VISION PLAN OF AMERICA
Provider Agreement

This Provider Agreement (the "Agreement") is made and entered into this ____ day of _____, 20____ by and between Vision Plan of America, a California corporation (the "Plan"), and _____ _____ the ("Provider"), with reference to the following facts.

(I) The Plan and the Provider are desirous of cooperating in establishing a system of vision care services, committed to the advancement of patient care and to the development of innovative approaches for delivery of vision care services.

(II) In furtherance of the above, the Plan is undertaking to enroll subscribers and/or members and will offer each subscriber and/or member an option to select for themselves and their family dependents a Provider affiliated with the Plan, who will provide primary vision care.

THEREFORE, is consideration of the mutual covenants and agreements herein contained, and for other good and valuable consideration, the parties hereby agree as follows:

1. DEFINITIONS:

For purposes of the Agreement, the terms set forth herein shall have the meanings described below: except where it is clear that the context indicates that such meanings are not intended. In the event a disagreement arises with regard to the definition of any term which has been defined by the California Knox-Keene Care Service Plan Act of 1975, as amended (the "Act"), the parties agree to make reference to the Act in order to resolve those disputes:

(a) Benefits and Coverage: Vision Care services available under the Group or Individual Subscriber Agreement in which member is enrolled.

(b) Child: All natural, adopted, foster, and stepchildren.

(c) Co-payment: An additional fee charged to a subscriber and/or member which is approved by the Department of Manage Health Care who regulated the Plan pursuant to the Knox-Keene Act, provided for in the Plan contract and disclosed in the Evidence of Coverage/Disclosure Form.

(d) Provider Facilities: Centers selected by the Plan to provide vision care services.

(e) Vision Care Services: The professional vision care services to which subscribers and/or members are entitled pursuant to the Group or Individual Subscriber Agreement. These professional services include: Comprehensive Eye Analysis, Cataract Test, Auto Refraction (where available), Glaucoma Test, Refraction, Dilation (as needed) and, if desired, Contact Lens Evaluation and Fitting.

(f) Materials: Ophthalmic Lenses, Ophthalmic Frames, Contact Lenses and Medically Necessary Contact Lenses (where indicated and upon approval).

(g) Dependent:

(1) The subscriber's lawful spouse.
(2) A child of the subscriber up to the child's 26th birthday.
(3) Any otherwise eligible child of the subscriber, regardless of age, who is wholly dependent upon the subscriber for support because of mental retardation or physical handicap.

(h) Emergency Services: Provider shall provide the following limited emergency services during usual business hours to Plan Members on an expedited basis: repair or replacement of broken eyeglass frames or lenses, or torn or lost contact lenses.

(i) Evidence of Coverage/Disclosure Form: The document provided to a subscriber and/or member, which sets forth the benefits and coverage to which the subscriber and/or member is entitled and the terms of

the Group or Individual Subscriber Agreement to afford subscriber and/or member with a full and fair disclosure of the provisions of the Plan in readily understood language and in a clearly organized manner.

(j) Member: Any subscriber or dependent, as defined above, who is enrolled under the Group or Individual subscriber Agreement and who is entitled to the benefits and coverage made available under the Group or Individual subscriber Agreement in return for the payment required to be made to the Plan under such Agreement.

(k) Participating Provider: Provider selected by the Plan to provide vision care services for subscribers and/or members.

(l) Plan: Vision Plan of America.

(m) Plan Provider: Providers of vision care services licensed by the State to provide these services who have contracted with the Plan to render services to subscribers and/or members in accordance with the Group or Individual Subscriber Agreement. The names, locations, hour or services and other information regarding plan Providers may be obtained by contacting the Plan office.

(n) Prepayment Fee: The amount payable each month by the subscriber group or annually by the individual subscriber to obtain benefits and coverage provided under the Group or Individual Subscriber Agreement.

(o) Designated Provider: The Plan Provider chosen by the subscriber and/or members and designated by the Plan to be responsible for the general vision care of the subscriber/or member and their dependents, and who is receiving the consideration provided for hereunder for the vision care of such subscriber and/or member. All family members must choose the same Designated Provider.

(p) Specialist: A doctor who is responsible for specific specialized medical care of a subscriber and/or member, when such subscriber and/or member is referred by a participating Provider affiliated with the Plan.

(q) Subscriber: The person who has entered into the Individual Subscriber Agreement and who is responsible for payment to the Plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the Plan.

(r) Subscriber Group: The organization or company which has entered into a Group subscriber Agreement with the Plan under which benefits and coverage are made available to eligible group members and their dependents.

