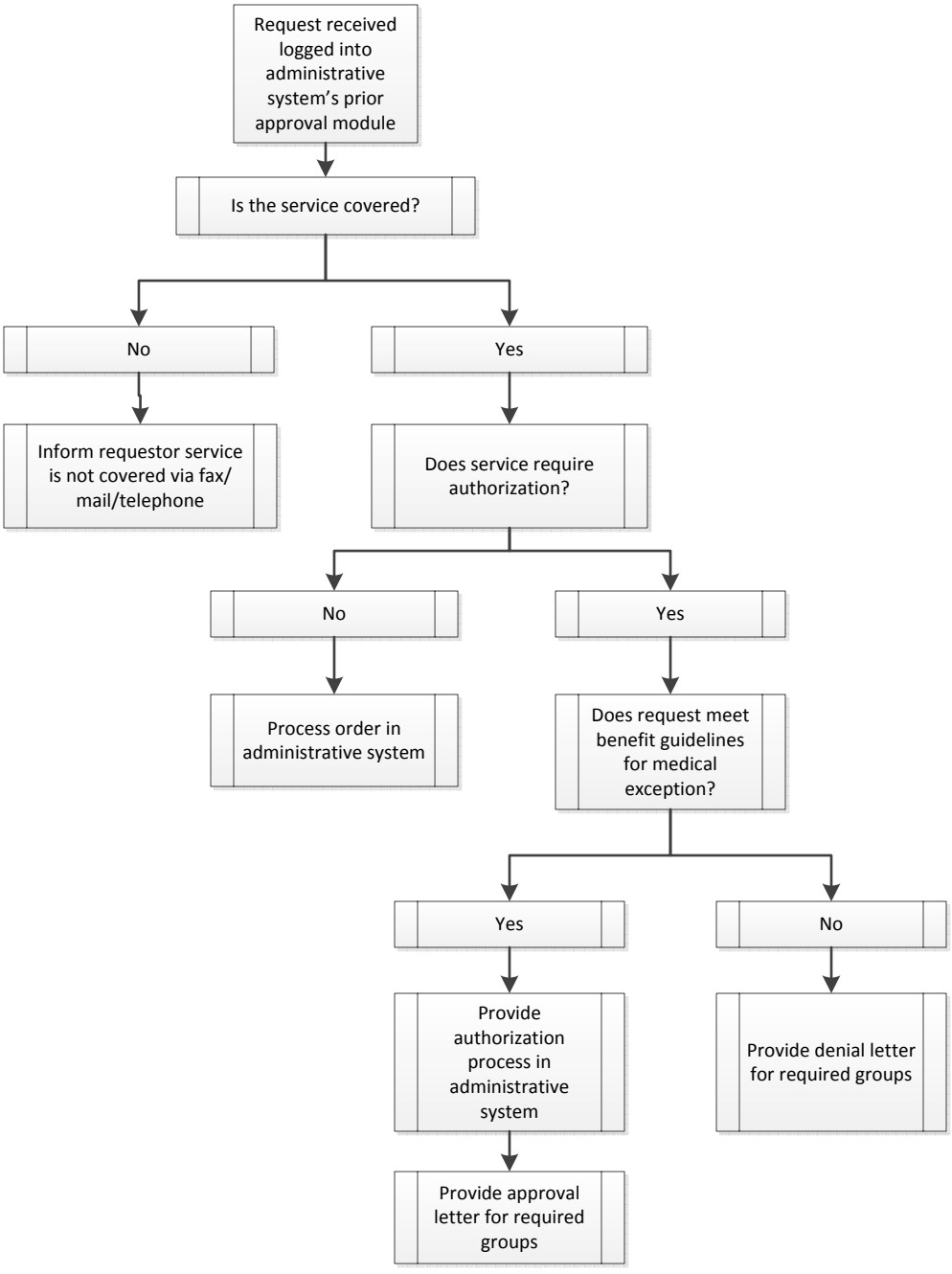
1	**Select a participating vision care provider.**	Find a Doctor	
2	**Call the selected provider to schedule an appointment.** [1]	Confirm Enrollment	
3	**Provider verifies eligibility concurrent with scheduling the appointment.**	Check Eligibility	
4	**Patient visits provider office and an eye examination is performed.**	Order Entry	
5	**Provider places order/claim.**	Order Entry	
6	**Eyeglasses/contact lenses fabricated/provided by Davis Vision Regional Laboratories.**	Order Tracking	
7	**Eyewear is shipped. Patient returns to provider office for dispensing and fitting.** [2]	Claim History	

[1] Some participating retailers accept walk-ins, schedule permitting.
[2] Some participating retailers have the capability for 24-hour turnaround.

