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20/20 HEARING CARE NETWORK AGREEMENT
(Discount Programs – Payor Plans)

This 20/20 Hearing Benefits Agreement ("**Agreement**") is entered into this_____ day of _____20_____, ("**Effective Date**") by _____and between _____(the "**Business**") and 20/20 Hearing Care Network, LLC a Florida corporation, (individually "**Party**" and collectively, the "**Parties**").

RECITALS

1. 20/20 contracts with various insurance companies to provide their subscribers and members of such companies with discounted hearing aid products and services through the 20/20 hearing program (the "**20/20 Program**").

2. The companies include insurance carriers, self-insured employers and workers' compensation programs (collectively, "**Payor Plans**"). With respect to Payor Plans, an insurance carrier or employer ("**Payor**") pays for the discounted products and services on behalf of covered subscribers.

3. The companies also include associations, unions and similar affinity groups (collectively, "**Discount Programs**"). With respect to Discount Programs, the members of such organizations pay for the discounted products and services (also referred to in the industry as "private pay").

4. When used in this Agreement, the term "**Contractors**" shall mean both Payors and Discount Program organizations.

5. Payor subscribers and Discount Programs members (collectively, the "**20/20 Patients**" or "**Patients**") are entitled to receive hearing health care services (audiology diagnostic services and hearing aid fitting, evaluation and dispensing services) ("**Services**"), and hearing health care products (hearing aids, earmolds, remote controls, SurfLink, and related products) ("**Products**"), through the 20/20 Program (subject to the terms and conditions in the separate agreements between 20/20 and the Contractors).

6. 20/20 maintains a network of retail hearing health care businesses (the "**Network**") to provide such Services and Products to Patients on behalf of 20/20 as non-exclusive agents of 20/20.

7. Business employs or contracts with hearing health care professionals (audiologists, licensed dispensers and/or otolaryngologists) ("**Hearing Professional(s)**") who are qualified and licensed to provide Services and Products to consumers, and Business desires to join the 20/20 Network to provide such Services and Products to Patients as a non-exclusive agent of 20/20.

The Parties covenant and agree as follows (including the provisions in the Recitals):

AGREEMENT

1) SERVICES AND PRODUCTS TO 20/20 PATIENTS

a) Services and Products. Business shall provide Services and Products (collectively, "**Covered Services**") to 20/20 Patients in accordance with the terms and provisions of this Agreement including the exhibit, which is incorporated into this Agreement by reference.

b) Fee Schedule. Business agrees to provide Covered Services in accordance with this Agreement and all other 20/20 Network policies and procedures as updated by 20/20 from time to time. Business agrees to accept the rates set forth in the separate "**Covered Services Fee Schedule**" (or "**Fee Schedule**") as full compensation for providing Covered Services to Patients as 20/20's agent. 20/20 will make the most current Fee Schedule available to Business (Fee Schedules will be updated from time to time as new products are commercialized in the course of business).

c) Contractor Requirements. Business understands and agrees that agreements between Contractors and 20/20 include specific terms and conditions with which all Businesses must comply, for example, several Contractors mandate that Covered Services be performed exclusively by an audiologist or otolaryngologist. Business further understands that from time to time a Contractor may require a limited selection of Businesses to provide Covered Services to its Patients. In such event, 20/20 may, in its sole discretion, select and assign certain Businesses to provide Covered Services to Patients of such Contractor excluding other contracted Businesses. Business understands and agrees that this Agreement does not guarantee Business access to each Contractor with which 20/20 has contracted.

d) Business Compliance. Business understands and agrees that it shall be solely responsible for ensuring its Hearing Professionals comply with this Agreement, 20/20 Network policies and procedures, 20/20 credentialing requirements, and Contractor agreement provisions.

e) Sales Process; Fee Payment. Business understands and agrees that the process described below (the "**Sales Process**") shall be followed.

If the Patient is a *Discount Program member* then the Parties shall follow the Sales Process below:

1. 20/20 refers Patients to Business and may schedule initial appointment
2. Hearing Professional at Business checks Patient eligibility. 20/20 will issue authorization number which follows patient. Business tests Patient for hearing loss (and related diagnostic services), and, if appropriate, recommends a Product
3. Patient confirms intent to purchase the Product
4. Patient signs two (2) documents: (1) a purchase agreement with Business, and (2) a Bill of Sale with 20/20 (which references the Business' purchase agreement)
5. Hearing Professional finalizes the Product recommendation and orders product.
6. Manufacturer ships the Product to Business
7. Hearing Professional fits Patient with the Product
8. During the fitting appointment, the Patient or Business contact the 20/20 patient call center to pay for the Product
9. 20/20 pays the Fee to Business per the Fee Schedule approximately two (2) weeks after expiration of the Return Period

If the Patient is a *Payor employee* then the Parties shall follow the Sales Process below:

1. 20/20 refers Patients to Business; 20/20 may schedule initial appointment at Business; or Patient may contact Business directly
2. Hearing Professional at Business checks eligibility. 20/20 will issue authorization number which follows patient. Business tests Patient for hearing loss (and related diagnostic services), and, if appropriate, recommends a Product
3. Patient confirms intent to purchase the Product
4. Patient signs one (1) document: a purchase agreement with the Business for a Product
5. Business forwards a copy of the purchase agreement to 20/20 and orders Product through Manufacturer.
6. Manufacturer ships the Product to Business
7. Hearing Professional fits Patient with Product
8. Business sends the required Fitting Confirmation Document signed by Patient and any other required documentation per Payor to 20/20 & Manufacturer.
9. 20/20 pays Business for Services on behalf of Patient per product price schedule. This occurs 2 weeks after expiration of Return Period.
10. 20/20 **offsets** the a n y **u p g r a d e d** Product price per contract provisions with Payor and pays the Fee to Business per the Fee Schedule[3.]

New Contractors are added routinely to 20/20's Program. The Sales Process set forth above is current as of the Effective Date. Changes may occur with respect to the Contractors and the contractual terms with 20/20, and with 20/20's business model. Accordingly, 20/20 reserves all rights to revise the Sales Process as necessary from time to time during the term of the Agreement, and will advise Business of any such revisions, which will automatically amend and modify this Agreement without the requirements set forth in Paragraph 5 (c).

f) Hearing Aid Returns. Business shall permit any Patient to return any hearing aid product at any time for any reason within sixty (60) days of fitting, or within a longer period if required by applicable state law (the "**Return Period**"). Business shall notify 20/20 or Manufacturer of such returns by forwarding a copy of the return receipt, and shall promptly forward the returned hearing aids to Manufacturer. Upon receipt of the hearing aids, 20/20 will refund Patient the full cost of the hearing aids.

Business may, in its discretion, charge Patients a *non-refundable* fee for Services rendered on and before the fitting date. For clarification, Business may not charge Patients any other non- refundable fees related to Covered Services under the 20/20 Program. Business understands and agrees that it is solely responsible to comply with all applicable local and state laws governing non- refundable fees, to clearly communicate with Patient regarding such fees (verbally and in the hearing aid purchase agreement), and to indemnify 20/20 and its affiliates from any claims or legal actions by Patients or governmental or licensing authorities related to non-refundable fees. Business is solely responsible to collect any such fees directly from Patient.

g) Refitting and Follow up Services. As further described in the Fee Schedule, Business shall provide each Patient with refitting and other necessary follow-up services for a period of twelve (12) months following the sale. These services shall be provided at no additional cost and shall be provided notwithstanding any termination of this Agreement, *subject to* the exception that Business may charge Patients additional fees for more than six (6) follow-up fittings during the 12-month period. For additional services and items that are not specific to the Product (e.g., additional diagnostic testing and replacement earmolds), Business agrees to apply Business's usual and customary charge with any required discounts specified by 20/20.

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[3] 20/20 will provide Business with its standard Bill of Sale, which is intended to be used in conjunction with Business' standard purchase agreement. Discount Program patients must receive and sign both a purchase agreement and Bill of Sale.

