FIRSTSIGHT VISION SERVICES, INC.
1202 Monte Vista Avenue, Suite 17
Upland, California 91786
(800) 841-2790

www.firstsightvision.net

COMPREHENSIVE EYE EXAM MEMBERSHIP

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 FIRSTSIGHT COMPREHENSIVE EYE EXAMINATION MEMBERSHIP PLAN. 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.

UNIFORM HEALTH PLAN AND BENEFITS COVERAGE MATRIX:

CO-PAYMENTS AND DEDUCTIBLE:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE 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.

PREPAYMENT FEE: $ 51.00

DEDUCTIBLES:	NONE
LIFETIME MAXIMUM:	NONE
PROFESSIONAL SERVICES: COMPREHENSIVE EYE EXAM (includes dilated fundus exam, as indicated)	$ 7.00 Co-payment
Second eye exam	$ 10.00 Co-payment
Subsequent eye exams if your Plan Optometrist believes they are necessary	$10.00 Co-payment (for each eye exam)
CONTACT LENS EVALUATION AND FITTING (includes follow-up contact lens exams for 90 days)	
STANDARD	$ 38.00 Co-payment
COMPLEX (gas permeable, toric, bi-focal)	$ 63.00 Co-payment
Follow-up contact lens exams after 90 days from date of Contact Lens Evaluation and Fitting	$ 25.00 Co-payment for each follow-up exam

DEDUCTIBLES:	NONE
LIFETIME MAXIMUM:	NONE
PROFESSIONAL SERVICES: COMPREHENSIVE EYE EXAM (includes dilated fundus exam, as indicated)	$ 7.00 Co-payment
Second eye exam	$ 10.00 Co-payment
Subsequent eye exams if your Plan Optometrist believes they are necessary	$10.00 Co-payment (for each eye exam)
CONTACT LENS EVALUATION AND FITTING (includes follow-up contact lens exams for 90 days)	
STANDARD	$ 38.00 Co-payment
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COMPREHENSIVE EYE EXAMINATION MEMBERSHIP PLAN

INDIVIDUAL SERVICES AGREEMENT AND EVIDENCE OF COVERAGE FOR VISION CARE BENEFITS

Welcome to FirstSight Vision Services, Inc. ("FirstSight" or the "Plan"). This Individual Services Agreement and Evidence of Coverage for Vision Care Benefits (this "Agreement") describes the vision care Benefits available to FirstSight Members. We provide comprehensive eye exams, contact lens evaluation and fittings, and follow-up exams as Covered Services under this Comprehensive Eye Examination Membership Plan.

To become a Member, call to schedule an appointment or visit any FirstSight office. When you give us your signed Enrollment Form along with the required Premium, you become an enrolled Member and can receive Benefits under this Agreement.

You may receive a copy of this Agreement upon request. Please read this Agreement carefully so that you will understand all of our duties and all of your responsibilities.

Table of Contents:

1. Definitions.

This Agreement uses the following defined terms:

1.1 AGREEMENT: This Individual Services Agreement and Evidence of Coverage for VISION CARE BENEFITS for the Comprehensive Eye Examination Membership Plan.

1.2 BENEFITS and COVERAGE: The health services available to Members upon enrollment and under the Plan contract.

1.3 CO-PAYMENT: The cost a Member is required to pay to the Plan at the time services are rendered for the specific services, which cost is in addition to your Premium. Section 2.1 lists the Co-payments that apply under this Agreement.

1.4 EXCLUSION: Those services and products that are not provided as Benefits or Coverage to Members.

1.5 ENROLLMENT FORM: The form that you complete in order to become a Member.

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

1.7 MEMBER: An individual who is enrolled in the Plan and entitled to receive eye care Benefits under this Agreement.

1.8 MEMBERSHIP PERIOD: The one-year term that begins on the date you enroll in the Plan and pay your required Premium, and terminates 365 days later.

1.9 PLAN OPTOMETRIST: A licensed optometrist who provides the eye care Benefits under this Agreement.

1.10 PREMIUM: The annual pre-payment fee you pay that, when provided with your Enrollment Form, entitles you to the Benefits of the membership plan you have chosen.

