This is Your

PREFERRED PROVIDER ORGANIZATION CONTRACT

Issued by

MVP Health Services Corp.

This is Your individual Contract for preferred provider organization coverage issued by MVP Health Services Corp. This Contract, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Contract, constitute the entire agreement between You and Us.

You have the right to return this Contract. Read it carefully. If You are not satisfied, You may return this Contract to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Contract. We will refund any Premium paid including any Contract fees or other charges.

Renewability. The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Contract or by the Subscriber upon 30 days' prior written notice to Us.

This Contract offers You the option to get Covered Services on two benefit levels.

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our Network affiliate's EyeMed Network. You should always consider getting vision care services first through the in-network benefits portion of this Contract.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Contract provides coverage when You get Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You get out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge.

READ THIS ENTIRE CONTRACT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

This Contract is governed by the laws of New York State.

The insurance evidenced by this Contract provides Vision insurance ONLY.

By:

Christopher Del Vecchio,
Chief Executive Officer
MVP Health Services Corp.

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Schedule of Benefits .... **Attached**

SECTION I - Definitions

Defined terms will appear capitalized throughout the Contract**.**

Allowance: Means a flat dollar amount payable under the Policy towards a Covered Expense. Allowances are shown in the Schedule of Benefits. If the Providers charge is less than the Allowance, we will only pay up to the providers charge.

Appeal: A request for Us to review a decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non- Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Contract: This Contract issued by MVP Health Services Corp., including the Schedule of Benefits and any attached riders. The Contract explains the benefits available to You under the Group Contract.

Child, Children: The Subscriber's Children, including any natural, adopted or Step-Children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Contract.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for an eye examination or toward the cost of materials. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments.

Covered Expense- means the benefits listed in the Schedule of Benefits. The term "Covered Expense" or "Covered Expenses" does not include:

- Any services or Materials that are not listed in the Schedule of Benefits; or
- Any services or Materials shown as "Not Covered" in the Schedule of Benefits or

- An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an "In-Network Benefit" or an "Out-of-Network Benefit" during any one Frequency period; or
- More than one type of contact lenses at a time during any one Frequency period.

Dependents: The Subscriber's Spouse or Domestic Partner and Children

Discount: Means the percentage that a Participating Provider has agreed to reduce their charge by for the requested service, material or procedure. Discounted vision services, materials, supplies and treatments are described in the Schedule of Benefits.

Exclusions: Vision care services that We do not pay for or Cover.

Frequency: The time period shown in the Schedule of Benefits during which you are eligible for the Covered Expenses. The time period is measured from the date of your last eye examination or the date you got eyeglasses, frames, spectacle lenses or contact lenses.

Grievance: A complaint that You communicate to Us.

Group: The employer or party that has entered into an agreement with Us as a contract holder.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You get the service. The amount can vary by the type of Covered Service.

Member: The Subscriber or a covered Dependent for whom Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with EyeMed to provide services to You. You will pay more to see a Non-Participating Provider.

Participating Provider: A Provider who has a contract with EyeMed to provide services to You. A list of Participating Providers and their locations is available on Our website at **mvphealthcare.com** or upon Your request to Us. The list will be revised from time to time by Us**.**

Plan Year: The 12-month period beginning on the effective date of the Contract or any anniversary date thereafter, during which the Contract is in effect.

Premium: The amount that must be paid for Your vison insurance coverage.

Provider: An appropriately licensed, registered or certified Ophthalmologist, Optometrist or Optician. Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under this Contract.

Retail Price: means the charge made by other Providers rendering or furnishing vision care, treatment or supplies within the same geographic area

Schedule of Benefits: The document attached to this Contract that describes the Member Cost-Sharing responsibility.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Albany, Broome, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, St. Lawrence, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates Counties.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Contract is issued.

Us, We, Our: MVP Health Services Corp. and anyone to whom We legally delegate performance, on Our behalf, under this Contract.

You, Your: The Member.

SECTION II - How Your Coverage Works

A. Your Coverage under this Contract.

You have purchased a vision insurance Contract from Us. We will provide the benefits described in this Contract to You and/or Your covered Dependents. You should keep this Contract with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will get Covered Services under the terms and conditions of this Contract only when the Covered Service is:

- Provided by a Participating or Non-Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Contract; and
- Received while Your Contract is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at **mvphealthcare.com**.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. Vision Providers.

To see a Provider, call his or her office and tell the Provider that You are a Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, we will approve a referral to a specific Non-Participating Provider until You no longer need care or We have a Participating Provider in Our network that meets the time and distance compliance standards and Your care has been transitioned to that Participating Provider. Covered Services

rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

E. Access to Providers.

To see a Provider, call his or her office and tell the Provider that You are an MVP Health Services Corp. Member with benefits administered by EyeMed, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

F. Out-of-Network Services.

We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Contract for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Important Telephone Numbers and Addresses.