[4] 20/20 is obligated to pay Business the Fee regardless of whether Payor/TPA pays 20/20 for the Covered Services.

g) Selling and Fitting Non-20/20 Products. For Patients referred to Business through the 20/20 Program, Business shall offer, demonstrate, fit and sell only 20/20 authorized Products except where Products offered through 20/20 cannot meet the medical needs of the Patient. In these instances, Business must contact 20/20, provide information explaining why 20/20 Products cannot meet Patient's medical needs, and obtain prior written permission to *discuss* non-20/20 Products not covered under a Contractor agreement with the Patient. Business shall clearly communicate to Patients what Products and Services are Covered Services under the 20/20 Program, and that additional or different products and services are not Covered Services and will result in additional charges to Patients.

h) Full Participation in 20/20 Program. By signing this Agreement, Business understands and agrees that it is obligated to provide Covered Services to all Patients of all Contractors referred to Business through the 20/20 Program subject to the following exceptions and upon reasonable proof from Business: (1) Business is not qualified to do so because of its inability or failure to comply with the requirements described in this Agreement or in a Contractor contract (e.g., Business has no available audiologist if mandated by Contractor); or, (2) Business is a party to an existing contract with a Contractor that precludes Business from providing Covered Services to Patients of such Contractor under the 20/20 Program.

i) Trademarks and Trade Names; Advertising Material. 20/20 hereby grants Business with a limited license to use trademarks and trade names (the "**Marks**") owned by 20/20 in connection with Business's provision of Covered Services to Patients under the 20/20 Program and only in the form and manner authorized by 20/20. Upon termination of this Agreement for any reason, Business shall immediately and without notice discontinue using such Marks, the limited license shall automatically terminate, and upon 20/20's request, Business shall return or destroy all materials (including signage) bearing the Marks. Business is solely responsible to ensure that all advertising and promotion of Covered Services is conducted in compliance with applicable state and local laws and regulations.

2) BUSINESS RESPONSIBILITIES

k) 20/20 Credentialing Requirements. During the term of this Agreement, Business shall ensure compliance by it and its Hearing Professionals with 20/20's credentialing and re-credentialing programs and requirements. Business shall maintain at all times, all licenses, certifications, and credentials specified under federal, state, and local law for Business and its Hearing Professionals. Business will make known to 20/20 all Hearing Professionals that may provide Covered Services to Patients and will ensure all such Professionals are fully credentialed by 20/20 no later than sixty (60) days after the Professional is made known to 20/20. Covered Services performed by Hearing Professionals not fully credentialed within sixty (60) days of being made known to 20/20 may not be paid. Business shall provide proof of continuing education credits

("**CEU**") if requested by 20/20. Business shall provide to 20/20 annual evidence of license and certification renewal for Professionals.

l) Insurance. Business shall carry and retain malpractice and professional liability insurance in the amount of at least $1 million per occurrence/$3 million in the aggregate for each of its Hearing Professionals, and Business shall supply to 20/20 evidence of such coverage annually.

m) Business – Patient Relationship. The Parties understand and agree that the provisions in this Agreement do not pertain to and do not control the professional and practical relationship between and among the Business, the Hearing Professional and the Patients. Nothing in this Agreement shall be interpreted to affect the legal, ethical or professional relationship between such parties.

n) Access to Records. Business shall retain and permit 20/20, any state or federal agency, including, but not limited to, the United States Department of Health and Human Services, the Comptroller General of the United States, Centers for Medicare and Medicaid Services ("**CMS**"), or their designees, to audit, evaluate, and inspect all medical, billing, evaluation, utilization, and other records of Business to the extent that such records relate to any aspect of the Covered Services provided to Patients, to the extent allowed by applicable law. This right to inspect and audit shall extend no less than ten (10) years from the later of (1) the last day of the calendar year in which the books or records were created, (2) the date of completion of any audit relating to those books and records by the Department of Health and Human Services, the Comptroller General, CMS or their designees, or (3) such other date determined by CMS in accordance with its regulatory authority. To the extent requested by state or federal officials under their regulatory authority, Business shall furnish copies of such books and records to 20/ 20 at no charge. Business shall provide access to and make available its premises, physical facilities and equipment to state and federal authorities for audit and compliance review purposes.

o) Non-interference with Contractor Contracts. During the term of this Agreement and thereafter indefinitely, Business shall not engage in any conduct that in any way causes any Contractor to alter, modify, or terminate its relationship with 20/20.

p) Quality Improvement Review. Business shall participate in and fully cooperate with any quality improvement review implemented by 20/20, any Contractor, or any independent quality review and improvement organization with which a Contractor contracts.

q) Covered Services Dispensing/Audiology Obligations. Business acknowledges and agrees that it shall be solely responsible for ensuring that all Covered Services, in particular (but without limitation), hearing aid products, are provided to Patients by qualified Hearing Professionals in accordance with applicable federal and state laws and regulations governing hearing aid dispensing and audiology, including without limitation, laws and regulations requiring medical

examinations and/or medical examination waivers prior to dispensing, use of appropriate equipment, hearing aid product purchase agreements and receipts of delivery, and notification of return rights.

r) Patient Care. Business shall provide Covered Services to Patients in a culturally competent manner that is consistent with professionally recognized standards of care. Business shall provide Covered Services without discrimination in the access to, treatment of, or quality of service rendered to Patients on the basis of age, sex, marital status, sexual orientation, ethnicity, national origin, religion, health status, disability (mental or physical), or payment source.

s) Patient Records; HIPAA Business Associate Agreement. Business shall maintain in a timely manner detailed and accurate records of all Services performed for, and all Products sold to, Patients. Business shall ensure the confidentiality of such records and shall release such information only in accordance with state and federal law. The Parties shall comply with the provisions set forth in the HIPAA (Health Insurance Portability and Accountability Act) Business Associate Agreement ("**BAA**") attached hereto as Exhibit A.

t) Non-Disparagement. Business agrees that during the term of this Agreement neither Business nor its Hearing Professionals shall, in any communications with the press or other media, or with any Patient, customer, client or supplier of 20/20, or any 20/20 affiliates, criticize, ridicule, or make any statements which disparage or are derogatory of 20/20, 20/20 employees, the 20/20 Program or its affiliated companies.

u) Confidentiality. In the performance of its obligations under this Agreement, Business may receive or otherwise have access to 20/20'sproprietary business information, including, without limitation, this Agreement, financial and fee information, forms, manuals, reports, standards, Contractor information and customer lists (collectively, "**20/20 Confidential Information**"). Business and its staff shall at all times maintain the confidentiality of the 20/ 20 Confidential Information and shall not, except as necessary to perform its obligations under this Agreement, as specifically authorized in writing by 20/20, or as otherwise required by law, reproduce any 20/20 Confidential Information or disclose or provide any 20/20 Confidential Information to any person.

v) Non-Diversion; Non-Solicitation of 20/20 Patients; Penalty. Business shall not bill or accept payments from any 20/20 Patient for Covered Services except through 20/20 unless such Patient is determined to be ineligible for Covered Services. While this Agreement is in effect, and for a one (1) year period after termination for any reason, Business shall not directly or indirectly solicit any 20/20 Patient or sell any hearing health care services or products that would otherwise be a Covered Service to an 20/20 Patient. "**Solicitation**" shall mean any action by Business through its Hearing Professionals, employees, agents or representatives that may reasonably be interpreted as designed to persuade or encourage any 20/20 Patient to receive hearing health care services

and/or products that would otherwise be a Covered Service from Business. 20/20 has the right to audit Business's records upon reasonable notice to ensure compliance with this provision and at a mutually convenient date and time. If Business breaches this subsection (l), a penalty in the amount of $500 *per ear* shall become immediately due and owing by Business to 20/20, and shall be paid within five (5) business days from 20/20's request for payment.

