ANCILLARY PROVIDER AGREEMENT

This Ancillary Provider Agreement ("Agreement") is made and becomes effective as of February 1, 2019, by and between Care Wisconsin Health Plan, Inc. ("Health Plan") and March Vision Care Group, Incorporated ("Provider").

RECITALS

A. WHEREAS, Provider is a professional medical corporation able to arrange for the provision of Covered Services as set forth herein.

B. WHEREAS, Provider and Health Plan desire to enter into an agreement whereby Provider agrees to arrange for Covered Services to be provided to Enrollees of Health Plan.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties agree as follows:

ARTICLE I – DEFINITIONS

1.1 "Abuse" means actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

1.2 "Contracting Providers" means those health care professionals with whom Provider has contracted or may contract with to provide Covered Services to Enrollees hereunder.

1.3 "Copayment and Deductible" means those charges for Covered Services which shall be collected directly by Provider or any Contracting Providers from Enrollee.

1.4 "Covered Services" means those health care services, equipment and supplies which an Enrollee is entitled to receive.

1.5 "Downstream Entity" means any party that enters into a written arrangement with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between the Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.6 "Enrollee" means a person who is enrolled in Health Plan, including their eligible spouses and dependents, and who is entitled to receive Covered Services.

1.7 "First Tier Entity" means any party that enters in a written arrangement with the Health Plan to provide administrative or health care services for an enrollee of that health plan.

1.8 "Fraud" means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

1.9 "Medically Necessary" means those health care services and supplies which are provided in accordance with recognized professional medical and surgical practices and standards which are determined by Health Plan or Provider to be: (i) appropriate and necessary for the symptoms, diagnosis or treatment of Enrollee's medical condition; and (ii) provided for the diagnosis and direct care and treatment of such medical condition; and (iii) not furnished primarily for the convenience of Enrollee, Enrollee's family, or the treating provider or other provider; and (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Health Plan's policies.

1.10 "Non-Covered Services" means those health care services, equipment and supplies which an Enrollee is not entitled to receive.

1.11 "Waste" means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be cause by criminally negligent actions but rather the misuse of resources.

ARTICLE II– SERVICES TO BE PERFORMED BY PROVIDER

2.1 Covered Services. Provider agrees to arrange for the provision of Covered Services set forth in Attachment "A" to Enrollees. Attachment "A" is attached to this Agreement and incorporated by this reference into it.

2.2 Claims Processing. Provider shall accept, process and adjudicate claims for benefits in Attachment A. Claims shall be checked for eligibility, benefit design, cost share requirements and exclusions to ensure proper adjudication. After termination of this Agreement, Provider shall process claims for dates of service on or before the effective date of termination, for a period of three hundred and sixty-five (365) days, provided all payment provisions required under this Agreement are honored by the Health Plan. Thereafter, unless otherwise agreed, in writing, claims received by the Provider shall be rejected. Provider shall provide to Health Plan a weekly encounter file in the EDI 837 Health Care Claim Payment/Advice format. The weekly file will consist of all claims processed for the week and will be provided no later than two business days after the end of each week.

2.3 Member Notices. Provider shall provide member notices in accordance with applicable Medicare regulations. Provider shall provide translated notices in compliance with CMS requirements. Health Plan shall provide or approve member notice template(s) and standard language inserted into templates.

2.4 Network Access. Provider shall provide Enrollees with access to its hybrid network of independent providers and retail locations which will provide the Covered Services. Provider shall send Health Plan mutually agreed upon demographic information for Contracting

Providers in a mutually agreed upon electronic format. Contracting Providers shall be authorized to provide services to Medicare members and may not be currently sanctioned or excluded by Medicare or by OIG or by any other State or Federal agency.

2.5 Early Disease Detection and Dilated Retinal Exam ReportsAs applicable, Provider shall provide early disease detection reports and dilated retinal exam reports available via eyeSynergy®.

2.6 Customer Service Department. Enrollees and Contracting Providers shall have access to Provider's customer service department staffed by a team of live English-speaking and bilingual agents Monday through Friday from 8:00 am to 5 pm Central Time. Provider shall obtain telephonic interpreter services for languages not spoken by employed agents.