- CLAIMS
  EyeMed Vision
  P.O. Box 8504,
  Mason, OH 45040-7111
  (Submit claim forms to this address.)

- COMPLAINTS AND GRIEVANCES APPEALS
  Call MVP Health Care at: 1-888-687-6277

- CUSTOMER CARE CENTER
  Call the number on Your ID card

  EyeMed Dedicated MVP Health Care Commercial: TOLL FREE # 866-895-3278

  (Customer Care Center Representatives are available Monday – Friday 7:30 a.m. – 11:00 p.m., Saturday 8:00 a.m. – 11:00 p.m., and Sunday 11:00 a.m. – 8:00 p.m.)

- OUR WEBSITE
  mvphealthcare.com

SECTION III – Cost Sharing Expenses and Allowed Amount

Please refer to the Schedule of Benefits attached to this Contract for Copay, Coinsurance, Cost-Sharing requirements, frequency limits, and differences between in-network and out-of-network services.

A. Deductible.

There is no Deductible for Covered Services under this Certificate during each Plan Year.

B. Copayments.

Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits attached to this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Co-payment, You are responsible for the lesser amount.

C. Coinsurance.

Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits attached to this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. Benefit Maximums, Allowances and Frequency Limits

The amount we pay for your benefits is subject to your benefit maximums, allowances and frequency limits. We will not pay for vision care services that go over your benefit maximums or allowances, or for services that are received more than the allowed frequency limits. Benefit maximums, allowances, and frequency limits are stated in the Schedule of Benefits.

E. Allowed Amount

We will pay up to the maximum allowable amount for covered services. You may be required to pay a part of the maximum allowable amount. This is called your cost share amount. Copayments and Coinsurance are examples of a cost share amount. See the Schedule of Benefits for your cost share amount for covered services.

Your cost share amount may vary depending on whether you get vision care from a Participating or Non-Participating Provider. You may be required to pay higher cost sharing amounts when using Non-Participating Providers. In addition Participating Providers will provide a 20% discount on other lens add-ons that you may wish to purchase.

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

The Allowed Amount for Non-Participating Providers will be 70% of the In-Network Provider Allowed Amount less any Member cost share.

We will not pay for vision care that is not covered under this plan. You are required to pay all charges for vision care that is not covered. Vision care that you get after you have met any benefit maximums or benefit frequency limits are also not covered.

SECTION IV - Who Is Covered

A. Who is Covered Under this Contract.

You, the Subscriber to whom this Contract is issued, are covered under this Contract. You must live or reside in Our Service Area to be covered under this Contract. Members of Your family may also be covered depending upon the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse, then You and Your Spouse or domestic partner are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse or Domestic Partner and Your Child or Children, as described below, are covered.

C. Children Covered Under this Contract.

If You selected parent and child/children or family coverage, Children covered under this Contract include Your natural Children, legally adopted Children, Step-Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and grandchildren are covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's

incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Contract at any time.

D. When Coverage Begins.

Coverage under this Contract will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.

2. If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We get notice of such marriage and any Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We get Your application. If We do not get notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.

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E. Domestic Partner Coverage.

This Contract covers domestic partners of Subscribers as Spouses. Children covered under this Contract also includes the Children of Your Domestic Partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists, or

2. For partners residing where registration does not exist, by:
   a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
      - The partners are both 18 years of age or older and are mentally competent to consent to contract;

- The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
- The partners have been living together on a continuous basis prior to the date of the application; and
- Neither individual has been registered as a member of another domestic partnership within the last six (6) months

b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
   - A joint bank account;
   - A joint credit card or charge card;
   - Joint obligation on a loan;
   - Status as an authorized signatory on the partner's bank account, credit card or charge card;
   - Joint ownership of holdings or investments;
   - Joint ownership of residence;
   - Joint ownership of real estate other than residence;
   - Listing of both partners as tenants on the lease of the shared residence;
   - Shared rental payments of residence (need not be shared 50/50);
   - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
   - Shared household budget for purposes of getting government benefits;
   - Status of one (1) as representative payee for the other's government benefits;
   - Joint ownership of major items of personal property (e.g., appliances, furniture);
   - Joint ownership of a motor vehicle;
   - Joint responsibility for child care (e.g., school documents, guardianship);
   - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
   - Execution of wills naming each other as executor and/or beneficiary;
   - Designation as beneficiary under the other's life insurance policy;
   - Designation as beneficiary under the other's retirement benefits account;
   - Mutual grant of durable power of attorney;
   - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
   - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION V - Vision Care

We cover the following vision services:

A. Routine Exam: A routine eye exam is defined as an office visit for the purpose of checking vision, screening for eye disease, and/or updating eyeglass or contact lens prescriptions. Routine eye exams can produce diagnosis that includes nearsightedness, farsightedness or astigmatism.