Out-of-Network Claims Process

1	**Claim form is received from member via mail/fax** ▪ Claim is sent to processing unit in Latham, NY ▪ Claim is scanned into the Macess workflow system ▪ Scanned claims are routed through a queue system which disperses the claims out for processing	CONTACT VIA   FAX WEBSITE
2	**Claim examiner attempts to locate patient record** ▪ Record located, verify eligibility ▪ Patient record not located, create eligibility inquiry to verify coverage ▪ Eligibility Team verifies with group and updates record to continue claim	
3	**Claim processed** (Payment generated/Claim denied/Claim returned to member for additional information) ▪ Verify claim has all necessary information (signature, date of service, services received, amounts and patient information) ▪ Pay claim, if eligible ▪ Write back for further information, if necessary ▪ Deny if not eligible	  IVR MSRs   FAX WEBSITE
4	**Payment processed** ▪ Payment made to member	

Medical Exception Program
Prior Approval Process



DAVISVISION®
SEE LIFE

Progressive Addition (PAL) and Intermediate Lens Formulary

In order to best support each practitioner's professional judgment in providing the ideal PAL design for an individual patient's needs, Davis Vision has implemented a 2-tier progressive lens formulary for most groups. Under this formulary, members may receive either Standard or Premium progressive lens designs. The patient charge for either category may differ and is indicated on the group specified Service Record Form or Personalized Service Record Form. A listing of all progressive lens designs in each category is represented in the following table:

STANDARD PROGRESSIVE STYLES

Short Corridor:

AO Compact
AO Compact Ultra
Armorlite Navigator Short
Vision Ease Outlook
Vision Ease Tegra Outlook

Traditional Corridor:

Armorlite Navigator
Essilor Adaptar
Essilor Natural
Hoya GPWide
Sola Instinctive
KbCo Fusion II
Sola VIP / VIP Gold
X-Cel Freedom ID
Younger Image

PREMIUM PROGRESSIVE STYLES

Short Corridor:

Armorlite Kodak Concise
Armorlite Kodak - Precise Short
Essilor Smallfit
Hoya Summit CD
Seiko Proceed III
Varilux Ellipse
Varilux Physio Short
Zeiss GT2 Short

Traditional Corridor:

AO Easy
Armorlite Kodak Precise
Essilor Accolade
Essilor Ovation
Hoya Summit ECP
Seiko Proceed II
Sola SolaMax
Sola SolaOne
Varilux Comfort (New Design)
Varilux Physio
Vision Ease Illumina
Zeiss GT2

INTERMEDIATE LENS STYLES

For task specific uses such as computer vision

AO Sola Access
Hoya Tact
Zeiss Gradal RD
Zeiss Business

Please note: If your patient cannot successfully adapt to progressive lenses within 60 days, standard bifocals will be remade without any cost to the member. However, co-payments or patient charges (if any) will not be refunded to the patient.

These formularies are subject to change at any time. Please visit the Davis Vision website at www.davisvision.com for the current formularies

NYS Vision Plan
Listing of Plan Contact Lenses

Contact Lens Description	# of Lenses Provided to Enrollees	Copayment for PEF, M/C & unrepresented ($25 or $45)
Soft Daily Wear lenses:		
Daily wear lenses are no longer offered due to the advancements in technologies of contact lens materials and modalities. Daily wear lenses no longer provide the healthiest lens options for patients due to their outdated technology in material and wearing schedules.		
Planned Replacement:		
Frequency Aspheric	2 boxes	$25
Disposable:		
Avaira*	4 boxes	$25
Biomedics 55	4 boxes	$25
ACUVUE® 2	4 boxes	$25
ACUVUE® OASYS®	4 boxes	$25
Daily Disposables:		
Focus Dailies	4 boxes	$45
ClearSight (1-Day)	4 boxes	$45
(1-Day) ACUVUE® MOIST®	4 boxes	$45
Toric Disposables:		
Avaira Toric*	4 boxes	$45
Biomedics Toric	4 boxes	$45
ACUVUE® OASYS® for ASTIGMATISM	4 boxes	$45
Multifocal Disposables (2-week)		
ACUVUE® OASYS® for PRESBYOPIA	4 boxes	$45

**Only available at ECCA, Davis Vision and Empire Vision stores.*

Received by Davis Vision

PRIOR APPROVAL/MEDICALLY NECESSARY CONTACT LENS REQUEST FORM

Submit To: Toll Free Fax 1-800-584-2329 **Questions? Call: 1-800-328-4728 x6811**

IMPORTANT: PLEASE VERIFY MEMBER BENEFIT PRIOR TO SUBMITTING REQUEST.

Patient Information

Patient Name (Please Print)		Member/Patient ID Number
Patient Date of Birth	New Patient Yes ☐ No ☐	Group/Employer Name

Provider Information

Provider Name (Please Print)	Provider Panel Number	Today's Date
Provider Telephone Number	Provider Fax Number	

Services Requested **Diagnosis/Reason for Services**

Exam Only ☐	Contact Lens Evaluation ☐	Keratoconus ☐	Progressive Myopia ☐
Exam & Eyeglasses ☐	Low Vision Evaluation ☐	Aphakia/Post Cataract ☐	Pathological Myopia ☐
Eyeglasses Only ☐	Additional Exam ☐	Anisometropia ☐	Diabetes ☐
Repair/Replace ☐			Other _____

Provider Comments **Supporting Documents Attached** ☐

Prescription Information **Fees (Information Required)**

Rx Eyeglasses	OD OS	VA OD VA OS	Professional Fee $_____
Contact Lenses	OD OS	VA OD VA OS	Material Fee $_____ Contact Lenses ☐ Low Vision Aids ☐ Eyeglasses ☐

BOTH OLD AND NEW PRESCRIPTION MUST BE COMPLETED BELOW FOR REQUESTS RELATED TO SIGNIFICANT CHANGES IN RX.

Old Rx	OD OS	**New Rx**	OD OS

FOR DAVIS VISION USE ONLY – DO NOT WRITE BELOW THIS AREA

Approved Date	Auth No./Benefit	Denied Date	Reviewed By: Signature
Comments:			
Additional Information Required		Date Requested	Date Received

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