2.7 Non-Solicitation of Enrollees. Provider shall not attempt to influence Enrollees to change health care coverage.

2.8 Liability Insurance. Provider shall secure and maintain, at Provider's sole expense throughout the term of this Agreement, comprehensive general liability and professional liability insurance to insure it and its employees and agents against any claim or claims for damages occasioned directly or indirectly in connection with the performance of any services by such party, the use of any facilities or property of such party including operation of motor vehicles for business purposes, and the activities performed by it in connection with this agreement. Such coverage shall be at a minimum amount of $1,000,000 per claim and $3,000,000 in the annual aggregate with a licensed insurance company reasonably acceptable to Health Plan. Provider shall notify Health Plan promptly whenever an Enrollee files a claim or notice of intent to commence legal action against Provider. Provider shall also carry Cyber Liability coverage at a minimum amount of not less than $1,000,000. The obligations of this Section shall survive the termination of this Agreement.

2.9 Performance. Provider shall devote the time and attention necessary to competently and effectively perform its obligations under this Agreement.

2.10 Compliance with Laws. Provider and any Contracting Provider shall at all times during the term of this Agreement comply with all applicable federal, State of Wisconsin and municipal laws, including but not limited to applicable Medicare laws, regulations, and CMS instructions.Cooperation with Governmental and Other Agencies. The parties agree to cooperate with each other to meet any requirements imposed on Health Plan or Provider by municipal, state and federal laws and community standards. Provider agrees to maintain such books, documents, records and financial statements, and provide such information to Health Plan, applicable state and federal regulatory agencies, and other representatives of regulatory and accrediting organizations, for compliance as required. Such obligations shall not be terminated upon termination of this Agreement. Provider agrees to retain such books, documents, records and financial statements for the longer of ten (10) years or such time period as may be required by applicable law or regulation. Provider further agrees at all reasonable times, upon forty-eight hours notice when possible and during customary business hours, to permit Health Plan, a governmental agency and their designees, right to inspect, evaluate and audit its premises, physical

facilities, equipment and records. Such audit extends through ten (10) years from the final date of the contract period or completion of any audit, whichever is later, unless there has been a termination, dispute or fraud or similar fault by Health Plan, in which case the retention may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute or fraud or similar fault. Provider shall provide any peer review organization or accrediting organizations and their designees, access to and copies of all facilities, books, records and documents maintained or utilized by Provider in the performance of Covered Services to Enrollees pursuant to this Agreement, the cost thereof and the amounts of any payments received from Enrollees or others on Enrollees' behalf. Provider agrees to participate in Medicare Program audits and the annual Medicare Data Validation audit for any organization determination, reconsideration or grievance that may related to a service or member contact that occurs under the terms of this agreement. The obligations of this paragraph shall survive termination of the Agreement.

2.12 Nondiscrimination. Provider agrees: (1) not to differentiate or discriminate in its duties to Enrollees because of race, color, national origin, ancestry, religion, sex, health status, marital status, sexual orientation or age; and (2) to fulfill its duties to Enrollees in the same manner, in accordance with the same standards and within the same time availability as offered to non-Enrollees consistent with existing medical, ethical and legal requirements for providing continuity of care to any patient. Provider further agrees that it will not deny, limit or condition the furnishing of services to Enrollees on the basis of any factor that is related to health status.

2.13 Performance Measures. Provider shall provide services in accordance with the Service Level Agreements in Attachment "C."

ARTICLE III– REPRESENTATIONS

3.1 Representations by Provider. Provider hereby warrants and represents it (i) has and shall maintain at all times during this Agreement all required federal and state registrations, accreditations, certifications and licenses; (ii) shall at all times during this Agreement comply with any and all applicable federal and state laws and regulations; (iii) has the full right and authority to enter into this Agreement; and (iv) is duly organized and in good standing under the laws of the state of California. Provider represents and warrants that Provider shall immediately notify Health Plan in the event that any action is taken to suspend, revoke or restrict in any manner, a license, certification, accreditation or registration necessary for performing Provider's duties under this Agreement.

