

MAX VISION CARE, INC.

PROVIDER SERVICES AGREEMENT

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PROVIDER SERVICES AGREEMENT

THIS PROVIDER SERVICES AGREEMENT is made and entered into as of _____ 200__ by and between _____, an individual or a California optometric professional corporation or partnership ("Provider"), and MAX VISION CARE, INC., a California corporation ("MVC").

RECITALS

A. Provider is an optometrist who is, or an optometric corporation or partnership whose owner(s)and/or members is/are, duly licensed and qualified to perform optometry services in the State of California. Provider conducts an optometric practice at each of the office location(s) listed on the signature page hereto.

B. MVC is or shall be as of the effective date of this Agreement duly licensed by the California Department of Managed Health Care ("DMHC") as a vision care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 ("the Knox-Keene Act"). MVC arranges for optometric services for members of MVC's optometric plan(s) within MVC's service area.

C. MVC desires to contract with Provider to provide covered optometric services under the terms and conditions specified herein.

NOW, THEREFORE, the parties hereto hereby agree as follows:

1. DEFINITIONS

In addition to the terms defined elsewhere in this Agreement:

- (a) "Covered Services" means the necessary optometric services listed in Exhibit "A" attached hereto that are covered benefits under the applicable plan of MVC.
- (b) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- (c) "Medically Necessary" means treatment required by a Member for a particular condition within an optometrist's scope of practice and in accordance with the standard of care in the optometric community.

- (d) "Member" means any individual entitled to receive Covered Services (as defined below) pursuant to a vision care plan of MVC.
- (e) "MVC Provider Manual" means the document, incorporated herein by this reference, that is created by MVC to inform Provider of MVC's administrative policies, procedures and guidelines applicable to Provider's performance under this Agreement.
- (f) "Plan" means the benefit plan or plans offered by MVC to Members and set forth in Exhibit "B" attached hereto, as may be amended from time to time, under which Members receive vision care benefits in return for a periodic premium payment.
- (g) "UR/QA Program" means the utilization review and quality assurance program administered by MVC's Quality Assurance committee and its governing board to assure that optometric services are necessary and that they are being provided in a manner consistent with accepted standards of optometric practice and with applicable laws, regulations and standards.

2. PROVIDER DUTIES

Provider agrees that:

- (a) Provider shall accept as patients all Members referred by MVC without discrimination. Provider shall provide MVC with a minimum of sixty (60) days advance written notice of Provider's inability to accept new patients. Provider shall provide each Member the same level of courtesy and service given to any patient of Provider's practice.
- (b) MVC shall notify Provider in writing ("New Plan Notice") of the Covered Services, compensation and any other additional or modified terms and conditions applicable to new Plans offered by MVC. MVC shall provide the respective New Plan Notice to Provider at least forty-five (45) business days' prior to the new Plan's implementation. Prior to the implementation, Provider has the right to negotiate and agree to participate in the New Plan. If Provider does not agree, Provider has the right to terminate this Agreement prior to the implementation of the new Plan.
- (c) Provider agrees to provide Covered Services to Members in accordance with the terms and conditions hereof, in accordance with MVC Plans, policies and procedures as described or referenced in this Agreement, and in accordance with all applicable laws, regulations and guidelines, including without limitation, applicable statutes and regulations promulgated by the DMHC. It is expressly acknowledged and agreed MVC is subject to the provisions of the Knox-Keene Act (Chapter 2.2 of Division 2 of the California Health and Safety Code) and implementing regulations (Chapter 1 of Division 1 of Title 28 of the California

Code of Regulations) and any provision required to be in this Agreement by either of the above shall bind MVC whether or not provided in this Agreement.