B. Lenses: You have a choice of lenses under this plan that include the following:

- **Single Vision:** glasses lenses that only offer ONE type of vision correction**.** This means that they are crafted to help people see better at farther or shorter distances (nearsighted or farsightedness), but never both.

- **Bifocal:** a lens that has two focal points, usually one portion for viewing distant objects, and another for viewing close objects.

- **Trifocal**: lenses look and perform similar to bifocal lenses, with an added viewing zone to help correct vision in the intermediate field, and two visible lines where the viewing zones change.

- **Lenticular**: a corrective lens type that requires a very high power to correct your vision. High power often means a very thick and heavy eyeglass. To keep the **lens** from being so thick that it'd be hard to wear, eyeglass manufacturers created the lenticular lens**.**

- **Standard Progressive**: characterized by a gradient of increasing lens power, added to the wearer's correction for the other refractive errors. The gradient starts at the wearer's distance prescription at the top of the lens and reaches a maximum addition power, or the full reading addition, at the bottom of the lens.

- **Premium Progressive:** referred to as "free-form design" or "wave-front technology**.".** Premium progressive lenses provide a much wider, distortion-free reading area.

C. Frames: You have a benefit allowance towards your choice of frames. You may apply that allowance towards the frames of your choice. If the frame you select is more than your allowance, then you are responsible for the difference.

D. Contact Lenses: Your lens benefit may apply to eyeglass lenses, elective contact lenses, or non- elective contact lenses. Non-elective lenses are lenses that are prescribed for certain conditions such as, Anisometropia, High Ametropia, Keratoconus. If you get elective or non-elective contact lenses, an eyeglass lens benefit will not be available until your benefits renew. The Schedule of Benefits tells you the benefit frequency for lenses.

SECTION VI - Exclusions and Limitations

No coverage is available under this Contract for the following:

A. Employment: Any Vision Examination, or any corrective eyewear required as a condition of employment, such as safety eyewear.

B. Sunglasses: Non-Prescription sunglass lenses or accompanying frames.

C. Non-Prescription Lenses: Any non-prescription lenses, eyeglasses, contacts or plano lenses. This also includes any lenses that have no refractive power.

D. Lost or Broken Lenses, Frames or Contacts: Any lost or broken lenses, frames or contacts will not be covered until you reach a new benefit period.

E. Duplicates: Two pair of glasses in lieu of bifocals.

F. Medical Services: We do not Cover vision services that are medical in nature, including any Hospital charges or prescription drug charges, including pathological and/or surgical treatment of the eye, eyes or supporting structures.

G. Services Not Listed: We do not Cover services that are not listed in this Contract as being Covered.

H. Services Provided by a Family Member: We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

I. Workers' Compensation: We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION VII - Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can call Us at the phone number in the How Your Coverage Works Section of this Contract or in writing to file a Grievance. You or Your designee has up to 180 calendar days from when You got the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 5 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at **mvphealthcare.com**. You can opt out of electronic notifications at any time.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and let You know within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 45 calendar days of receipt of all necessary information

D. Grievance Appeals.

If You are not satisfied with the result of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card or in writing. However, Urgent Appeals may be filed by phone.

You have up to 60 business days from the time you received the Grievance determination to file an Appeal.

When We get Your Appeal, We will mail an acknowledgment letter within 5 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and let You know in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

<u>Pre-Service Grievances</u>: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your Appeal.
<u>Post-Service Grievances</u>: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your Appeal.
<u>All Other Grievances</u>: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services

Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: **dfs.ny.gov**

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Ave., 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail **cha@cssny.org**
Website: **communityhealthadvocates.org**

SECTION VIII - Claim Determinations

A. Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.
Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; address; date of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name, and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information.

C. Timeframe for Filing Claims.
Claims for services must be submitted to Us for payment within 12 months after You receive the services for which payment is being requested.

D. Claim Determinations.
If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

E. Payment of Claims.
Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION IX - Termination of Coverage

This Contract may be terminated as follows:

A. Automatic Termination of this Contract.

This Contract shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Contract will terminate as of the last day of the month for which the Premium has been paid.

B. Automatic Termination of Your Coverage.

Coverage under this Contract shall automatically terminate:

1. For Spouses in cases of divorce, the date of the divorce.
2. For Children, the end of the month in which the Child turns 26 years of age.
3. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

C. Termination by You.

The Subscriber may terminate this Contract at any time by giving Us at least 30 days' prior written notice.

D. Termination by Us.

We may terminate this Contract with 30 days' written notice as follows:

1. For Non-Payment of Premiums.

   Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:

   - If the Subscriber fails to pay the Premium within a 30-day grace period, this Contract will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Contract terminates.

