AMERICA'S BEST
VISION PLAN

PROVIDED BY **FIRSTSIGHT VISION SERVICES, INC.**
1202 Monte Vista Avenue, Suite 17
Upland, California 91786
(800) 841-2790
www.abvisionplan.com

3-YEAR CONTACT LENS EXAM BENEFIT (FOR INDIVIDUALS)

UNIFORM HEALTH PLAN AND BENEFITS COVERAGE MATRIX

CO-PAYMENTS AND DEDUCTIBLES:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Any benefits provided under this Agreement may duplicate pediatric vision service benefits provided by a full service health plan.

MEMBERSHIP FEE: $129 One-Time Fee for 3 Years (1095 Days) from the Date You Enroll and Pay Your 3-Year Contact Lens Exam Benefit Membership Fee

DEDUCTIBLES:	NONE
LIFETIME MAXIMUM:	NONE
PROFESSIONAL SERVICES: Contact Lens Eye Exam (includes dilated fundus exam, as indicated) with fitting and evaluation	No Co-payment
Unlimited number of contact lens exams (includes dilated fundus exam, as indicated), fitting and evaluation for 3 years	No Co-payment
Additional, unlimited eye exams for 3 years	No Co-payment
Access to a 10% discount that will be applied to all products available at Eyewear Provider (America's Best Contacts & Eyeglasses) offices, including contact lenses and eyeglasses, which Member purchases. Exclusions and Limitation apply (see below)	Prices Vary

PRINCIPAL EXCLUSIONS AND LIMITATIONS: • All Benefits must be received from a Network Provider within the Membership Period • No eyeglasses are provided as Benefits • No contact lenses are provided as Benefits • Services and products received from a Referral Ophthalmologist not included • Goods and services purchased from an Eye Exam Provider or an Eyewear Provider that are not Benefits are at Member's cost. • 10% discount Benefit cannot be used to purchase other products or services that are provided as benefits under a health plan or insurance policy in which Member is enrolled. • Member's current valid prescription needed for use of 10% discount Benefit for prescription eyewear.	
OUTPATIENT SERVICES:	NONE
HOSPITALIZATION SERVICES:	NONE
EMERGENCY HEALTH COVERAGE:	NONE
AMBULANCE SERVICES:	NONE
PRESCRIPTION DRUG COVERAGE:	NONE
DURABLE MEDICAL EQUIPMENT:	NONE
MENTAL HEALTH SERVICES:	NONE
CHEMICAL DEPENDENCY SERVICES:	NONE
HOME HEALTH SERVICES:	NONE
OTHER:	NONE

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3-YEAR CONTACT LENS EXAM BENEFIT

INDIVIDUAL SERVICES AGREEMENT AND EVIDENCE OF COVERAGE FOR VISION CARE BENEFITS

THIS INDIVIDUAL SERVICES AGREEMENT AND EVIDENCE OF COVERAGE CONTAINS ALL OF THE TERMS AND CONDITIONS OF THE AMERICA'S BEST VISION PLAN'S *3-YEAR CONTACT LENS EXAM BENEFIT*. AN APPLICANT SHOULD REVIEW IT PRIOR TO ENROLLMENT. PLEASE READ IT COMPLETELY. INDIVIDUALS WITH SPECIAL VISION NEEDS SHOULD READ CAREFULLY THOSE SECTIONS THAT APPLY TO THEM.

IF YOU HAVE ANY QUESTIONS ABOUT THIS PLAN, CONTACT
FIRSTSIGHT VISION SERVICES, INC. at **(800) 841-2790.**

MEMBERSHIP PERIOD: Three Years (1095 Days) from the Date You Enroll and Pay Your 3-Year Contact Lens Exam Benefit Membership Fee (ONE TIME FEE OF $129)

Welcome to America's Best Vision Plan (referred to as "**America's Best Vision Plan**" or the "**Plan**"), provided by FirstSight Vision Services, Inc. This Individual Services Agreement and Evidence of Coverage for Vision Care Benefits (referred to as this "**Agreement**") describes the Benefits available to our Members with the **3-Year Contact Lens Exam Benefit**. Under this Membership Plan, we provide eye exams with contact lens evaluations and fittings and discounts off products available in any America's Best Contacts & Eyeglasses office including contact lenses and eyeglasses, subject to the limitations and exclusions described in Section 2.