1.11 PROVIDER DIRECTORY: A list of the Plan Optometrists or locations available to you.

1.12 REFERRAL OPHTHALMOLOGIST: An ophthalmologist who has agreed with us to accept referrals of Members from Plan Optometrists.

1.13 SERVICE AREA: The geographic area in which we provide or arrange eye care Benefits under this Agreement.

1.14 WE, US and OUR: Refers to FirstSight Visions Services, Inc.

1.15 YOU and YOUR: Refers to you, the individual who is or becomes a Plan Member.

2. Your Membership Benefits.

2.1 <u>Principal Benefits and Coverage.</u> As a Member, you are entitled to receive the following benefits from a Plan Optometrist during your Membership Period. You must receive each of the products and services from a Plan Optometrist and pay the required Co-payment. The Provider Directory lists the locations of the Plan offices.

COMPREHENSIVE EYE EXAM MEMBERSHIP	PREMIUM: $51
BENEFITS	**ADDITIONAL CHARGES**
COMPREHENSIVE EYE EXAM	
You are entitled to receive one comprehensive eye exam, which includes a dilated fundus examination ("DFE" or "dilation"), if your Plan Optometrist deems it necessary. Dilation is the procedure of inserting drops into your eyes to dilate them in order to conduct a more extensive evaluation of the interior structure of the eye.	$ 7.00 Co-payment
At your request, you are entitled to receive a second eye exam.	$10.00 Co-payment
You may receive additional eye exams if your Plan Optometrist believes it is necessary.	$10.00 Co-payment for each additional eye exam.

COMPREHENSIVE EYE EXAM MEMBERSHIP	CONTINUED
BENEFITS	**ADDITIONAL CHARGES**
CONTACT LENS EVALUATION AND FITTING	
You are entitled to receive one contact lens evaluation and fitting within 90 days after you receive your first comprehensive eye exam.	$38.00 Co-payment for a standard contact lens evaluation and fitting. The Co-payment for a complex contact lens evaluation and fitting (gas permeable, toric, or bifocal contact lenses) is $63.00.
You may receive follow-up contact lens exams after the end of the 90-day period described above if your Plan Optometrist believes it is necessary.	$25.00 Co-payment for each follow-up contact lens exam provided after the end of the 90-day period.
REFERRALS	
If your Plan Optometrist believes you need to see another health care provider, your Plan Optometrist will use his or her best efforts to make a referral. This may include a referral to a Referral Ophthalmologist.	You must pay for all services you receive from another health care provider. This includes all services you receive from a Referral Ophthalmologist.
ADDITIONAL SERVICES AND PRODUCTS	
Additional ophthalmic products and services will be available upon request, at your FirstSight office. As a Member, you will also have access to any FirstSight promotions offered to Members of your Membership Plan.	Prices vary.

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

2.2 Exclusions and Limitations.

(a) Services We Will Not Provide. Your membership entitles you to only the Benefits described above in this Agreement. Your membership does not include services provided by an optometrist, ophthalmologist, or other professional provider who is not an employed or contracted Plan provider and you will not be reimbursed for those services. Any additional, non-covered services or products that your Plan Optometrist may recommend or you may request are not a part of this plan. For example, your membership does not include services:

- For anyone other than you;
- Provided before or after your Membership Period; or
- That are not part of a comprehensive eye exam, contact lens evaluation and fitting or follow-up 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;
  - For prolonged occlusion tests to aid special remedial care or a diagnosis of strabismus; or
  - For medical or surgical treatment of your eyes, which is legally outside of the scope of an optometrist's practice.

Your membership provides you with access to other FirstSight services and products. You may choose to purchase those additional services and products but you will be responsible for paying for any additional charges and fees associated with them.

We will not provide, arrange, or pay for the services of a health care provider other than a Plan Optometrist. A Plan Optometrist may refer you to another health care provider, including an ophthalmologist, but you must pay for all services that you receive. This includes services that you receive from a Referral Ophthalmologist.

2.3 Effective Dates of Coverage. We will provide coverage to you beginning on the day we receive your signed Enrollment Form and the required annual Premium. Your coverage will last for one year, unless this Agreement ends before then. Section 10 discusses when this Agreement may end. If you have a valid, unexpired eyeglass prescription, your coverage that allows you to purchase additional ophthalmic materials or services will continue for up to an additional one-year period.