3.2 Third Party Beneficiary. This Agreement is not a third party beneficiary contract and shall not, in any manner whatsoever, increase the rights of any Enrollee with respect to Health Plan or the duties of Health Plan to any Enrollee or create any rights on behalf of Enrollees regarding Provider. Health Plan and Provider reserve the right to amend or terminate this Agreement as set forth herein without notice to, or consent of, any such Enrollee.

3.3 Representations of Health Plan. Health Plan hereby warrants and represents it (i) has and shall maintain at all times during this Agreement all required federal and state registrations, accreditations, certifications and licenses; (ii) shall at all times during this

Agreement comply with any and all applicable federal and state laws and regulations; (iii) has the full right and authority to enter into this Agreement; and (iv) is duly organized and in good standing under the laws of the state of Wisconsin.

ARTICLE IV – COMPENSATION

4.1 Compensation. Health Plan shall compensate Provider in accordance with Attachment "B," which is attached to this Agreement and incorporated by reference into it.

4.2 Verification of Eligibility. Health Plan shall provide timely good and accurate eligibility information for Enrollees to Provider in a mutually agreed upon electronic format. Eligibility information shall be processed by Provider and effective within at most [redacted] business days of the receipt of clean eligibility information from Health Plan. Provider or Contracting Provider is responsible to verify Enrollees' eligibility prior to providing Covered Services. Subject to Provider's or Contracting Provider's compliance with verification of eligibility procedures, Health Plan shall be financially responsible for all care provided by Provider or Contracting Provider to an ineligible person or a retroactively cancelled Enrollee due to erroneous, incomplete or delayed eligibility information.

4.3 Patient Billing; Enrollee Hold Harmless. Provider shall look only to Health Plan for payment of Covered Services and shall at no time seek compensation from Enrollees for Covered Services, except for applicable Copayments and Deductibles. Such payment by Health Plan, together with any Copayments and Deductibles, will be considered payment in full for Covered Services. No surcharge to any Enrollee shall be permitted. A surcharge for purposes of this Agreement shall be any additional fee not permitted by Health Plan, but not fees for Non-Covered Services which have been disclosed and agreed to by the Enrollee prior to such services being rendered. Provider agrees that under no circumstance shall an Enrollee by liable to Provider for any sums owed by Health Plan to Provider.

4.4 Patient Responsibility. Provider shall use its best efforts to, or cause Contracting Providers to, bill and collect from Enrollees all Copayments and Deductibles permitted by Health Plan. Provider and Contracting Providers shall be permitted to bill an Enrollee for its or their usual and customary charges for those Non-Covered Services provided to an Enrollee; provided, however, that Provider acknowledges that Health Plan does not allow a provider to bill an Enrollee for Non-Covered Services unless the Contracting Provider obtains the prior written consent of the Enrollee to provide such services. Consequently, Contracting Provider is advised to obtain such prior written consent before it provides any Non-Covered Services to an Enrollee. Health Plan shall not be financially responsible for any amounts owed to a Contracting Provider by an Enrollee.

4.5 Submission of Electronic Encounter Data. Provider agrees to furnish Health Plan regularly with encounter data in accordance with the Health Insurance Portability and Accountability Act 837 file format or mutually agreed upon format. The encounter data will be furnished to Health Plan through a secure format.

ARTICLE V – COORDINATION OF BENEFITS

5.1 Definition. Coordination of Benefits ("COB") refers to the determination of which of two or more plans are primarily and secondarily responsible for the Covered Services provided to an Enrollee. Such coordination is intended to preclude the Enrollee from receiving an aggregate of more than one hundred percent (100%) of charges from all plans. When primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures consistent with Medicare and applicable State of Wisconsin regulations.

5.2 COB Obligations of Provider. Provider agrees to cooperate with COB with Health Plan and to bill and collect from other financially responsible entities the charges they are responsible for paying when they are the primary payor.

5.3 Mutual COB Obligations. Each shall endeavor to supply the other party with COB information obtained from Enrollees.

ARTICLE VI– MEDICAL RECORDS

Provider and its employees or Contracting Providers and their employees shall maintain for each Enrollee receiving Covered Services under this Agreement confidential records in such form, containing such accurate, descriptive and timely information and preserved for such time periods, each as required by federal, state and municipal laws but not less than ten (10) years. Provider will ensure that unauthorized individuals are unable to gain access to or alter its physical or electronic medical records. Original medical records will be released only in accordance with federal or state laws, court order or subpoenas. To the extent required or permitted by law or regulation, Provider shall permit Health Plan, and appropriate regulatory agencies, to inspect and make copies of Provider's records relating to Enrollees pursuant to this Agreement and upon request shall provide timely copies of such records at no charge to Health Plan or Enrollees.