To become a Member, call or go to our website to schedule an appointment or to enroll, or walk into any America's Best Contacts & Eyeglasses office in California, our Eyewear Provider. When you give your Eyewear Provider or us your signed Enrollment Form with your Membership Fee, you are enrolled as a Member and can receive your Benefits as described in this Agreement.

You may receive a copy of this Agreement at any time by downloading it from our website or by requesting it from an America's Best Contacts & Eyeglasses office. Please read this Agreement carefully so that you will understand all of our duties and all of your responsibilities.

Please note that pediatric vision services for children up to age 19 may be provided as an essential benefit under your full service health plan. Any benefits provided under this Agreement may duplicate pediatric vision service benefits provided by a full service health plan.

PRIVACY: YOUR PRIVACY IS IMPORTANT TO US. THE PLAN WILL NOT DISCLOSE YOUR MEDICAL INFORMATION RELATED TO SENSITIVE HEALTH CARE SERVICES TO THE PRIMARY MEMBER, IF ANY, OR ANY OTHER MEMBER, ABSENT YOUR EXPRESS AUTHORIZATION. A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS

IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST OR YOU CAN VIEW OR DOWNLOAD IT AT OUR WEBSITE.

FREE LANGUAGE ASSISTANCE SERVICES: Language assistance services, including sign language, are available to members free of charge. You can get an interpreter at no cost to talk to your doctor or health plan. You may also request health plan materials translated in your language. To get an interpreter or to ask about translated written materials in your language, call the health plan's telephone number at 1-800-841-2790. Someone who speaks your language can help you.

DISABILITIES: For individuals with disabilities, auxiliary aids and services are available, including qualified interpreters and information in alternate formats. These aids and services are free of charge and will be provided in a timely manner when they are necessary to ensure an equal opportunity for members with disabilities to participate.

<u>NO DISCRIMINATION:</u> We will not refuse to enter into this Agreement, cancel, decline to renew, or refuse to reinstate this Agreement, or modify its terms because of the race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability of any party or prospective party to this Agreement or any person we reasonably expect will benefit from this Agreement. See Section 12.2 regarding your right to file a complaint.

Table of Contents:

1. DEFINITIONS

The terms underlined below in this Section 1 shall have the meaning directly following the term, throughout this Agreement:

1.1 Benefits: The vision services and products that a Member is entitled to receive upon payment of the Membership Fee and any required Co-payment, in accordance with this Agreement.

1.2 Co-payment: The fee in addition to the Membership Fee, which a Member must pay to a Network Provider to obtain a product or service that is part of the Benefits. Those Co-payments are listed in Section 2.

1.3 Enrollment Form: The form that you complete as a step to becoming a Member.

1.4 Exclusions: Those services and products that are not provided as Benefits to Members.

1.5 Eye Exam Provider: A licensed ophthalmologist or optometrist who is responsible for providing or supervising the rendering of your Benefits, who is a Network Provider. All Eye Exam Providers operate their vision care practices independent of the Eyewear Providers and are located on the premises of the Eyewear Providers.

1.6 Eyewear Provider: A registered dispensing optician's office operated by America's Best Contact Lens & Eyeglasses and located in California, which is a Network Provider that is responsible for providing the discount portion of your Benefits.

1.7 Limitations: Any provision other than an excluded service or procedure that restricts your coverage under the Plan.

1.8 Member: An individual who is enrolled in the Plan and entitled to receive the Benefits described in this Agreement (sometimes referred to as an "**Enrollee**").

1.9 Membership Fee: The one-time prepayment fee you pay to the Plan that, along with your submission of your Enrollment Form, entitles you to receive the Benefits during the 3-Year Membership Period (1095 Days).

1.10 Membership Period: The time period during which you are eligible to receive your Benefits, starting on the day that you submitted your Enrollment Form AND paid your Membership Fee. Your Membership Period is stated on the first page of this Agreement.

1.11 Network Provider: An Eye Exam Provider or an Eyewear Provider that contracts with **America's Best Vision Plan** to provide all or part of the Benefits to You.

1.12 Provider Directory: A list of the locations of the Eyewear Providers and the Eye Exam Providers, where you can receive your Benefits.