3. How to Use Your Benefits.

During the year for which you pay the required Premium, you are entitled to receive a comprehensive eye exam with dilation, if indicated, a contact lens evaluation and fitting, and follow-up exams. You must receive each exam from a Plan Optometrist and pay the required Co-payment. You may receive an exam from any Plan Optometrist. The Provider Directory lists the Plan locations available to you.

3.1 Comprehensive Eye Exams. To receive a comprehensive eye exam (which includes dilation when your Plan Optometrist deems it necessary), you must schedule an appointment with a Plan Optometrist. Some offices will allow you to "walk-in" to receive an exam. Please understand, however, that: we cannot guarantee that an appointment will be available; and Members with scheduled appointments will be seen first. Your Plan Optometrist will provide the tests and procedures required by professionally recognized standards of practice.

If you need an eyeglass prescription, your Plan Optometrist will give you a copy of the prescription. You must buy your eyeglasses (frames or lenses) yourself and you may buy them from anyone you choose, including FirstSight. Your Plan Membership allows you to purchase the frames, lenses, and other products at FirstSight for the prices listed. You also can participate in any promotions that FirstSight might offer to Members of your Membership Plan.

At your request, you are entitled to receive a second eye exam at any time during the year and your Plan Optometrist will provide it. You must schedule an appointment with your Plan Optometrist and you must pay the required Co-payment.

If your Plan Optometrist believes you need an eye exam other than the first or second one, he or she will tell you. Your Plan Optometrist will schedule the exam with you and you must pay the required Co-payment for each subsequent eye exam. You may receive an additional eye exam only if your Plan Optometrist believes it is necessary, in his or her professional judgment.

3.2 Contact Lens Evaluation and Fitting. To receive a contact lens evaluation and fitting, you must schedule an appointment with your Plan Optometrist. You must receive this evaluation and fitting within 90 days after you receive your first comprehensive eye exam. Your Plan Optometrist will provide the tests and procedures required by professionally recognized standards of practice. You must pay the required Co-payment for a standard contact lens evaluation and fitting. If your evaluation and fitting is complex – gas permeable, toric, or bifocal contact lenses – your Co-payment will be higher. You must purchase your contact lenses yourself at FirstSight or another provider of your choice.

Once you have purchased and received your contact lenses, you should see your Plan Optometrist. You are entitled to follow-up contact lens exams for up to 90 days after your initial contact lens evaluation and fitting. You must schedule the follow-up exams with your Plan Optometrist and there is no Co-payment charged.

If your Plan Optometrist believes you need a follow-up contact lens exam after the end of this 90-day period, he or she will tell you. Your Plan Optometrist will schedule the follow-up exams with you, and you must pay your Co-payment for each follow-up contact lens exam provided after the end of the 90-day period. You may receive additional follow-up contact lens exams only if your Plan Optometrist believes it is necessary, in his or her professional judgment.

3.3. Referrals. Your Plan Optometrist will tell you if, in his or her professional judgment, you should see another health care provider. Your Plan Optometrist 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 Plan Optometrist will try to coordinate the referral through your PCP. If you need to see an ophthalmologist and you do not have a PCP, your Plan Optometrist will give you a list of Referral Ophthalmologists.

The Referral Ophthalmologists have agreed to receive referrals from the Plan Optometrists. If you have an Emergency, they have agreed to provide telephone service 24-hours a day. The Referral Ophthalmologists also have agreed with us that they will not charge you more than their usual and customary fees.

You must pay for all services you receive from any other health care provider. This includes all services you receive from a Referral Ophthalmologist.

3.4 Second Opinions. If you would like a second opinion about a prescription or a referral made by your Plan Optometrist, you may request and receive an additional eye exam from another Plan Optometrist. You must pay the Co-payment required for the additional eye exam.

4. Prepayment Fees (Premiums).

You must include payment for one year's Premium with your Enrollment Form when you give it to us. You may provide payment by check, cash, or an authorized credit card. We will not change your Premium during your one-year Membership Period.

