Delaware

avēsis

Vision Provider Contracting Checklist

To ensure that we have all the information we need to process your application efficiently, please complete the following steps. Each Provider Entity that will be submitting claims must complete the following documents for each TIN being used to submit claims.

- [ ] **Avēsis Provider Agreement Execution Page**
  - Complete the Provider Execution Section and select all products and networks in which you wish to participate.
  - An authorized signer must sign and date.

- [ ] **Exhibit B Provider Roster (Required)**
  - Complete all information for each provider at the practice.
  - Select all applicable networks for each provider.

- [ ] **Hospital Affiliations**
  - Complete hospital affiliations form if you have privilege to practice at hospitals.

- [ ] **Form W-9**
  - Your name must match the name you will use to file your tax returns.
  - Select at least one option in box number three.
  - Only include one taxpayer identification number per W9 form.

- [ ] **Disclosure of Ownership Forms – Business Entity and Individual**
  - Choose business entity or individual disclosure of ownership (DOO) form, whichever pertains to your practice. The form must match your W9.

- [ ] **Avēsis Electronic Funds Transfer Form (Optional)**
  - Complete, sign, and date the form.
  - Attach a voided check.

- [ ] **Americans with Disabilities Act Survey (Required)**
  - Each practice location must be listed on your ADA survey.

- [ ] **Commercial Plan Fee Schedule**
  - If enrolling in commercial networks, complete the fee schedule form.

Provider Agreement Execution Page

This Provider Agreement ("**Agreement**"), by and between Avēsis Third Party Administrators LLC ("**Avēsis**"), for itself and on behalf of its Affiliated Companies (defined below), which include but are not limited to **Avēsis Third Party Administrators, LLC**, **Avēsis LLC**, **Avēsis Insurance** (collectively "**Avēsis**"), and

_____

Practice Name (Entity name as it appears on W9 and tax returns)

for itself and, if applicable, on behalf of its employed or contracted providers (collectively "**Provider**"), shall be effective this _____ day of _____ , 20 _____ (the "**Effective Date**"). For purposes of this Agreement, unless otherwise specified, Avēsis and Affiliated Companies shall be referred to collectively as "**Avēsis**." **By execution of this Agreement and checking below, Provider agrees to participate in those products and networks operated or administered by Avēsis, or one or more Affiliated Companies. Full descriptions of products are set forth in Exhibit C attached hereto.**

- ☐ Commercial
- ☐ Medicaid
- ☐ Medicare Advantage
- ☐ CHIP
- ☐ Medicare/Medicaid Duals

This Agreement, together with its Exhibits, constitutes the entire understanding of the Parties with respect to the subject matter expressed herein and supersedes any prior agreements between the Parties. In consideration of the mutual covenants and promises stated herein, and for good and valuable consideration, the Parties hereby agree:

Provider Execution Section:

_____ _____

Practice Name (Entity name as it appears on W9 and tax returns) | Tax ID Number

By: _____ _____

Authorized Signature | Printed Name and Title

_____ _____

NPI-2* | Date

Address for Notice: _____

*FQHCs, certain health plans and/or regulatory agencies require the inclusion of the NPI-2 (organizational NPI) for claims to be paid. Please provide the NPI-2, if available.

Avēsis Execution Section:

Avēsis Third Party Administrators LLC
10400 N. 25th Avenue, Suite 200
Phoenix, AZ 85021
Attn: Eye Care Provider Contracting

By: _____

Avēsis Authorized Signature

_____

Printed Name and Title

_____

Date

*Avēsis executes this Agreement on behalf of, and binds, those Affiliated Companies listed in Exhibit D.

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Attn: Eye Care Provider Contracting

By: _____

Avēsis Authorized Signature

_____

Printed Name and Title

_____

Date

*Avēsis executes this Agreement on behalf of, and binds, those Affiliated Companies listed in Exhibit D.

PROVIDER AGREEMENT

RECITALS

WHEREAS, Avēsis or Affiliated Companies are appropriately licensed by the Department of Insurance (or other state agency or division with jurisdiction over such companies) to insure or otherwise arrange and provide coverage for Eye Care Services (defined below);

WHEREAS, Provider is licensed under applicable State law to provide those eye care services described below; and

WHEREAS, Avēsis and Provider mutually desire for Provider to participate in Avēsis' networks of Participating Providers to render Covered Benefits to Members, as those terms are defined below.

NOW THEREFORE, in consideration of the promises and mutual covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed by and between the Parties as follows.

TERMS AND CONDITIONS

A. DEFINITIONS.

1. Affiliated Companies **–** those companies that are owned by or affiliated with Avēsis and are listed on **Exhibit D** attached hereto and incorporated by reference to this Agreement.

2. CMS - the Centers for Medicare and Medicaid Services.

3. Covered Benefits - those Eye Care Services within Provider's license and scope of practice that are covered and payable under the applicable Sponsor Plan and offered to Members. Covered Benefits are listed in **Exhibit A** and may vary by Sponsor/Sponsor Plan.

4. Claim - a request for payment submitted by Provider, in a format acceptable to Avēsis as identified in the Provider Manual for the processing of payment for Covered Benefits.

5. Clean Claim – unless otherwise defined by applicable law, a complete and accurate Claim that is free of errors and/or omissions for services personally provided by Provider.

6. Eye Care Services - the eye examination, lenses (including contact lenses, if applicable under the Sponsor's benefit) and frames; or eye medical/surgical procedures when covered under the Sponsor Plan or other related services as permitted by the Sponsor Plan, within the scope of practice of Participating Provider and necessary as determined by his professional judgment.

7. Federally Qualified Health Center ("**FQHC**") - a provider that receives a federal grant pursuant to Section 330 of the Public Health Service Act, 42 U.S.C. 254b, ("**Section 330**") administered by the Health Resources and Services Administration ("**HRSA**") within the United States Department of Health and Human Services, to provide community-based comprehensive primary and preventive health care and related enabling services to medically underserved populations regardless of the individual's or family's ability to pay for such services.

8. Fee Schedule - A listing of fees paid by Avēsis to Provider for Covered Benefits rendered.

9. HIPAA – The Health Insurance Portability and Accountability Act of 1996 including all pertinent regulations (45 CFR Parts 160 and 164) issued by the U.S. Department of Health and Human Services as amended from time to time.

10. Member - an individual, spouse or dependent who is eligible to receive Covered Benefits under a Sponsor Plan.

11. Participating Provider(s) – a health care provider, including but not limited to an optometrist, physician, hospital, or other professional, facility, or supplier, that has entered into a direct or indirect written agreement with Avēsis to provide Covered Benefits to Members.

12. Provider Manual – Avēsis' policies and procedures applicable to Participating Providers, including Provider, including but not limited to the administrative policies and procedures established by Avēsis for the provision of Covered Benefits to Members. The Provider Manual is expressly incorporated by reference into this Agreement.

13. Rural Health Clinic ("**RHC**") - a federally qualified health clinic situated in rural areas and certified to receive special Medicare and Medicaid reimbursement. RHCs must demonstrate that they have met the conditions set forth in Section 330 of the Public Health Service Act.

14. Sponsor -an insurer, self-funded group, employer, union trust, Medicaid managed care plan, Medicare Advantage plan, MA Special Needs Plan, Medicare/Medicaid Duals Plan, CHIP plan, or Medicare Advantage managed care organization, State Medicaid agency, or other entity that has directly or indirectly entered into an agreement with Avēsis or an Affiliated Company, through which Avēsis or an Affiliated Company must arrange for provision of Covered Benefits to Members enrolled in such Sponsor's health benefit plan products ("Sponsor Plans").

B. RESPONSIBILITIES OF AVESIS

1. Sponsor Contracts.
   a. Avēsis or one or more Affiliated Companies may, from time to time, enter into agreements with Sponsors whereby Avēsis or such Affiliated Companies will arrange for the provision of Covered Benefits for Members through one or more networks of Participating Providers. Avēsis and each Affiliated Company are party to this Agreement only insofar as such entity contracts with Provider hereunder for Provider's participation in a network related to Sponsor Plan for which Avēsis or an Affiliated Company is contracted to provide services. By executing this Agreement, Provider agrees to participate in the networks that Avēsis makes available to Sponsors.

   b. **Exhibit C**, attached hereto and incorporated by reference, lists the following: (i) all Sponsors offering Medicare Advantage or Medicaid plans (including Medicaid managed care, Medicare Advantage, MA Special Needs Plans, CHIP plans, and Medicare/Medicaid Duals plans) that are under contract with Avēsis or an Affiliated Company as of the Effective Date; and (ii) general descriptions of the Commercial Sponsor Plans as of the Effective Date.

c. From time to time, Avēsis or an Affiliated Company may update the list of Sponsors within a line of business (i.e., Medicaid or Medicare Advantage or commercial) by commercially reasonable means including fax-blasts, e-mail, web portal updates, etc., provided that such notice is not subject to the methods described Section I below and does not require signature or amendment of this Agreement unless otherwise required by applicable law. Provider shall have thirty (30) days to accept or reject participation in new Sponsors' Plans. If Provider does not respond within such thirty (30) day timeframe, participation is deemed accepted.

d. In the event Avēsis or an Affiliated Company is adding a new line of business to this Agreement the Parties shall agree to the terms and conditions for such line of business in writing. For example, if Provider only agrees to participate in commercial Sponsor Plans as of the Effective Date, in the event Avēsis or an Affiliated Company or Provider seeks to include Provider in Medicaid or Medicare Advantage Sponsor Plans at a later date, such modification would require a mutually executed and agreed upon amendment to this Agreement.

e. Those specific terms and conditions required to be included in this Agreement pursuant to state or federal law applicable to a Sponsor Plan are attached hereto and incorporated by reference as **Exhibit E (Medicare Advantage Required Terms), Exhibit E-1 (Medicare/Medicaid Duals Required Terms), Exhibit F (Medicaid Required Terms), Exhibit F-1 (CHIP Required Terms), and Exhibit G (Commercial Required Terms)** (collectively, the "**Product Addendum")**.

f. Where part of a Sponsor Plan, Members may present an identification card that denotes coverage by or enrollment in Avēsis or an Affiliated Company or such Sponsor Plan. From time to time, Members enrolled in Sponsor Plans outside of Provider's typical service area may be traveling and seek care from Provider on an emergency, urgent, or other limited basis. In such instances, so long as such Members present evidence of enrollment in a Sponsor Plan administered by Avēsis, Provider shall render Covered Services to such Members and accept payment from Avēsis (or Sponsor, if applicable) as payment in full.

g. Provider understands and agrees that Provider's participation in any current or future Sponsor Plan does not mean that Provider shall be permitted to participate in each and every Sponsor Plan.

h. Affiliated Companies shall be bound to this Agreement in the event, and to the extent, Provider participates in a network or Sponsor Plan administered by an Affiliated Company.

2. Payment for Covered Benefits. Avēsis or the relevant Affiliated Company shall compensate Provider for Covered Benefits in accordance with this Agreement and Exhibit A attached hereto. Payment is made to Provider based upon information submitted by Provider to Avēsis or the relevant Affiliated Company.

3. Provider Directory. Avēsis shall make available to Members, through Avēsis' and/or the Sponsor's website or through a toll-free telephone number, the names, addresses, phone numbers and specialties of all providers who agree to participate under each Sponsor's program. Provider shall not be listed for any Sponsor Plan in which they do not participate.

4. Provider Manual. Avēsis shall make available to Provider a Provider Manual which supplements and is made a part of and incorporated into this Agreement. Avēsis may amend the Provider Manual from time to time upon notice to Provider by posting to Avēsis' provider website, email or other means of notice. Unless otherwise required by law, changes to the Provider Manual are not required to follow the Notice and Amendment provisions of this Agreement (Sections I and J.8, respectively). Changes to the

Provider Manual shall become effective thirty (30) days after posting or notice, or as of another time period required for Avēsis to comply with federal or state laws, Sponsor program requirements or accreditation standards. Provider shall have and maintain systems necessary for access to Avēsis' provider website, and check for revisions to the Provider Manual from time to time.

5. Payment Processing. In consideration of Provider's agreement to provide Covered Benefits in accordance with this Agreement, Avēsis or the relevant Affiliated Company shall pay Provider in accordance with any specific and applicable terms and conditions in Exhibit A. Avēsis or the relevant Affiliated Company shall pay Clean Claims within thirty (30) days or as otherwise required in a Product Addendum or applicable state law. If Avēsis or the relevant Affiliated Company fails to pay Provider in accordance with this Section, Avēsis or the relevant Affiliated Company shall pay interest in addition to any reimbursement due for Covered Benefits at such interest rate then in effect pursuant to applicable law, from the date payment was due until payment is made.

6. Non-Avēsis Payors. In the event Avēsis or an Affiliated Company is not the ultimate payor of Claims, such as in the case of self-funded or self-insured Sponsors, such Sponsor shall have the ultimate obligation and liability to Provider with respect to any Claim or fee for Covered Benefits relating to, or arising under, this Agreement. Provider agrees that it shall not file suit against Avēsis or an Affiliated Company as a result of such Sponsor's nonpayment. Avēsis cannot guarantee payment by an ultimate payor, such as a self-funded or self-insured Sponsor payors, other than Avēsis or an Affiliated Company.

7. Administration of Duties. From time to time, during the term of the Agreement, Avēsis or an Affiliated Company, as applicable, may delegate or subcontract certain of its claims payment, utilization review, or other operations to another Affiliated Company, in which case the Affiliated Company shall comply with the terms of this Agreement.

C. RESPONSIBILITIES OF PROVIDER.

1. Professional Services. Provider agrees to be a Participating Provider in one or more networks offered by Avēsis and provide Covered Benefits to Sponsors and their Members. Provider shall be properly licensed in the jurisdiction where services are provided and shall ensure all Covered Benefits rendered are consistent with professionally recognized standards of practice. Provider shall furnish Covered Benefits to Members as required by the Sponsor, **Exhibit A** and Product Addendum. Provider agrees to provide services to Members in a timely manner and on the same basis as other patients. Provider reserves the right to limit or reduce the number of members accepted by Provider in the event that Provider reaches its capacity to provide comprehensive care to its existing patients and in order to meet its legal obligations to provide services to all other patients residing in the service area regardless of ability to pay. Provider shall make every reasonable effort to satisfy the needs of Members. All services rendered by Provider under this Agreement shall be furnished in accordance with the Provider's best professional judgment and in compliance with applicable laws, rules and regulations of the licensing or other governmental bodies having jurisdiction as well as the guidelines as set forth by the appropriate national association(s).

2. Identification Cards. Provider shall verify the identity of the Member by requiring the Member to produce his/her identification card and another form of identification with a photo whenever possible or by confirming eligibility and benefits through the IVR line, customer service, or using the provider web portal. If Member is a minor, a parent's identification will be acceptable if the Member's eligibility is verified with Sponsor as otherwise set forth in this Section. If eligibility has not been confirmed and authorization is not obtained (when required), Avēsis reserves the right to deny all or part of payment for the Claims.