3) TERM AND TERMINATION

a) Term. This Agreement shall become effective as of the Effective Date stated at the beginning of this Agreement, and shall remain in effect until terminated under this Section 3.

b) Termination. Termination of this Agreement shall mean that Business and its Hearing Professionals are removed from the 20 / 20 Network and 2 0 / 2 0 Patients will no longer be referred to Business for Covered Services. Upon termination, Patients will be directed to other 20/20 Businesses for Covered Services. Both Parties must comply with the terms of this entire Agreement until the effective date of termination. This Agreement may be terminated by the Parties as follows:

i. Either Party may terminate *without cause* upon ninety (90) day written notice to the other Party;

ii. Either Party may terminate *with cause* (which shall mean a material breach of either Party's obligations under this Agreement) after providing the other Party with written notice specifying the nature of the alleged breach and providing thirty (30) days to cure ("**Cure Period**"). If the breach is not cured within the Cure Period to the reasonable satisfaction of the non-breaching Party, then the Agreement will automatically terminate without further notice; or

Iii. Immediately, provided that both Parties consent in writing to termination.

c) Survival. The provisions in the following Sections shall survive termination of this Agreement: Section 1 (f) and (g) (both, for Products sold pre-termination); Section 2 (d) and (j) through (l); Section 4; and, Section 5.

4) PERFORMANCE PROVISIONS

CMS REQUIRMENTS. Provider agrees to comply with CMS requirements if participating for Medicare:

The Centers for Medicare and Medicaid Services ("CMS") and associated laws, rules and regulations regarding the Medicare Advantage ("MA") program require that managed care organizations provide for compliance of contracted network providers and their respective employees and contracted individuals and entities with certain MA program requirements including, without limitation, inclusion of certain provisions in MA provider participation agreements and/or associated documents including agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement, as applicable. A list of some of these requirements can be found in the Managed Care Manual, Chapter 11, Section 100.4, as published by CMS and available on the CMS website. Provider agrees to the following terms and conditions as they pertain to services rendered to MA Members enrolled in applicable Health Plans MA coordinated care plans ("Health Plan Members"). Since the agreement between you ("Provider") and 20/20 Hearing Care Network ("First Tier Entity"), relates to services provided to Health Plan Members, you are required by CMS and contracted health plans to agree to and comply with the following requirements:

> For purposes of the Medicare Advantage Program Requirements, reference to "Provider" means the individual or entity identified as a named party to the Agreement, its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities performing services related to the Agreement. Provider acknowledges that the requirements contained in this section shall apply equally to the above referenced individuals or entities and that Provider's agreements with such individuals or entities shall contain the applicable MA requirements set forth in this section.

Compliance with Law. Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of the contract between Health Plans and CMS (the "Medicare Contract") and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation: (1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and/or the anti-kickback statute (section 1128B(b)) of the Act); (2) applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time; and (3) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164; and (4) laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, Provider agrees to maintain full participation status in the Federal Medicare program and shall ensure that none of its employees, contractors, or subcontractors is excluded from providing services to Medicare beneficiaries under the Medicare program. [42 C.F.R. § 422.504(b)(4) and 42 C.F.R. § 422.752 (a) (8)].

Medicare Advantage Member Privacy and Confidentiality. Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or requirements in the Medicare Contract regarding privacy, security, confidentiality, accuracy and/or disclosure of

records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) HIPAA and the rules and regulations promulgated thereunder, (2) 42 C.F.R. § 422.504(a)(13), and (3) 42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable State and/or Federal law or pursuant to court orders or subpoenas.

Audits; Access to and Maintenance of Records. Provider shall permit inspection, evaluation and audit directly by First Tier Entity, Health Plans, the Department of Health and Human Services (DHHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the DHHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (I) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Health Plan Members to their medical, health and enrollment

information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Health Plan and/or CMS with timely access to records, information and data necessary for: (1) Health Plan(s) to meets its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by the Health Plan(s) under the Medicare Contract. [42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v).]

Prompt Payment of Claims. Health Plan and/or First Tier Entity and/or Provider, as applicable, agree to process and pay or deny claims for Covered Services within thirty (30) calendar days of receipt of such claims in accordance with the Agreement. [42 C.F.R. § 422.520(b).]

Hold Harmless of Health Plan Members. Provider hereby agrees: (i) that in no event, including but not limited to, non-payment by Health Plan or First Tier Entity, Health Plan or First Tier Entity's determination that services were not Medically Necessary, Health Plan or First Tier Entity insolvency, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an MA Member for amounts that are the legal obligation of Health Plan or First Tier Entity; and (ii) that Health Plan Members shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Health Plan Members; (b) shall survive the termination of this Agreement regardless of the cause giving rise to termination, and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Health Plan Members, or persons acting on behalf of an MA Member. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i).]

Hold Harmless of Dual Eligible Members. With respect to those Health Plan Members who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill Health Plan Members the balance of ("balance-bill"), and that such Health Members are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept Health Plan's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R.§ 422.504(g)(1)(iii)]

Accordance with Health Plan's Contractual Obligations. Provider agrees that any services provided to Health Plan members shall be consistent with and comply with applicable state laws, regulatory agencies, accrediting bodies and the Medicare and Medicaid contract including the requirements set forth in [42 C.F.R. § 422.504(i)(3)(iii), 42 C.F.R. § 438.230, 42 C.F.R. § 455.104, 42 C.F.R. § 455.105, 42 C.F.R. § 455.106.]

Delegation of Provider Selection. As applicable, Provider understands that if selection of providers who render services to Health Plan Members has been delegated to First Tier Entity and/or Provider by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements. [42 C.F.R.§ 422.504(i)(5)].

Accountability. First Tier Entity and Provider hereby acknowledge and agree that Health Plans shall oversee the provision of services by Provider and First Tier Entity and shall be accountable under the Medicare Contract for services provided to Health Plan Members under the Agreement regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Provider under the Agreement. Furthermore, the First Tier Entity certifies that all information (i.e., claims) sent to the Health Plan is valid and accurate.[42 C.F.R.§ 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii).]

Delegated Activities. Provider acknowledges and agrees that to the extent First Tier Entity, in its sole discretion, elects to delegate any administrative activities or functions to Provider, Provider understands and agrees that: (i) Provider may not delegate, transfer or assign any of Provider's obligations under the Agreement and/or any separate delegation agreement without First Tier Entity's prior written consent; and (ii) Provider must demonstrate, to First Tier Entity's satisfaction, Provider's ability to perform the activities to be delegated and the parties will set out in writing: (1) the specific activities or functions to be delegated and performed by Provider; (2) any reporting responsibilities and obligations pursuant to First Tier Entity or Health Plan's policies and procedures and/or the requirements of the Medicare Contract; (3) monitoring and oversight activities by First Tier Entity or Health Plan including without limitation review and approval by First Tier Entity or Health Plan of Provider's credentialing process, as applicable, and audit of such process on an ongoing basis, at least annually; (4) The credentials of medical professionals affiliated with Provider and/or Health Plan or, in the event Health Plan has delegated credentialing to Provider and/or First Tier Entity, Provider's and/or First Tier Entity's credentialing process will be reviewed and approved by Health Plan, monitored on an ongoing basis and audited at least annually; and (5) corrective action measures, up to and including termination or revocation of the delegated activities or functions and reporting responsibilities if CMS or First Tier Entity or Health Plan determines that such activities have not been performed satisfactorily. [42 C.F.R. § 422.504(i)(3)(iii); 422.504(i)(4)(i)-(v).] Provider agrees that this Agreement does not in any way relieve the Health Plan of any responsibility for the performance of duties due under its Medicare Advantage contracts, existing now or entered into in the future with CMS.

Compliance with First Tier Entity and Health Plan Policies and Procedures. Provider shall comply with all policies and procedures of First Tier Entity and Health Plans including, without limitation, written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) provider consideration of MA Member input into Provider's proposed treatment plan; and (d) Health Plan's accreditation standards; and compliance program which encourages

effective communication between Provider and Health Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. The aforementioned policies and

procedures are identified in First Tier Entity and Health Plan Provider Manuals which are incorporated herein by reference and may be amended from time to time by First Tier Entity or Health Plan. [42 C.F.R. § 422.112; 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

Continuation of Benefits. Provider agrees that except in instances of immediate termination by First Tier Entity or Health Plan for reasons related to professional competency or conduct and upon expiration or termination of the Agreement, Provider will continue to provide Covered Services to Health Plan Members as indicated below and to cooperate with First Tier Entity or Health Plan to transition Health Plan Members to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of the Medicare Contract, First Tier Entity's or Health Plan's accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to Health Plan Members after the expiration or termination of the Agreement, whether by virtue of insolvency or cessation of operations of First Tier Entity or Health Plan, or otherwise: (i) for those Health Plan Members who are confined in an inpatient facility on the date of termination until discharge; (ii) for all Health Plan Members through the date of the applicable Medicare Contract for which payments have been made by CMS to First Tier Entity or Health Plan; and (iii) for those Health Plan Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above. [42 C.F.R. 422.504(g)(2) & (3).]