- (d) Provider shall maintain written records of such tests and procedures in accordance with Plan requirements and the requirements of applicable regulatory agencies, including without limitation the state optometric licensing agency and the DMHC, and Provider shall make such records available to MVC from time to time upon request, subject to applicable patient record confidentiality requirements, as well as to such agencies in accordance with this Agreement.
- (e) Provider shall make available Covered Services to Members during its customary service hours at each facility of Provider listed on the signature page hereto (collectively, "Office(s)"). If Provider offers services on weeknights or weekends, Provider shall extend such hours to Members to receive Covered Services, and shall accept referrals of Members from other provider offices. If a Member desires services after hours when Provider is unavailable, Provider shall refer the Member to the nearest MVC Provider who offers services at such times. Provider shall monitor Provider's Office hours to ensure that Members have adequate access to Covered Services at convenient times. At all times during business hours, Provider or another MVC-approved optometrist shall be available to furnish Covered Services at the Office. Each Office shall be adequately equipped and staffed to provide complete optometric vision care services, including comprehensive vision evaluation, low vision care, dispensing services, and provision of ophthalmic materials and supplies. Provider will make best efforts, to the extent feasible, to render services in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
- (f) Provider agrees to comply with availability and accessibility standards as are promulgated by MVC from time to time, including without limitation, waiting times for optometric appointments and eyeglass fittings. Provider agrees to submit to periodic audits of the Offices by MVC to ensure compliance with MVC's standards.
- (g) If Members request services or items that are not covered by the Plan (i.e., optional optical procedures or higher priced frames), Provider shall inform Members of their responsibilities for payment for such non-Covered Services and obtain written consent from Members prior to rendering any such services. Provider shall be entitled to require Members to make payment for such non-Covered Services directly to Provider.
- (h) In the event a Member at Provider's Offices requires services to treat an Emergency Medical Condition or urgent care services beyond the scope of Provider's training or licensure (e.g., detached retina) or an Member contacts Provider requiring such treatment during business hours, the following shall apply: In no event shall Provider provide medical or surgical services to any

Member beyond the scope of Provider's optometric license. Provider is to treat all Emergency Medical Conditions within the Provider's scope of optometric license (e.g., contact lens removal problem). In the case of Emergency Medical Conditions that are beyond the scope of the Provider's optometric license (e.g., detached retina), Provider shall advise the Member to obtain immediate medical attention. Provider shall ensure that Members are informed of the appropriate agencies or resources to contact in the event of an Emergency Medical Condition or urgent care condition after hours.

- (i) Provider shall comply with the standards and procedures contained in the MVC Provider Manual.
- (j) Provider acknowledges that it is a "Covered Entity" as that term is defined in the HIPAA Standards for Privacy of Individually Identifiable Health Information adopted by the United States Department of Health and Human Services on December 28, 2000, as amended (the "Privacy Rule"). Provider shall adequately protect the confidentiality of individually identifiable health information and shall comply with the Privacy Rule and all state and federal laws governing the confidentiality of Member medical information.
- (k) MVC has established an Anti-Fraud Plan to organize and implement an anti-fraud strategy to identify and reduce costs to MVC, Members, providers and others caused by fraudulent activities, and to protect consumers through the timely detection, investigation and prosecution of suspected fraud. Provider shall adhere to and comply with the requirements of MVC's Anti-Fraud Plan.

3. UTILIZATION REVIEW AND QUALITY ASSURANCE

- (a) Provider agrees to be bound by and comply with the UR/QA Program of MVC. Provider acknowledges that Provider has received documentation of MVC's UR/QA Program at least fifteen (15) business days prior to the execution of this Agreement. Provider shall be bound by and comply with any amendments or modifications to such programs may be adopted from time to time during the term hereof. MVC shall notify Provider of any such amendments or modifications in writing, and they shall be effective within thirty (30) days of such notice unless Provider objects in writing prior to the end of such thirty (30) day period; provided, however, that MVC must provide Provider with forty-five (45) days' prior written notice of a change in any material term set forth in the UR/QA Program, during which time Provider has the right to negotiate and agree to the change. If MVC and Provider cannot agree to the change, Provider has the right to terminate this Agreement prior to the implementation of the change. MVC may require such amendments to be binding on Provider with less than forty-five (45) business days' prior notice if the change is necessary to comply with either state or federal law or regulations, or any accreditation requirements of a private sector accreditation organization.