3. Appointments. Unless otherwise required by a Product Addendum, Covered Benefits shall be provided to Members in a timely manner and in accordance with Provider's routine practice pattern. Provider shall provide services as quickly as possible but no more than thirty (30) days after an appointment is first sought. In the case of emergencies, Provider shall make every reasonable effort to see the Member immediately. Avēsis reserves the right to require Provider to submit quarterly reports stating average wait times for Members or, alternatively, Avēsis may randomly and anonymously telephone Provider offices to ascertain this information.

4. Claims and Payment.

   a. Claims Processing.

      i. Provider shall submit Clean Claims for reimbursement, and any encounter data or forms as required in the Provider Manual or a Product Addendum. Provider shall bill and code claims in accordance with generally accepted industry standards. Avēsis reserves the right to require appropriate documentation and coding to support payment for Covered Benefits.

      ii. Clean Claims shall be submitted to Avēsis or Affiliated Company within the time frame specified in the Product Addendum. If no time frame is specified, Clean Claims shall be submitted within ninety (90) days of the date of service unless otherwise required by law.

      iii. Provider understands and agrees that failure to submit Clean Claims or requested documentation within the specified time period may result in denial, reduction, rejection, or loss of reimbursement for services provided.

      iv. By submitting claims, Provider certifies and represents that all claims and related data are accurate complete and truthful based on best knowledge, information and belief.

      v. In accordance with applicable state law, Avēsis shall have the right to recover claims payments, or retain portions of future claims payments, in the event that Avēsis determines that a Member was not eligible for coverage at the time of services, or in the event of duplicate payment, overpayment, payment for non-Covered Benefits, or fraud.

   b. Member Payment and Hold Harmless. Provider agrees to accept as payment in full those amounts listed or referenced in Exhibit A. Unless otherwise permitted by applicable law, Provider agrees and warrants that in no event, including but not limited to nonpayment by Avēsis insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Member or persons acting on behalf of any Member for providing Covered Benefits. This provision does not prohibit Provider from seeking to collect co-insurance, copayments or deductibles from Members or fees for non-Covered Benefits delivered on a fee for service basis to Members as well as services received by ineligible persons in accordance with the terms of the Covered Benefits and Fee Schedule, if allowed by applicable state law or as stated in a Product Addendum attached hereto. Provider agrees that the Member shall be held harmless and Provider shall not bill the Member for non-Covered Benefits if the non-Covered Benefits are not covered as a result of any error or omission by Provider. This hold harmless provision shall supersede any oral or written agreement entered into between Provider, Avēsis, Sponsor and Members or designees and shall survive the termination of the Agreement regardless of the cause giving rise to the termination.

c. Non-Covered Benefits. Provider shall enter into a written agreement with Member to pay for non-Covered Benefits if the Member knowingly elects to receive non-Covered Benefits and the fees charged do not exceed the usual fees to Provider.

d. Coordination of Benefits. Provider will notify Avēsis when it is determined that a Member may be entitled to coverage under any other benefit plan. If Avēsis is the primary carrier, Provider agrees that Avēsis' obligation to Provider will not exceed the compensation described or referenced in **Exhibit A**. If Avēsis is the secondary carrier, Provider agrees that Avesis' obligation to Provider will not exceed the compensation described or referenced in **Exhibit A** and Provider will refund the aggregate compensation that Provider received from other Sponsor for services or goods in question. If Member is covered by one or more Sponsor Plans, Avēsis shall coordinate benefits between the Sponsor Plans and, unless otherwise required by law or the applicable Sponsor Plans, pay according to the lowest applicable fee schedule.

5. Code of Ethics. Provider shall adhere to the code of ethics of the state or national board to which the Provider belongs.

6. Program Coverage. For Covered Benefits requiring prior authorization as required by a Sponsor Plan, Provider agrees to submit the prior authorization request prior to providing the Covered Benefits requested. Provider acknowledges that possession of an Avēsis or Sponsor's identification card does not guarantee that an individual is still a Member on the date services are rendered, or that a Member is necessarily covered for any or all services or materials to be provided. Provider is strongly encouraged to verify eligibility prior to rendering services to a Member.

7. Provider Identifiers.

   a. NPI Number/Taxonomy Codes. Provider shall only submit claims for Covered Benefits using the NPI numbers assigned by CMS to Provider. Provider shall only submit claims under the NPI number of the individual who personally rendered the services. Provider may also submit claims under the NPI Type 2 (group) for the group practice with which he/she is attached. Provider shall not loan or otherwise allow any person or entity to bill claims under his/her individual NPI number. Provider may be required to submit a valid taxonomy number that corresponds with the taxonomy Provider has on file with a federal or state governing body.

   b. Use of Provider Number(s). Provider identification numbers (PIN), required to establish the login for the Avēsis web portal shall not be provided until the credentialing process has been successfully completed.

8. Personnel and Office.

   a. Rosters. Provider shall provide Avēsis with a complete list (roster) of all employed, contracted, Locum Tenens or other health care provider that will see Members at each location concurrent with the execution of this Agreement using the forms attached hereto as **Exhibit B and Exhibit B-1**. Rosters must include the status of each listed provider (owner, employee, independent contractor, Locum Tenens). Provider shall provide updated rosters to Avēsis at least every ninety (90) days and within ten (10) business days of an addition or termination of listed providers. Listed providers must be credentialed prior to rendering services to Members. Those who are independent contractors working at the Provider's location must be credentialed and contracted with Avēsis. Updated rosters and other updates to Provider demographic information shall be emailed as directed by Avēsis.

b. Prohibitions. Provider represents and warrants that neither it or any of its employees, principals, providers, subcontractors, or persons with an ownership or controlling interest in Provider, or an agent or managing employee of Provider is currently, or has been: (a) excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act or state health care programs; or (b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person. In no event shall Provider employ, or subcontract any responsibilities hereunder to, any individual excluded, debarred, or suspended from participation as specified in this Section.

c. Locum Tenens. Provider may use the services of a Locum Tenens provider subject to the following:

i. Provider is unavailable to provide the Covered Benefits;
ii. the Member has arranged or seeks to receive Covered Benefits from Provider;
iii. the Provider pays the Locum Tenens for his/her servicers on a per diem basis or similar fee for time basis;
iv. the Locum Tenens provider does not provide the Covered Benefits to Members for a period of time greater than (60) continuous days within a twelve (12) month period;
v. the Locum Tenens provider has a valid NPI number;
vi. the Locum Tenens provider has a valid State Medicaid number, if providing services to Medicaid Members; and
vii. Provider notifies Avēsis in writing of any Locum Tenens arrangement prior to submitting claims for services rendered by the Locum Tenens provider.

Should the above conditions be met, Provider shall submit a claim to Avēsis in compliance with the claims submissions requirements of this Agreement and the Provider Manual. The claim shall be submitted with the Provider as the billing provider and the Locum Tenens as the servicing/rendering provider, as applicable.

d. Provider Additional Affiliations. If Provider provides services to Members at a location or practice not affiliated with Provider, Provider must execute a separate Provider Agreement for that location or practice. Provider shall not bill for services rendered by Provider at a location not specifically defined in this Agreement.

e. Closing of Practice. If the Provider desires to no longer see Members, Provider must notify Avēsis in writing and comply with the applicable Sponsor's continuity of care requirements. Should Sponsor not have a continuity of care policy, Provider may close the practice to the specified Members effective the first of the following month provided Provider gave Avēsis written notice at least five (5) business days before the end of the month; otherwise, the policy will become effective the first of the following month.

9. Records. Provider shall complete and maintain, in a timely manner, confidential, complete, adequate, legible and proper Member records, claims and correspondence in accordance with applicable State or Federal law, this Agreement and Product Addendum, and industry standards, with respect to all services rendered to Members of Avēsis. Notwithstanding the termination of this Agreement, the Provider shall maintain Member records for a period of not less than ten (10) years or other period required by applicable law. Records shall be maintained in accordance with applicable industry standards and the requirements

of applicable state or federal law. Records shall be provided to any subsequent designated Provider according to state and federal law or Sponsor requirements.

a. Confidentiality of Records. Confidentiality of Member records and personal information shall be maintained in accordance with all applicable federal and state law. Provider shall not use any information received in the course of providing services to Members except as necessary for the proper discharge of his/her obligations under this Agreement. Provider agrees to comply with all of the applicable federal requirements for privacy and security of health information as set forth in HIPAA and the American Recovery and Reinvestment Act of 2009.

b. Records Access. Member and billing records, and any other records maintained as part of, or relevant to this Agreement, shall be subject to inspection, audit or copying by Avēsis, the Sponsor, state Medicaid agency, the U.S. Department of Health and Human Services, CMS, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's place of business, and at no charge. Notwithstanding termination of this Agreement, this right of access to Member records shall continue for a period of seven (7) years after termination of this Agreement or as set forth in a Product Addendum. Provider further agrees to make copies of the records available, at no charge, to Avēsis, the Sponsor, state Medicaid agency, the U.S. Department of Health and Human Services, CMS, and any other duly authorized representative of the state or federal government.

10. Compliance with Law, Policies and Procedures and Provider Manual. Provider shall at all times:
    a. conduct his professional practice and supervise all personnel in a manner that complies with:
        i. all applicable laws and regulations;
        ii. this Agreement and its Exhibits;
        iii. policies and procedures of Avēsis;
        iv. the Provider Manual, as amended from time to time;
        v. Sponsor(s)'s policies and procedures, as applicable; and
        vi. accreditation standards, as applicable;
    b. maintain in good standing and keep current all permits, certificates and licenses required by all applicable federal and state laws and regulations to provide services under this Agreement; and
    c. comply with all applicable federal and state laws, including but not limited to those relating to advance directives and those relating to non-discrimination and equal opportunity.

11. Required Notices. In addition to any other notices required under this Agreement, Provider shall give notice to Avēsis within two (2) business days of the occurrence of any of the following events, or any event that could reasonably be expected to impair the ability of Provider to comply with the obligations of this Agreement:

    a. Relocation or closure of Provider's office, change in Provider's office telephone number;
    b. an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of Provider to be inaccurate;
    c. Provider fails to maintain insurance as required by this Agreement;
    d. Provider's license, certification, DEA certificate, or accreditation expires or is suspended, revoked, conditioned, or otherwise restricted;
    e. Provider has a confirmed medical disability that limits Provider's ability to practice medicine;
    f. Provider is excluded, suspended, disbarred from, or sanctioned under a federal or state health care program;
    g. a disciplinary action is initiated by a governmental authority against Provider;
    h. where applicable, Provider's hospital privileges are suspended, limited, revoked or terminated;

i. a grievance or legal action is filed by a Member concerning Provider;
j. Provider no longer participates in the Medicare Program and, if applicable, the state Medicaid program in which Provider practices;
k. Provider is under investigation for fraud or a felony; or
l. Provider enters into a settlement related to any of the items listed above.

12. Non-discrimination. Unless otherwise specified in a Product Addendum, Provider, its employees and contractors shall not discriminate in the treatment or quality of services provided to Members on the basis of age, race, religion, gender identity, color, national origin, or creed. Provider agrees to comply, and ensure that all employees and contractors comply with all applicable federal and state laws relating to non-discrimination and equal opportunity. As may be applicable, in compliance with Section 1557 of the Affordable Care Act, Provider shall post non-discrimination notices in its office and on its website to provide meaningful access to effective communications for patients with limited English proficiency and/or disabilities.

13. Credentialing Program. Provider shall meet and maintain NCQA and/or established industry standards for credentialing adopted by the Avēsis Credentialing Program as well as any other requirements that may be imposed by the Sponsor, from time to time. These include, but are not limited to: a) current licensure; b) current certifications, as appropriate; c) professional liability insurance coverage; d) compliance with continuing education requirements; and e) other requirements and qualifications as may be required by Avēsis, Sponsor or any federal or state agency. Specific Sponsor or state requirements will be described in the applicable Sponsor Addendum. Failure to cooperate with the credentialing or recredentialing requirements may result in payment for services rendered being withheld or denied until all recredentialing materials have been received by Avēsis. Provider shall notify Avēsis of subsequent changes in status of any information relating to Provider's ownership or professional credentials.

14. Insurance. While this Agreement is in effect, Provider shall keep in force all professional liability insurance coverage required by state and/or federal law. If the state does not require specific limits, Provider agrees to maintain professional liability insurance of One Million Dollars ($1,000,000) per claim and THREE MILLION DOLLARS ($3,000,000) annual aggregate, or such other amounts as may be recommended by the State licensing board. Insurance shall cover, at a minimum, each location where Provider provides services under this Agreement. Provider also agrees to maintain comprehensive general liability insurance and/or such other available insurance as shall be necessary to insure Provider and his employees against and from any and all damages arising from its duties and obligations under this Agreement. Proof of such insurance shall be made available to Avēsis within two (2) business days of its request. The costs of securing said insurance coverages shall be borne by the Provider. Insurance carried by Provider will not relieve Provider from the indemnity obligations in this Agreement. Provider shall notify Avēsis or Sponsor at least thirty days prior to the cancellation of any such policy. Provider shall notify Avēsis immediately upon the termination of any such policy. Where applicable, the Federal Tort Claims Act or state-specific Tort Claims Act shall either replace of supplement the Provider's professional liability insurance to meet the requirements stated in this paragraph.

15. Licensure. Provider and employees or agents rendering services to Members shall be appropriately licensed to render such services as required by state or federal law or any regulatory agency. Such licenses shall be maintained in good standing. Provider shall provide Avēsis a copy of said license(s) at the time of credentialing, upon renewal and/or at recredentialing.

16. Professional Training and Education. Provider and all employees or agents rendering services to Members shall possess and maintain the training and ability and other qualifications necessary to provide quality care to Members. Avēsis will review the status of the Provider following notification of

any action by the state licensing agency. Provider comply with all continuing education standards as required by federal or state law or regulation or by the applicable state licensing board.

17. Professional Standards. Provider and all employees or agents rendering services to Members shall provide care that meets or exceeds the standards of care for like providers in the region as determined by the applicable state board and shall comply with all standards for like providers as established by federal or state law or regulation.

18. Member Grievances and Appeals. Provider agrees to cooperate with Avēsis as reasonably necessary to resolve Member grievances and appeals, including providing Avēsis or Sponsor with requested relevant information within specified timeframes.

19. Quality Improvement. Provider agrees to respond and / or comply with Avēsis' Quality Improvement Program as it relates to quality assurance, independent quality review, utilization review and Member grievance program as explained in the Provider Manual or required by applicable law. Provider shall cooperate with all Avēsis or Sponsor Quality Improvement activities, including independent quality review/improvement activities.