(s) Subscriber Agreement: The applicable Individual or Group Subscriber Agreement under which any subscriber and/or member is entitled to specified vision care services to be provided pursuant to enrollment in the Plan.

(t) Surcharge: An additional fee which is charged to the subscriber and/or member for covered service but which is not approved by the Department of Manage Health Care, provided for in the Plan contract and disclosed in the Evidence of Coverage/Disclosure Form used as Evidence of Coverage.

(u) Subscription Cost: The charge paid by or on behalf of subscriber or member in order to enroll the subscriber and/or member and their dependents in the Plan.

(v) Fee For Service Charge: The amount which a Plan Provider normally or usually charges his patients who are not members of a Prepaid Vision Plan or Preferred Provider Plan, for a particular service.

(w) Capitation: The portion of the monthly or annual member premium paid to the provider, on a monthly basis for the delivery of vision services.

2. SERVICES PROVIDED BY PROVIDER: COMPENSATION:

(a) Appointment: The Plan desires to appoint Provider as a Designated Provider to provide the appropriate vision care service described in the Individual and Group Subscriber and/or members for whom Providers is responsible as designated by the Plan and Provider hereby accepts such appointments.

(b) Compensation: In consideration of the performance by Provider of all Vision Care Services required to be provided pursuant to the Individual or Group Subscriber Agreement to each subscriber and/or member for

whom Provider has been designated. Provider agrees to accept as full payment from the Plan a portion of the premium as capitation, based upon the following factors:

i. Plan types: Plan A (12.12.12.); Plan B (12.12.24); Plan C (12.24.24); Plan MQ-2 and M-PLUS (Co-payment based plans)
ii. Frame allowance from $30.00 to $120.00 (retail allowance)
iii. Co-Payments toward the eye examination and/or materials, whichever occurs first, from 0 to $50.00.
iv. Other Adjustments: the capitation percentage is affected based upon the following factors:
    1) Voluntary groups – add 10%

Sample: (Illustration only)

The following is a sample of the minimum rate paid for some of the most popular plans by percentage of the premium:

- *Plan A – with a 0 co-payment …… 50%*
- *Plan A – with a $50.00 co-payment …….. 20%*
- *Plan B – with a 0 co-payment …… 39%*
- *Plan B – with a $50.00 co-payment …….. 15%*
- *Plan C – with a 0 co-payment …… 30%*
- *Plan C – with a $40.00 co-payment …….. 18%*
- *Plan MQ-2 and M-PLUS (co-payment based plans)*
  - with premiums of > $3.00 per subscriber….15%

In addition to the appropriate co-payments paid directly to the Provider by the Individual or Group Subscriber Member. The payment by the Plan to the Provider will be made monthly and will continue as long as member/subscriber is in good standing with the Plan.

(c) Sole Remedy Against Plan: Provider agrees that should the Plan fail to pay for vision care service, his sole remedy will be against the Plan and not the Subscriber and/or member. 1300.67.8(e). 1300.67.4(a)(10).

(d) Substitute Provider: If for any reason Provider is to be absent for an extended period of time, Provider shall be responsible for the entire fee-for-service payment to the substitute for the service rendered. Substitutes who provide services to subscribers and/or members more than three times in a 12 month period must have entered into Provider contracts with the Plan.1300.67.0.

(e) Specialist: In the event a problem arises which is not within the scope of knowledge, experience or ability of Provider, or is questionable as to whether the problem is within the scope of Provider's knowledge, experience or ability, or is a medical problem which should be treated by a Specialist, Provider is obligated under this Agreement to refer the patient to a Specialist or, if the member is covered by a medical benefits program requiring referral through the primary care physician, to refer the member to such physician. Provider should refer the patient to a Specialist who is a contracting Provider with the Plan or if the member is covered by a medical benefits program requiring referral the primary care physician. Provider shall refer the Member to the primary care physician prior to any referral; Provider may request review of the case by the Plan Medical Director. The Medical Director will consult with the Provider in order to review the basis upon which referral to a Specialist should be made. If it has been determined by Provider or the Medical Director that a specialist is required for treatment of a subscriber and/or member, Provider shall arrange for the services of such Specialist or shall request the member's primary care physician to follow the require procedures of the medical benefits program. In the event there is a dispute between the Medical Director and the Provider or a subscriber and/or member, the Quality Assurance Committee shall make the final determinations to whether the patient should be referred to a Specialist within five days of non-emergency situations. In emergency situations, referral shall be deemed appropriate in all cases. The Plan shall notify the subscriber and/or member immediately of each decision.