Physician Incentive Plans. The parties agree: (i) that nothing contained in the Agreement nor any payment made by First Tier Entity or Health Plan to Provider is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Health Plan Members; and (ii) that any incentive plans between First Tier Entity or Health Plan and Provider and/or between Provider and its employed or contracted physicians and other health care practitioners and/or providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Contract. Upon request, Provider agrees to disclose to First Tier Entity or Health Plan the terms and conditions of any "physician incentive plan" as defined by CMS and/or any state or federal law, rule or regulation. [42 C.F.R.§ 422.208.]

AHCA Requirements. Provider agrees to comply with AHCA requirements if participating in Medicaid.

PROVIDER

Provider, on behalf of Provider and each individual provider participating with HEALTH PLAN under the Agreement (herein severally and collectively, as the context may require, "Provider"):

a. Represents that: (i) Provider is eligible for participation in the Florida Medicaid Program and shall have a unique Florida Medicaid Provider number as required by

the Medicaid contract, (ii) Provider is not excluded from or ineligible for participation in any state or federal health care program, and (iii) Provider does

b. not employ or contract with individuals or entities that are excluded from or ineligible for participation in any state or federal health care program;

c. Shall not seek payment from the Medicaid Members for any Covered Services provided to the Medicaid Members within the terms of this Contract and that Provider will look solely to the Health Plans for compensation for services rendered, with the exception of nominal cost sharing, pursuant to the State Medicaid HEALTH PLAN and the Florida Coverage and Limitations Handbooks. Provider shall indemnify and hold AHCA harmless from any costs, including legal fees relating to the improper billing practices or consequential effects caused by breach of the terms of this agreement;

d. Agrees that any contracts, agreements, or subcontracts entered into by the Provider for the purposes of carrying out any aspect of this Contract must include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of this Contract;

e. Shall make best efforts to cooperate with the HEALTH PLAN' peer review, grievance, QIP and Utility Management activities, as well as with the HEALTH PLAN' monitoring and oversight, including monitoring by the HEALTH PLAN (or its Subcontractor) of services rendered to Medicaid Members.

f. Shall provide assurance that all licensed Providers are credentialed in accordance with the HEALTH PLANS' and the Agency's credentialing requirements.

g. Shall cooperate with provider of other health plans to assure maximum health outcomes for Medicaid members transitioning into HEALTH PLAN. If at any time during the term of this Agreement a member's health or safety is in jeopardy, Provider agrees to arrange for the immediate transfer to another primary care provider or other health plan, as applicable;

h. Shall meet appointment waiting time standards pursuant to the Medicaid Contract.

i. Shall submit notice of withdrawal from the network at least ninety (90) calendar days prior to the effective date of such withdrawal;

j. Shall notify the HEALTH PLAN in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida Statutes;

k. Shall offer hours of operation that are no less than the hours of operation offered to commercial HMO members or comparable Medicaid FFS Recipients (Applicable if the Provider serves only Medicaid Recipients);

l. Shall make best efforts to comply with HEALTH PLAN'S cultural competency guidelines as set out in the HEALTH PLAN Provider Manual and under which provider shall render services to Medicaid Members of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of Medicaid Members and protects and preserves their dignity;

m. Shall (i) require any community outreach materials related to this current AHCA contract, that are displayed by the provider, be submitted to the BMHC for written approval before its use, (ii) provide for submission of all reports and clinical information required by the HEALTH PLAN, including Child Health Check-Up reporting (if applicable);

n. Shall safeguard information about Medicaid Members according to 42 CFR, Part 438.224 and comply with HIPAA privacy and security provisions;

o. Shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to the HEALTH PLAN. Provider shall maintain such records for a period not less than five (5) years from the close of this Agreement, and retain them further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the HEALTH PLAN if the Provider Contract is continuous);

p. Agrees that the Department of Health and Human Services ("DHHS"), AHCA, Medicaid Program Integrity ("MPI") and/or the Medicaid Fraud Control Unit ("MFCU"), shall have the right to inspect, evaluate, and audit all of the following related to this Contract: (1) Pertinent books, (2) financial records, (3) medical records, and (4) documents, papers, and records of any Provider involving financial transactions. Provider shall cooperate fully in any investigation by AHCA, MPI, MFCU, or any subsequent legal action that may result from such an investigation;

q. Shall, during the life of this Agreement, secure and maintain worker's compensation insurance (complying with the Florida's Worker's Compensation Law) for all of its

employees connected with the work under the Medicaid Contract, unless such employees are covered by the protection afforded by the HEALTH PLAN;

r. Notwithstanding the termination of this contract, including breach of Provider Contract due to insolvency, Provider assures that neither Medicaid Members nor the AHCA shall be held liable for any debts of Provider. Provider agrees to hold the AHCA and the HEALTH PLAN' Medicaid Members harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from this Agreement. Provider agrees that this clause shall survive the termination of this Agreement, including breach due to Insolvency.

s. shall indemnify, defend and hold harmless Plan, its employees, agents, independent contractors, officers and Board of Directors, AHCA, OIR, CMS and Members from and against all claims, damages, causes of action, cost or expense, including court costs and reasonable attorney's fees, which may arise from any negligent act or other wrongful conduct by Provider under this Agreement. This clause shall survive termination of this Agreement regardless of the reason for termination, including breach of this Agreement due to insolvency. AHCA may waive this requirement for itself, but not for health plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a state agency or sub-unit as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by ACHA.

HEALTH PLAN

a. This Agreement does not in any way relieve the HEALTH PLAN of any responsibility for the provision of services due under the Medicaid Contract. The HEALTH PLAN shall remain accountable and responsible to the AHCA for compliance with the terms and conditions of the Medicaid Contract and shall assure that all services and tasks related to this Agreement are performed in accordance with the terms of the Medicaid Contract.

b. The parties agree that the HEALTH PLAN shall make no payment or compensation to Provider, directly or indirectly, as an inducement to reduce, limit or withhold Medically Necessary services to Medicaid Members;

c. The HEALTH PLAN shall not prohibit Provider from (i) discussing treatment or non-treatment options with Medicaid Members that may not reflect the HEALTH PLAN's position or may not be covered by the HEALTH PLAN; (ii) acting within the lawful scope

of practice, advising or advocating on behalf of an Enrollee for the Enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered; and (iii) advocating on behalf of the Medicaid Member in any Grievance System or Utilization Management process, or individual authorization process to obtain necessary health care services;

d. The HEALTH PLAN shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of such license or certification, nor does the HEALTH PLAN discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. Provider agrees that this provision should not be construed as an "any willing Provider" contract obligation as it does not prohibit the HEALTH PLAN from limiting provider participation to the extent necessary to meet the needs of the Medicaid Members and does not interfere with measures established by the HEALTH PLAN that are designed to maintain quality and control costs;

e. Pursuant to the Medicaid Contract and in addition to any other right to terminate the Provider contract, and notwithstanding any other provision of the Medicaid Contract, the AHCA or the HEALTH PLAN may request immediate termination of a Provider contract if, as determined by the AHCA, Provider fails to abide by the terms and conditions of this contract, or in the sole discretion of the AHCA, the Provider fails to come into compliance with this Agreement within fifteen (15) Calendar Days after receipt of notice from the HEALTH PLAN specifying such failure and requesting Provider abide by the terms and conditions thereof;

f. Provider shall utilize the applicable appeals procedures outlined in the HEALTH PLAN provider manual. Provider agrees that no termination of the Agreement or of any participation under this Agreement creates an additional or separate right of appeal to the AHCA or the HEALTH PLAN, solely as a result of the HEALTH PLAN act of terminating, or decision to terminate Provider. The HEALTH PLAN shall provide sixty (60) Calendar Days' advance written notice to Provider before canceling this Agreement without cause, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental Agency.

g. Pursuant to Florida Statute 641.315(10), nothing contained herein shall be construed to require Provider to contract for more than one Plan product or otherwise be excluded.

h. Pursuant to Florida Statute 641.315(6), nothing contained herein shall be construed to prohibit or restrict the Provider from entering into a commercial contract with any other contractor.

i. Pursuant to Medicaid guidelines, HEALTH PLAN shall notify enrollees in accordance with the provisions of the contract regarding provider termination prior to the effective date of the termination
To the extent the terms of this Agreement conflict with the provisions of the Medicaid Contract, the parties agree that the provisions of the Medicaid Contract shall control.