20. Utilization Management. When applicable, Provider shall comply with Avēsis and Sponsor's Utilization Management programs including pre- and post-payment review of certain Covered Benefits. Covered Benefits requiring Pre-Treatment/Prior Authorization estimates are defined in Sponsor Addendums, the Provider Manual and on the Avēsis provider website.

    a. Provider shall follow the Pre-Treatment/Prior Authorization referral guidelines defined in the Avēsis Provider Manual except for emergencies.

    b. Provider shall provide requested documentation to the Avēsis claims and utilization management departments upon request. Failure to provide the requested documentation will result in the denial of a pending claim or the recoupment of a paid claim.

    c. Failure of Provider to participate in the utilization management program shall be deemed a breach of this Agreement and may result in termination by Avēsis.

21. Applicability of Avēsis Programs. None of Avēsis' or Sponsor's utilization management, quality management, credentials verification or provider sanction programs shall either: a) override the professional or ethical responsibility of Provider; or b) interfere with Provider's ability to provide information or assistance to Members.

22. Physician Incentive Plans. Provider agrees to comply with the Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210. No specific payment will be made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

23. Fraud and Abuse. Provider agrees to comply with applicable laws and regulations designed to prevent, detect, and correct fraud, waste, and abuse. Provider shall institute, operate, and maintain, an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal law. Such compliance program shall be appropriate to Provider's organization and operations and shall require participation by all officers, directors, employees, contractors, and agents of Provider. In the event Provider treats Medicare Members, the compliance program shall meet all applicable CMS

requirements.

24. Reporting. Provider shall comply and cooperate with any applicable statutory, regulatory, Avēsis or Sponsor-required reporting requirements, including but not limited to those related to encounter data. All reporting must be true, complete, and accurate.

D. RELATIONSHIP OF PARTIES.

1. Professional Judgment. Provider has the sole right and responsibility for determining treatment and administering care. Nothing in this Agreement shall be construed to interfere with the Provider/Member relationship or limit Provider from discussing treatment or non-treatment options with Member that may not be covered in whole or part by Sponsor. Nothing in this Agreement shall be construed to limit Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care or non-treatment options, including any alternative treatments that may be self-administered by the Member. Nothing in this Agreement shall limit or prohibit Provider from advocating on behalf of the Member in any grievance system, utilization review process or individual authorization process to obtain necessary health care or Covered Benefits.

2. Independent Contractor. Provider is an independent contractor(s), and nothing herein shall be construed to create an agency, employment, partnership, joint venture or fiduciary relationship between Avēsis, Provider and Sponsor.

3. Non-Exclusive Relationship. Each Party's rights hereunder are non-exclusive. Provider may provide services to non-Avēsis patients, and Provider may enter into agreements with other networks and organizations for such purposes. Avēsis may contract with other providers to render Covered Benefits to Members.

4. Rights Reserved by Avēsis retains all ownership rights in the Avēsis networks and system, the sole and exclusive right to operate offices or license other providers to participate in the Avēsis system, and exclusive rights in and to the names and marks of Avēsis and its Affiliated Companies, together with any and all other trademarks and service marks that may hereafter be adopted or used by Avēsis. Provider shall not advertise or use any names, symbols, trademarks or service marks of Avēsis in any advertising or public communication without the prior written authorization of Avēsis.

E. INDEMNIFICATION. Neither Avēsis nor any Sponsor, their officers, shareholders, directors, employees, agents, successors nor assigns ("**Indemnified Party**") shall be responsible for, or guarantee the quality of, any services or materials furnished by Provider. Provider agrees to indemnify and hold Avēsis and all Sponsors, their officers, directors, employees and agents from and against any claim, damage, loss (including any amounts paid in compromise or settlement of disputed claims), expenses, liability, obligation, action or cause of action, including reasonable attorneys' fees and all costs of investigation (collectively the "**Indemnified Claims**"), which the Indemnified Party may sustain pay, suffer incur by reason of any service provided by Provider to any Member. Attorneys' fees shall include not only those fees incurred in connection with investigating and defending the Indemnified Claims but also all attorneys' fees incurred by Avēsis in prosecuting, enforcing and collecting this indemnity. The Indemnified Party is not responsible for nor does the Indemnified Party guarantee the quality of any services or materials furnished by Provider. Provider shall indemnify Avēsis and all Sponsors from all claims, liabilities and damages incurred in connection with, or arising out of Provider's material breach of this Agreement or any services furnished, or to be furnished, by Provider to Members. The obligations of indemnification shall survive the termination of the Agreement.

F. REPRESENTATIONS, WARRANTIES AND COVENANTS OF PROVIDER.

Except as otherwise disclosed to Avēsis in writing prior to execution of this Agreement, Provider hereby warrants that the representations, warranties and covenants set forth below in this are true and accurate as of the date of this Agreement, and that they shall remain true and accurate at all times throughout the Term of this Agreement. Provider acknowledges that the accuracy and fulfillment of these representations, warranties and covenants are a condition of initial and continued survival of this Agreement:

1. Authorization. The individual executing this Agreement on behalf of Provider is duly authorized to do so; and upon its execution, this Agreement shall constitute the legal, valid and binding obligation of Provider. Further, Provider is authorized to enter into this Agreement for itself and, if Provider is a group practice or group of Participating Providers, Provider's execution of this Agreement binds all employees, contractors, partners, etc., that operate as part of Provider's practice, and all such individuals agree to be so bound.

2. No Inducements. Except as otherwise specifically set forth herein, no promises or guarantees of specific payment or volume or value of referrals have been made to Provider as an inducement to reduce, delay or limit specific, medically necessary services covered by the Sponsor Plans or by any person representing either party to induce Provider to execute this Agreement. Provider agrees that they shall not profit from provision of Covered Benefits that are not medically necessary or appropriate.

3. Review. Provider and any employees, contractors, partners or shareholders, if applicable, have read the entire Agreement and represent that each of them is capable of complying and will comply with it.

4. Licensure and Standards for Practice. Provider shall at all times render services to Members of Avēsis in a competent, professional, and ethical manner, in accordance with prevailing standards of professional care and practice, and all applicable statutes, regulations, rules, orders, and directives of any and all applicable governmental and regulatory bodies having competent jurisdiction. Provider is duly licensed, registered and in good standing, and shall maintain such licensure throughout the Term, to practice in the states where s/he provides services under this Agreement and such license and registration is not restricted, conditioned or limited in any way. Provider has no obligation to others that is inconsistent with Provider's obligations under this Agreement and the undertaking of this Agreement by Provider will not constitute a breach of any other agreement to which Provider is a party or any obligation to which Provider is bound. Provider is currently not, and has not in the past been, the subject of any investigation for suspected healthcare fraud or abuse or violation of any other state or federal law, nor has Provider's Medicare or Medicaid provider status been limited, conditioned, revoked, or suspended for any reason. Provider represents and warrants that he is not now under any obligation to any person or entity nor does he have any other interest which is inconsistent with or in conflict with this Agreement or in conflict with any other agreement which would prevent, limit or impair, in any way, his performance of any of the covenants or duties herein. If Provider is a group practice, Provider represents and warrants that the foregoing also is true and accurate as it relates to the employed or contracted providers and staff that operate as part of Provider's practice under this Agreement.

    a. Provider's license to practice in any state has never been suspended, limited, conditioned, revoked or voluntarily relinquished under the threat of disciplinary action;

    b. Provider has never been reprimanded, sanctioned or disciplined by a licensing board or state or local professional society or specialty board;

    c. There has never been entered against Provider a claim, final judgment or agreed settlement in a malpractice action;

G. TERM AND TERMINATION.

1. Term. The term of this Agreement shall be for a period of one (1) year beginning on the Effective Date ("**Initial Term**"). Upon expiration of the Initial Term, this Agreement will automatically renew for successive one-year periods (each one-year period a "**Renewal Term**" and the Initial Term and all Renewal Terms, if any, referred to collectively as the "**Term**"), unless otherwise terminated by either party in accordance with the terms of this Agreement.

2. Termination without Cause. This Agreement may be terminated, in whole or in part, without cause by either Party providing written notice to the other at least ninety (90) calendar days prior to the end of the then-current Initial or Renewal Term. It is understood that during the ninety (90) day period, the terms and conditions of this Agreement shall remain in force and effect. Terminations without cause may not be appealed, except where a state or local law exists requiring such terminations to be appealable.

3. Termination for Cause.
   a. Breach. Either Party may terminate this Agreement for breach of a material term, condition, or provision of this Agreement, after thirty (30) days prior written notice to the other Party specifying the nature of such breach. The breaching Party shall have such thirty (30) day period, or longer if mutually agreed upon by the Parties, to cure or correct such material breach. If the breaching Party fails or refuses to cure the material breach within such time, then the non-breaching Party may elect to terminate the Agreement effective the last day of the month following the end of the thirty (30) day notice period. The remedy herein shall not be exclusive of, but shall be in addition to, any remedy available at law or in equity to the non-breaching Party. In the event a Party contests the claim of breach; the Agreement shall remain in effect until the dispute is resolved in accordance with Section J.5 below.

   b. Immediate Termination by Avesis. Avēsis may terminate this Agreement immediately, in whole or in part, by providing written notice to Provider, of any of the following:
      i. Provider poses an imminent danger to Avēsis Members or the public health, safety and welfare;
      ii. Provider is charged or convicted with, or files a plea of no contest to, a felony or a crime of moral turpitude;
      iii. Provider is charged with or convicted of, or files a plea of no contest to, an offense related to health care delivery, Medicaid, or Medicare;
      iv. Provider has been excluded, debarred, or suspended from Medicare or Medicaid;
      v. Provider fails to satisfy the credentialing or recredentialing program requirements;
      vi. Provider ceases participating in Avēsis network(s) through non-renewal of credentialing application or denial of approval for participation;
      vii. Provider's license, certification, or accreditation has been terminated, revoked, suspended, or otherwise limited;
      viii. Provider's insurance has been terminated or significantly limited, or Provider is deemed uninsurable;
      ix. Provider fails to obtain or maintain hospital privileges, if applicable;
      x. Provider's death;
      xi. Provider files bankruptcy, voluntarily or involuntarily, declares insolvency, or has a receiver or conservator of assets appointed; or
      xii. Sponsor has a good faith reason to require Avēsis to terminate the Agreement.

4. Effect of Termination. Termination of this Agreement does not nullify Provider's responsibility for the adequacy of service provided to Members. Under no circumstances will reimbursement be made by Avēsis for any services rendered after the termination date of this Agreement unless required by the applicable state law provisions regarding continued coverage of services for Members. Any due process or appeal rights of Provider shall be governed by the provisions defined in the Provider Manual, incorporated herein by reference, unless superseded by conflicting and governing state law. Upon termination of this Agreement, Provider shall immediately and forever cease and desist from using Avēsis advertising and promotional materials, and all trade secrets and confidential material delivered to Provider pursuant to this Agreement. Provider shall also refrain from doing anything which would indicate that Provider is participating in Avēsis' network.

5. Suspension. Avēsis may, in its sole and absolute discretion, suspend rather than terminate Provider's participation in the network if any of the following were to occur.

   a. Upon claims or utilization review by Avēsis, billing or claims submission issues occur with such frequency that Avēsis, in its sole and absolute discretion, determines that Provider should be suspended pending further investigation by Avēsis and such billing and claims issues are resolved.

   b. Provider has been determined by Sponsor, CMS, or a State Medicaid Agency to be subject to an order of suspension due to a credible allegation of fraud.

   c. Breach of this Agreement by Provider for which Avēsis elects, in its sole and absolute discretion, to suspend Provider until such problem or problems that caused the breach of this Agreement have been cured.

6. Non-Solicitation. So long as this Agreement is in effect, and for a period of one (1) year after its termination, Provider agrees that it will not solicit, advise, or counsel any Sponsor or Member to terminate its relationship or contract with Avēsis, or otherwise interfere with Avesis' relationship. Avēsis or Sponsor shall be solely responsible for notifying Members that Provider is no longer a Participating Provider. Nothing in this Section shall be construed as Avēsis' violation of Section D.1 above. In the event either Party violates this Section, the other Party may seek injunctive relief. This Section shall survive termination of this Agreement.

7. Termination of Individual Participating Providers. Where Provider is a group practice, Avēsis may require that one or more Participating Providers who are employed by, or contracted with, Provider to provide Covered Benefits to Members are terminated or suspended from participation under this Agreement under those circumstances listed in Sections G.3(a), G.3(b), or G.5 above.

H. SPECIAL REMEDIES.

Provider acknowledges that if Provider breaches any of the provisions of this Agreement, Avēsis may have incomplete and inadequate remedies at law. Therefore, Provider agrees that Avēsis may, in addition to any other available remedies, obtain an injunction and/or temporary restraining order to terminate or prevent the continuation of any such violation.

I. NOTICES.

All notices provided for in this Agreement shall be in writing and sent to the address below. Notices shall be deemed to have been duly given upon (a) actual delivery; (b) five (5) days after deposit for mailing by registered

or certified mail, postage prepaid, return receipt requested, addressed to the other party at the address shown at the end of this Agreement; or (c) one business day after delivery to a commercial overnight delivery service addressed as provided above for delivery the next business day. Either party may change its address by written notice to the other party. Any notices required to be given pursuant to the terms and provisions hereof shall be sent by mail to:

If To Avēsis:

Avēsis Third Party Administrators LLC
Attn: Vision Contract Notices
10400 N. 25th Avenue, Suite 200
Phoenix, AZ 85021

With an electronic copy to:
compliance@avesis.com

IF TO PROVIDER:
At address on execution page

J. GENERAL PROVISIONS.

1. **Headings.** Headings are for convenience and shall not affect interpretation. Words in this Agreement shall be deemed to refer to whatever number or gender the context requires. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their permitted successors and assigns. No right or remedy shall be exclusive of any other right or remedy herein or provided by law, but such rights and remedies shall be cumulative and enforceable simultaneously or sequentially.

2. **Severability.** If any provision of this Agreement shall be declared invalid or unenforceable, that provision shall be deemed modified to the extent necessary to make it valid and enforceable. If it cannot be so modified, then the provision shall be severed, and the modified or remaining provisions shall remain in full force and effect.

3. **Assignment.** Neither this Agreement nor any of the rights or obligations hereunder shall be assigned, transferred or delegated by Provider, by operation of law or otherwise, without the prior written consent of Avēsis. Any change of ownership interest in Provider shall be deemed an assignment of the Agreement, and would require the prior written consent of Avēsis. Avēsis may assign its rights and obligations hereunder.

4. **Choice of Law**. This Agreement and all questions relating to its validity, interpretation, performance and enforcement, shall be governed by and construed, interpreted and enforced in accordance with the laws in the state where Provider is located without regard to such state's choice of law provisions.