5. Co-payments and Other Charges.

5.1 Payment of Co-payments by You. You must pay us the Co-payment that applies for the services or goods you receive at the time you receive them.

5.2 Payment of Other Charges by You. You must pay for all services and goods other than the Benefits that we cover under this Agreement. This includes payment for services from anyone other than a Plan Optometrist, even if a Plan Optometrist refers you for those services. It also includes payment for eyeglasses (frames or lenses) or contact lenses if your Membership Plan does not include an eyeglass or contact lens Benefit. If your Membership Plan has an eyeglass or contact lens Benefit, you must pay any additional charges for frames, lenses, and enhancements not covered as Benefits, which you may choose.

6. What to Do If You Receive a Bill.

You must pay all Co-payments that apply for any services that you receive under this Agreement. You should not receive a bill for any other amount for a Benefit that you receive from a Plan Optometrist under the terms of this Agreement. If you receive a bill and you do not believe you owe the sums set forth on the bill, please send it to us at:

FirstSight Vision Services, Inc.
1202 Monte Vista Ave., Suite 17
Upland, California 91786
Attention: Member Services

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

7. Choice of Optometrists; Facilities.

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

You must receive your vision care Benefits at a FirstSight office or from a Plan Optometrist. Our Provider Directory lists the FirstSight office locations available to you. Office hours may vary by location. You may call us at **1-800-841-2790** for information about locations and hours of the FirstSight offices.

We will honor your request to see a particular Plan Optometrist to the extent possible. If the requested Plan Optometrist is not available, however, we will refer you to an available Plan Optometrist.

If a Plan Optometrist's contract with the Plan is terminated, we will be responsible for the Benefits provided to you by the terminated Plan Optometrist, other than for co-payments or excluded services. You must remain an eligible Member at the time of the termination, however, until the Benefits being provided to you by the Plan Optometrist are completed. We can make reasonable and appropriate provisions for another Plan Optometrist to assume those services. Plan Optometrists are employed by FirstSight. We typically pay our Plan Optometrists on a salaried or hourly basis. We may provide incentive compensation plans or pay a bonus to Plan Optometrists. We will not pay a bonus to anyone to deny, reduce, limit, or delay the provision of an eye exam. If you would like to know more about these arrangements, you may request additional information from us or from your Plan Optometrist.

We provide or arrange eye exams only in a specific geographic area, known as our Service Area. All of the Plan Optometrists are located in our Service Area.

8. Your Responsibilities.

You have certain responsibilities under this Agreement. You must comply with all of the terms of this Agreement which require you to take or prohibit you from taking specific actions. This includes, for example, paying the Premium and paying the Co-payments and other charges that apply. Please see Sections 4 and 5 of this Agreement. You are also responsible for following the Plan Optometrist's directions and orders regarding your vision care, including following up with any exams or recommended referrals.

9. Our Responsibilities.

9.1 Vision Care. If you pay your Premium and you follow the terms of this Agreement, we will provide you with the vision care services or products that we have agreed to provide to you.

9.2 Renewal Provisions. We will renew this Agreement if you pay your annual Premium and we do not have good cause to end (terminate) it. We may change the Premium or the Benefits at the time of renewal.

9.4 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 Plan Optometrist's office to determine whether to schedule an appointment or be referred to the nearest emergency facility. You should go immediately to the emergency room nearest you if your emergency occurs after business hours. FirstSight does not provide or pay for emergency services and care other than appointments that may be scheduled with a Plan Optometrist at a Plan location during normal business hours.

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

10. Rights of Cancellation and Termination of Benefits.

10.1 End of Year. When you pay your annual Premium, you become entitled to receive the services or products associated with your membership, for your Membership Period, with the payment of any applicable Co-payments. After one year, your right to receive these Benefits will not continue. At the end of the year, you must pay an additional annual Premium to us in order to renew your membership.

10.2 Good Cause.

(a) Fraud or Deception in the Use of Services or Facilities.

We may end (terminate) this Agreement or refuse to renew your contract if you engage in fraud or deception in the use of 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 identification card.