Florida Healthy Kids Program: Provider agrees to comply with Florida Healthy Kids requirements if participating in the Healthy Kids Contract:

Participation in Healthy Kids Contracts. Subject to and in accordance with the terms and conditions of the Agreement, including this Attachment, Provider shall participate in Benefit Plans offered or administered by 20/20 on behalf of its HEALTH PLAN partner(s) under Healthy Kids Contracts (as defined below).

Compensation for Covered Services provided to Members of Benefit Plans under Healthy Kids Contracts is set forth in the rate pages attached to the Provider Agreement.

Additional Definitions.

"**Emergency Care**" or "**Emergency Services**" means the level of care required for the treatment of an injury or acute illness that, if not treated immediately, could reasonably result in serious or permanent damage to the Member's health.

"**FHKC**" means the Florida Healthy Kids Corporation.

"**Healthy Kids Contract**" means the agreement between 20/20's Health Plan partner(s) and FHKC for Health Plan to provide or arrange for the provision of health care items and services to enrollees in the Healthy Kids program, as amended from time to time. A Healthy Kids Contract is a Government Contract as defined in the Agreement.

"**Member**" means an individual enrolled in a Healthy Kids Benefit Plan.

"**Medically Necessary**" or "**Medical Necessity**" means services that include medical or allied care, goods or services furnished or ordered to: (i) meet the following conditions: (A) be necessary to

protect life, to prevent significant illness or significant disability or to alleviate severe pain; (B) be individualized, specific and consistent with

symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs; (C) be consistent with the generally accepted professional medical standards as determined by the Healthy Kids program, and not be experimental or investigational; (D) be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and (E) be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker or the provider. (ii) For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. (iii) The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit. "**Routine Care**" means the level of care can be delayed without anticipated deterioration in the Member's condition for a period of seven days.

"**Urgently Needed Care**" or "**Urgent Care**" means the level of care that is required within a 24 hour period to prevent a condition from requiring emergency care.

All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment except to the extent a provision of the Agreement exceeds the minimum requirements of the Attachment. Any obligation of Contracted Provider in this Attachment shall apply to Providers to the same extent that it applies to Contracted Provider.

Provider agrees to meet or exceed the following appointment access standards:

Emergency Care shall be provided immediately.

Urgently Needed Care shall be provided within 24 hours

Routine Care of Healthy Kids Members who do not require Emergency Care or Urgent Care shall be provided within seven days of the Member's request for such services.

Follow up care shall be provided as medically appropriate.

Facilities used for Members shall meet applicable accreditation and licensure requirements and meet facility regulations specified by the Florida Agency for Health Care Administration.

The parties shall comply with 42 CFR § 457.985(a), which prohibits 20/20 and its Health Plan partners from interfering with the advice of health care professionals to Members and requires Providers to provide 20/20 with information about treatment of Members. The parties shall comply with 42 CFR § 457.985(b) and other applicable Federal and State laws and regulations pertaining to physician incentive plans, including disclosure requirements related to such plans.

20/20 and Provider shall hold Members harmless from all claims for payments of Covered Services except applicable co-payments, including court costs and attorney fees, arising out of the Healthy Kids Contract. Provider and 20/20 agree that in no case shall FHKC or Members be liable for the debts of 20/20.

Provider shall maintain medical records for each Member in accordance with applicable Federal and State laws for such period of time as required by applicable Federal and State laws and the Healthy Kids Contract. 20/20, its Health Plan partner(s), FHKC and regulatory agencies may audit Members' medical records and Provider's records with respect to the costs of providing services to Healthy Kids Members. Provider shall maintain the confidentiality of all Members' records and abide by HIPAA. Provider further agrees that each Member may request and receive a copy of records and information pertaining to that Member in a timely manner and/or request that such Member's records be corrected or supplemented.

Provider shall provide all Covered Services required under the Healthy Kids Contract to Members and comply with all requirements of Health Plan under the Healthy Kids Contract. Upon request, 20/20 will make available to Provider the Healthy Kids Contract requirements, which include, among other things, quality improvement plan, and utilization management program requirements, submission of complete, timely and accurate encounters, and data collection requirements, and member grievances and appeals.

Provider shall comply with 20/20's Encounter Data and Clean Claim submission reporting requirements, including, without limitation, timeframe, process and format.

Provider shall comply with 20/20's cultural competency plan.

Provider shall not use FHKC marketing materials without seeking the approval of 20/20 prior to such use and Provider and 20/20 agree to comply with Healthy Kids Contract marketing requirements and restrictions.

Provider shall comply and cooperate with 20/20's and the Healthy Kids Contract's coordination of benefits and subrogation policies.

Provider shall comply with all terms and conditions of the Healthy Kids Contract and Federal and State laws applicable to Provider's performance of services under the Agreement.

Provider shall not delegate any services covered under this Agreement provided to Members without the written consent of 20/20 and/or Health Plan.

20/20 may further amend this Agreement to comply with the Healthy Kids program requirements, the State of Florida, Federal, and local regulatory requirements upon notice to Provider of such amendment and its effective date, upon notice, but without the consent of Provider.

20/20 shall not discriminate with respect to participation, reimbursement, or indemnification of Provider when acting within the scope of his, her or its respective professional license or certification under Florida law, solely on the basis of such license or certification; provided, however, that 20/20 is not prohibited from limiting Provider participation to the extent necessary to meet the needs of Members and provided, further, that this provision does not interfere with measures established by 20/20 that are designed to maintain quality and control costs. 20/20 agrees that it shall not discriminate against Provider if Provider serves high-risk populations or specializes in conditions requiring costly treatments from serving such populations or specializing in such conditions.

Fraud and Abuse. Provider agrees to actively detect and report potential fraud and abuse in compliance with 42 C.F.R. § 438.608; 42 C.F.R. 455. Provider must have anti-fraud policy and procedures on-site and a signed implementation and training date. Provider will post Anti-Fraud language for both employees and members to see.

In accordance with Florida Statues, employees of your practice are advised to be alert to the possibility of fraudulent activity and to understand that it is their responsibility to report suspected fraudulent activity to the Florida Department of Financial Services. The Department offers a reward of up to $25,000 for confirmed information leading to conviction. Any indication of fraudulent activity is to be referred immediately to 20/20 or the Florida Department of Financial Services at 800.378.0445. 20/20 does not retaliate against any individual who reports violations of suspected Fraud and Abuse.

SECTION III- DISPUTE RESOLUTION

Member Grievance Procedure. Provider agrees to cooperate in the implementation of Plan Member grievance procedures.

a. Provider shall promptly notify 20/20 of receipt of any letters from attorneys regarding Contracted Services provided to Members by Provider.

b. 20/20 shall promptly notify Provider of receipt of any letters from attorneys regarding Contracted Services provided to Members by Provider.

c. Provider agrees to cooperate with 20/20 in resolving member complaints brought to Provider's attention. Provider shall investigate such complaints and use his or

d. her best efforts to resolve them in a fair and equitable manner. Provider agrees to provide full details of the nature, circumstances and disposition of such complaints to 20/20. Provider further agrees to participate and assist in resolving Member complaints through Plan grievance procedures.