2. Fraud or Misrepresentation of Material Fact.

   If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his or her enrollment application, or in order to get coverage for a service, this Contract will terminate immediately upon a written notice to the Subscriber from Us. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application. We

will rescind coverage if the facts misrepresented would have led Us to refuse to issue this Contract and the application is attached to this Contract. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Contract. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives or resides in Our Service Area.

4. The date the Contract is terminated because We stop offering the class of contracts to which this Contract belongs, without regard to claims experience or health related status of this Contract. We will provide the Subscriber with at least 90 days' prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

SECTION X - Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Contract, an extension of benefits shall be provided for a period of no less than 30 days to complete a vision service that was started before Your coverage ended.

SECTION XI - Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than five (5) years of active duty.

You must ask Us in writing to have Your coverage suspended during a period of active duty. Your unearned Premium will be refunded during the period of such suspension.

At the end of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right to resume coverage extends to for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XII - General Provisions

1. Agreements between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Contract does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any vision benefits program.

2. Assignment.

You cannot assign any benefits under this Contract to any person, corporation, or other organization. Any assignment of benefits by You will be void and unenforceable. Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Contract. However, You may request Us to make payment for services directly to Your Provider instead of You.

3. Changes in This Contract.

We may unilaterally change this Contract upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.

This Contract shall be governed by the laws of the State of New York.

5. Clerical Error.

Clerical error, whether by You or Us, with respect to this Contract, or any other documentation issued by Us in connection with this Contract, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.

Any term of this Contract which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.

Some of the benefits in this Contract may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status

changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Entire Agreement.
This Contract, including any endorsements, riders and the attached applications, if any, constitutes the entire Contract.

9. Fraud and Abusive Billing.
We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. Furnishing Information and Audit.
All persons covered under this Contract will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Contract. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider; or make decisions regarding the medical necessity of Your care.

11. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Contract. To be entitled to such services or benefits, Your Premiums must be paid in full at the time you go to get services.

12. Incontestability.
No statement made by the Subscriber in an application for coverage under this Contract shall avoid the Contract or be used in any legal proceeding unless the application or an exact copy is attached to this Contract.

13. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You or Your covered Spouse while getting care from any Participating Provider or in any Participating Provider's facility.

14. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies by calling the number on the back of your ID card.

15. Material Accessibility.

We will give You ID cards, Contracts, riders and other necessary materials.

16. More Information about Your Vision Plan.

You can request additional information about Your coverage under this Contract; Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- Written application procedures and minimum qualification requirements for Providers.

17. Notice.

Any notice that We give You under this Contract will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to: the address on Your ID card.

18. Premium Payment.

The first month's Premium is due and payable when You apply for coverage. Coverage will begin on the effective date of this Contract as defined herein. Subsequent Premiums are due and payable on the first of each month thereafter.

19. Premium Refund.

We will give any refund of Premiums, if due, to the Subscriber.

20. Recovery of Overpayments.

On occasion a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after you get notification from Us. However, We shall not make a request for repayment more than 24

months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. Renewal Date.

The renewal date for this Contract is January 1 of each year. This Contract will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Contract, or by the Subscriber upon 30 days' prior written notice to Us.

22. Reinstatement after Default.

If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract.

23. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Contract. Those standards will not be contrary to the descriptions in this Contract. If You have a question about the standards that apply to a particular benefit, You may contact Us, and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Contract.

24. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

25. Severability.

The unenforceability or invalidity of any provision of this Contract shall not affect the validity and enforceability of the remainder of this Contract.

26. Third Party Beneficiaries.

No third-party beneficiaries are intended to be created by this Contract and nothing in the Contract shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Contract. No other party can enforce this Contract's provisions or seek any remedy arising out of either Our or Your

performance or failure to perform any portion of this Contract, or to bring an action or pursuit for the breach of any terms of this Contract.

27. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Contract. You must start any lawsuit against Us under this Contract within two (2) years from the date the claim was required to be filed.

28. Translation Services.

Translation services are available free of charge under this Contract for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

29. Waiver.

The waiver by any party of any breach of any provision of this Contract will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

30. Who May Change this Contract.

This Contract may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Contract in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

31. Who Receives Payment under this Contract.

Payments under this Contract for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

32. Workers' Compensation Not Affected.

The coverage provided under this Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

33. Your Vision Records and Reports.

In order to provide Your coverage under this Contract it may be necessary for Us to get Your vision records and information from Providers who treated You. Our actions to provide that

coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Contract; except as prohibited by state or federal law, You automatically give Us or Our designee permission to get and use Your vision records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a vision professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a vison professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your vison records by Us.

We agree to maintain Your vision information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Contract, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.