5. **Disputes.** In the event the Parties cannot resolve a dispute by good faith negotiation among their executives, except as may otherwise be provided for herein, and, where permissible by law, any and all disputes arising out of or relating to this Agreement and the transactions contemplated herein, shall be solely and finally settled by binding arbitration and administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules (the "**Rules**"), by a single arbitrator selected in accordance with the Rules (the

"**Arbitrator**"). The Arbitrator shall not have been employed by or affiliated with any of the parties or their affiliates. Except as set forth below, the parties hereby renounce all recourse to litigation as to matters subject to arbitration hereunder, and the parties agree that the award of the Arbitrator shall be final and subject to no judicial review, except as expressly provided by applicable law. The Arbitrator shall decide the issues submitted to him in accordance with: (a) the provisions and purposes of this Agreement; and (b) the laws in the state where Provider is located**,** and shall issue a written award setting forth the reasons for his decision. Judgment on the award of the Arbitrator may be entered in any court having jurisdiction thereof. Notwithstanding the foregoing, each party shall have the right to seek injunctive or other equitable relief in any court of competent jurisdiction to enforce the provisions of this Agreement without first seeking or obtaining any decision of the Arbitrator with respect to the subject matter of this Agreement, even if a similar or related matter has already been referred to arbitration in accordance with the terms of this paragraph.

6. **Attorneys' Fees.** Should Avēsis incur attorneys' fees in order to enforce the terms and conditions of this Agreement, including post-term covenants, whether or not a legal action is instituted, Avēsis shall be entitled to reimbursement of such attorneys' fees and costs, in addition to any other remedies Avēsis may have at law or in equity.

7. **Confidentiality.** This Agreement shall be regarded as confidential and its terms and contents shall not be disclosed to any other party unless agreed to in writing by the Parties. In addition, each Party shall maintain the confidentiality of the other Party's proprietary information that is not otherwise public information, provided that Avēsis may disclose reimbursement terms to a Sponsor if necessary. Both Parties may disclose the terms and contents to their legal representation or government agents without the consent of the other Party.

8. **Amendment**. Except as otherwise required by applicable law or as stated in Section B.1.c above, this Agreement may be amended in writing by Avēsis at any time upon thirty (30) days prior written notice to Provider. If an amendment is not acceptable to Provider, he/she must reject such amendment by providing written notice to Avēsis at the addresses set forth in Section I of this Agreement within such thirty (30) day period. In the absence of such notice of rejection by Provider to Avēsis, Provider will be deemed to have accepted such amendment as of its stated effective date. If Provider rejects the amendment, Avēsis shall have the right to continue the terms of this Agreement without giving effect to the proposed amendment. Avēsis reserves the right to immediately amend this Agreement upon notice to Provider with respect to an amendment which it reasonably believes is required by applicable law or regulation.

9. **Waiver of Breach.** The waiver by either party of a breach or violation of the Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.

10. **Entire Agreement.** This Agreement, including the Execution Page, the Recitals and Terms and Conditions, together with the Provider Manual and any Exhibits or Addendums referred to herein, constitute the entire Agreement between Provider and Avēsis. This Agreement supersedes all prior and contemporaneous agreements, understandings and conditions, express or implied, oral or written, of any nature whatsoever with respect to the subject matter hereof.

11. **Exhibits**. Any Exhibits attached hereto are incorporated by reference into this Agreement and made a part hereof.

12. **Responsibility for Actions**. Each party shall be responsible for any and all claims, liabilities, damages, or judgments that may arise as a result of its own negligence or intentional wrong doing.

13. **Form.** All words used herein in the singular number shall extend to and include the plural. All words used in the plural number shall extend and include the singular. All words used herein apply to all genders.

14. **Errors.** Avēsis shall make every effort to maintain accurate information however, Avēsis shall not be held liable for any damages directly or indirectly due to typographical errors. Provider agrees to notify Avēsis of any errors found in remittance statements.

EXHIBIT A

COVERED BENEFITS AND FEE SCHEDULES

Unless otherwise stated in a Product Addendum, Covered Benefits shall be paid at the lesser of Provider's billed charges or the applicable fee schedules for the applicable Sponsor. Fee Schedules are attached to this Agreement in this Exhibit A. A full listing of Sponsor Plan designs and Covered Benefits can be found by logging into your Provider Web Portal at www.avesis.com.

REFER TO EXHIBIT A FEE SCHEDULE ATTACHMENTS

Provider Roster by Practice Location

Please list all individuals, either contracted with or employed by provider, who are a party to this contract per location.

Note: Please be certain that the provider has checkmarked the Release of Data to any organization that requests data on the CAQH website, authorizing Avēsis Third Party Administrators to access data. And please be sure that all information on the CAQH website is complete and current.

*Required if Medicaid network participation is checked

Provider Information	Specialty (Select primary)	Network Participation (Check all that apply)	Primary Location?
Provider's Full Name ____ Service Address ____ Gender (M/F) ____ SSN (last 4) ____ City, State Zip ____ County ____ Date of Birth (mm/dd/yyyy) ____ Phone ____ NPI ____ Email ____ CAQH# (if applicable) ____ Fax ____ Provider Offers Telehealth Services ☐ Yes ☐ No	☐ Ocularist ☐ Ophthalmologist ☐ Optician ☐ Optometrist Subspecialties (If applicable): ____ ____	☐ Commercial ☐ Medicare ☐ Medicaid Medicaid ID: ____	☐ Yes ☐ No Group Medicaid ID: ____
Provider's Full Name ____ Service Address ____ Gender (M/F) ____ SSN (last 4) ____ City, State Zip ____ County ____ Date of Birth (mm/dd/yyyy) ____ Phone ____ NPI ____ Email ____ CAQH# (if applicable) ____ Fax ____ Provider Offers Telehealth Services ☐ Yes ☐ No	☐ Ocularist ☐ Ophthalmologist ☐ Optician ☐ Optometrist Subspecialties (If applicable): ____ ____	☐ Commercial ☐ Medicare ☐ Medicaid Medicaid ID: ____	☐ Yes ☐ No Group ID: ____
Provider's Full Name ____ Service Address ____ Gender (M/F) ____ SSN (last 4) ____ City, State Zip ____ County ____ Date of Birth (mm/dd/yyyy) ____ Phone ____ NPI ____ Email ____ CAQH# (if applicable) ____ Fax ____ Provider Offers Telehealth Services ☐ Yes ☐ No	☐ Ocularist ☐ Ophthalmologist ☐ Optician ☐ Optometrist Subspecialties (If applicable): ____ ____	☐ Commercial ☐ Medicare ☐ Medicaid Medicaid ID: ____	☐ Yes ☐ No Group ID: ____
Provider's Full Name ____ Service Address ____ Gender (M/F) ____ SSN (last 4) ____ City, State Zip ____ County ____ Date of Birth (mm/dd/yyyy) ____ Phone ____ NPI ____ Email ____ CAQH# (if applicable) ____ Fax ____ Provider Offers Telehealth Services ☐ Yes ☐ No	☐ Ocularist ☐ Ophthalmologist ☐ Optician ☐ Optometrist Subspecialties (If applicable): ____ ____	☐ Commercial ☐ Medicare ☐ Medicaid Medicaid ID: ____	☐ Yes ☐ No Group ID: ____

Multiple Location/TIN Setup Form

Attachment B – 1

**Please Note: This form is only required for Contracting Entities with two or more locations and/or TINs.*

This form is designed to help Avēsis understand all the Tax Entities covered under the terms of your Provider Agreement and to assist Contracting Entities with multiple locations or Tax ID Numbers (TINs) with the proper setup of their web portal access. Please list all locations, addresses, and associated TINs that will be covered under the terms of your Provider Agreement. Please include a completed W9 form for each TIN listed below.

Check only one box below to indicate web portal access and check payment status.

☐ Single Business Unit ID for all locations – All locations will receive one consolidated check and would access the Provider Web Portal using a single username and password for all locations.

☐ Multiple Business Unit ID Setup – Each location will receive a separate check and would access the Provider Web Portal using a username and password specific to each location.

*Please indicate if the location is a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Private Corporation, or Individual. All locations identified as FQHC or RHC are **REQUIRED** to include their business entity NPI where indicated.

Contracting Entity Name:

Location Name	Street Address	TIN	FQHC/RHC	Business Entity NPI (NPI2)
			☐ FQHC ☐ RHC	
			☐ FQHC ☐ RHC	
			☐ FQHC ☐ RHC	
			☐ FQHC ☐ RHC	
			☐ FQHC ☐ RHC	
			☐ FQHC ☐ RHC	
			☐ FQHC ☐ RHC	

I attest that all Locations and Tax Identification Numbers listed above are bound under the terms of the agreement signed by the Contracting Entity.

Authorized Signature: _____ Date: _____

Avēsis, LLC
P.O. Box 38300
Phoenix, Arizona 85069-8300

www.avesis.com

HOSPITAL AFFILIATIONS

Do not show in directory

HOSPITAL PRIVILEGES

HOSPITAL NAME: ____________________ TIN: __________

ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________

PHONE NUMBER: __________ FAX NUMBER: __________

PROVIDER FIRST NAME: __________ PROVIDER LAST NAME: __________

HOSPITAL PRIVILEGES

HOSPITAL NAME: ____________________ TIN: __________

ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________

PHONE NUMBER: __________ FAX NUMBER: __________

PROVIDER FIRST NAME: __________ PROVIDER LAST NAME: __________

HOSPITAL PRIVILEGES

HOSPITAL NAME: ____________________ TIN: __________

ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________

PHONE NUMBER: __________ FAX NUMBER: __________

PROVIDER FIRST NAME: __________ PROVIDER LAST NAME: __________

HOSPITAL PRIVILEGES

HOSPITAL NAME: ____________________ TIN: __________

ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________

PHONE NUMBER: __________ FAX NUMBER: __________

PROVIDER FIRST NAME: __________ PROVIDER LAST NAME: __________

HOSPITAL PRIVILEGES

HOSPITAL NAME: ____________________ TIN: __________

ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________

PHONE NUMBER: __________ FAX NUMBER: __________

PROVIDER FIRST NAME: __________ PROVIDER LAST NAME: __________

EXHIBIT C

DELAWARE SPONSORS AND SPONSOR PLANS

MEDICARE ADVANTAGE AND MEDICARE/MEDICAID DUALS SPONSORS

None at this time – Notification of Health Plan Sponsors will be sent in accordance with section B.1.c of the Agreement

MEDICAID AND CHIP SPONSORS

AmeriHealth Delaware

COMMERCIAL SPONSORS

Various PPO and self-funded ASO accounts, which may be as evidenced by Member Identification card or other evidence of insurance/coverage presented to Provider at time of service. For information regarding Commercial plan designs and Commercial Sponsors, please reference the website listed on the Member's identification card or the Avesis provider website.

EXHIBIT D
List of Avēsis Affiliated Companies

Avēsis LLC
Avēsis Insurance
Avēsis Third Party Administrators, LLC

EXHIBIT E
MEDICARE ADVANTAGE PRODUCT ADDENDUM (if relevant to Provider)

THIS MEDICARE ADVANTAGE ADDENDUM (this "**MA Addendum**") to the Provider Agreement ("**Agreement**") is made as of the Effective Date of the Agreement. Avēsis or Affiliated Companies (for purposes of this **Exhibit E**, "**Affiliated Company**") are under one of more contracts with a Sponsor that is an MA Organization (defined below) and listed on **Exhibit C** to the Agreement. Provider agrees to provide Covered Benefits to Members enrolled in one or more Sponsor's Medicare plans listed on **Exhibit C** ("**Sponsor Plans**"). The Centers for Medicare and Medicaid Services ("**CMS**") requires that specific terms and conditions be incorporated into provider agreements in order to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108- 173, 117 Stat. 2066 ("**MMA**"). Affiliated Company is a First Tier Entity to one or more Sponsors. Except as provided herein, all other provisions of the Agreement not inconsistent with the terms and conditions stated below shall remain in full force and effect. This MA Addendum shall supersede and replace any inconsistent provisions to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

Definitions:

Completion of An Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity.

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

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

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

Medical Necessity: For purposes of determinations of Medical Necessity of services provided to Members in Sponsor's Medicare Products, Affiliated Company and Sponsor will utilize the following definition in accordance with CMS regulations:

Medical Necessity or Medically Necessary means medical or hospital services that are determined by Affiliated Company or Sponsor to be: (1) Rendered for the treatment or diagnosis of an injury or illness; and (2) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and (3) Not furnished primarily for the convenience of the Member, the attending physician or other provider of service. Whether there is "sufficient scientific evidence" shall be determined by Affiliated Company or Sponsor based on the following: peer reviewed medical literature; publications; reports; evaluations and regulations issued by State and federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Affiliated Company or Sponsor.

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

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

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

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

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

1. **Record Retention.** Provider shall give the U.S. Department of Health and Human Services (HHS), the Comptroller General, and their authorized designees, the right to collect, audit, evaluate and inspect any pertinent information for any particular contract period, including but not limited to, books, contracts, computer or other electronic systems (including medical records), and other records of Provider relating to its participation in Sponsor's Medicare Advantage product(s) and to services furnished to Medicare Advantage Members, and any other relevant information that the Centers for Medicare and Medicaid Service (CMS) may require during the term of this Agreement and for a period of ten (10) years following the final date of the final contract period of the contract entered into between CMS and Sponsor, or from the date of Completion Of An Audit, whichever is later, unless such time frame is extended pursuant to 42 C.F.R. § 422.504(e)(4) (such as in the event of fraud). This provision shall survive termination of the Agreement. Provider shall require that any of its Related Entities or Downstream Entities acknowledge and agree that HHS, the Comptroller General, and their authorized designees also have the right to audit, evaluate, collect, and inspect any records described in this Section.

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

3. **Hold Harmless.** Provider shall not, at any time including insolvency of Sponsor, hold Members liable for payment of any fees that are the legal obligation of the MA Organization. Provider shall not hold Members who are eligible for both Medicare and Medicaid liable for Medicare Part A and B cost-sharing when the applicable State program is responsible for paying such amounts. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Provider will (a) accept the MA plan payment as payment in full, or (b) bill the appropriate state source. This provision shall survive termination of the Agreement.

4. **Prompt Payment.** Affiliated Company and Provider agree to follow prompt pay regulations regarding clean claims payment within thirty (30) days according to arrangements set forth in the Agreement and Affiliated Company policy as outlined in the Provider Manual.

5. **Delegation.** If Provider is delegated any activities or responsibilities that fall under Sponsor's MA contract, Affiliated Company and Provider shall specify delegated activities and reporting responsibilities in a written document. The written document shall also identify revocation of delegation activities and reporting requirements or specify other such remedies in instances where CMS, Sponsor, or Affiliated Company determines that Provider has not performed satisfactorily. Sponsor or Affiliated Company shall monitor the performance of Provider. If the credentialing process is delegated, Affiliated Company or Sponsor shall audit the credentialing process on an ongoing basis. Sponsor retains the right to approve, suspend, or terminate any individual Provider selected or credentialed by Provider.

6. **Compliance with Medicare Advantage Program Laws, Policies and Procedures.** Provider, and any Related Entity, contractor, or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions, and all services or other activity performed under the Agreement shall be consistent and comply with Sponsor's contractual obligations. In addition, Affiliated Company agrees to comply with such other terms and conditions as CMS may find necessary and appropriate in order to implement MA requirements. [42 C.F.R. § 422.504(j)]

7. **Federal Funds.** Payments made to Provider for the treatment of a Member enrolled in an MA Organization are made, in whole or in part, from Federal funds, and subject Provider to all laws applicable to the individuals or entities who receive Federal funds, including the False Claims Act (32 USC 3729, et. seq.), the Anti-Kickback Statute (section 1128B(b) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973. Provider shall comply with such laws.