(b) Other Good Cause. We may end this Agreement if:

(i) You fail to pay a required Co-payment within 15 days after your Plan Optometrist tells you in writing of the amount you owe;

(ii) Your repeated behavior substantially impairs the Plan's ability to provide services to other patients; or

(iii) You threaten to harm us or any of our employees or a Plan Optometrist or any of his or her employees.

We will tell you in a written notice if we end this Agreement. The notice will set forth our reason and the date on which this Agreement will end. In general, the notice will be effective 15 days after mailing the notice to you. We may make the notice effective on the date mailed if we end this Agreement for fraud or deception in the use of services or facilities.

10.3 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.

10.4 Effects of End of this Agreement. If this Agreement ends for any reason, our obligation to provide or arrange a comprehensive eye exam, subsequent eye exam, contact lens evaluation and fitting, follow-up exams or eyeglasses for you will end on that date. You must pay for all eye exams or eyeglasses that you receive after that date.

If you or we end this Agreement, we will return to you, within 30 days, the pro-rata portion of the Premium you paid which corresponds to Benefits you have not received, less any amounts you owe to us. We will not return any Premium to you if we end this Agreement for fraud or deception in the use of our services or facilities, or your knowingly permitting another person to use your membership card or engage in fraud or deception to receive our services.

10.5 Your Right to Review. If you allege that we have ended this Agreement based on your health status or need or requirements for eye exams or eyeglasses, 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 11, but we do not require that you do so.

11. Grievance Procedures.

If you have a complaint or suggestion under this Agreement, please let us know so that we can promptly resolve it. This may include a complaint about a Plan Optometrist, the quality of the care

you receive, or services you did not receive. It also may include a complaint about a referral or any other issue you think is important.

To contact us about any questions, disputes, or complaints, please call us at **1-800-841-2790** or write to us at:

FirstSight Vision Services, Inc.
1202 Monte Vista Avenue, Suite 17
Upland, California 91786
Attention: Member Services

We will work with you to resolve your complaint in accordance with our established grievance procedures. You may file a verbal grievance by calling the telephone number listed above. You may also complete a written complaint form and mail or deliver it to the Director of Quality Assurance at the address above. You can obtain a form from any FirstSight office or from the FirstSight website: www.firstsightvision.net. Personnel at our headquarters, each optometric office, or at the telephone number above will be available to assist you in completing the form.

We will acknowledge receipt of your written grievance within five (5) days and will notify you in writing of our resolution within thirty (30) days from the date we receive your complaint. 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 of the complaint's receipt.

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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.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.

12. 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.

13. General Provisions.

13.1 Termination of Providers; Certain Notices. If you are scheduled to receive a comprehensive eye exam, contact lens evaluation and fitting, or follow-up exam from a Plan Op-

tometrist who is no longer associated with the Plan at the time of your appointment, we will schedule you with another Plan Optometrist at the same location.

13.2 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, sexual orientation, or age of any party to this Agreement or any person we reasonably expect will benefit from this Agreement.

13.3 No Refusal Based Upon Physical or Mental Impairment. We will not refuse to cover or refuse to renew coverage, limit the amount, extent, or kind of coverage available to you, or charge a different Premium solely because of a physical or mental impairment unless based on sound actuarial principles applied to actual experience or sound underwriting practices.

13.4 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.

13.5. Availability of Guidelines. We have adopted practice guidelines that we use to help us and our Plan Optometrists determine whether additional eye exams are called for. We would be pleased to provide copies of each of the practice guidelines to you (or to anyone you designate), upon request. You should mail requests to the Member Services Department, at the address indicated in Section 13.8 of this Agreement.

13.6 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) making the required Premium payment to us. We may adopt reasonable rules and policies to achieve the goals of this Agreement. You agree to be bound by those rules and policies.

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

13.8 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. You may change your address by giving us written notice at least ten (10) days before the change takes effect.

You will send notices to us at:
FirstSight Vision Services, Inc.
1202 Monte Vista Avenue, Suite 17
Upland, California 91786
Attention: Member Services

We may change this address by giving you written notice at least ten (10) days before the change takes effect.

13.9 Entire Agreement. This Agreement – together with your Enrollment Form – 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.