1.13 Referral Ophthalmologist: An ophthalmologist to whom an Eye Exam Provider may refer you.

1.14 Telehealth Services: The delivery of eye exam services to a Member who is located in a Network Provider's office, by a California licensed optometrist located at a distant site, through real-time communication technology.

1.15 Toll-free Number: The telephone number associated with **America's Best Vision Plan** and operated by FirstSight Vision Services.

1.16 We, Us and Our (capitalized or not): **America's Best Vision Plan**, provided by FirstSight Vision Services, Inc.

1.17 You and Your (capitalized or not): Refers to you, the individual who is or becomes a Member.

2. YOUR MEMBERSHIP BENEFITS

Principal Benefits and Coverage

The Contact Lens Exam Benefit Membership includes only eye examinations with contact lens fittings and evaluations. It does not include any contact lenses or eyeglass frames and lenses or medical or surgical treatments.

THREE YEAR CONTACT LENS CLUB MEMBERSHIP	Membership Fee $129
BENEFITS	**ADDITIONAL CHARGES**
EYE EXAMS	
You are entitled to receive unlimited contact lens eye exams, including fittings and evaluations, for three years. • This includes a dilated fundus examination ("**DFE**" or "**dilation**") when your Eye Exam Provider deems it necessary or you otherwise request it. • This also includes unlimited eye exams for eye glasses at no additional charge during the membership period.	None
DISCOUNTED ADDITIONAL SERVICES AND PRODUCTS	
Your Membership allows you to purchase additional ophthalmic products, such as eyeglass frames and lenses and contact lenses, which are not part of your Benefits or the benefits of another health plan or insurer, at 10% off their retail prices from your Eyewear Provider. Valid prescriptions may be required, as applicable.	You will be responsible for paying your Eyewear Provider for any additional products and services. Prices vary.
REFERRALS	
If your Network Provider believes you need to see another health care provider, your Network Provider will use his or her best efforts to make a referral for services that are not Benefits. This may include a referral to a Referral Ophthalmologist.	You must pay for all services you receive from a health care provider who is not a Network Provider, including all services you may receive from a Referral Ophthalmologist.
ADDITIONAL SERVICES AND PRODUCTS	
Any services, products or upgrades to those products that you may purchase from one of our Network Providers or any other health care provider that are not Benefits are solely at your cost.	

If you have any questions about your Benefits, please call us at **1-800-841-2790.**

3. GENERAL EXCLUSIONS AND LIMITATIONS OF YOUR BENEFITS

Limitations

- All Benefits must be received from a Network Provider within the Membership Period.
- 10% discount Benefit cannot be used to purchase other products or services that are provided as benefits under a health plan or insurance policy in which Member is enrolled.

- Member's current valid prescription needed for use of 10% discount Benefit for prescription eyewear.
- Member's purchase of additional optical goods and services that are not Benefits and are available from a Network Provider or other health care provider are at Member's own cost.
- Any upgrades or additional frame or lens features are at Member's cost and not part of the Benefits.

Exclusions: Services We Will **Not** Provide

As a Member, you are entitled to receive only the Benefits described in this Agreement and provided by a Network Provider. Your Benefits **do not include** the following and you will need to purchase them at your cost. We will not reimburse you for them.

- Eyeglasses.
- Contact lenses.
- Services or products that are not part of your Benefits, which you may request or your Network Provider may recommend. For example, your membership does not include services:
  - For anyone other than for you;
  - Provided by another health care provider or a Referral Ophthalmologist
  - Provided before or after your Membership Period; or
  - That are not part of an contact lens eye exam, such as services:
    - To improve your visual perception, your binocular vision, or the coordination of your eyes;
    - To treat a difference in the size or shape of your ocular images;
    - To attempt to change the cornea's shape through the use of contact lenses in order to reduce the refractive error;
    - To aid you if you are partially sighted; or
    - For prolonged occlusion tests to aid special remedial care or a diagnosis of strabismus.
    - For medical or surgical treatment of your eyes.

4. ACCESSING AND USING YOUR BENEFITS

4.1 Effective Date of Coverage

You can receive your Benefits at any time during the Membership Period once you are enrolled in the Plan, with no waiting periods. You are enrolled on the date we receive your completed Enrollment Form AND your Membership Fee.