ARTICLE VII– TERM

7.1 Term. This Agreement will become effective on the date first written above and will continue until December 31, 2019 ("Initial Term"). This Agreement will automatically renew for successive twelve (12) month periods on the same terms and conditions unless terminated pursuant to this Agreement.

7.2 Renegotiation. Either Party may initiate renegotiation with ninety (90) days prior written notice to the other party. Notwithstanding the terms as set forth in ARTICLE VII, Term or ARTICLE VIII, Termination, should the Parties fail to reach mutual agreement after a reasonable period of renegotiation, either party may terminate by giving the other party ninety (90) days prior written notice. Termination under these circumstances in no way releases Provider or Health Plan from their mutual obligations following termination or accruing prior to termination.

ARTICLE VIII – TERMINATION

8.1 Termination. Either party may terminate this Agreement for any reason at any time by giving the other party one hundred eighty (180) days prior written notice during the Initial Term and one hundred twenty (120) days prior written notice after the Initial Term. Either party may terminate this Agreement with cause by giving sixty (60) days prior written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. The party claiming the right to terminate hereunder shall set forth in the notice of intended termination required hereby the facts underlying its claim that the other party is in material breach of this Agreement. Remedy of such breach within thirty (30) days of the receipt of such notice shall render the notice of termination ineffective and the Agreement shall continue in effect for the remaining term, subject to any other rights of termination contained in this Agreement.

8.2 Responsibility for Enrollees at Termination. Provider shall continue to provide Covered Services to any Enrollee who is receiving Covered Services from it on the termination date of the benefits of a hospitalized Enrollee through discharge of a hospitalized Enrollee or on the effective termination date of this Agreement until the Covered Services being rendered to the Enrollee by it are completed, consistent with existing medical, ethical and legal requirements for providing continuity of care to a patient, unless Health Plan makes reasonable and medically appropriate provisions for the assumption of such Covered Services by another provider. Health Plan shall compensate Provider for those authorized Covered Services provided to an Enrollee pursuant to this Paragraph 9.2 (prior to and following the effective termination date of this Agreement).

8.3 Immediate Termination. Health Plan may terminate this Agreement immediately for any of the following reasons:

(a) Provider's loss or any agency action preventing performance of its license, certification and/or registration necessary to perform its obligations pursuant to this Agreement;

(b) the loss of any insurance required by this Agreement;

(c) Provider's services jeopardize the health and safety of Enrollees, as determined by appropriate medical review; and

(d) any other reason enumerated in this Agreement as grounds for immediate termination.

ARTICLE IX– COOPERATION AND DELEGATION

9.1 Utilization Review and Quality Assurance Procedures. Provider shall cooperate with Health Plan's utilization review and quality assurance programs as applicable.

9.2 Grievance Procedures. Grievance procedures shall be established by Health Plan for the processing of Enrollee complaints. Provider shall comply with and, subject to Provider's rights of appeal, shall be bound by such grievance procedures.

9.3 Prompt Payment. Provider agrees that claims for Covered Services rendered will be processed by Provider in accordance with applicable prompt payment requirements and procedures set forth in this Agreement and with all such requirements under applicable law or regulation.

9.4 Subcontractor Credentialing. Provider agrees to provide evidence that each Contracting Provider is adequately qualified, properly licensed, maintains appropriate levels of malpractice insurance, and, where necessary or appropriate to assure the maintenance of the quality of care mandated by this Agreement, is fully accredited or certified by recognized accrediting organizations. Provider shall also undertake to monitor the performance of any Contracting Provider and shall promptly notify Health Plan of any breach of the Contracting Provider's obligations of which Provider becomes aware.