(f) Change In Terms Benefits and Coverage: It is specifically understood that the terms and/or benefits and coverage under the Individual and/or Group subscriber Agreements may be changed from time to time

during the term of this agreement. Plan agrees to notify Provider in writing of the nature and extent of such changes. Unless within thirty (30) days after receipt of such notification. Provider notifies plan in writing that he declines to provide vision care services to subscriber and/or members under these new subscriber agreements. Provider agrees to continue to perform vision care services as modified subscriber agreements and the Agreement shall be deemed amended in accordance with these modifications.

(g) Non-Exclusion: This Agreement is not exclusive in any respect. The Plan, subscriber group or individual subscriber and/or member is entitled to enter into similar contracts with other Providers and Provider is free to enter into similar agreements with other parties or with other groups not affiliated with Plan and to maintain his private practice.

(h) Independent Contractor: Provider shall maintain the Doctor-Patient relationship with the subscriber and/or member and shall be solely responsible to the patient for Eye care advice and treatment. It is expressly agreed between the parties that Provider is an independent contractor and that neither, the Plan Subscriber Group, nor Individual Subscriber and/or member shall have any dominion or control over Provider's practice, Doctor-Patient relationship, Provider facilities.

3. COVENANTS OF THE PROVIDER:

(a) To use his or her best efforts in rendering high quality vision care services and accepted Eye care practices prevailing from time to time in the State of California and to provide primary vision care within the scope of their practice.

(b) To provide for the availability of vision care services at such times as shall be necessary and practical for the prompt and proper rendition thereof.

(c) To cooperate and communicate freely with other persons caring for the subscriber and/or member, to integrate his records with the records or other Providers associated with the Plan and to provide all necessary information and data requested by the plan or its Provider, including, if requested, access by the Plan to records of his financial condition, and to release certain information to the non-custodial parent of a covered child if necessary.

(d) To remain solely and absolutely responsible for all vision care services and advice performed or prescribed by him or her, and to maintain the Doctor-patient relationship without improper interference by the Plan or any persons affiliated with it subject to paragraphs 3(g) and 3(f) below.

(e) To maintain such records and provide such information to the Plan or to the California Department of Managed Health Care, as may be necessary for compliance by the Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated hereunder. Such record shall be retained for at least five (5) years. Provider further agrees that this obligation is not terminated upon termination of this Agreement, whether by recession or otherwise 1300.67.8(b). The provider agrees to protect the security of confidential medical information and will release medical information to a county coroner in specified circumstances.

(f) To provide to the Plan, at all reasonable times and upon demand, access to the books, records and documents of Provider relating to the vision care services provided to subscribers and/or members, to the cost of such services, and to payments received by Provider from subscribers and/or members or from others on their behalf 1300.67.8(c)

(g) To participate in the Quality Assurance System developed from time to time by the Plan in its sole discretion, the primary purpose of which shall be to evaluate the quality of the services provided to subscribers and/or members and to ensure that such services conform to the standards of quality vision care establishes by the Plan and the members of the Quality Review Committee.

(h) To cooperate with and participate in the Plan's Grievance Program and to have available at Provider's office both a copy of the Plan grievance procedures and grievance forms for subscribers and/or

members. To forward to the Plan a copy of all complaints received from Plan members, even if Provider resolved such complaint to the subscribers and/or member's satisfaction.

(i) To hold open for inspection by the California Department of Managed Health Care, during normal business hours, all records, books and papers of Provider. Provider further agrees that such books and records shall not be removed from the State of California without prior consent of the California Department of Managed Health Care.

(j) To participate in the system for monitoring and evaluating accessibility of care developed from time to time by the Plan in its sole discretion and to cooperate in addressing problems that develop, including those related to , but not limited to, waiting time and appointments.

(k) The provider has no liability for decisions made by the plan, however, is still required to offer an opinion and record that opinion on the member record chart.

4. REPRESENTATION AND WARRANTIES OF PROVIDER:

(a) Provider is duly licensed to practice optometry or ophthalmology in the State of California.

(b) Provider has been advised by the Plan that each subscriber and his dependents shall have the right to select their own designated Providers and shall have the right to change such designated Provider if dissatisfied for any reason.

(c) Provider shall not assess any surcharges for covered vision care services and hereby acknowledges that should the Plan receive notice of any such charge, it shall have the right to cancel this Agreement effective upon receipt by Provider of notice of such cancellation. The Plan has a right of action against Provider for recovery of any surcharge and the Plan shall immediately repay the subscriber and/or member the amount of surcharge 1300.67.8(d)

(d) Provider shall not discriminate against any contracting party, prospective contracting party, subscriber and/or member because of race, color national origin, ancestry, religion, sex, marital status, sexual orientation or age.