8. **Medicare Number.** In accordance with CMS guidelines, if Provider writes prescriptions for Members, Provider must either apply for a Medicare ID number or a Referring Provider Medicare ID number prior to implementation of CMS's requirement which is scheduled to be fully implemented on January 1,2019.

9. **Accountability.** In accordance with 42 CFR 422.504(i)(3)(ii)(A), Affiliated Company is accountable for monitoring Provider on an ongoing basis and is accountable to Sponsor (and Sponsor is accountable to CMS) for any functions or responsibilities that are described in applicable regulations.

10. **Medicare Participation.** Provider shall participate in the Medicare Program. Provider shall notify Affiliated Company of any change in participation status in accordance with the Agreement.

11. **Continuation of Care.** Provider and its related entities, contractors, subcontractor or transferees, shall continue to provide Covered Benefits to Members through the period for which CMS payments have been made for said Members. Such continuation of care shall be in accordance with the terms and conditions of the Agreement, including, but not limited to the reimbursement rates. This paragraph shall survive the termination of this Agreement.

12. **Missed Appointments. Under no circumstances shall Affiliated Company bill or charge Members for missed appointments.**

EXHIBIT E -1
MEDICARE ADVANTAGE/MEDICAID DUALS PRODUCT ADDENDUM
(if relevant to Provider)

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EXHIBIT F

Delaware Medicaid Addendum

This State of Delaware Medicaid Addendum ("**Delaware Addendum**") to the Provider Agreement ("**Agreement**") is effective as of the date of the Agreement between Provider and Avēsis Third Party Administrators, LLC("Avēsis"). Provider agrees to provide Covered Benefits to Members enrolled in one or more Sponsor's Medicaid managed care plans ("**Sponsor Plans**") in the State of Delaware Medicaid program, known as Diamond State Health Plan (the "**Program**"). The Program includes the Delaware Healthy Children Program ("**DHCP"**) and the Diamond State Health Plan Plus Program ("**DSHP Plus**"). Sponsor Plans are listed on **Exhibit C** and may be updated from time to time. All other terms and conditions of the Agreement with Avēsis apply hereto unless in conflict, in which case the terms and conditions of this Delaware Addendum apply as to the Program.

ARTICLE 1 DEFINITIONS

The following terms shall have the meanings set forth below.

1.1 Agency. "Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of the Delaware Medicaid Program, including the Delaware Department of Health and Human Services, Division of Medicaid and Medical Assistance ("**DHSS**").

1.2 CMS. "CMS" means the Center for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.3 Claim. "Claim" means (a) a bill for services submitted to Avēsis manually or electronically, (b) a line item of service on a bill, or (iii) all services for one Member within a bill, in a format prescribed by DHSS.

1.4 Clean Claim. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in the State's claims system. It does not include a Claim from a provider who is under investigation for fraud, waste, or abuse, or a claim under review for Medical Necessity.

1.5 Covered Benefits. "Covered Benefits" means those services that a Member is entitled to receive through the Program under the applicable benefit package for the Program in which the Member is enrolled and as set forth on Attachment A to the Agreement.

1.6 Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

1.7 Emergency Services. "Emergency Services" subject to applicable law means, inpatient and outpatient Covered Benefits furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard.

1.8 Encounter. "Encounter" means a record of any claim adjudicated by Avēsis for a Member, including Medicare claims for which there is no Medicaid reimbursement amount and/or a record of any service or administrative activity provided by Avēsis for a Member that represents a specific service or administrative activity, regardless of whether that service was adjudicated as a Claim or whether payment for the service was made.

1.9 Encounter Data. "Encounter Data" means the set of Encounters that represent the number and types of services rendered to Members during a specific time period, regardless of whether Provider was reimbursed on a capitated or fee-for-service basis.

1.10 Medical Necessity. "Medical Necessity" means the essential need for health care or services in order that the Member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility environments and activities, which, when delivered by or through authorized and qualified providers, will:

(a) be directly related to the diagnosed medical condition or the effects of the condition of the Member (the physical or mental function deficits that characterize the Member's condition), and be provided to the Member only;
(b) be primarily directed to the diagnosed medical condition or the effects of the condition of the Member, in all settings for normal activities of daily living (ADLs), but will not be solely for the convenience of the Member, the Member's family, or the Member's provider;
(c) be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the Member and the Member's family;
(d) be timely, considering the nature and current state of the Member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
(e) be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of funds;
(f) be the most appropriate care or service that can be safely and effectively provided to the Member, and will not duplicate other services provided to the Member;
(g) be sufficient in amount, scope and duration to reasonably achieve its purpose;
(h) be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; and
(i) be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

In addition, the services will be reasonably determined to:
(j) diagnose, cure, correct, or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions, or
(k) prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
(l) effectively reduce the level of direct medical supervision required, or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or
(m) restore or improve physical or mental functionality, including developmental functioning, lost or delayed as a result of an illness, injury, or condition, or
provide assistance in gaining access to needed medical, social, educational and other services

required to diagnose, treat, or support a diagnosed condition, or the effects of the condition.

1.11 Program Contract. "Program Contract" means the contract between the applicable Sponsor and the State of Delaware Medicaid Program which governs the delivery of managed health care services to Program beneficiaries.

1.12 Regulatory Requirements. "Regulatory Requirements" means any requirements imposed by applicable federal, state or local laws, rules, regulations, a Program Contract, or otherwise imposed by an Agency in connection with the operation of a Program or the performance required by either party under this Agreement.

ARTICLE 2 PROVIDER OBLIGATIONS:

2.1 Provider Services. Provider shall provide to Members Covered Benefits that meet the definition of Medical Necessity within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement, and Providers shall be responsible to the applicable Sponsor for such performance. Provider shall not discriminate in the acceptance of Members for treatment, and shall provide to Members the same access to services as Provider gives to all other patients.

2.2 Cooperation with Avēsis Programs. Provider shall participate and cooperate in any applicable QM/QI monitoring, UM, Peer review and or Appeal procedures including any remediation or quality improvement activities. Avēsis shall monitor the quality of Provider's services and initiate corrective action when necessary to improve quality of care in accordance with the level of care that is recognized as acceptable professional practice in the community in which Provider participates and/or standards established by the State. Provider shall comply with any corrective action plans initiated or requested by Avēsis. Avēsis shall determine Medical Necessity on a case-by-case basis. Neither Provider nor Avēsis shall arbitrarily deny or reduce the amount, duration, or scope of a Medically Necessary service solely because of a Member's diagnosis, type of illness, or condition.

2.3 Licensure and Accreditation. At all times during the term of this Agreement, Provider shall (a) be a certified Medicare and certified Medicaid Provider, to the extent required under the applicable Programs, and maintain a National Identification number ("NPI") as required by applicable law; (b) obtain and maintain any accreditation required to fulfill its obligations under this Agreement at all times during the term of this Agreement from the applicable nationally recognized accrediting body (c) not be subject to any determination or action that adversely impact Provider's ability to perform under this Agreement. Each of Provider's employees is required to be duly licensed, certified or registered as required under Program and applicable standards of professional ethics and practice. Provider shall notify Avēsis within five (5) business days following Provider's receipt of any notice of any restrictions upon any suspension or loss of, any such licensure, certification, registration, or receipt of any notice of any restrictions, suspension or revocation of such accreditation hereunder. Provider shall submit to Avēsis evidence of Provider's satisfaction of the requirements set forth in this section upon Avēsis's reasonable request.

2.4 Member Verification. Provider shall verify a Member's eligibility for services prior to rendering services, except in the case of an Emergency Medical Condition where no verification or authorization is required. In the case of an Emergency Medical Condition, Provider shall establish a Member's eligibility as soon as

reasonably practical. Avēsis shall provide a system for Providers to contact Avēsis to verify Member eligibility 24 hours a day, 7 days per week. Nothing contained in this Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for emergency room services provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such services. Nothing contained in a Provider agreement may have the effect of modifying benefits, terms, or conditions contained in the Program Contract.

2.5 Manner and Method of Treatment. Neither Sponsor nor Avēsis shall be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides dental or vision care services to Members. Provider shall be solely responsible for all dental or vision advice and dental or vision services provided by Provider to Members. Provider acknowledges and agrees that Avēsis may deny payment for provider services rendered to a Member which it determines are not Medically Necessary, are not Covered Benefits pursuant to an applicable Program Contract, or are not otherwise provided in accordance with this Agreement. Neither such a denial nor any action taken by Avēsis pursuant to a utilization review, referral, discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Member under applicable law and any code of professional responsibility. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary Covered Benefits. Under no circumstances may Provider encourage or suggest that children by placed into state custody in order to receive medical, behavioral, or LTSS benefits covered by the State of Delaware.

2.6 Claim Submission. Provider shall submit to Avēsis all information necessary for Avēsis to make payment. Provider shall have one (1) year from the date of rendering a Covered Benefit to file a claim with Avēsis, except in situations regarding coordination of benefits or subrogation in which case Provider is pursuing payment from a third party or if Member is enrolled in a Sponsor Plan with a retroactive eligibility date. In situations of third party benefits, the one (1) year filing timeframe shall begin on the date that the third party documented resolution of the claim. In situations of retroactive eligibility, the timeframe for filing a claim shall begin on the date that Sponsor receives notification from the Program of the Member's eligibility/enrollment.

2.7 Appointment Standards. Provider shall offer hours of operation that are no less than the hours of operation offered to patients with other insurance coverage, including but not limited to commercial health plans. Office wait times for Members holding appointments shall not exceed one (1) hour, unless Provider is working in an urgent case, when a serious problem is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made. Provider shall inform Members as soon as possible in the event of such a delay. If the delay will result in more than a ninety (90) minute wait, then the Member must be offered a new appointment. Provider shall make urgent care appointments available within forty-eight (48) hours of a Member's request, and routine care appointments available within three (3) weeks of Member's request. Provider shall maintain a master history of appointments scheduled for Members for one (1) year from the date of service to allow for monitoring and investigation of grievances related to scheduling. In the event these appointment standards are not met, Avēsis shall implement a corrective action plan for Provider, with which Provider shall comply.

2.8 Restriction on Balance Billing. Provider acknowledges and agrees that the compensation paid to Provider under this Agreement for services rendered by Provider to Members constitutes payment in full for such services and Provider shall not solicit or accept or balance bill any additional amounts for such services, except for applicable permitted outstanding co-payments, if any. In no event shall Provider send any Members' billing statements to a collection agency. Provider shall immediately, by certified mail return

receipt requested, notify Avēsis, the applicable Sponsor and the State of Delaware if Provider becomes aware for any reason that he/she is not entitled to payment for a particular Member.

2.9 Insurance Coverage.

(a) Coverage Requirements. At all times during the term of this Agreement, Provider shall maintain general commercial and professional liability insurance. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to such limits as required by law and consistent with industry standards for its provider type; and (iii) include coverage for the professional acts and omissions of Provider and any employee, agent or other person for whose acts or omissions Provider is responsible.

(b) Workers Compensation. Provider shall maintain workers' compensation insurance for Provider's employees. Said insurance shall be obtained from a carrier authorized to conduct business in the jurisdiction in which Provider operates and shall provide such limits of coverage as required by applicable Regulatory Requirements.

(c) Evidence of Insurance. Provider shall provide Avēsis with evidence of Provider's compliance with the foregoing insurance requirements as reasonably requested by Avēsis from time to time during the term of this Agreement, but in no event less than annually. Provider shall provide Avēsis with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider's coverage, and shall secure replacement coverage as needed to meet the requirements above so as to ensure no lapse in coverage. Provider shall furnish Avēsis with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting Agency upon request. Provider may maintain coverage hereunder through a self-funded insurance plan, provided that Provider maintains actuarially sound reserves related to such self-funded plan and provides Avēsis on a semi-annual basis an opinion letter from an independent actuarial firm or other proof reasonably acceptable to Avēsis attesting to the financial adequacy of such reserves.

2.10 Records:

(a) Maintenance: Provider shall maintain complete and accurate medical, financial and administrative records regarding services provided to Members in accordance with industry standards and Regulatory Requirements, including without limitation applicable federal and state privacy and security provisions. Providers shall retain such records for the period of time required under Regulatory Requirements applicable to the Program involved. Provider shall provide Avēsis, the applicable Sponsor and state and federal agencies access to review records related to services provided hereunder for off-site review, or on-site at Provider's facility, in accordance with Regulatory Requirements. Provider shall maintain the records referenced in this section for a period of five (5) years from the termination of the Agreement or (until all evaluations, audits, reviews, or investigations or prosecutions are completed if longer than five (5) years.

(b) Confidentiality: Provider shall treat all information which is obtained through its respective performance under the Agreement, including but not limited to protected health information ("**PHI**") as confidential information, pursuant to applicable state and federal law, including without limitation information that is confidential pursuant to 42 C.F.R. §422.118 and 45 C.F.R. Parts 160 and 164, as may be amended from time to time or other applicable law, and shall not use any information obtained except as necessary to the proper discharge of its obligations and

securing of its rights hereunder. Provider shall comply with 42 C.F.R. Part 2, and the HIPAA Privacy and Security Rules. Provider shall have a system in effect to protect all records and all other documents deemed confidential by law which are maintained in connection with the respective activities of Provider and performed in connection with this Agreement. Any disclosure or transfer of confidential information by Provider will be in accordance with applicable Regulatory Requirements. HIPAA does not bar disclosure of PHI to the State, authorized Federal agencies, or authorized representatives of the State or federal Agency.

(c) Right to Inspect, Review, and Audit Records. Any state or federal oversight agency, or their authorized representatives, including but not limited to, the DHSS, the United States Department of Justice, HHS, CMS, the Office of Inspector General Comptroller, the State of Delaware State Auditor's Office, and the State of Delaware Attorney General's Office shall have immediate access to Provider's records upon request, including records requested for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring, as well as for administrative, civil, and criminal investigations or prosecutions. State and federal agencies or their authorized representatives shall have the right to enter Provider's business premises during normal business hours to inspect, monitor, audit, or otherwise evaluate, whether announced or unannounced, the work being done under this Agreement and any records pertinent to this Agreement including quality, appropriateness and timeliness of services. Such evaluation, when performed, shall be performed with the cooperation Provider.