13.10 Incorporation by Reference. All attachments to this Agreement – including every Appendix –and your Enrollment Form are incorporated by reference into this Agreement.

13.11 Amendments Only in Writing. Except as otherwise expressly stated in this Agreement, this Agreement may not be amended or modified in any way except by an endorsement or amendment signed by us.

13.12 Permitted Assignment by FirstSight Vision Services, Inc. FirstSight Vision Services, Inc., in its sole and absolute discretion, may assign its rights and delegate its duties under this Agreement to any corporation which controls, is controlled by, or is under common control with FirstSight Vision Services, Inc. or to any successor in interest to FirstSight Vision Services, Inc., whether by merger or otherwise, to the extent permitted under the Knox-Keene Health Care Service Plan Act of 1975 or any successor to that law.

13.13 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 specifically set forth in this Agreement.

13.14 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.

13.15 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.

13.16 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.

13.17 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.

13.18 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.

13.19 Confidentiality of Medical Records. A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

13.20 Governing Law. This Agreement shall be governed by California law. We are subject to the Knox-Keene Health Care Service Plan Act of 1975, which begins with Section 1340 of the Health and Safety Code, and the Rules of the Director of the Department of Managed Health Care 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.

13.21 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**.

FIRSTSIGHT VISION SERVICES, INC.

By: _____
President

FIRSTSIGHT VISION SERVICES, INC.

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-800-841-2790 . Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un interprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un interprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1-800-841-2790 . Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 1-888-466-2219. (Spanish)

重要提示：您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或索查詢中文書面資料，請先致電您的保健計畫，電話號碼： 1-800-841-2790 。請粵語或國語人士將爲您提供協助。
如需更多協助，請致電 HMO 協助中心 1-888-466-2219。 (Cantonese or Mandarin)

هام: يمكن الحصول على خدمات مترجم مجانا للتحدث مع طبيبك أو الخطة الصحية، للحصول على مترجم أو طلب معلومات مكتوبة باللغة العربية أولا اتصل برقم الهاتف الخاص بالخطة الصحية 1-800-841-2790 ، وسيساعدك شخص يتحدث باللغة العربية، وإذا كنت بحاجة إلى مزيد من المساعدة، فاتصل بمركز مساعدة HMO على الرقم 1-888-466-2219. (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿՈՒԹՅՈՒՆ. Դուք կարող եք խոսել Ձեր բժշկի կամ առողջապահական ծրագրի հետ՝ օգտվելով թարգմանչի ծառայություններից առանց որևէ վճարի: Թարգմանիչ ունենալու կամ հայերենով գրավոր տեղեկություն ստանձնելու համար նախ զանգահարե՛ք առողջապահական ծրագրի հեռախոսահամարով՝ 1-800-841-2790 : Ձանկացած մեկը, ով խոսում է հայերեն, կարող է օգնել Ձեզ: Եթե Ձեզ լրացուցիչ օգնություն է անհրաժեշտ, ապա զանգահարե՛ք Առողջապահական Օժանդակության Կազմակերպության Օգնության Կենտրոն՝ 1 888 466 2219: (Armenian)

ចំណាំ: បោកអ្នកអាចទទួលបានអ្នកបកប្រែជាំពៅ ដើម្បីនិយាយជាមួយគ្រូពេទ្យរបស់អ្នក ឬដើម្បីសុំព័ត៌មានជាលាយលក្ខណ៍អក្សរជាភាសាខ្មែរ ។ ដើម្បី ទទួលបានអ្នកបកប្រែជាំពៅ ឬសួរអំពីព័ត៌មានជាលាយលក្ខណ៍អក្សរជាភាសាខ្មែរ សូមបោកអ្នកទូរស័ព្ទទៅកាន់លេខទូរស័ព្ទនៅលើកាតសុខភាពរបស់បោកអ្នក តាមរយៈលេខ 1-800-841-2790 ជាមុនសិន ។ អ្នកមីយាយភាសាខ្មែរ អាចជួយបោកអ្នកបាន ។ ប្រសិនបើបោកអ្នកត្រូវការជំនួយបន្ថែម សូមទូរស័ព្ទមកកាន់មជ្ឈមណ្ឌលជំនួយរបស់អង្គការថែទាំសុខភាព (HMO) តាមរយៈលេខ 1-888-466-2219 ។ (Khmer)