(e) Provider shall not differentiate or discriminate in the treatment of the patients by reason of the fact that certain of his patients are subscribers and/or members. Provider agrees further to render health services to subscriber and/or members in the same manner, in accordance with the same standards and within the same time availability as offered his other patients.

(f) Upon termination of this contract, for any cause, Provider shall continue to provide for covered services to a subscriber and/or member who retains eligibility under the Individual or Group Subscriber Agreement or by operation of law, and who is under the care of Provider at the time of such termination, until the services rendered to the subscriber and/or member by Provider area completed or until the Plan makes reasonable and medically appropriate provision for the assumption of such services by a contracting Provider. Plan shall be liable for the fee-for-service charge for such services rendered by Provider (less applicable co-payments during the interim period).

5. COVENANTS OF THE PLAN:

(a) The Plan agrees to determine the identity and eligibility of all subscribers and/or members and to furnish to Provider each month, a list of the names of all subscribers and/or members eligible for services by Provider.

(b) The Plan agrees to perform or have performed all the necessary administrative, enrollment, and other functions appropriate for the administration of the Plan and this agreement.

(c) Except as otherwise provided pursuant to the Quality Assurance Program and the grievance procedure, the Plan shall not intervene in any manner with the rendition of services provided by Provider it being agreed that Provider shall have the sole responsibility in connection therewith.

(d) The Plan agrees to collect membership dues and other appropriate charges to which the Plan shall be entitled, except for such charges as the parties shall mutually agree may be more conveniently collected by Provider.

(e) The Plan assumes the liability for those medically necessary services provided by the Plan's benefit design.

(f) LANGUAGE ASSISTANCE PROGRAM:

In order to comply with new State of California Department of Managed Health Care requirements, Vision Plan of America has set up a Language Assistance (LA) program. Under the LA program, Limited English Proficient (LEP) enrollees are entitled to free language assistance at all points of contact including at the provider's office at the time of service. VPA Providers are hereby instructed to offer interpretation services on an "as needed" basis and make a notation on the enrollee's patient chart if they accept OR decline the service. In order to facilitate this process, VPA Providers are instructed to contact the Plan's toll free customer service line (800) 400-4872 where interpretation services will be provided by conferencing to a 3rd party certified interpreter service. This service is offered at no charge to either the provider or enrollee.

6. INSURANCE IDENTIFICATION:

(a) Provider at his sole cost and expense, shall procure and maintain such policies of professional liability in the amount of $1,000,000.00 per occurrence, and other insurance as shall be necessary to insure Provider and his employees, agents and affiliates against any claim or claims for damages arising be reason of personal injuries or death associated directly in connection with the performance of any service by Provider, the use of any property and facilities provided by Provider or his agents, and the activities performed by the Provider in connection with this Agreement, or any amendment hereof. Provider agrees to furnish the Plan with a Certificate of Insurance issued by Provider's carrier to evidence the existence of such policy or policies, and to name Vision Plan of America as additional insured.

(b) Provider shall, and hereby does, indemnify and hold harmless the Plan and its officers, directors, agents, representatives, and employees from and against all liabilities, claims losses, obligations, actions, demands, costs and expenses (including, without limitations, actual attorneys' fees incurred, without regard to any court schedule otherwise used for the determination thereof). **(i)** which may arise out of any act or omission in connection with any vision care or other service to be performed or directed by Provider pursuant to this Agreement or to be performed or directed by any Provider or his agents to perform any of his representations employed by Provider, or **(ii)** which may arise or result from or is related to any breach or failure of Provider or his agents to perform any of his representations, warranties, agreements or covenants hereunder, or **(iii)** which may arise or result from or is related to any liabilities of Provider, whether contingent or absolute, direct or indirect, matured or unmatured.

(c) Plan, at its sole cost and expense, shall procure and maintain such policies of professional liability and other insurance as shall be necessary to insure the Plan against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the provision of health care services, the use of any property and facilities provided by the Plan, and the activities performed by the Plan in connection with this Agreement, or any amendment hereof.

(d) The Plan shall, and hereby does, indemnify and hold harmless the Provider from and against all liabilities, claims losses, obligation, actions, demands, costs and expenses (including, without limitations, attorney's fees incurred, without regard to any court schedule otherwise used for the determination thereof, (i) which may arise out of omission in connection with any vision care or other service to be performed or directed by the Plan pursuant to this Agreement, or (ii) which may arise or result from or is related to any branch or failure of the Plan to perform any of its representations, warranties, agreements or covenants hereunder, or (iii) which may arise or result from or related to any liabilities of the Plan, whether contingent or absolute, direct or indirect, matured or unmatured.