9.5 Accountability. Provider agrees that consistent with the requirements of federal and state laws, Health Plan has responsibilities for quality management and improvement, medical management, Enrollee rights and responsibilities, preventive health services and medical record review and Provider shall cooperate with Health Plan in the performance of all of the foregoing managed care functions and to perform its obligations under this Agreement in a manner consistent with the proper administration of these managed care functions by Health Plan. If and to the extent that any of the foregoing functions are delegated to Provider, Provider shall perform such functions in strict compliance with all requirements relating thereto that are applicable to Health Plan or otherwise applicable law or regulation. The Provider shall notify the Health Plan of any Downstream Entities, and the Provider shall provide oversight and enforcement of Downstream Entity compliance with all requirements related to the applicable functions and services. Provider shall notify Health Plan of potential non-compliance by the Provider or a Downstream Entity. Non-compliance that impacts enrollees must be reported to the Health Plan immediately upon discovery.

9.6 Fraud, Waste and Abuse. Provider must ensure annual training on the topic of preventing, detecting and reporting fraud, waste, and abuse is completed by employees and must verify that Downstream Entities conduct annual training on this topic. Provider must have a mechanism for employees and Downstream Entities to report suspected fraud, waste, and abuse. Provider must report any and all suspected fraud, waste, or abuse to the Health Plan as soon as practicable upon discovery and no later than 5 working days after discovery.

9.7 Compliance Program. Provider shall maintain an effective Compliance Program. Provider shall provide the Health Plan with reasonable assurance of the program through attestations and/or audits upon request by the Health Plan.

ARTICLE X – GENERAL PROVISIONS

10.1 Notices. Any notice required or permitted to be given under this Agreement by either party to the other may be given by personal delivery in writing, courier service, or by registered or certified mail, postage prepaid, return receipt requested. Notices shall be addressed to the parties at the addresses indicated on the signature page of this Agreement. Either party may change its address by written notice given in accordance with this

Paragraph 10.1. Notices delivered personally will be deemed delivered when received and mailed notices will be deemed delivered upon verification of return receipt acknowledgement.

10.2 Entire Agreement of the Parties. This Agreement supersedes any and all agreements, either written or oral, between the parties with respect to the subject matter contained in this Agreement. Each party acknowledges that no representations, inducements or promises, oral or written, have been made by either party which are not embodied in this Agreement.

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

10.4 Arbitration. Any controversy or claim arising out of this Agreement will be settled by arbitration in Dane County, Wisconsin, in accordance with the commercial rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The costs of arbitration shall be shared equally by the parties except that each party shall be responsible for its own attorneys' fees.

10.5 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Wisconsin.

10.6 Amendments. All amendments to this Agreement must be in writing. Health Plan may amend the Agreement as necessary to comply with any applicable municipal, state or federal law, and will give Provider thirty (30) days prior written notice of its intended Amendment. All other amendments will be in writing and mutually agreed to by both parties prior to implementation.

10.7 Assignment. This Agreement shall be binding upon and shall inure to the benefit of the parties to it and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, neither Provider nor Health Plan may assign any of its respective rights or delegate any of its respective duties under this Agreement without the prior written consent of the other party.

10.8 Independent Contractor. The relationship between the parties is that of independent contractors, and neither party shall be deemed to be an agent, servant or employee of the other party.

10.9 Confidentiality. The provisions of this Agreement are confidential and shall not be disclosed except as necessary to the performance of this Agreement and as required by law.

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

10.11 Headings. The subject headings of this Agreement are included for the purpose of convenience only and shall not affect the construction or interpretation of any of its provisions.

10.12 Indemnification. Health Plan and Provider agree to indemnify, defend and hold harmless each other and their directors, officers, employees and agents against any and all liability and expense, including defense costs and legal fees as they are incurred in connection with claims or demands for damages of any nature whatsoever including, but not limited to, bodily injury, death, personal injury or property damage arising from or caused by the indemnifying party's acts or failure to act or the acts or failure to act of its directors, officers, employees or agents.

10.13 Attachments. All Attachments attached to this Agreement, and/or referenced herein, are incorporated into and made part of this Agreement.

10.14 Authority to Bind. The signatory of this document represents and warrants individually on behalf of themselves and the party on whose behalf they are signing that they are duly authorized to execute this Agreement.