4.2 Identification Required

We may require that you provide us with a form of identification such as a photo ID at the time you enroll and each time you access your Benefits:

4.3 Choice of Eye Exam Providers and Facilities

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT NETWORK PROVIDERS YOU MAY OBTAIN YOUR BENEFITS.

You must receive your Benefits at the Network Provider offices listed in our Provider Directory, which you can access at **abvisionplan.com** or request by calling our Toll-free Number **(800) 841-2790**. Our Network Providers are located at the following locations for the Benefits listed:

Eye Exams: At any Eye Exam Provider's office, each of which are located on or by the premises of the America's Best Contacts & Eyeglasses offices located in California.
Product Discounts: At any America's Best Contacts & Eyeglasses office located in California.

We will honor your request to see a particular Eye Exam Provider to the extent possible. If the requested Eye Exam Provider is not available, however, we will schedule you or you can make an appointment with another Eye Exam Provider.

If a Network Provider's contract with **America's Best Vision Plan** is terminated, we will continue to be responsible for your Benefits in accordance with this Agreement. We will make reasonable and appropriate provisions for another Network Provider to assume the service of your Benefits. You must remain an eligible Member to continue to receive your Benefits.

We contract with our Network Providers and pay them for the claims they submit to us. We will not pay a bonus to anyone to deny, reduce, limit, or delay the provision of your Benefits. If you would like to know more about these arrangements, you may request additional information from us or from your Network Provider.

We provide or arrange for your Benefits only in a specific geographic area, known as our Service Area. All of the Network Providers are located in our Service Area.

We will not decrease your Benefits during your Membership Period.

4.4 Accessing Your Benefits

Office Hours: Office hours may vary by location but generally are 9:00 am – 7:00 pm, Monday – Friday; 9:00 am – 6:00 pm on Saturdays. Some offices may be open on Sunday. You should call the office you will visit to determine their office hours and the hours when an Eye Exam Provider will be available to see you.

Appointments: You can receive your Benefits by calling your Network Provider's office listed in the Provider Directory to schedule an appointment or schedule the appointment on-line at www.abvisionplan.com. Your appointment will be scheduled in a timely manner consistent with professional standards of practice and your health needs. Interpreter services are available free of charge if needed and may be scheduled at the time you make your appointment.

Walk-Ins: Most offices will allow you to "walk-in" to receive your Benefits. Please understand, however, that we cannot guarantee that an appointment will be available, and Members with scheduled appointments will be seen first. Your Eye Exam Provider will assure that you receive the tests and procedures required by professionally recognized standards of practice.

Prescriptions: If you need an eyeglass prescription, your Eye Exam Provider will give you a copy of the prescription. If you need a contact lens prescription, your Plan Optometrist will give you a copy after your exam or successful fittings. You can purchase your eyewear from anyone you choose but to obtain your product discount Benefit, you must obtain your eyewear at an America's Best Contacts & Eyeglasses office with a current and valid prescription. You or, at your request, your Network Provider, can call the office of any optometrist or ophthalmologist who has issued you a prescription that is current and valid and that you would like to use to receive the eyeglass part of your Benefits.

Subsequent Eye Exams: You are entitled to receive subsequent eye exams at any time during your Membership Period at your Eye Exam Provider's office. You must pay the required Co-payment at the time you receive your eye exam.

Discount on Eyewear Products from a Network Provider: You are entitled to have a 10% discount applied against any goods that you may purchase from your Eyewear Provider, in accordance with Sections 2 and 3 above. To use the discount, you will need to visit and purchase goods from your Eyewear Provider's store.

Telehealth Services: If your Network Provider provides telehealth eye exam services and delivers such services to you at their office, we will provide coverage for the Telehealth Services on the same basis and to the same extent that we are responsible for covering the eye exams through in-person diagnosis, consultation, or treatment. Your Network Provider will determine whether or not they can provide such Telehealth Services to you. All services that are made available via telehealth are also available to you on an in-person basis. . Your Network Provider is required to obtain your informed consent to the Telehealth Services prior to the telehealth eye exam.

4.5 Second Opinions

If you would like a second opinion about a prescription or a referral made by your Eye Exam Provider, you may request and receive an additional eye exam from another Eye Exam Provider. You must pay the Co-payment required for the additional eye exam, if any.