In performing his obligations under this Agreement, Provider acknowledges that he is, and shall remain at all times, an independent contractor and is not an employee or agent of the Plan.

7. TERM OF AGREEMENT:

(a) This Agreement shall be effective as of date of execution hereof and shall remain in effect for a period of one year, unless terminated by either party, as provided herein. If this agreement is not so terminated, it shall be deemed automatically renewed for continuing one year periods.

(b) Notwithstanding section (a) of this paragraph. Provider and the Plan shall have the right to terminate this agreement effective upon ninety (90) days notice in writing to the other party to affect the orderly transfer of members to a new Provider at any time during this ninety (90) day period.

8. MISCELLANEOUS:

(a) Amendments: This agreement may be amended in whole or in part by mutual agreement of both parties. Such modifications shall be made in writing and must be signed by each part hereto. All such amendments shall become part of this Agreement.

(b) Any notice or other communications required or permitted hereunder shall be in writing, and shall be deemed to have been given if personally delivered or twenty-four hours after having been placed in the United States mail, registered or certified, postage prepaid, addressed as follows:

If to the Plan: VISION PLAN OF AMERICA
3250 Wilshire Boulevard #1610
Los Angeles, California 90010

If to Provider: Name: _____
Address: _____
City/Zip: _____
Phone: _____
Fax: _____
E-mail: _____

(c) Entire Agreement: This Agreement along with any amendments constituted the entire Agreement between the parties hereto pertaining to the subject matter hereof and supersedes all prior agreements, understandings, negotiations and discussions, whether oral or written, of the parties. No supplement, modification or waiver of termination constitutes a continuing waiver unless otherwise expressly provided.

(d) Successors and Assigns: This Agreement is personal in nature and cannot be assigned by Provider without consent of the Plan. Subject such restriction all of the terms, provisions and obligation of this Agreement shall be binding upon and shall insure to the benefit of the parties hereto and the respective heirs, representatives, successors and assigns.

(e) Governing Law: The parties hereby agree that the validity, constriction and interpretation of this Agreement shall be governed by the laws of the State of California in force from time to time.

(f) Regulatory Requirements: The Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code, and to Subchapter 5.5 of Chapter 3 of Title 10 of the California Administrative code, and any provisions required to be in the Provider Agreement by either of the above shall bind the Plan whether or not set forth here..

(g) Gender: Whenever the context of this agreement so requires, the masculine gender includes the feminine gender.

(h) Notice Regarding Acceptance of New Patients: Provider shall notify Plan in writing within five (5) business days when either of the following occur: (a) Provider is not accepting new patients; or (b) if Provider had previously not accepted new patients, Provider is currently accepting new patients. References to the responsibilities of Provider in this Section shall be interpreted, as appropriate under Health and Safety Code Section 1367.27 to apply to (a) each optometrist or ophthalmologist providing Covered Services to Members, if Provider is a group of optometrists or ophthalmologists and (b) to each location of Provider where Covered Services are provided to Members. If Provider is not accepting new patients and is contacted by a Member or

potential Member seeking to become a patient, Provider shall direct the Member or potential Member to the Plan for additional assistance in finding a provider and to the California Department of Managed Health Care to report any inaccuracy with Plan's provider directory or directories.

(i) Verification of Provider Information: Provider shall comply with Health and Safety Code Section 1367.27. Provider shall provide profile information requested by Plan in order to satisfy the requirements of Health and Safety Code Section 1367.27.

(j) Failure to Verify Provider Information: In the event Provider does not comply with Section 8(i) of this Agreement Provider shall be removed from the Plan provider directory(s). For purposes of this Agreement, "verify" shall mean to contact Vendor in writing, electronically, or by telephone to confirm whether Provider's information is correct or requires updates after receiving a notice from Plan to verify or correct such Provider Information.

IN WITNESS WHEREOF, this Agreement has been executed in California as of the day and year first above written

VISION PLAN OF AMERICA

BY:_____
Phillip Needleman
President

Additional Offices:

Address:_____
City/Zip: _____
Phone: _____
Hours: _____

Provider Information:

Signature: _____
Date: _____
License #: _____
Renewal Date: _____
NPI#_____
Renewal_____

Address: _____
City/Zip: _____
Phone: _____
Hours: _____
TPA #: _____

Languages Spoken in the Office_____
DPA _____
Renewal Date_____

EACH PROVIDER IN THE PRACTICE MUST COMPLETE THE ENCLOSED DOCUMENTS.