مهم: شما می توانید برای گفتگو با پزشک تان یا طرح بهد شتی بطور رایگان یک مترجم را بدست بیاورید. بمنظور کسب یک مترجم یا تقاضا دربارهٔ اطلاعات کتبی بزبان فارسی، اول به این شماره تلفن 1-800-841-2790 به طرح بهداشتی ای زنگ بزنید. کسی که بفارسی حرف می زند می تو ند بشما کمک بکند. گر شما حتیاج به کمک بیشتری د رید، به این شمارهٔ مرکز کمک HMO 1-888-466-2219 تماس بگیرید. (Farsi)

TSEEM CEEB: Muaj tus neeg txhais lus pub dawb rau koj kom koj tham tau nrog koj tus kws kho mob los yog nrog lub chaw pab them nqi kho mob rau koj. Yog xav tau ib tug neeg txhais lus los yog xav nug txog tej ntaub ntawv sau ua lus Hmoob, xub hu rau koj lub chaw pab them nqi kho mob tus xov tooj ntawm 1-800-841-2790 . Yuav muaj ib tug neeg hais lus Hmoob pab tau koj. Yog koj xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Txais Tos Pab Neeg ntawm 1-888-466-2219. (Hmong)

중요: 의사나 건강 플랜에 이야기할 때 무료로 통역사를 이용할 수 있습니다. 통역사를 이용하거나 한국어로 된 서면 정보에 관해 문의하려면 먼저 건강 플랜 1-800-841-2790 로 전화하십시오. 한국어 구사자가 도와 드릴 수 있습니다. 더 도움이 필요하면 HMO 헬프 센터 1-888-466-2219로 전화하십시오. (Korean)

ສິ່ງສຳຄັນ: ທ່ານສາມາດຫາໃຫ້ແປພາສາໆໂດຍບໍ່ເສຍຄ່າໃນການລົມກັບທ່ານໝໍ ຫລື ແຜນສຸຂະພາບ. ເພື່ອຫາຜູ້ແປພາສາ ຫລື ຖາມກ່ຽວກັບຂໍ້ມູນເປັນລາຍລັກອັກສອນພາສາລາວ, ກ່ອນອື່ນໝົດໃຫ້ຫາເບີໂທຂອງແຜນສຸຂະພາບຂອງທ່ານທີ່ໝາຍເລກ 1-800-841-2790 . ຜູ້ທີ່ສາມາດເວົ້າພາສາລາວຈະຊ່ວຍເຈົ້າໄດ້. ຖ້າຫາກເຈົ້າຕ້ອງການຄວາມຊ່ວຍເຫລືອເພີ່ມເຕີມໃຫ້ໂທຫາສູນຊ່ວຍເຫລືອ HMO ທີ່ໝາຍເລກ 1-888-466-2219. (Lao)

ВАЖНО: Вы можете бесплатно воспользоваться услугами переводчика во время обращения к врачу или в страховой план. Чтобы запросить переводчика или спросить о наличии печатных материалов на русском языке, позвоните в свой страховой план по телефону 1-800-841-2790 . Вам окажет помощь русскоговорящий сотрудник. Если вам нужна помощь в других вопросах, позвоните в справочный центр Организации медицинского обеспечения (HMO) по телефону 1-888-466-2219. (Russian)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o sa planong pangkalusugan. Upang makakuha ng isang tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa Tagalog, mangyaring tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 1-800-841-2790 . Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng dagdag na tulong, tawagan ang Sentro na Tumutulong ng HMO sa 1-888-466-2219. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể nhận được dịch vụ thông dịch miễn phí khi khám tại bác sĩ hoặc khi liên hệ với chương trình bảo hiểm sức khỏe của quý vị. Để nhận được dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt, trước tiên hãy gọi số điện thoại chương trình bảo hiểm sức khỏe của quý vị theo số 1-800-841-2790 . Sẽ có người nói được tiếng Việt để giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, hãy gọi Trung tâm Hỗ trợ HMO theo số 1-888-466-2219. (Vietnamese)