4.6 Referrals

Your Eye Exam Provider will tell you if, in his or her professional judgment, you should see another health care provider. Your Eye Exam Provider will use his or her best efforts to refer you to an appropriate provider. If you have other health coverage under which a primary care physician (a "**PCP**") must refer you for care, your Eye Exam Provider will try to coordinate the referral through your PCP. If you need to see an ophthalmologist and you do not have a PCP, your Eye Exam Provider will give you one or more names of Referral Ophthalmologists located nearby, if any. The Referral Ophthalmologists are not associated with the **America's Best Vision Plan** for the provision of ophthalmology services that are not Benefits. You must pay for all services you receive from any other health care provider. This includes all services you receive from a Referral Ophthalmologist.

4.7 Emergency and After Hours Coverage**.** An "Emergency Ocular Medical Condition" means a sudden and unforeseen eye-related illness or injury, including significant eye pain, redness, or blurred vision. If you experience an emergency ocular medical condition during normal business hours, you should call your **America's Best Vision Plan** office and have your Eye Exam Provider determine whether to schedule an appointment or refer you to the nearest emergency facility. You should go immediately to the emergency room nearest you if your emergency occurs after business hours. We do not provide or pay for emergency services and care other than appointments that may be scheduled with an Eye Exam Provider during normal business hours.

WE ENCOURAGE MEMBERS TO CALL 911 IMMEDIATELY IF THEY ARE EXPERIENCING AN EMERGENCY CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

5. MEMBERSHIP FEES AND COPAYMENTS

5.1 Membership Fees/Prepayment Fees

You must include payment for your Membership Fee with your Enrollment Form when you give it to us. You may provide payment by check, cash, or an authorized credit or debit card. We will not change the amount of your Membership Fee during your Membership Period.

5.2 Co-payments and Other Charges

There is no co-payment or other charge that you must pay the Network Provider for the Benefits you receive under this Agreement at the time you receive them. If you use the 10% discount to which you are entitled for other

products that you purchase from an Eyewear Provider, you are responsible for paying the Eyewear Provider for the cost of those products plus any sales tax, after the discount is applied.

5.3 What to Do If You Receive a Bill for Your Benefits

You should not receive a bill for any amount other than your applicable Co-payment, for a product or service that is a Benefit, which you receive at a Network Provider's office. If you receive a bill and you do not believe you owe the sums set forth on the bill, please send it to the attention of Member Services at our address on the front page of this Agreement. You are responsible for payment for any services or products that are not part of your Benefits.

CALIFORNIA LAW STATES THAT A NETWORK PROVIDER MAY NOT COLLECT OR ATTEMPT TO COLLECT FROM YOU ANY SUMS THAT A HEALTH PLAN OWES THE NETWORK PROVIDER.

6. RENEWAL OF MEMBERSHIP

When you pay your Membership Fee, you become entitled to receive the services or products that comprise your Benefits for your Membership Period, with the payment of any applicable Co-payments. At the end of the Membership Period or thereafter, we will renew this Agreement at your request if you pay your Membership Fee and we do not have good cause to end (terminate) this Agreement. We may change the Membership Fee or the Benefits at the time of renewal.

7. RIGHTS OF CANCELLATION AND TERMINATION OF BENEFITS

7.1 Your Right to Disenroll

You may voluntarily disenroll or cancel this Agreement at any time for any reason by notifying us in writing of your intent to cancel your membership.

7.2 Termination of Benefits

We may end (terminate) this Agreement or refuse to renew it if we demonstrate that you engaged in fraud or deception in enrolling as a Member or using the services or facilities that we provide. This includes when you knowingly permit such fraud or deception by another person, including allowing someone else to use your benefits. If we make that determination, we will send you written notice thirty (30) days before the date this Agreement terminates and five (5) days after your coverage is terminated.

If you believe that your health care coverage has been or will be improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with us or the Department of Managed Health Care. If we receive your grievance before this Agreement terminates, we will continue to provide coverage to you under the terms of this Agreement until we and/or the Director resolve your grievance.

7.3 Effects of End of this Agreement

If this Agreement ends for any reason, our obligation to provide or arrange for you Benefits will end on that date. You may renew your membership or purchase a different membership in accordance with Section 6.