- (b) Provider agrees to cooperate with and abide by and adhere to rulings of the MVC Quality Assurance Committee, and further agrees that upon request, the doctor will furnish case records of MVG patients for whom claims have been submitted, and that MVC may use any information so obtained for statistical, actuarial, scientific, peer review or other reasonable purposes, provided that the committee shall maintain the confidentiality of such information in accordance with applicable state and federal laws and regulations.

4. COMPENSATION; BILLING AND PAYMENT

- (a) In exchange for Covered Services provided to and/or arranged and paid for on behalf of eligible Members covered under the Plan, MVC agrees to pay Provider at those rates set forth in Exhibit "C" attached to this Agreement, less any applicable copayments and/or deductibles of which Provider is advised in writing. Provider shall be entitled to collect from an Member directly for all applicable copayment or deductible amounts. Provider shall report to MVC in writing all copayments paid by MVC Members directly to the doctor.
- (b) Provider may bill an Member for services that are not Covered Services; however, prior to providing any service that is not a Covered Service, Provider shall so inform the Member, and Provider shall obtain the written consent of the Member of his or her responsibility for payment for such services and that MVC is not liable for the cost of such services. Provider shall not charge Members for non-Covered Services in excess of rates that Provider's normally charge non-MVC patients. Provider shall not bill MVC for non-Covered Services.
- (c) Provider shall use all commercially reasonable efforts to submit claims to MVC for Covered Services within ninety (90) days after the rendering of such services. Any claims for Covered Services not billed within ninety (90) days from the date of service shall be deemed waived and Provider shall not bill MVC, Covered Persons, or any third party for such services. However, if MVC denies a claim because it was filed beyond the claim filing deadline, MVC shall, upon Provider's submission of a provider dispute and the demonstration of good cause for the delay, accept, and adjudicate the claim. Each claim shall be in such form and format specified by MVC and by applicable law and regulations, and as set forth in Exhibit "D" hereto and incorporated herein by reference, and shall describe the Covered Services rendered to the Member with sufficient particularity to enable MVC to reasonably determine whether or not the services rendered were Covered Services.
- (d) Provider retains the right to seek additional reimbursement from other third party payors pursuant to coordination of benefits. If MVC is the primary carrier, MVC will pay Provider as provided herein. If MVC is not the primary payor, MVC shall be responsible for the difference between Provider's usual and customary fees and the amount payable by the primary payer, not to exceed the applicable rates set forth Exhibit "C" hereto.

- (e) Except for any applicable copayments and deductibles and except as otherwise provided in Section 4(c) above, Provider agrees to accept payment from MVC as payment in full for Covered Services. Provider shall not invoice or balance bill Members for the difference between Provider's billed charges and the reimbursement paid by MVC for any Covered Services, and agrees not to bill or to assess any surcharge to MVC or Members regardless of whether or not payment is received from MVC. Provider acknowledges that attempting to charge for or collect from a Member any surcharge may result in termination of this Agreement or other appropriate action by MVC. Neither Provider, nor any agent, trustee or assignee of Provider, may maintain any action at law against a MVC Member for sums owed to the Provider by MVC, and MVC Members shall not be liable to Provider for such sums.

5. ELIGIBILITY AND AUTHORIZATION VERIFICATION

Each Member shall be furnished with an identification card, and Provider shall make a photocopy of such card. Provider shall also contact MVC's telephone verification service during regular business hours through which Provider may verify (i) whether a person seeking services pursuant to this Agreement is eligible for Covered Services, (ii) that the services sought are Covered Services that have been authorized by Payor, and (iii) the amount of applicable copayments and deductibles, if any. If Provider obtains a copy of the identification card and obtains verification in the manner set forth in this Section 5, such verification shall be conclusive as to MVC unless and until MVC notifies Provider to the contrary in writing.