(d) Audits. Provider agrees that Avēsis, Sponsor, and any state or federal oversight agency, or their authorized representatives, including but not limited to, the DHSS, the United States Department of Justice, HHS, CMS, the Office of Inspector General Comptroller, the State of Delaware State Auditor's Office, and the State of Delaware Attorney General's Office has the right to inspect, evaluate, and audit the books, financial, and/or medical records related to the provision of services hereunder. Provider agrees to cooperate fully in any investigation by Sponsor, Avēsis, or the aforementioned state and federal Agencies, and in any subsequent legal action that may result from such an investigation involving the provison of dental or vision services hereunder. Provider shall permit Sponsor or Avēsis or its designated agent or a third party contractor to review or audit records in Provider's possession directly related to services provided to Members, to the extent that disclosure is consistent with HIPAA and or any other applicable privacy laws and regulations, either by providing such records to Avēsis or to its designated agent for off-site review, or on-site at Provider's facility, upon reasonable notice from Avēsis and during regular business hours. Provider shall supply the records described above upon request and at no charge. Provider agrees to cooperate with any evaluation, inspection or audit. Should such inspection, evaluation or audit result in a requirement by the Sponsor or DHSS that Provider be placed on a corrective action plan to correct any deficiencies noted, Provider agrees to cooperate with and abide by any such corrective action plan.

2.11 Provider Listing; Marketing/Advertising. For the purposes of enrolling and referring Members, marketing, complying with Program Contract requirements, reporting to Agencies, and otherwise carrying out the terms and conditions of this Agreement, Avēsis shall be entitled to use the name(s), business address(es), and phone number(s) of Provider. Avēsis shall also be entitled to use information related to any such individual Provider's education, specialty, subspecialty, licensure, certification and hospital affiliation for the purposes described above.

2.12 Limitations on Reimbursement. In the event Avēsis compensates Provider in an arrangement other than

fee-for-service (e.g., capitation, bundled payment): (a) if Provider becomes aware for any reason that he/she is not entitled to payment for a particular Member, Provider shall immediately notify Avēsis, Sponsor, and the Program by certified mail, return receipt requested; and (b) Provider shall promptly submit utilization or Encounter Data as specified so as to ensure Sponsor's and Avēsis's ability to submit Encounter Data to the Program that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims. In addition, as may be directed by the Sponsor, Avēsis or the Program, Avēsis may impose financial consequences on Provider, as appropriate, if Provider fails to comply with the Agreement and this Delaware Addendum.

2.13 Disclosure and Screening Requirements. Avēsis is under no obligation to make payments for Claims to Provider unless Provider has submitted completed disclosures required by applicable state and federal law (i.e., 42 CFR Part 455, subpart B) to the Program or to Avēsis, including but not limited to disclosure regarding ownership and control, business transactions, and criminal convictions. Provider shall submit to Avēsis, upon request, completed disclosures as part of initial credentialing and annually thereafter, using a state-approved disclosure form.

2.14 Reassignment of Payment. Any reassignment of payment must be in accordance with 42 CFR 447.10. All tax-reporting provider entities shall not be permitted to assign state funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion and debarment screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out-of-country individuals and/or entities are prohibited.

2.15 Notification Regarding DSHP Plus LTSS Members. In the event Provider rendered services to DSHP Plus LTSS members, Provider shall notify Member's case manager as expeditiously as warranted by the Member's circumstances in the event of any known significant changes in the Member's condition or care, hospitalizations, or recommendations for additional services.

2.16 Provider-Preventable Conditions. Provider shall comply with 42 CFR §438.6(f)(2) and identify provider-preventable conditions as a condition of payment under the Agreement.

2.17 Language Interpretation Services. Provider shall have written procedures for the provision of language interpretation services for any Member who needs such services, including but not limited to Members with limited English proficiency.

2.18 Identification of Third Party Liability. Provider shall identify third party liability coverage, including Medicare and long term care insurance, as applicable, and, except as otherwise provided in the Program Contract, to seek such payment before submitting claims to Avēsis.

2.19 Physician Incentive Plans**.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Avēsis, nor Sponsor, nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

2.20 Delaware Prescription Monitoring Program. Contracting Provider shall comply with the requirements of the Delaware Prescription Monitoring Program ("**PMP**") and to query the PMP to view information

about client usage before prescribing Schedule II or III controlled substances.

ARTICLE 3 PROHIBITED PRACTICES

3.1 Non-Discrimination. Provider shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Member from participation in any aid, care, service or other benefit, or deny any Member such services on the grounds of handicap, race, color, national origin, sex, age, disability, political beliefs or religion. Provider shall not subject any Member to discrimination due to such Member's status as a Program Contract beneficiary. Provider shall not discriminate in any manner against any employee or applicant for employment that would constitute a violation of any applicable law.

3.2 Marketing. Provider shall not engage in any marketing activities to Members, for or on behalf of the applicable Sponsor, except in accordance with Regulatory Requirements. Specifically, Provider shall not distribute any marketing materials to Members or in connection with services unless such materials are first submitted by Provider to the applicable Sponsor, and the applicable Sponsor submits such materials to state Agency for approval. Provider shall not use the State of Delaware's name or logos for any materials intended for dissemination to Members or patients without approval from the state. This prohibition, however, shall not include references to whether Provider accepts Medicaid.

3.3 Employed or Contracted Individuals. In no event shall Provider employ or subcontract any responsibilities hereunder to any individual who has been excluded from participation under any federal or state health benefits program, including without limitation the Medicaid or Medicare programs. Provider must immediately report to Avēsis any exclusion information discovered. Provider shall screen all employees and contractors initially, and on an ongoing monthly basis, to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any federal health care program (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Provider shall report immediately to Avēsis any exclusion information discovered. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Members.

3.4 Prohibited Referrals. In accordance with federal and state law, Provider is prohibited from referring any Members for designated health services to any entity in which Provider, or a member of Provider's or Provider's immediate family, has a financial relationship.

3.5 Laboratory Services. If Provider performs laboratory services, Provider must meet all applicable requirements of the Clinical Laboratory Improvement Amendments ("**CLIA**") of 1988, including either a CLIA certification or waiver of certification with a CLIA identification number, and any applicable state requirements.

3.6 Prohibited Terms. Avēsis shall not require Provider to agree to, and nothing in this Agreement shall be construed to be:

(a) a covenant-not-to-compete. Provider is not restricted from contracting with other managed care organizations ("**MCO**"); or

(b) an incentive or disincentive that encourages Provider not to enter into a contractual relationship with another MCO; or

(c) a prohibition or other restriction on Provider, if Provider is acting within the lawful scope of practice, from advising or advocating for a Member who is a patient of Provider; or

(d) compensation terms that discourage Provider from serving any specific eligibility category or population covered by the Program Contract.

3.7 No Refusal to Provide Services. Neither Provider nor Provider shall refuse to provide Medically Necessary or covered preventive services to Members for non-medical reasons.

3.8 No Gag Clauses. Nothing in this Agreement shall be construed as prohibiting Provider, when acting within the lawful scope of practice, from any of the following for a Member who is Provider's patient:

(a) advising regarding the risks, benefits, and consequences of treatment or non-treatment;

(b) advising regarding the Member's health status, medical care, or treatment or non-treatment options, for the Member's condition of disease, including any alternative treatments that might be self-administered by the Member, regardless of whether the treatment or care is a Covered Benefit;

(c) advising regarding any information the Member needs in order to decide among relevant treatment options;

(d) advocating on behalf of a Member within the utilization review or grievance processes established by the applicable Sponsor or individual authorization process to obtain Medically Necessary Covered Benefits; and

(e) advising or advocating regarding the Member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Nothing in this Section, however, shall require Avēsis to provide or reimburse any service if Avēsis (i) can demonstrate that the service in question is not a Covered Benefit; (ii) determines that the service is not Medically Necessary; or (iii) objects to the provision of a counseling or referral service on moral or religious grounds and makes available information to Members consistent with 42 CFR §438.10 and notifies DHSS as required by the Program Contract.

ARTICLE 4 PROVIDER REPRESENTATIONS AND WARRANTIES

4.1 Provider Status. Provider hereby represents and warrants that Provider: (i) has the power and authority to enter into this Agreement; (ii) is legally organized and operated to arrange for the dental or vision of services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an

admission of guilt of such conduct which is a matter of record; (v) is capable of providing all reports, data, and clinical information related to the services provided hereunder in a timely manner as reasonably required by Avēsis to satisfy Regulatory Requirements.

4.2 Provider Information and Documentation. Provider represents and warrants that all information provided to Avēsis is true and correct as of the date such information is furnished, and Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider shall provide Avēsis with written notice of any material changes to such information within five (5) business days of such change.

4.3 Reporting Fraud and Abuse. Provider agrees to comply with Program's program integrity requirements and have in place and in force written policies and procedures with regard to the compliance with federal and state fraud, waste, and abuse standards. Furthermore, Provider agrees that all employees shall complete training regarding the fraud, waste, and abuse policies as well as additional trainings as may be required by DHSS, within ninety (90) days of hire and annually thereafter. Provider shall cooperate with Avēsis's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of state or federal law, Provider shall immediately report such activity directly to the Chief Compliance Officer of the applicable Sponsor or through the Compliance Hotline. Provider shall comply with DCH approved fraud and abuse policies and procedures applicable to Provider.

ARTICLE 5 AVĒSIS OBLIGATIONS

5.1 Legal Responsibility. Nothing herein shall terminate or reduce Avēsis's responsibility to ensure that all activities under the Agreement and this Delaware Addendum are carried out. Avēsis shall provide all necessary training and information to Provider to ensure satisfactory performance as specified in the Program Contract.

5.2 Document; Denied Authorizations. Avēsis shall provide Provider with a copy of applicable Member Handbooks and Provider Manuals via website or other method, and notify Provider in the event of denied authorizations.

5.3 Suspension of Agreement. In the event the Program suspends Provider, Avēsis reserves the right to suspend this Agreement immediately.

5.4 Payment of Claims. Avēsis shall pay Provider's Clean Claims for Medically Necessary Covered services rendered to Members and provided in accordance with the requirements of the Program Contract, Avēsis's policies and procedures implementing the Program Contract, and applicable state and federal law. Avēsis shall adjudicate Clean Claims within thirty (30) calendar days of receipt.

ARTICLE 6 MISCELLANEOUS

6.1 Amendments. This Agreement may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties that is attached to the Agreement as originally executed. The Parties may be required to amend or revise the Agreement as directed by the State.

6.2 Termination of Agreement. The State of Delaware reserves the right to direct Avēsis to terminate or modify this Agreement when the State of Delaware determines it to be in the State's best interest.

6.3 Termination of Program Contract. In the event the Program Contract is terminated, Provider shall immediately make available to the State of Delaware, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the Provider's activities under the Agreement and this Delaware Addendum, at no expense to the State.

6.4 Continuation of Benefits. Except in cases where Provider was terminated for cause, if Provider is no longer participating in Avēsis's network, Provider shall continue treating Members for the lesser of ninety (90) days or until the Provider releases Member from care.

6.5 Rights Upon Termination. In the event that Provider's Agreement with Avēsis is terminated for any reason, Provider agrees that the only applicable appeals are to Avēsis. Provider agrees that there can be no appeal to DHSS or a Sponsor of any decision for termination made by Avēsis.

6.6 Indemnification. Provider agrees to indemnify and hold harmless the Program, the State of Delaware, its departments and agencies, and Members and their eligible dependents from and against:

(a) all claims, losses, or suits relating to activities undertaken pursuant to the Program Contract;

(b) any claims, damages, or losses arising from services rendered by Provider in connection with performance of the Agreement;

(c) any claims, damages, or liability resulting to any person or firm injured or damaged by Provider by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Program Contract in a manner not authorized by the Program Contract or federal or state law;

(d) any failure of Provider to observe federal or state law, including but not limited to labor law and minimum wage law;

(e) any claims, damages, or liability resulting from Avēsis or Sponsor insolvency, inability or failure to pay its officers, agents, employees, providers, or subcontractors, or any other person or firm furnishing work or supplying work, services, materials, or supplies, in connection with the performance of the Program Contract; and

(f) any claims, damages, losses or costs associated with legal expenses, including but not limited to, those incurred by or on behalf of the State in connection with the defense of claims for such injuries, losses, claims, or damages specified above.

6.7 Overpayments. Participating Provider shall comply with Federal and State policy regarding overpayments, including but not limited to reporting overpayments. Provider shall refund any overpayment amounts to Avēsis within thirty (30) calendar days of identification of such overpayment so that Avēsis an ensure that it returns the overpayment to the Program within sixty (60) days. In the event an overpayment has been identified but not reported or returned within such sixty (60) day timeframe, Provider shall be subject to penalty, and Avēsis reserves the right to reduce future payments to Provider in the amount of the overpayment(s).

6.8 Compliance with Applicable Law. Provider shall comply with all applicable state and federal law and Program requirements. The Agreement and this Delaware Addendum incorporates by reference all applicable law, and revisions of such shall be automatically incorporated herein as they become effective. Provider further understands and agrees that each claim submitted to Avēsis, Sponsor, or the Program

constitutes a certification that the Provider has complied with all applicable Federal and State laws and Program requirements (including but not limited to the Federal anti-kickback law and the Stark law). Participating Provider shall report suspected abuse, neglect or financial exploitation of children in accordance with applicable law. The terms of the Agreement, as amended, shall be interpreted in a manner consistent with applicable requirements under State of Delaware law.

6.9 Conflict of Interest and Anti-Lobbying Certification. By signing this Contract, Provider certifies, to the best of its knowledge and belief, that Federal funds have not been used for lobbying as prohibited by 31 USC 1352 and 45 CFR Part 93, that Participating Provider shall disclose any lobbying activities using non-Federal funds in accordance with 45 CFR Part 93 and that Provider presently has no interest and shall not acquire any personal interest, direct or indirect, in the Program Contract which would conflict in any manner or degree with the provision of Covered Benefits.

EXHIBIT F-1
Children's Health Insurance Program (CHIP) Product Addendum
(if applicable to provider)

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EXHIBIT F-2

Medicaid and Children's Health Insurance Program (CHIP)
Managed Care Addendum for Indian Health Care Providers (IHCPs)

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EXHIBIT G
COMMERCIAL PRODUCT ADDENDUM

This State of Delaware Commercial Vision Product Addendum ("**Commercial Addendum**") to the Provider Agreement ("**Agreement**") is effective as of the date of the Provider Agreement. Provider agrees to provide Covered Benefits to Members enrolled in one or more commercial vision plans listed on **Exhibit C** in the State of Delaware that are underwritten or administered by Avēsis as an Affiliated Company under the Agreement. All other terms and conditions of the Agreement apply hereto unless in conflict, in which case the terms and conditions of this Commercial Addendum apply.