Provider Grievance Procedure.

a. Introduction. Except as provided herein, the resolution of any dispute, controversy or claim arising out of this Agreement including but not limited to the payment or nonpayment of a claim, the eligibility of a Member, the determination of Covered Services, or the determination of medically necessary procedures, shall be governed and subject to the provisions of this Section III.

b. Notification of Grievance.

i. If there is any claim, disagreement or grievance ("Grievance") relating to this Agreement, to Members or to other 20/20 Providers (except malpractice claims), either party (the "Claimant") shall notify the other in writing at the other's principal place of business.

ii. When notification is made by Provider to 20/20, 20/20 shall investigate the Grievance within fifteen (15) calendar days.

iii. Within fifteen (15) calendar days following the review of the Grievance, 20/20 shall advise Provider in writing of 20/20's conclusions regarding the Grievance, and of any action that will be taken regarding the Grievance.

c. Mediation.

i. If, following 20/20's written notice to Provider, Provider is still not satisfied with 20/20's action regarding the Grievance, Provider may elect to submit

the dispute to a sole mediator. The parties shall select the mediator by mutual agreement or, if the parties fail to agree upon a mediator within fifteen (15) calendar days from the date of election to mediate, the mediator shall be selected by the American Arbitration Association. The Commercial Mediation Rules of the American Arbitration Association shall govern mediation.

ii. The parties shall bear their own costs associated with the mediation and shall share equally the costs of the mediator. If the parties do not resolve the dispute within thirty (30) calendar days from the commencement of the mediation and do not mutually agree to extend the thirty (30) calendar day period, either party may submit the dispute to binding arbitration. The parties, their representatives, other participants and the mediator shall hold the existence, content and results of the mediation in confidence.

d. Arbitration.

i. If either party so elects, the dispute shall be submitted to a sole arbitrator, whose decision shall be final and binding on the parties. The parties shall select the arbitrator by mutual agreement or, if the parties fail to agree upon an arbitrator within fifteen (15) calendar days from the date of election to arbitrate, the arbitrator shall be selected by the American Arbitration Association. The Commercial Arbitration Rules of the American Arbitration Association shall govern the arbitration.

ii. The award rendered by the arbitrator(s) shall be final and may ne entered upon in any court having jurisdiction thereof. The place of arbitration shall be Broward County, Florida.

iii. The arbitrator(s) shall decide legal issues pertaining to the dispute, controversy or claim pursuant to the laws of the State of Florida. Subject to the control of the arbitrator(s), or as the parties may otherwise mutually agree, the parties shall have the right to conduct reasonable discovery, including depositions. The parties agree that this Agreement involves interstate commerce and is therefore enforceable pursuant to Title 9, United States Code.

iv. The parties shall bear their own costs associated with the arbitration, and shall share equally the costs of the arbitrator(s). If either party fails to comply with the terms of the arbitrator's final decision within ninety (90) calendar

days of said decision, either party may petition a court of competent jurisdiction to enter a judgment based upon the arbitrator's final decision. The parties, their representatives, other participants, and the arbitrator shall hold the existence, content and result of the arbitration in confidence, except that the parties may disclose the arbitration award to enforce the arbitrator's judgment.

Injunctive Relief. Nothing in this Section III shall be construed to preclude any party from seeking injunctive relief to protect its rights pending negotiation/mediation/arbitration, including, but not limited to, for the reasons set forth in Section 2.29(d)

Equitable Relief. This Section III shall not prohibit a party from seeking equitable relief in any court having jurisdiction thereof for a breach of Section 2.29 ("Confidential Information").

Attorney's Fees. If any arbitration or any other judicial proceeding is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees, costs and expenses, in addition to any other relief to which such party is entitled.

SECTION V – MISCELLANEOUS

Federal Requirements. Provider recognizes that 20/20 may, for some purposes, such as Medicare risk contracts, be considered a government contractor and, as such, be subject to various federal laws, executive orders and regulations, some of which may also be applicable to subcontractors. Provider, therefore, agrees that all applicable clauses shall be incorporated herein as required by federal laws, executive orders, and regulations including, but not limited to, the following:

a. The nondiscrimination clauses contained in: Executive Order 11246, as amended relative to equal opportunity for all persons without regard to race, color, religion, sex, or national origin; the Rehabilitation Act of 1973, as amended, relative to the employment of qualified handicapped individuals without discrimination based upon their physical or mental handicaps; the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, relative to the employment of disabled veterans and veterans of the Vietnam Era, and the implementing rules and regulations prescribed by the Secretary of Labor in Title 41, Part 60 of the Code of Federal Regulation.

b. The utilization of small and minority business concerns clauses contained in: the Small Business Act, as amended; Executive order 11625, and the Federal Acquisition

Regulation (FAR) at 48 CFR Chapter 1, Part 19, Subchapter D and Part 52, Subchapter H, relative to the utilization of minority business enterprises, small business concerns and small business concerns owned and controlled by socially and economically disadvantaged individuals, in the performance of contracts awarded by federal agencies.

c. The utilization of labor surplus area concerns clauses contained in: the Small Business Act, as amended; Executive order 12073; 20 CFR Part 654, Subpart A; and the Federal Acquisition Regulation (FAR) at 48 CFR Chapter 1, Part 20 of Subchapter D and Part 52 of Subchapter H, relative to the utilization of labor surplus area concerns in the performance of government contracts.

5) INDEMNITY AND LIMITATION OF LIABILITY

a. Indemnity. In addition to Business' indemnity obligations set forth in other provisions, 20/20 shall not be liable for any claims, injuries, demands, or judgments based upon negligence or alleged negligence, or any other grounds arising out of or related to the provision of Covered Services by Business (or its Hearing Professional) to any Patient. Accordingly, and to the extent allowed by law, Business shall indemnify and hold 20/20 and its affiliates harmless from any and all such claims, liabilities, damages, and losses, including reasonable attorneys' fees at trial or on appeal in the event of such action.

b. LIMITATION OF LIABILITY. EXCEPT FOR ANY THIRD PARTY CLAIM DESCRIBED ABOVE IN SECTION 4 (a), NEITHER PARTY SHALL BE LIABLE TO THE OTHER FOR ANY SPECIAL, INCIDENTAL, CONSEQUENTIAL, INDIRECT OR PUNITIVE DAMAGES, INCLUDING WITHOUT LIMITATION, LOSS OF PROFITS, ARISING IN ANY WAY OUT OF THIS AGREEMENT.

6) MISCELLANEOUS

a. Relationship of Parties; Independent Contractors. The Parties understand and agree that Business is acting as 20/20's non-exclusive agent for the limited purpose of providing Covered Services to Patients through the employment of its Hearing Professionals and pursuant to the provisions in this Agreement. Neither Party is to be considered the agent of the other for any other purpose. It is understood that both Parties are independent contractors and engage in the operation of their respective businesses. Each Party is responsible for its own employees, e.g., Business is solely responsible for its Hearing Professionals, and the employees of one Party shall not be deemed to be the employees of the other Party for any purpose. None of the provisions of this Agreement are intended to create between Business and 20/20 any partnership, joint venture, employment, representative or any other relationship other than that of independent contractor.

b. Force Majeure. Neither Party shall be liable or deemed in default of this Agreement for any delay or failure to perform caused by Acts of God, war, disasters, strikes, or any similar cause beyond the reasonable control of either Party.

c. Entire Agreement; Amendments. This Agreement constitutes this entire Agreement between 20/20 and the Business and shall not be altered or amended except as agreed in a written Amendment signed by both Parties.

d. Waiver of Breach. Waiver by either Party of any breach of any provision of this Agreement or the failure to insist upon strict compliance with any provision of this Agreement shall not operate or be construed as a waiver of such provision or any other provisions.

e. Disputes. In the event of a dispute between the Parties related to this Agreement, a representative with full authority from each Party shall confer in a mutually convenient manner and make a good faith effort to resolve the dispute. If this effort fails, the Parties will complete mediation in Florida within thirty (30) days after discussions cease. The cost of mediation will be shared equally. If mediation fails, either Party may file a lawsuit pursuant to subsection (f) below but not before expiration of a twenty (20) day cooling off period following completion of mediation.