6. TERM AND TERMINATION

- (a) Unless sooner terminated in accordance with this Agreement, the initial term of this Agreement shall be one (1) year from and after the Effective Date. Upon the expiration of the initial and each subsequent term, this Agreement shall automatically renew for additional terms of one (1) year each, unless sooner terminated in accordance with this Agreement. For purposes of this Agreement, "Effective Date" shall mean the first date on which all of the following shall have occurred: (a) MVC receives applicable regulatory approvals from the DMHC; and (b) MVC contracts for its initial Members.
- (b) Either party may, at its option, terminate this Agreement upon at least sixty (60) days prior written notice to the other party without cause, and thirty (30) days prior written notice for cause. For purposes of this Agreement, "cause" for termination shall include, without limitation, any material breach not cured by the end of the notice period.
- (c) MVC may terminate this Agreement upon thirty (30) days prior written notice in the event that Provider fails to provide MVC with any information reasonably requested by MVC for the purposes of this Agreement.

- (d) Upon the issuance of written notice, MVC may immediately terminate this Agreement in the event Provider loses any license required to perform services hereunder or is involved in any activity that MVC reasonably believes may jeopardize patient safety.
- (e) Upon the expiration or earlier termination of this Agreement for any reason, Provider shall continue to provide Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such expiration or termination until the services are completed, or until MVC makes reasonable and appropriate provision for the assumption of such services by another MVC provider. Provider shall be entitled to compensation (less applicable deductibles and copayments, if any) at the rates specified in Exhibit "C" hereto for Covered Services provided pursuant to this subsection 6(d).

7. INSURANCE; INDEMNIFICATION

- (a) Provider shall maintain in full force and effect during the term of this Agreement general and professional liability insurance with coverage amounts of at least One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) annual aggregate. If such insurance is "claims made", upon termination of any policy, "tail" coverage shall be procured for a period of at least five (5) years after the date of termination. Upon request, Provider shall provide MVC with certificates evidencing the insurance coverages required herein. Provider shall obtain the written commitment of its insurer(s) to provide MVC with no less than thirty (30) days written notice prior to any modification, diminution or termination of Provider's coverage. Provider shall, at least thirty (30) days prior to the expiration of such policy or policies, furnish MVC with renewals or binders thereof.
- (b) Provider agrees to indemnify, defend and hold harmless MVC from and against any and all claims, liability, cost or expense (including without limitation litigation costs and attorneys' fees) arising out of or resulting from any act or failure to act by Provider, to the extent the claim, liability, cost or expense is not otherwise covered by insurance.

8. RECORDKEEPING; ACCESS TO RECORDS

- (a) Provider shall maintain patient visit records and billing and payment records for all Members treated by Provider. All such records shall be maintained in accordance with prudent recordkeeping practices and as required by law.
- (b) Any request by MVC for supporting medical record Documentation shall be provided at MVC's expense at \$.50 per page.

- (c) Without limiting any of the foregoing, Provider agrees to maintain such records (including patient care records) and provide such information as may be required by law or regulation to MVC, the California Department of Managed Health Care, or to their authorized representatives, and to permit MVC, such agencies and their representatives at all reasonable times to have access upon demand to Provider's books, records and papers relating to optometric services provided by Provider to Members, to the cost thereof, to the payments received by Provider from or on behalf of Members, and, as otherwise may be necessary for compliance by MVC with, and/or to inspect all facilities maintained or utilized by Provider in the performance of services pursuant to this Agreement. Provider agrees to retain such books and records as are required to be maintained by this Agreement for a term of at least five (5) years from and after termination of this Agreement, whether by rescission or otherwise.

9. DISPUTES AND GRIEVANCES

- (a) Provider may submit information regarding disputes to MVC at the address or telephone number designated in Section 10(d) of this Agreement, which address or telephone number may be modified from time to time by written notice hereunder. Such disputes shall be resolved in accordance with MVC's provider dispute resolution mechanism. If the parties are unable to resolve the dispute in accordance with the provider dispute resolution mechanism, then any matters remaining in controversy shall be subject to binding arbitration in accordance with Section 10(i) of this Agreement.
- (b) MVC shall notify Provider in writing of the grievance procedures established by MVC for redress of concerns of Members regarding Provider and of Provider regarding Members, including without limitation disputes as to services, materials, or payment for same. Provider agrees to comply with and be bound by such grievance procedures. Further, Provider agrees to be bound by any arbitration decision resulting from the disposition of any grievance involving an Member to the same extent as would apply if MVC were a party to an arbitration agreement.