1. **Dispute Resolution**. The Parties shall attempt to resolve disputes with each other informally before requesting arbitration pursuant 18 Del. C. § 333, summarized as follows:
    a. Avēsis shall submit to arbitration any dispute with Provider regarding reimbursement for an individual claim, procedure, or service for health care services upon a request for arbitration by Provider.
    b. Provider shall request arbitration within 60 days after the receipt of Avēsis' decision regarding the claim, procedure, or service. Pursuant to applicable law, Provider shall be deemed to have agreed that it will not bill Member for the difference between its charge and any reimbursement awarded by the arbitrator if it is forbidden from such billing by the Agreement.
    c. The Parties acknowledge and agree that:
        i. the arbitration program shall be administered by the Department of Insurance; and
        ii. the losing Party shall have a right to trial de novo in the Superior Court so long as notice of appeal is filed with that Court in the manner set forth by Superior Court rules within 30 days of the date of the arbitration decision being rendered.
    d. The following issues shall not be subject to arbitration through the Department of Insurance pursuant to this Section:
        i. disputes as to whether the patient for whom health care services were provided was a Member at the time services were rendered, or was otherwise entitled by contract to receive health care services or reimbursement for health care services;
        ii. disputes that are already pending before a court of law;
        iii. disputes that fall under Avēsis' own arbitration program, which has been granted an exemption by the Commissioner of the Department of Insurance because Avēsis maintains a substantially similar program to that created by 18 Del. C. § 333.
    e. Arbitrations conducted pursuant to 18 Del. C. § 333 shall be subject to 29 Del. C. § 10122 and 10125, provided that arbitrations shall not be conducted in public. Except as otherwise stated in applicable law, arbitration proceedings shall not be considered case decisions under 29 Del. C. Ch. 101.
    f. Arbitration under 18 Del. C. § 333 that is also subject to arbitration pursuant to 18 Del. C. § 332 shall be stayed during the pendency of those proceedings. If a decision is entered under 18 Del. C. § 332 regarding an issue identical to one for which arbitration is sought hereunder, and no appeal is pending, the decision entered under § 332 shall govern the outcome of the arbitration brought under this Section.

g. The Parties shall also comply with CDR § 18-1300-1313.

2. **Clean Claim, Defined**:
    a. (i) Provider's non-electronic claim if the claim is submitted using CMS Form 1500 (if a non-institutional provider) or CMS Form UB-92 (if an institutional provider) or, if approved by the Commissioner of the Department of Insurance or CMS, a successor form. Data for all relevant fields must be provided in the format called for by the form in order for the claim to constitute a clean claim; or (ii) Provider's electronic claim, submitted using the appropriate ASC X12N 837 format in compliance with the standards specified at 45 CFR § 162.1102.
    b. Avēsis and Provider may agree to use fewer data elements than are required by the relevant form/format if permitted by federal law. An otherwise Clean Claim that includes additional fields, data elements, or other information not required by applicable regulations is considered to be a Clean Claim for the purposes of applicable regulations.
    c. A claim by submitted by a Member that is submitted in Avēsis' standard form using information called for by the forms, with all required fields completed, is a Clean Claim. Any claim submitted by a Provider or Member that includes an unspecified, unclassified or miscellaneous code or data element to constitute a Clean Claim shall also include appropriate supporting documentation or narrative which explains the unspecified, unclassified or miscellaneous code and describes the diagnosis and treatment or service rendered. A claim for the same health care service provided to a particular Member on a particular date of service that was included in a previously submitted claim is a duplicate claim and does not constitute a Clean Claim.

3. **Submission of Clean Claims**. Claims may be submitted by U.S. Mail, delivery service, electronically, by facsimile, or by hand-delivery. No more than 30 days after receipt of a Clean Claim, Avēsis shall do one of the following:
    a. if the entire claim is deemed payable, pay the total allowed amount of the claim;
    b. if a portion of the claim is deemed payable, pay the allowable portion that is deemed payable and specifically notify Provider in writing why the remaining portion will not be paid;
    c. if the entire claim is deemed not payable, specifically notify the Provider in writing why the claim will not be paid; or
    d. if Avēsis needs additional information from Provider to determine the propriety of payment, Avēsis shall request in writing that Provider provide documentation that is relevant and necessary for clarification of the claim. Such request shall describe with specificity the clinical information requested and relate only to information Avēsis can demonstrate is specific to the claim or the claim's related episode of care. Provider is not required to provide information that is not contained in, or is not in the process of being incorporated into, the Member's billing or medical record as maintained by Provider. Avēsis may only make one request under this Section in connection with a claim. Avēsis shall take the action stated in Sections 3(b) and 3(c) above within 15 days of receiving properly requested information.
    e. Avēsis is limited to one request on the same claim beyond that permitted by Section 3(d) above as may be necessary to administer coordination of benefits or determine whether a claim is a duplicate.

4. **Collection of Overpayments**.
    a. Other than recovery for duplicate payments, whenever it engages in overpayment recovery efforts, Avēsis shall provide written notice to Provider that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery. Avēsis shall give Provider the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for Provider to follow to challenge an overpayment recovery. Avēsis shall not initiate overpayment recovery efforts more than 24 months after the original payment for the claim was made; provided, that such time limit shall not apply to recovery efforts that are:
        i. based on a reasonable belief of fraud, abuse, or other intentional misconduct;
        ii. required by, or initiated at the request of, a self-insured plan; or
        iii. required by a state or federal government plan.
    b. Avēsis may pursue recovery of overpayments that occurred prior to June 14, 2018, where the Avēsis gave Provider with notice of such recovery efforts prior to June 14, 2018.
    c. Anything in the Agreement that is in conflict with the provisions of 18 Del. C. § 2730 or that purports to waive any requirements 18 Del. C. § 2730 is null and void.
    d. 18 Del. C. § 2730 may not be waived by this Agreement.
5. **Balance Billing Prohibited.** Provider may not balance bill a Member for health care services not covered by Avēsis if Provider fails to give disclosure to Member, or fails to obtain a signed copy of the written consent form included with the Provider's disclosure form, prior to rendering services to Member.

6. **Prohibited Actions.** Avēsis shall not refuse to contract with, or compensate for Covered Benefits, Provider solely because Provider has, in good faith, communicated with one or more of Provider's current, former, or prospective patients regarding the provisions, terms, or requirements of Avēsis' products or services as they relate to the needs of the Provider's patients.

7. **Termination.** n the event Avēsis proposes to terminate or not renew the Agreement, Avēsis shall give no less than 60 days written notice to Provider prior to the effective date of the termination of the Agreement. The notice shall include a statement of Provider's right to request a written explanation and to request an internal administrative review within 20 days. Upon Provider's request for an explanation, Avēsis shall provide written explanation by certified or registered mail of the reasons for the proposed termination/non-renewal unless such explanation has already been provided, and an opportunity for an internal administrative review of the decision to terminate. Provider's request must be made within 20 days after receipt of Avēsis' notice of termination or non-renewal. Avēsis shall provide the written explanation and administrative review not less than 20 days after receipt of Provider's request for same. If Provider reasonably believes that Avēsis' decision to terminate or not renew the Agreement was solely based on reasons prohibited by Section 6 above, Provider may request that the concern be addressed in the written explanation and administrative review provided by Avēsis. Upon such request, Provider shall give Avēsis a list of Avēsis' Members with whom the Provider has communicated and upon whom Provider relies to support his or her belief and a statement of the nature of the information provided to each Member that is protected by this Section 6 above. Avēsis shall not be prohibited, however, from terminating or not renewing the Agremeent, with or without

cause, for economic reasons or any other reason not prohibited by Section 6 above, but a written explanation of the reasons for the proposed termination or non-renewal must be provided pursuant to this Section. This Section shall not apply to a decision by Avēsis to or renew the Agreement due to breach of contract, loss of professional liability insurance, indictment or arrest or conviction for a felony or crime of moral turpitude, final internal disciplinary action (excluding judicial appeals) by a hospital, licensing board or other governmental agency that impairs Provider's ability to practice or clinical privileges, failure to meet the minimum requirements for participation in Avēsis' plan, as previously disclosed to Provider, adjudication of fraud or in cases involving imminent harm to patient care.

8. **Collection of Professional Profiling Data.** If Avēsis collects and maintains professional profiling data and the written explanation provided pursuant to Section 7 above states that Avēsis used such data to evaluate the performance or practice of Provider, this data shall be provided to Provider and be discussed during the administrative review pursuant to Section 7 above. Data provided by Avēsis pursuant to this Section shall be confidential and shall not be disclosed by Provider or Avēsis to third parties without the consent of the other party, except such data may be disclosed to a party's attorney or as otherwise required by law.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

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

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

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

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

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

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

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

Disclosure of Ownership Form
Business Entity

Use this form when applying for network participation as a business entity or at the time of recredentialing if you are already contracted with Avēsis as a business entity. A business entity is a partnership or corporation that provides covered services to Avēsis members or clients who seek services from an Avēsis-contracted business entity. Please update the form to reflect any significant changes to your information. Examples include but are not limited to change of ownership, addition of a new managing employee, or change of business location.

Please answer all questions as they pertain to the date of the form's completion. If you need additional space, please note on this form that the answer is continued on a separate attachment; on that attachment, please refer to the item number from this form.

Respond to all applicable questions; write N/A to questions that are not applicable. **No questions may be left blank.** Once the form is complete, return it to Avēsis and retain a copy for your files.

Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this form. Dates of birth and Social Security Numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).

I. IDENTIFYING INFORMATION

Business Entity Name: _____

Business Entity D.B.A Name: _____
(Only complete if different from Entity Name)

Business Entity Federal Tax Identification Number: _____

Business Entity NPI	Medicaid Identification Number	Business Entity Telephone	Business Entity Address (If more than one practice location, list all locations)

II. OWNER OR CONTROLLING INTEREST INFORMATION

Definitions: An **Owner** is a person or company that owns 5 percent or more of the assets, stock, or profits of the Business Entity. Ownership can be direct or indirect; example of indirect ownership is an individual who may own 50 percent of a company that owns the actual Business Entity. In addition to ownership of stock, an Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Business Entity. A person with **Controlling Interest** is someone who directs the Business Entity; examples include Directors, Trustees, and Officers of Corporations and Partners in a Partnership. A **Managing Employee** makes the day-to-day decisions for the Business Entity; examples include office managers, billing managers, finance manager, or any individual who has responsibility for key operational areas of the Business Entity and would be typically listed below the corporate officers on an organizational chart. An **Agent** is an individual who has the legal ability to bind or enter into contracts on behalf of the Business Entity.

IF A BUSINESS ENTITY IS A NONPROFIT ENTITY, RESPOND N/A IN THE COLUMN FOR % OF OWNERSHIP.

Please provide the following information for Owners, persons with Controlling Interests, Agents, and Managing Employees of the Business Entity.

Ownership & Controlling Interest Listing:

Full Legal Name and Title	Complete Address Home address for Individual(s) All street and PO Boxes for Company(s)	Date of Birth	SSN for Individual(s) FEIN for Company(s)	% of Ownership

A) Is any person on the Ownership and Controlling Interest listing related to another person listed on the Ownership and Controlling Interest list as a spouse, parent, child, or sibling?

☐ Yes ☐ No

If Yes is checked, provide the following information:

Full Legal Name of First Person: _____ Related By: _____

(Spouse, Parent, Child, or Sibling)

Full Legal Name of Person Related To: _____

B) Does any person or entity on the Ownership and Controlling Interest Listing have an ownership or controlling interest in any other Business Entity?

☐ Yes ☐ No

If Yes is checked, provide the following information about the other Business Entity:

Business Entity Name: _____

Business Entity Full Address: _____

Business Entity Tax Identification Number: _____

C) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **convicted** of a criminal offense related to that person's or company's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs? Convicted means having been found guilty by a jury or judge, or having pled guilty, nolo contendre, best interest plea, pretrial diversion, or suspended sentence.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Name on Court Record: _____ SSN: _____

Description of Offense: _____ Date of Conviction: _____

Sanction Period: _____

If Sanctioned by Office of the Inspector General (OIG)

D) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **debarred** from participation in federal government contracts? **Debarred** means individual or company is not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the healthcare area.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Date Debarred: _____ Length of Debarment: _____

Reason for Debarment: _____

E) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **excluded** from participation in federal healthcare programs (Medicare, Medicaid, CHIP, or TRICARE) in the past? **Excluded** means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Date Excluded: _____ Date of Reinstatement: _____

Reason for Exclusion: _____

F) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever been **terminated** from a state's Medicaid or CHIP program for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a state's Medicaid or SCHIP program for a cause related to fraud or abuse

☐ Yes ☐ No

If Yes is checked, provide the following information:

State Issuing Termination: _____ Date of Termination: _____

Reason for Termination: _____

G) Have any of the individuals or companies on the Ownership and Controlling Interest Listing ever had **Civil Monetary Penalties (CMPs)** assessed against them? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

☐ Yes ☐ No

If Yes is checked, provide the following information:

State Assessing CMP: _____ Date of CMP: _____ Amount of CMP: _____

Reason for CMP: _____

H) Did any of the individuals or companies on the Ownership and Controlling Interest Listing obtain ownership interest as a result of (1) a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal healthcare program, or was excluded or terminated from participation in a federal healthcare program, and (2) where the original owner is or was a member of the current owner's immediate family or a member of the current owner's household at the time of the transfer of ownership?

☐ Yes ☐ No

If Yes is checked, supply the following information:

Full Legal Name of Original Owner: _____ SSN or Tax Identification Number: _____

Place of Transfer: _____ Date of Transfer: _____

I) Are there any subcontractor(s) with whom the Business Entity has a direct or indirect ownership of 5% or greater. Examples of subcontractors include billing services/agents, laboratory, radiology center, etc.

☐ Yes ☐ No

If Yes is checked, supply the following information:

Full Legal Name of Subcontractor: _____

Subcontractor Tax Identification Number: _____

Subcontractor Full Address: _____

List any additional subcontractors.

Full Legal Name of additional Subcontractor: _____

Additional Subcontractor Tax Identification Number: _____

Additional Subcontractor Full Address: _____

Full Legal Name of additional Subcontractor: _____

Additional Subcontractor Tax Identification Number: _____

Additional Subcontractor Full Address: _____

J) For each subcontractor listed in 2I, please provide the following information for the individuals with an ownership or controlling interest in the subcontractor(s).

Full Legal Name and Title: _____

Date of Birth: _____ SSN for Individual(s) FEIN for Company(s): _____ % of Ownership: _____

Complete Address: _____

Home address for Individual(s). All street and PO Boxes for Company(s).

K) Is any individual listed above in J related to any individual listed on the Ownership and Controlling Interest Listing?

Full Legal Name of First Person: _____ Related By: _____

(Spouse, Parent, Child, or Sibling)

Full Legal Name of Person Related To: _____

III. BUSINESS TRANSACTIONS

A) Has the disclosing Business Entity had any financial transaction with any subcontractor totaling more than $25,000 or any significant business transactions with any subcontractor in the previous 12-month period, and any significant business transactions between Business Entity and any wholly owned supplier, or between the Business Entity and any subcontractor during the past 5-year period?

☐ Yes ☐ No

If Yes is checked, provide the following information:

Full Legal Name of Subcontractor: _____

Subcontractor Tax Identification Number: _____

Subcontractor Full Address: _____

B) Does the Business Entity wholly own a supplier? A supplier means an individual, agency, or organization from which the Business Entity purchases goods and/or services used in carrying out its responsibilities under Medicaid. Examples include commercial laundry, a manufacturer of hospital beds, or a pharmacy.