f. For its own employees. Business is solely responsible for its Hearing Professionals, and the employees of one Party shall not be deemed to be the employees of the other Party for any purpose. None of the provisions of this Agreement are intended to create between Business and 20/20 any partnership, joint venture, employment, representative or any other relationship other than that of independent contractor.

g. Force Majeure. Neither Party shall be liable or deemed in default of this Agreement for any delay or failure to perform caused by Acts of God, war, disasters, strikes, or any similar cause beyond the reasonable control of either Party.

h. Entire Agreement; Amendments. This Agreement constitutes this entire Agreement between 20/20 and the Business and shall not be altered or amended except as agreed in a written Amendment signed by both Parties.

i. Waiver of Breach. Waiver by either Party of any breach of any provision of this Agreement or the failure to insist upon strict compliance with any provision of this Agreement shall not operate or be construed as a waiver of such provision or any other provisions.

j. Disputes. In the event of a dispute between the Parties related to this Agreement, a representative with full authority from each Party shall confer in a mutually convenient manner and make a good faith effort to resolve the dispute. If this effort fails, the Parties will complete mediation in Florida within thirty (30) days after discussions cease. The cost of mediation will be shared equally. If mediation fails, either Party may file a lawsuit pursuant to subsection (f) below but not before expiration of a twenty (20) day cooling off period following completion of mediation.

k. Applicable Law; Jurisdiction. This Agreement shall be subject to and interpreted in accordance with the substantive and procedural laws of the State of Florida, without regard to principles of conflicts of laws. Any lawsuit shall be filed in the federal or state courts as applicable in the State of Florida and Business consents to jurisdiction in Florida.

l. Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be deemed received when sent by certified or registered mail, return receipt requested, (or, if by email, upon acknowledgment of receipt) to the Parties at the addresses set forth below.

2020 Hearing Care Network, LLC

2900 West Cypress Creek Rd Ste 4

Fort Lauderdale, FL 33309

Attention: Robert Coppola, President

(954) 917-2337 ext 1024

Email: rcoppola@2020eyecareplan.com

Business: _____

_____

_____

Attention: _____

Email: _____

m. Severability. If any provisions or parts of provisions in this Agreement are held to be unenforceable, the remainder of this Agreement shall continue in full effect as allowed by law.

n. Assignment. Business shall not assign or transfer its rights, duties or obligations under this Agreement without the prior written consent of 20/20.

o. Third-Party Rights. Unless specifically provided in this Agreement, the Parties have not created and do not intend to create any enforceable rights in or to any third-parties, including without limitation, Patients. Unless specifically provided in this Agreement, the Parties understand and agree that there are no third-party beneficiaries to this Agreement.

20/20 Hearing Care Network, LLC **Business**

Signature Robert C. Coppola, OD	Signature
Print Name President	Print Name
Title Date	Title Date

HIPAA Business Associate Agreement

This **HIPAA Business Associate Agreement** (the "Agreement"), is made and is effective as of the Effective Date of the ("Effective Date"), 20/20 Hearing Care Network, LLC and Business (as the "Covered Entity" herein) (each a "Party" collectively the "Parties").

BACKGROUND

This Agreement sets forth the terms and conditions pursuant to which Protected Health Information that is created, received, maintained or transmitted by the Business Associate from or on behalf of Covered Entity ("PHI"), will be handled between the Business Associate and Covered Entity. The Parties are committed to complying with the Privacy Standards for Individually Identifiable Health Information (the "Privacy Rule") and the Security Standards for electronic Protected Health Information (the "Security Rule") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and implementing regulations (the "HIPAA Rules"), as each is amended from time to time.

1. Definitions. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms are defined in HIPAA and the HIPAA Rules.

1.1 Breach. "Breach" means the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI.

1.2 Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Manufacturer.

1.3 Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Company.

1.4 Protected Health Information. "Protected Health Information" or "PHI" has the meaning as set out in its definition at 45 CFR §160.103, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of the Covered Entity, and includes "Electronic Protected Health Information ("ePHI") as defined in 45 CFR §160.103.

2. Permitted Uses and Disclosures by Business Associate

(a) Business Associate may only use or disclose PHI as necessary to perform the services set forth in any underlying services agreement between the Parties.

(b) Business Associate may use or disclose PHI as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for PHI consistent with Covered Entity's minimum necessary policies and procedures.

(d) Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity, except for the specific uses and disclosures set forth below.

(e) Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(f) Business Associate may provide data aggregation services relating to the health care operations of Covered Entity.

(g) Business Associate may de-identify information in accordance with HIPAA standards and use such information for internal business purposes.

3. Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose PHI other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;

(c) Report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including a Breach of unsecured PHI as required at 45 CFR 164.410, and any Security Incident of which it becomes aware;

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information;

(e) In the time and manner agreed upon by Covered Entity and Business Associate, make available PHI in a designated record set to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524;

(f) In the time and manner agreed upon by Covered Entity and Business Associate, make any amendment(s) to PHI in a designated record set as directed or agreed to by Covered Entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 CFR 164.526;

(g) Maintain and, in the time and manner agreed upon by Covered Entity and Business Associate, make available the information required to provide an accounting of disclosures to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528;

(h) To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

4. Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of any (i) limitation(s) in the notice of privacy practices of Covered Entity under 45 CFR 164.520; (ii) changes in, or revocation of, the permission by an individual to use or disclose his or her PHI; or (iii) restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522; the extent that such limitation, change or restriction may affect Business Associate's use or disclosure of PHI. Covered Entity represents that it has obtained all necessary authorizations, if any, for the use or disclosure of PHI to enable Business Associate to perform services for or on behalf of Covered Entity.

5. Term and Termination

5.1 Term. This Agreement shall become effective on the Effective Date and shall continue in effect until the termination of the underlying business relationship or it is terminated as set forth in this Section 5, whichever is sooner.

5.2 Termination by Covered Entity. Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has breached a material term of the Agreement and Business Associate has not cured the breach or ended the violation within 30 calendar days of such written notice.

5.3 Termination by Business Associate. If Business Associate reasonably believes that Covered Entity has breached a material term of this Agreement, Business Associate shall provide thirty (30) days' notice of its intention to terminate this Agreement. Business Associate will cooperate with Covered Entity to find a mutually satisfactory resolution to the matter prior to terminating.

5.4 Effect of Termination. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

(a) Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

(b) Return to Covered Entity or destroy the remaining PHI that the Business Associate still maintains in any form;

(c) Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to ePHI to prevent use or disclosure of such PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

(d) Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in Section 2 which applied prior to termination; and

(e) Return to Covered Entity or destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

5.5 Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

6. Miscellaneous

6.1 Amendments; Waiver. This instrument sets forth the entire understanding and agreement of the parties as to the subject matter of this Agreement. This Agreement may be changed or modified only by an agreement in writing signed by both parties. Any waiver of any term of this Agreement or the breach of any of its provisions shall not operate or be construed as a waiver of any other or subsequent failure of strict performance.

6.2 No Third-Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

6.3 Notices. All notices required under this Agreement shall be in writing, addressed to the other party at the address indicated in this Agreement, (or at such other address as either party may designate by proper written notice to the other party). Notices may be delivered by hand or sent by facsimile transmission or certified mail, return receipt requested. Notices shall be effective upon receipt. Notices sent by mail shall be deemed received on the date of receipt indicated by the return verification provide by the U.S. Postal Service.

6.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule and Security Rule.

IN WITNESS WHEREOF, the Parties have executed this Agreement in the manner appropriate to each as of the Effective Date.