10. MVC PROVIDER MANUAL

MVC's standards and procedures shall be set forth in the MVC Provider Manual. MVC may amend the Provider Manual from time to time. Changes to non-material terms of the Provider Manual shall be effective immediately upon notice to Provider. MVC shall provide Provider with forty-five (45) business days' prior written notice of a change in any material term of the Provider Manual, during which time Provider has the right to negotiate and agree to the change. MVC may require changes to material terms to be binding on Provider with less than forty-five (45) business days' prior notice if a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization require a shorter timeframe for compliance. If MVC and Provider cannot agree to the change, Provider has the right to terminate this Agreement

prior to the implementation of the change. Notwithstanding the foregoing, if the parties mutually agree, the forty-five (45) day notification requirement may be waived. Nothing in the Section limits the ability of the parties to mutually agree to the proposed change at any time after Provider has received notice of the proposed change.

11. MISCELLANEOUS PROVISIONS

- (a) In the performance of the work, duties and obligations of the parties to this Agreement, the parties shall be, and at all times are, independent contractors, and neither party shall consider itself or act as the agent of the other party. No relationship of employer and employee, or of partners or of joint venturers is created by this Agreement. Neither party shall have nor exercise any control or direction over the performance of services of any other party to this Agreement. Without limiting the foregoing, nothing contained herein shall be construed interfere with the ordinary relationship that exists between optometrist and patient. Nothing contained in this Agreement shall create any rights or remedies in any third party including, but not limited to, any Member.
- (b) Neither party shall, without the prior written consent of the other party, assign any of its rights or duties under this Agreement, except that MVC may assign this Agreement to a parent or affiliate entity under common ownership or control as MVC without Provider consent. Subject to the foregoing restrictions on assignment, this Agreement shall be binding upon the successors and assigns of the parties hereto.
- (c) Except as otherwise provided herein, no amendment or modification of this Agreement shall be valid, binding or effective unless it is in writing and signed by both parties hereto. Notwithstanding the foregoing, if MVC is required to amend this Agreement to comply with any state or federal law or regulations or any accreditation requirements of a private sector accreditation organization, MVC shall notify Provider in writing of such amendment and such amendment shall become effective as stated therein absent Provider's written approval thereof.
- (d) Any and all notices or other communications required or permitted by this Agreement shall be in writing and shall be delivered personally, by electronic communication, or by United States mail, first class, postage prepaid, certified or registered, return receipt requested, and addressed, as follows:

MVC: Max Vision Care, Inc.
6711 Comstock Avenue
Whittier, California 90601
Attn: President
Fax: (562) 693-4418

Provider: _____

Attn: _____
Fax: _____
Office Phone: _____

Such notices shall be effective upon delivery, or on the date indicated in the notice, whichever is later. Either party may change its notice address by giving written notice of the change to the other party.

- (e) The waiver of any breach of this Agreement shall not be deemed to be a waiver of any other breach of either the same or any different provision. This Agreement shall be construed and enforced in accordance with the laws of the State of California. This Agreement, including without limitation, any and all exhibits, schedules and attachments appended hereto or otherwise incorporated herein by reference, contains the entire agreement between the parties relating to the subject matter hereof and together supersedes any and all other agreements, negotiations, or representations, whether oral or written, between the parties with respect to the subject matter of this Agreement.
- (f) In the event any provision of this Agreement is rendered invalid or unenforceable by the enactment of any applicable statute, ordinance or regulation, or is made unenforceable by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.
- (g) Without the other party's prior written consent, neither party shall disclose any term or condition hereunder to any third party, except as required by law, regulations or by applicable agencies, or as necessary to administer this Agreement.
- (h) MVC agrees to list Provider as a participating optometrist on MVC's participating provider lists. In addition to any other indemnification provided hereunder, Provider hereby releases MVC, its officers, employees and agents from any and all liability for errors or omissions in preparation and dissemination of such provider lists. Provider shall not at any time use any trademarks, service marks, trade names, or other marks or names of MVC, whether or not registered or common law marks (collectively, "Marks"), nor prepare or distribute any forms, documents or materials of any kind using any Marks of MVC.