10.15 Exclusion of Damages, Remedies, and Waiver. NEITHER PARTY WILL BE LIABLE TO THE OTHER FOR INDIRECT, CONSEQUENTIAL, SPECIAL, INCIDENTAL, OR PUNITIVE DAMAGES, EVEN IF SUCH DAMAGES WERE FORESEEABLE, PROVIDED THAT THIS EXCLUSION WILL NOT APPLY TO DAMAGES CAUSED BY A PARTY'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT, OR OTHERWISE PAYABLE FOR VIOLATION OF THE CONFIDENTIALITY OR INDEMNIFICATION SECTIONS IN THIS AGREEMENT. The remedies specified in this Agreement are cumulative and in addition to any remedies available at law or in equity.

(signatures follow on next page)

IN WITNESS WHEREOF, the parties execute this Agreement the day and year set forth above.

CARE WISCONSIN HEALTH PLAN, INC		**MARCH VISION CARE GROUP, INCORPORATED**	
By:	Angela Seidl	**By:**	Patricia Boucher
Name:	Angela Seidl	**Name:**	Patricia Boucher
Title:	VP Quality & Regulatory	**Title:**	Chief Financial Officer
Date:	02/22/2019	**Date:**	02/26/2019
Address:	1617 Sherman Ave. Madison, WI 53704	**Address:**	6601 Center Drive West, Suite 200 Los Angeles, CA 90045

ATTACHMENT "A"

AUTHORIZED COVERED SERVICES

A. Covered Services

Care Wisconsin Covered Benefits

Benefit	DSNP
Routine Exam	[redacted]
Eyewear	[redacted]
Group/Benefit Plan IDs	

ATTACHMENT "B"

COMPENSATION:

I. Compensation for Services.

The parties agree that Health Plan will reimburse Provider for its cost of care plus an administrative fee of [redacted] per member per month. Provider shall invoice Health Plan every two weeks for the cost of care and such invoices shall be paid within five business days. The administrative fee shall be paid by Health Plan to Provider by the 10th of each month.

ATTACHMENT "C"

SERVICE LEVEL AGREEMENTS

Unless otherwise states in this attachment, targets set forth below shall be measured on a Contract Year basis and based on Care Wisconsin's book of business. The total amount of penalties payable by March Vision Care Group, Inc. shall not exceed [redacted] of total administrative fees paid to March Vision Care Group, Inc.. Each month, [redacted] of the administrative fees paid will make up the Service Level Credit Pool. Each service below is assigned a % of the pool to be paid out if the minimum service level is not met during that month. Unless otherwise stated, payment of penalties will be credited toward future Administrative fees. Failure to meet the service level agreements shall not be deemed to be in breach of this Agreement. At the request of one party hereto and no more than once per Contract Year, the other party agrees to meet with the requesting party and negotiate in good faith equitable modifications to this Attachment C.

In the event that any failure by March Vision Care Group, Inc. to meet any service level agreement is due to failure by the Health Plan to perform its obligations under this Agreement, or actions or inactions of the Health Plan that adversely impacts March Vision Care Group, Inc.'s ability to maintain these service levels until such circumstances have been resolved and any existing backlogs or other related effects have been eliminated.

Service	**Minimum Service Level**	**% of Service Level Credit Pool**
Covered Services	Quarterly report of member usage by benefit, reported by unique member and number of dollars. Provider has up to [redacted] days per weekly submission to submit report – less than [redacted] success is considered failure.	[redacted]
Claims Processing/Encounter Reporting	[redacted] of payments will be paid within [redacted] of receipt of clean claim	[redacted]
	[redacted] of claims processed free of procedural errors	[redacted]
	[redacted] of encounter files submitted by deadline as stated in master Agreement	[redacted]
	[redacted] of weekly encounter files accepted on first submission	[redacted]
Member Notices	[redacted] Integrated Denial Notices will be sent timely	[redacted]
Network Access	Network will meet CMS time/distance requirements in designated service area	[redacted]

Service	Minimum Service Level	% of Service Level Credit Pool
Customer Service	Average Speed of Answer less than [redacted] for member calls	[redacted]
	Less than [redacted] abandonment rate for member calls	[redacted]
Appeals and Grievances	[redacted] of Provider responses for appeals and grievances will be received by Health Plan due date	[redacted]