If you or we end this Agreement, we will return to you, within thirty (30) days, the pro-rata portion of the Membership Fee you paid and we received that corresponds to the Benefits you have not received, less any amounts you owe to us. We will not return any Membership Fee to you if we end this Agreement for fraud or deception as described in Subsection 7.2 above.

7.4 Your Right to Review

If you allege that we have ended this Agreement based on your health status or your need or requirements for the Benefits, you may request a review by the Director of the Department of Managed Health Care. You may first file a grievance with us under our Grievance Procedures in Section 8, but we do not require that you do so.

8. GRIEVANCE PROCEDURES

8.1 Filing a Grievance

If you have a complaint or want to express your dissatisfaction with our services related to this Agreement, please let us know so that we can promptly resolve it. This may include a complaint about a Network Provider, the quality of the care you received, or services you received or did not receive. It also may include a complaint about a referral or any other issue you think is important.

You can contact us about any questions, disputes, or complaints, file a grievance or obtain a written complaint form, in the following ways:

- Visit our website at **www.abvisionplan.com**
- Email us at memberservices@abvisonplan.com
- Call us at **1-800-841-2790**
- Fax us at 1-866-698-7733
- Visit any **America's Best Vision Plan** office
- Write to the attention of Member Services at:

  America's Best Vision Plan
  Attn: Grievance Administrator.
  1202 Monte Vista Avenue, Suite 17
  Upland, California 91786

We will work with you to resolve your complaint according to our established grievance procedures. You may file a verbal grievance by calling the telephone number listed above or by completing a written complaint form. Written grievance forms are available in English and Spanish at each Network Provider's office, on the website and at the **America's Best Vision Plan** headquarters. Personnel at the telephone number above or at a Network Provider's office will be available to assist you in completing the form.

We will acknowledge receipt and resolution of your written grievance in accordance with Section 1368 of the Health and Safety Code and 28 California Code of Regulations, Section 1300.68. We will expedite our review of your complaint in cases involving imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function. Under our expedited review procedures, we will provide you and the Department of Managed Health Care with a written statement of the disposition or status of your complaint within three (3) days from the date we receive the complaint.

8.2 California Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-841-2790** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**)

and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR applications forms, and instructions online.

You may submit your complaint or grievance to the Department for review after you have participated in our grievance process for at least thirty (30) days. If your grievance involves an imminent and serious threat to your health (including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function), you may submit the grievance to the Department without waiting thirty (30) days. In such a situation, we will inform you immediately of your right to notify the Department of Managed Health Care of your complaint.

9. PUBLIC POLICY PARTICIPATION

We have established a Public Policy Committee to allow Members to make recommendations regarding ways in which we can assure the comfort, dignity, and convenience of our Members and to improve our services or care. The Committee may review the nature, volume, and resolution of the complaints that we receive. You can submit comments by contacting us at our Toll-free Number. Any material changes affecting our public policy will be communicated to our Members.

10. YOUR RESPONSIBILITIES

You have certain responsibilities under this Agreement. You must comply with all of the terms of this Agreement that require you to take or prohibit you from taking specific actions. This includes, for example, paying the Membership Fee, the Co-payments and other charges that may apply. Please see Section 5 of this Agreement. You are also responsible for following the Network Provider's directions and orders regarding your vision care, including following up with any exams or recommended referrals.

11. OUR RESPONSIBILITIES

If you pay your Membership Fee and you follow the terms of this Agreement, we will provide you with your Benefits – the vision care services and products that we have agreed to provide to you.

12. GENERAL PROVISIONS

12.1 Termination of Providers; Certain Notices. If you are scheduled to receive Benefits from a Network Provider who is no longer associated with us at the time of your appointment, you, a Network Provider, or we can schedule you an appointment with another Network Provider at the same location if the location remains open, or at another Network Provider's location. We will try to accommodate you with regard to your preference for a location.

12.2 No Discrimination. We will not refuse to enter into this Agreement, cancel, decline to renew, or refuse to reinstate this Agreement, or modify its terms because of the race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability of any party or prospective party to this Agreement or any person we reasonably expect will benefit from this Agreement. If you believe you were discriminated against, you can file a discrimination grievance with us under our Grievance Procedures in Section 8. You have the right to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights (OCR) if you have a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file your complaint in writing, by phone, or online.