- (i) Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by compulsory and binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment on the award rendered may be entered in any court having jurisdiction thereof. Such arbitration shall be held in the County of Los Angeles, California. If either party to this Agreement initiates arbitration or any other legal proceedings against the other party, the prevailing party shall be allowed such costs and reasonable attorneys' fees as the court may allow. If the parties are unable to agree on a single arbitrator, each party shall appoint an arbitrator and the two appointed arbitrators shall select a third arbitrator who shall conduct the arbitration. All fees and expenses of the arbitrator(s) and the arbitration shall be shared equally by the parties, subject to the terms of Section 10(l) hereof.
- (j) This Agreement may be executed in any number of counterpart copies, all of which shall constitute one and the same Agreement and each of which shall constitute an original, and shall become effective upon execution and delivery to both parties hereto.
- (k) Provider acknowledges and agrees that the business relationship between MVC and its Members and/or with subscriber groups, as applicable, and all lists of Members accepted by Provider under this Agreement shall all be deemed valuable proprietary and confidential information of MVC. Accordingly, during the entire term of this Agreement and for a period of one (1) year after this Agreement expires or terminates for any reason, Provider agrees that he/she shall not, without the prior written consent of MVC, directly or indirectly within the service area of MVC: (a) interfere with MVC's contract and/or property rights; (b) solicit such Member to become enrolled with any other managed care organization; or (c) to disclose any proprietary information of MVC.
- (l) In the event of any litigation or other action involving a dispute or determination of rights or obligations under this Agreement, the prevailing party, as determined by the judge or arbitrator or arbitration panel, shall be entitled to court or arbitrator fees and reasonable attorneys' fees from the other party(ies) to the litigation or action.
- (m) The parties hereby acknowledge and agree that the terms and conditions hereunder neither require nor are in any way contingent upon the recommendation or referral by or to, or the provision of any item or service by or to, any party hereto or any patient.
- (n) Provider agrees to notify MVC at least thirty (30) days in advance of any office location change of address or addition or severance of any associates.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date first above written.

MVC:
Max Vision Care, Inc

By: _____
Its: _____

PROVIDER:

Signature: _____

Printed Name: _____
If entity, Title: _____

NPI#: _____
DEA#: _____

Provider Office information:

Address(es): _____

Cross Streets: _____

Office Hours/Days: _____

Primary Language: _____
Other Languages Spoken: _____

Optometrists*: _____

*Individuals must complete their own credentialing packet.

EXHIBIT "A"

COVERED SERVICES (MVC MEMBERS)

A. Covered Services are as follows:

1. Vision Examination. One vision examination and at least one follow-up visit per Member per each twelve or 24 month period (depending upon Plan design), beginning with the date of the last examination. The examination shall include a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities.

Examination to include, without limitation:

- a. Case history.
- b. Evaluate health status of the visual systems; including:
 - i. external and internal examination, including direct and/or indirect ophthalmoscopy;
 - ii. assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;
 - iii. biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;
 - iv. screening of the gross visual fields; and
 - v. pressure testing through tonometry.
- c. Evaluate refractive status, including:
 - i. evaluation for visual acuity;
 - ii. evaluation of subjective, refractive, and accommodative function; and
 - iii. objective testing of a patient's prescription through retinoscopy.
 - iv. Conduct binocular function test.

- d. Diagnosis and treatment plan, if needed.
 - e. At least one follow-up visit when scheduled by a Member, to ensure appropriate diagnosis and treatment and lens fittings.
2. Corrective Lenses and Frames. If indicated as necessary by the examination, one frame and one pair of corrective lenses per Member, including single vision, bifocal, trifocal or lenticular lenses as appropriate, for each twelve (12) or 24 month period, beginning from the date of the last examination. Frame and lenses are of a “basic” type, as defined by MVC from time to time.
3. Contact Lenses.
- a. One pair per Member who elects to purchase contact lenses (in lieu of one frame and one pair of corrective lenses), for each twelve or 24 month period, beginning from the date of the last examination.
 - b. Upon prior authorization, one pair of necessary contact lenses for the following conditions for each twelve or 24 month period beginning from the date of the last examination:
 - i. following cataract surgery;
 - ii. to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
 - iii. certain conditions of anisometropia; and
 - iv. keratoconus.
4. Second Opinion Examination. Upon receipt of an authorized referral for a second optometric opinion, an examination including one or more of the elements of an examination described in 1(a) through 1(e) above.