20/20 Hearing Care Network, LLC	**Business**
_____	_____
Signature	Signature
Robert C. Coppola, OD	
_____	_____
Print Name	Print Name
President	
_____	_____
Title Date	Title Date

Fee Schedule

20/20 Hearing Care Network May 15, 2022

SOLUTION	PRODUCT FAMILY	Product Notes	Member Price	Prof Fee*	Warranty
PREMIUM	PHONAK Paradise 90 R Tcoil	Advanced Recharge + Tcoil	$2,895	$650	3
	PHONAK Paradise 90 R	Advanced Rechargeable	$2,895	$650	3
	PHONAK Paradise 90 Tcoil (M-M, SP)	Advanced (M-M,SP models)	$2,875	$650	3
	PHONAK Paradise 90	Advanced	$2,875	$650	3
	PHONAK Marvel 90 R Tcoil	Premium Recharge + Tcoil	$2,845	$650	3
	PHONAK Marvel 90 R	Premium Rechargeable	$2,845	$650	3
	PHONAK Marvel 90 Tcoil (M-M, SP)	Premium (M-M,SP models)	$2,825	$650	3
	PHONAK Marvel 90	Premium	$2,825	$650	3
	PHONAK Marvel 90 Custom	Premium (NW Only)	$2,825	$650	3
	LIVIO 2400 CUSTOM RECHARGEABLE	ITE R, ITC R	$3,450	$650	3
	LIVIO 2400 RECHARGEABLE	RIC R	$3,300	$650	3
	LIVIO 2400	RIC 312, mRIC 312, BTE 13	$3,150	$650	3
	PICASSO i2400 Custom	Custom: ITE, ITC, HS	$3,300	$650	3
	PICASSO i2400/2400 CIC	CIC	$3,300	$650	3
HIGH	LIVIO 2000 CUSTOM RECHARGEABLE	ITE R, ITC R	$3,350	$600	3
	LIVIO 2000 RECHARGEABLE	RIC R	$3,200	$600	3
	LIVIO 2000	RIC 312, mRIC 312, BTE 13	$2,800	$600	3
	PICASSO i2000	Custom: ITE, ITC, HS	$2,800	$600	3
	PICASSO i2000/2000 CIC	CIC	$2,800	$600	3
MID	LIVIO 1600 CUSTOM RECHARGEABLE	ITE R, ITC R	$2,750	$500	3
	LIVIO 1600 RECHARGEABLE	RIC R	$2,550	$500	3
	LIVIO 1600	RIC 312, mRIC 312, BTE 13	$2,350	$500	3
	PHONAK Paradise 70 R Tcoil	Advanced Recharge + Tcoil	$2,420	$500	3
	PHONAK Paradise 70 R	Advanced Rechargeable	$2,420	$500	3
	PHONAK Paradise 70 Tcoil (M-M, SP)	Advanced (M-M,SP models)	$2,400	$500	3
	PHONAK Paradise 70	Advanced	$2,400	$500	3
	PHONAK Marvel 70 R Tcoil	Advanced Recharge + Tcoil	$2,370	$500	3
	PHONAK Marvel 70 R	Advanced Rechargeable	$2,370	$500	3
	PHONAK Marvel 70 Tcoil (M-M, SP)	Advanced (M-M,SP models)	$2,350	$500	3
	PHONAK Marvel 70	Advanced	$2,350	$500	3
	PHONAK Marvel 70 Custom	Advanced (NW Only)	$2,350	$500	3
	PICASSO i1600 CUSTOM	ITE, ITC, HS	$2,400	$500	3
	PICASSO i1600/1600 CIC	CIC	$2,400	$500	3
LOW	PHONAK Paradise 50 R Tcoil	Standard Recharge + Tcoil	$2,175	$400	3
	PHONAK Paradise 50 R	Standard Rechargeable	$2,175	$400	3
	PHONAK Paradise 50 Tcoil (M-M, SP)	Standard (M-M,SP models)	$2,155	$400	3
	PHONAK Paradise 50	Standard	$2,155	$400	3
	PHONAK Marvel 50 R Tcoil	Standard Recharge + Tcoil	$2,125	$400	3
	PHONAK Marvel 50 R	Standard Rechargeable	$2,125	$400	3
	PHONAK Marvel 50 Tcoil (M-M, SP)	Standard (M-M,SP models)	$2,105	$400	3
	PHONAK Marvel 50	Standard	$2,105	$400	3
	PHONAK Marvel 50 Custom	Standard (NW Only)	$2,105	$400	3
	LIVIO 1200 CUSTOM RECHARGEABLE	ITE R, ITC R	$2,250	$400	2
	LIVIO 1200 RECHARGEABLE	RIC R	$2,150	$400	2
	LIVIO 1200	RIC 312, mRIC 312, BTE 13	$1,850	$400	2
	PICASSO i1200 CUSTOM	ITE, ITC	$1,950	$400	2
	PICASSO i1200 CIC	CIC	$2,050	$400	2
BASIC	PHONAK Paradise 30 RT	CROS compatible, Audeo P30-RT, Naida P30-UP	$1,860	$300	2
	PHONAK Paradise 30	CROS compatible, Audeo P30-T, Naida P30-UP	$1,845	$300	2
	PHONAK Marvel 30 R Tcoil	Essential Recharge + Tcoil	$1,500	$300	2
	PHONAK Marvel 30 R	Essential Rechargeable	$1,500	$300	2
ECONOMY	Oticon Ruby 1 R	miniRITE R	$1,350	$200	2

Fee Schedule

20/20 Hearing Care Network May 15, 2022					
SOLUTION	PRODUCT FAMILY	Product Notes	Member Price	Prof Fee*	Warranty
ECONOMY RECHARGEABLE OPTION OR ACCESSORY	Oticon Ruby 2 R	miniRITE R	$1,300	$200	2
	Oticon Play PX 2 R	miniRITE R, miniBTE R	$1,350	$200	2
	EARMOLD	CUSTOM	$34	$0	0
	Starkey EARMOLD AP CUSTOM	ABSOLUTE POWER	$150	$0	0
	PHONAK EARMOLD POWER 'c-Shell'	Custom 4.0 STD, Med, PR, C-Shell, or Slim Tip	$150	$0	0
Models below are offered at NO cost to MMA Members					
RECHARGEABLE	DX Moxi Jump R T 3	Unitron Rechargeable R 3, RT 3	$1,250	$200	3
	DX Moxi Move R 3	Unitron Rechargeable R 3	$1,250	$200	3
ECONOMY	DX Moxi Fit 3	Unitron Standard	$1,000	$200	3
	Stride B1 BLU	Unitron BLU | PR, UP, 312	$1,250	$200	3
	Stride B1 BLU R	Unitron BLU | R, RT	$1,250	$200	3
	LIVIO 1000	RIC 312, mRIC 312, BTE 13	$1,250	$200	2
	PICASSO i1000/1000 CUSTOM	ITE, ITC, CIC	$1,250	$200	2
	Oticon Ruby 1	miniRITE, miniRITE-T, BTE, BTE PP	$1,250	$200	2
	Oticon Ruby 2	miniRITE, miniRITE-T, BTE, BTE PP	$1,250	$200	2
	PHONAK Marvel 30 Tcoil	Essential (M-M,SP models)	$1,250	$200	2
	PHONAK Marvel 30	Essential	$1,250	$200	2
	PHONAK Marvel 30 Custom	Essential (NW Only)	$1,250	$200	2
CHILD FRIENDLY	Oticon Play PX 2	miniRITE T, miniBTE T	$1,250	$200	2
	Oticon Opn Play 2	miniRITE,miniRITE-T,BTE PP	$1,250	$200	2
	Oticon Xceed Play 2	BTE SP/UP	$1,250	$200	2
	PHONAK Sky Marvel-50	M, SP	$1,250	$200	2
	PHONAK Sky Belong-50	M, P, SP, UP	$1,250	$200	2
	ReSound KEY 2	LP, MP, HP and UP	$1,250	$200	1
	ReSound ENZO Quatro 5	Premium Plus Severe to Profound	$1,250	$200	1
MMA APPROVAL REQUIRED FOR CROS ORDERS	Oticon Ruby 1 CROS	miniRITE, miniRITE-T, BTE, BTE PP	$1,250	$200	2
	Oticon Ruby 2 CROS	miniRITE, miniRITE-T, BTE, BTE PP	$1,000	$200	2
	PHONAK Paradise 30 CROS	1) Submit audiogram & discrimination	$1,450	$200	2
	PHONAK Sky B-50 CROS	2) Order upon approval	$1,450	$200	1

*per unit dispensed less any applicable plan copay