By phone: 1-800-368-1019 (TTY 711 or 1-800-537-7697)

By mail: The complaint form can be accessed at https://www.hhs.gov/sites/default/files/ocr-60-day-frn-cr-crf-complaint-forms-508r-11302022.pdf. The completed form may be submitted to OCR at Centralized Case

Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Bldg, Washington, D.C. 20201

By email: OCRComplaint@hhs.gov.

Online: Visit the Office of Civil Rights Complaint Portal Assistant at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

For more information about the OCR complaint process please visit https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

12.3 No Exceptions to Medi-Cal Coverage. This Agreement does not provide any exception for other coverage where the other coverage is entitlement to: (i) Medi-Cal benefits under Chapter 7 or Chapter 8 of Part 3 of Division 9 of the California Welfare and Institutions Code; or (ii) Medicaid benefits under Subchapter 19 of Chapter 7 of Title 42 of the United States Code. This Agreement also does not provide an exemption for enrollment because you are entitled to Medi-Cal or Medicaid benefits.

12.4. Binding Nature of this Agreement and Related Rules. By entering into this Agreement, you agree to accept all of its terms. You agree that the following constitute your agreement to be bound by this Agreement: (i) signing your Enrollment Form and giving it to us; and (ii) paying the required Membership Fee to us.

12.5 Returned Check Fee. If you pay your Membership Fee by check and the bank returns it to us for any reason, we will charge you $25.00.

12.6 Notices. Any notice required or permitted under this Agreement is given on the date deposited in the U.S. mail, certified, or registered, with return receipt requested and postage prepaid. A notice also is given on the date delivered personally to the party receiving it.

We will send notices to you at the address set forth on your Enrollment Form, which includes any email address you may have. Please notify us if you change your addresses (including email), by contacting us at our Toll-free Number or by sending us a written notice to the attention of Member Services at our address on page one of this Agreement.

12.7 Entire Agreement. This Agreement – together with your Enrollment Form and any applicable amendments or riders – constitutes the entire agreement between you and us with regard to the subject matter of this Agreement and supersedes all prior and contemporaneous agreements between you and us, whether written or oral.

12.8 Incorporation by Reference. Your enrollment form and all attachments to this Agreement – including each rider and amendment – are incorporated by reference into and made a part of this Agreement.

12.9 Amendments Only in Writing. This Agreement may not be amended or modified in any way except by a rider or amendment signed by us, except as this Agreement may otherwise expressly state.

12.10 Coordination of Benefits. The Plan does not coordinate benefits with other health plans or payers.

12.11 No Assignment by You. You may not assign any of your rights or delegate any of your duties under this Agreement without our written consent, except as expressly stated in this Agreement.

12.12 Successors and Assignees. All terms of this Agreement will bind you and all of your assignees, heirs, and personal representatives. All terms of this Agreement will bind us and all of our assignees and successors in interest.

12.13 Third Parties. Except as otherwise expressly stated in this Agreement, nothing in this Agreement will create any duty to, any standard of care with regard to, or any liability to anyone other than you or us.

12.14 Headings. The headings used in this Agreement are for ease of reference only and will have no effect on interpreting any provision of this Agreement.

12.15 Waivers. Any waiver of compliance with any term of this Agreement must be in writing and must be signed by the party making the waiver. If either you or we waive compliance with any term of this Agreement at any time, that waiver will not constitute either: (a) a waiver of the same term at any other time; or (b) a waiver of any other term at any time.

12.16 Severability. If any term of this Agreement is invalid or unenforceable under applicable law, the other terms of this Agreement will remain in full force and effect without any change.

12.17 Governing Law. California law shall govern this Agreement. We are subject to the Knox-Keene Health Care Service Plan Act of 1975, which begins with Section 1340 of the California Health and Safety Code, and the Rules issued under that Act, which begin with Section 1300.43 of Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by that Act or those Rules will bind us and you whether or not set forth in this Agreement.

12.18 Organ Donation. Organ donation provides you with the opportunity to save and enhance lives. Please consider becoming an organ and tissue donor. You can elect to become a donor by completing a form online at **www.organdonor.gov** or by contacting the Organ Donor Hotline at **1.800.24-DONOR**.

AMERICA'S BEST VISION PLAN
A BENEFIT PLAN PROVIDED *BY*
FIRSTSIGHT VISION SERVICES, INC.

By: _____
President