B. Non-Covered Services include:

- 1. Services that are not Medically Necessary and/or are not within the scope of practice of an optometrist.
- 2. Services not obtained in compliance with MVC's rules and policies.
- 3. Vision training.

4. Aniseikonic or plano lenses.
5. Two pairs of glasses in lieu of bifocals, unless Medically Necessary and with the prior authorization of the vision plan.
6. Replacement or repair of lost or broken lenses or frames.
7. Medical or surgical treatment of the eyes.
8. Services or materials which are covered under a Worker's Compensation policy.
9. Eye examinations required as a condition of employment.
10. Services or materials provided by any other group benefit providing for vision care.
11. Services or materials covered by California Children Services (“CCS”) program (Health and Safety Code Section 123,800 et seq.), provided the Member meets the medical eligibility requirements of that program, as determined by that program. Provider shall be responsible for identifying Members who have a CCS eligible condition and shall refer these individuals to the local CCS program for determination of eligibility. Covered Services unrelated to the CCS eligible condition shall be provided by Provider, and Provider shall ensure coordination of services between Provider, CCS providers, and the local CCS program.

**EXHIBIT “B”
MVC PLANS**

“12/12/12” PLAN

MAX VISION CARE BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
Deductibles	None
Lifetime Maximums	No lifetime maximums
Professional Services	
<i>MVC Provider Visit</i>	No charge A Member is entitled to one comprehensive eye examination in a 12-consecutive month period. A second eye examination in a 12-consecutive month period is covered at the request of the Member. The MVC Provider will determine the scope of the second eye examination. Additional eye examinations and contact lens follow-up examinations are covered during the same 12-consecutive month period if determined to be Medically Necessary by the MVC Provider.
Outpatient Services	Not covered
Hospitalization Services	Not covered
Emergency Health Coverage	Emergency medical services are not covered; however, MVC Providers will provide emergent/urgent optometric services within the scope of the optometrist’s licensure.
<i>Urgent/Emergent Optometric Services Visit</i>	No charge
Ambulance Services	Not covered
Prescription Drug Coverage	Not covered
Durable Medical Equipment	Not covered
Mental Health Services	Not covered
Chemical Dependency Services	Not covered
Home Health Services	Not covered
Other	
<i>Frames</i>	Limited to one frame in a 12-consecutive month period. MVC will pay up to \$130 of the MVC Provider’s usually and customary fee for frames (“the Allowable Amount”). Any charges over the Allowable Amount must be paid directly to the MVC Provider by the Member.
<i>Lenses</i>	Limited to one pair of lenses in a 12-consecutive month period if the examination indicates a Prescription Change. “Prescription Change” means any of the following: (1) a change in prescription of 0.5 diopter or more in one or both eyes, (2) a shift in axis of

MAX VISION CARE BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	astigmatism of 15 degrees, or (3) a difference in vertical prism greater than 1 prism diopter. MVC will pay the MVC Provider's usual and customary fee ("the Allowable Amount") for a clear uncoated plastic lens. Any additional lens options or extras in excess of the Allowable Amount, including but not limited to extra charges for oversize lenses (lenses that are 61 millimeters or over) are to be paid directly by the Member to the MVC Provider.
<i>Contact Lenses (Medically Necessary)</i>	One pair of contact lenses in a 12-consecutive month period when Medically Necessary and required for anisometropia or keratoconus, or following cataract surgery, or when visual acuity cannot be corrected to 20/20 in the better eye, except through the use of contacts. MVC will pay up to \$210 ("the Allowable Amount") of the MVC Provider's usual and customary fee for the Medically Necessary contact lenses. The balance, if any, in excess of the Allowable Amount must be paid directly to the MVC Provider by the Member.
<i>Contact Lenses (Cosmetic)</i>	Members may elect contact lenses for cosmetic reasons <u>instead of frames and lenses</u> once every 12-consecutive month period. MVC will pay up to \$100 ("the Allowable Amount") of the MVC Provider's usual and customary fee for the cosmetic contact lenses. The balance, if any, in excess of the Allowable Amount must be paid directly by the Member to the MVC Provider.