☐ Yes ☐ No

If Yes is checked, supply the following information about the supplier:

Supplier Name: _____ Subcontractor NPI: _____

Subcontractor Tax Identification Number: _____

Subcontractor Full Address: _____

IV. Signature

Avesis and the state or federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider or if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106.

THE SIGNATURE BELOW MUST BE THE WRITTEN SIGNATURE OF AN INDIVIDUAL WHO CAN LEGALLY BIND THIS BUSINESS ENTITY.

In compliance with 42 CFR 455.104c, Provider shall provide a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement at the time of re-credentialing/re-enrollment, and within 35-days after any change in ownership of the disclosing entity. In compliance with information outlined in section III, Business Transactions, above.

Name Individual Provider (printed):_____ Date: _____

Signature of Individual Provider: _____

STAMPED SIGNATURE NOT ACCEPTABLE

Authorized Individual Completing Form (printed): _____

Title of Authorized Individual Completing Form: _____

Phone Number of Authorized Individual: _____ Email of Authorized Individual: _____

Disclosure of Ownership Form
Individual

This form is to be used when applying for network participation as an individual provider or at the time of re-credentialing if contracted on an individual basis with Avēsis. If the addition of an individual provider to an existing entity will change the ownership or control structure of such entity, then a new disclosure form for the entity must be completed to reflect the new ownership or control structure. For example, the new individual provider will be an owner or high-ranking employee of the existing entity.

Please answer all questions as they pertain to the date the form is being completed. If additional space is needed, please note on the form the answer is being continued on a separate attachment and reference the item number on the attachment being continued. Please return the original document to Avēsis and retain a copy for your files. Respond to all applicable questions and respond N/A to any question not applicable. NO QUESTIONS CAN BE LEFT BLANK.

Website and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b)(1)(ii).

I. IDENTIFYING INFORMATION

Provider's Full Name: _____ SSN: _____ Date of Birth (DOB): _____

National Provider Identifier (NPI): _____ Medicaid Identification Number: _____

Provider's Home Address: _____

City: _____ State: _____ Zip Code: _____

Entity Name: _____
(List the individual provider's employer. If the individual provider is sole proprietor, list that provider's name.)

Entity D.B.A Name: _____
(Only complete if different from Entity Name)

Entity Federal Tax Identification Number: _____

Entity NPI	Medicaid Identification Number	Entity Address (If more than one (1) practice location, list all locations)

II. CRIMINAL OFFENSE ATTESTATION

A) Have you ever been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, SCHIP or the Title XX services program since the inception of those programs? Convicted means having been found guilty by a jury or judge, or having pled guilty, nolo contendre, best interest plea, pretrial diversion, or suspended sentence.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Name on Court Record: _____ SSN: _____ Date of Conviction: _____

Description of Offense: _____ Sanction Period: _____
(If Sanctioned by Office of the Inspector General (OIG))

B) Have you ever been debarred from participation in federal government contracts? Debarred means you are not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the healthcare area.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Date Debarred: _____ Length of Debarment: _____

Reason for Debarment: _____

C) Have you ever been excluded from participation in federal healthcare programs (Medicare, Medicaid, SCHIP or TRICARE) in the past? Excluded means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded health care program.

☐ Yes ☐ No

If Yes is checked, supply the following information:

Date Excluded: _____ Date of Reinstatement: _____

Reason for Exclusion: _____

D) Have you ever been terminated from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity (fraud or abuse)? Terminated means the Provider lost the right to bill a state's Medicaid or SCHIP program for a cause related to fraud or abuse.

☐ Yes ☐ No

If Yes is checked, supply the following information:

State Issuing Termination: _____ Date of Termination: _____

Reason for Termination: _____

E) Have you ever had Civil Monetary Penalties (CMPs) assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

☐ Yes ☐ No

If Yes is checked, supply the following information:

State Assessing CMP: _____ Date of CMP: _____ Amount of CMP: _____

Reason for CMP: _____

III. QUESTIONS FOR A SOLE PROPRIETOR

A) If you are a sole proprietor, please give the following information for your managing employees and agents. A managing employee is someone who makes day-to-day decisions on the running of your business such as an office manager or billing manager. An agent is someone besides yourself who can legally act for your business.

Managing Employee or Agent Name: _____ SSN: _____

DOB: _____ Complete Home Address: _____
(Street, City, State and Zip)

B) Has any person listed in question 3A ever been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Convicted means having been found guilty by a jury or judge, or having pled guilty, nolo contendre, best interest plea, pretrial diversion, or suspended sentence.

☐ Yes ☐ No

If Yes is checked, provide the following information:

Managing Employee or Agent's Full Name: _____

Date Convicted: _____ Sanction Period Issued by Office of Inspector General: _____

Explanation of Offense: _____

C) Has anyone on the list in question 3A ever been debarred from participation in federal government contracts? Debarred means someone is not allowed to participate in contracts paid for by the federal government, whether or not those contracts are in the healthcare area.

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Full Name: _____

Date of Debarment: _____ Length of Debarment: _____

Reason for Debarment: _____

D) Has any person on the list in question 3A ever been excluded from participation in federal healthcare programs (Medicare, Medicaid, CHIP or TRICARE) in the past?

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Name: _____

Date Excluded: _____ Date of Reinstatement: _____

Reason for Exclusion: _____

E) Has anyone on the list in question 3A ever been terminated from a state's Medicaid or SCHIP program for reasons having to do with Program Integrity (fraud or abuse)?

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Name: _____

State Issuing Termination: _____ Date of Termination: _____

Reason for Termination: _____

F) Has any person on the list in question 3A ever had a Civil Monetary Penalties (CMPs) assessed against them?

☐ Yes ☐ No

If Yes is checked, supply the following information:

Managing Employee or Agent's Name: _____

State Assessing: _____ Date of CMP: _____ Amount of CMP: _____

Reason for CMP: _____

IV. Signature

Avēsis and the state or federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a provider if it is determined that a provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106.

THE SIGNATURE BELOW MUST BE THE WRITTEN SIGNATURE OF THE PROVIDER.

In compliance with 42 CFR 455.104c, Provider shall provide a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement at the time of re-credentialing/re-enrollment, and within 35 days after any change in ownership of the disclosing entity. In compliance with information outlined in section III, Business Transactions, above.

Name of Individual Provider (printed): _____ Date: _____

Signature of Individual Provider: _____

STAMPED SIGNATURE NOT ACCEPTABLE

Authorized Individual Completing Form (printed): _____

Title of Authorized Individual Completing Form: _____

Phone Number of Authorized Individual: _____ Email of Authorized Individual: _____

Electronic Funds Transfer (EFT) Agreement

ACCOUNT REGISTRATION INFORMATION	
Name	Tax ID #
Address	NPI #
City, State, Zip	
BANK INFORMATION	
Bank Name ☐ Checking ☐ Savings ☐ Other _____	
Address	
City, State, Zip	
Routing #	Account #

I,_____, as the authorized party, allow Avēsis to deposit funds into my bank account using Electronic Funds Transfer (EFT). A voided check is included with this agreement to facilitate this process. This transfer is for my convenience. All claims filed are in accordance with the terms of the executed Avēsis Agreement and Avēsis Provider Manual. All funds shall be deposited into my bank account at the banking institution shown above. The bank shall provide to Avēsis the applicant's most current address upon request.

I understand that:

1. The origination of electronic credits to my account must comply with the provisions of United States law.
2. Avēsis and the bank will share limited account and contract information as necessary to affect these credits.
3. By signing this document, I agree to accept the terms of the EFT.
4. This form must be processed by Avēsis before funds will be transferred into my bank account.

_____
Printed Name of Account Holder

_____ _____
Signature of Account Holder Date

_____
Printed Name of Joint Account Holder

_____ _____
Signature of Joint Account Holder Date

_____
Telephone number

Please fax to 1-855-591-3564, Attention: NPID or 18555913564@fax.glic.com.

A voided check must be included with this application.

AMERICANS WITH DISABILITIES ACT SURVEY

		Meets accommodation standards?							
	Primary location	**Physical Accessibility**	**Restroom Accessibility***	**Exam Room Accessibility***	**Intellectually or Cognitively Disabled**	**Blind/Visually Impaired**	**Deaf/Hearing Impaired**	**Does the office have TTY?**	**Public Transportation** (check all that apply)
Location Name ______	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Bus
Street Address ______									
City, State Zip ______	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ Subway
Phone ______									☐ Regional Train
Email ______									
Location Name ______	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Bus
Street Address ______									
City, State Zip ______	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ Subway
Phone ______									☐ Regional Train
Email ______									
Location Name ______	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Bus
Street Address ______									
City, State Zip ______	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ Subway
Phone ______									☐ Regional Train
Email ______									
Location Name ______	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Bus
Street Address ______									
City, State Zip ______	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ No	☐ Subway
Phone ______									☐ Regional Train
Email ______									

I attest to the best of my knowledge that the above information is true, accurate, and complete.

____
Provider's Printed Name

____
Provider's TIN/EIN Number

____
Provider's Signature

____
Date

Rev. 08/20

*Required for New Hampshire, only.

AmeriHealth Caritas Delaware Medicaid & CHIP
Routine Eye Care Services Plan Sheet

Service	Benefit Codes	Avēsis Pays	Member Pays
ANNUAL ROUTINE EYE EXAMINATION All Members	S0620 S0621	$75.00 $70.00	$0.00
Materials for all members			
FRAME SELECTION	V2020 Whenever possible, member will utilize their existing frame	$49.74	$0.00
LENSES	See Below: (Must be billed in units)		
OR			
ELECTIVE CONTACT LENSES In lieu of eyeglasses	Fitting fee is bundled with Contact Lenses (S0500)	Up to $120.00	Amount Exceeding
Medically Necessary Contact Lenses			
MEDICALLY NECESSARY CONTACT LENSES All Members	**Prior Authorization required – Clinical Protocols Will Apply** Refer to Provider Manual for details benefit details	See fee schedule	$0.00

Diabetic Members: Providers are required to submit the appropriate CPT Category II Service Codes when providing professional services to members diagnosed as diabetic. (2022F, 2023F, 2024F, 2025F, 2026F, 3051F, 3052F, 3072F)

Benefit Frequency: Medicaid Members and Healthy Children (CHiP) Members
Exam: 1 exam every 12 months.
Frame/Lens: 1 Pair of eyeglasses every 12 months.

Lenses: A change in refractive error must exceed +/- 0.5 diopters or a 10-degree change in axis in order to qualify within the 12-month limitation.

Eyeglass Lens Fees:

Code	Fee
V2100	$38.15
V2101	$40.00
V2102	$58.93
V2103	$35.97
V2104	$38.98
V2105	$43.37
V2106	$48.13
V2107	$44.62
V2108	$47.40
V2109	$52.44
V2110	$51.74

Code	Fee
V2111	$53.06
V2112	$58.86
V2113	$1.79
V2114	$71.89
V2115	$63.63
V2118	$77.56
V2121	IC
V2199	IC
V2200	$52.57
V2201	$57.57
V2202	$69.55

Code	Fee
V2203	$54.25
V2204	$57.19
V2205	$61.83
V2206	$66.43
V2207	$58.71
V2208	$62.97
V2209	$67.36
V2210	$75.32
V2211	$72.60
V2212	$72.60
V2213	$68.64

Code	Fee
V2214	$88.57
V2215	$75.38
V2218	$106.98
V2219	$47.09
V2220	$38.19
V2221	IC
V2299	IC
V2300	$62.84
V2301	$73.64
V2302	$86.73
V2303	$57.57

Code	Fee
V2304	$67.29
V2305	$77.94
V2306	$82.73
V2307	$76.36
V2308	$79.36
V2309	$82.96
V2310	$88.00
V2311	$79.49
V2312	$79.95
V2313	$82.94
V2314	$106.56

Code	Fee
V2315	$94.65
V2318	$148.07
V2319	$52.52
V2320	$55.41
V2321	IC
V2399	IC
V2410	$82.58
V2430	$92.96
V2499	IC
V2715	$9.76
V2784	$37.16

MEDICALLY NECESSARY CONTACT LENSES:
Member must be provided: Contact lens and required care kits, Instructions on insertion, removal, and proper care of the lenses, A 90-day follow-up visit period that includes acuities, assessment of corneal physiology, biomicroscopy examination, and other procedures required (as necessary).

ASSIGNMENT:
The Provider must accept an Assignment of Benefits for all eligible members. The member's signature is required on the Assignment of Benefits clause. The claim form authorizing payment can be submitted online at https://www.avesis.com/Government3/Provider/Index.aspx or a CMS 1500 form can be mailed to Avēsis Third Party Administrators, LLC P.O. Box 38300, Phoenix AZ 85069-8300. Please direct questions regarding eligibility to 833.241.4243.

FRAMES & LENSES:
- Frame Requirement: Each frame dispensed must carry a minimum of a one (1) year manufacturer's warranty. If a Member selects frames outside the covered frame allowance, the Member will be responsible for the full payment of the frames. Avēsis may not be billed for the difference in cost. Minor adjustments are to be provided for a period of one (1) year at no additional charge.
- Deluxe Frames: (V2025) May be covered for children with special needs, infants with eye size under 42mm, a child with eye size over 58mm, or for safety reasons.
- Eyeglass Lens Requirement:
  - CR39 or glass lenses are a covered benefit for all Members
  - Polycarbonate or thermoplastic lens materials for a recipient's safety or documented medical condition (when necessary)
- Specialty Bifocals/Trifocals: May be covered with results of vision testing and statement of medical necessity detailing why standard bifocal or trifocal lenses are not sufficient.
- Variable Asphericity Lenses: May be covered for prescriptions greater than or equal to 12 diopters.

REPLACEMENT FRAMES AND LENSES:
Replacements materials are limited to one frame and one pair of eyeglass lenses per year due to irreparable wear or damage, breakage, or loss.
- Members are eligible to receive one (1) replacement pair per year, when damaged or broken. Prior authorization is not required.
- Lenses Requirement: Lenses must meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements and the current Food and Drug Administration (FDA) standards of impact resistance.

ELECTIVE CONTACT LENSES:
In lieu of eyeglasses, eligible members can elect to receive contact lenses. In this scenario, when the maximum benefit is exhausted, members will not receive additional material benefits until the following benefit period.

NON-COVERED FRAME AND LENSES:
Avēsis will not cover a frame or lenses that are non-covered, and Members cannot "buy up" and pay the difference between the Avēsis reimbursement amount and the retail cost of the frame or lenses. Members can purchase frames and/or lenses on a private pay basis. **Additional exclusions**: 1. Sunglasses and cosmetic lenses; 2. Replacement lenses without significant change in refractive error. 3. Blended or progressive multi-focal lenses, 4. Faceted lenses and 5. Replacement warranty.

Additional information regarding this program can be found in the Avēsis Delaware Medicaid Provider Manual or online at https://www.avesis.com/Government3/Provider/Index.aspx