“24/24/24” PLAN

MAX VISION CARE BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
Deductibles	None
Lifetime Maximums	No lifetime maximums
Professional Services	
<i>MVC Provider Visit</i>	\$10 Co-payment A Member is entitled to one comprehensive eye examination in a 24-consecutive month period. A second eye examination in a 24-consecutive month period is covered at the request of the Member. The MVC Provider will determine the scope of the second eye examination. Additional eye examinations and contact lens follow-up examinations are covered during the same 24-consecutive month period if determined to be Medically Necessary by the MVC Provider. Each visit is subject a separate \$10 Co-payment.
Outpatient Services	Not covered
Hospitalization Services	Not covered
Emergency Health Coverage	Emergency medical services are not covered; however, MVC Providers will provide emergent/urgent optometric services within the scope of the optometrist’s licensure.
<i>Urgent/Emergent Optometric Services Visit</i>	\$10 Co-payment
Ambulance Services	Not covered
Prescription Drug Coverage	Not covered
Durable Medical Equipment	Not covered
Mental Health Services	Not covered
Chemical Dependency Services	Not covered
Home Health Services	Not covered
Other	
<i>Frames</i>	Limited to one frame in a 24-consecutive month period. MVC will pay up to \$50 of the MVC Provider’s usually and customary fee for frames (“the Allowable Amount”). Any charges over the Allowable Amount must be paid directly to the MVC Provider by the Member.
<i>Lenses</i>	Limited to one pair of lenses in a 24-consecutive month period if the examination indicates a Prescription Change. “Prescription Change” means any of the following: (1) a change in prescription of 0.5 diopter or more in one or both eyes, (2) a shift in axis of astigmatism of 15 degrees, or (3) a difference in vertical prism greater than 1 prism diopter. MVC will pay the MVC Provider’s usual and customary fee (“the Allowable Amount”) for a clear

MAX VISION CARE BENEFIT DESCRIPTION	CO-PAYMENTS, DEDUCTIBLES AND OTHER LIMITATIONS
	uncoated plastic lens. Any additional lens options or extras in excess of the Allowable Amount, including but not limited to extra charges for oversize lenses (lenses that are 61 millimeters or over) are to be paid directly by the Member to the MVC Provider.
<i>Contact Lenses (Medically Necessary)</i>	One pair of contact lenses in a 12-consecutive month period when Medically Necessary and required for anisometropia or keratoconus, or following cataract surgery, or when visual acuity cannot be corrected to 20/20 in the better eye, except through the use of contacts. MVC will pay up to \$210 ("the Allowable Amount") of the MVC Provider's usual and customary fee for the Medically Necessary contact lenses. The balance, if any, in excess of the Allowable Amount must be paid directly to the MVC Provider by the Member.
<i>Contact Lenses (Cosmetic)</i>	Members may elect contact lenses for cosmetic reasons <u>instead of frames and lenses</u> once every 24-consecutive month period. MVC will pay up to \$100 ("the Allowable Amount") of the MVC Provider's usual and customary fee for the cosmetic contact lenses. The balance, if any, in excess of the Allowable Amount must be paid directly by the Member to the MVC Provider.

EXHIBIT "C"
COMPENSATION

MVC
Minimum Reimbursement Schedule

<u>Description</u>	<u>Fee Schedule</u>
Examination (minimum)	\$ 65.00
Single Vision Lens	\$ 32.00
Bifocal or Trifocal Lens	\$ 42.00
Progressive Lens (Plus, patient pays provider the difference of Progressive UCF minus the Bifocal UCF)	\$ 42.00
Frames (for a retail up to \$100.00)	\$ 45.00
Medically Necessary contact lenses (Exam is additional reimbursement)	\$210.00
Cosmetic contact lenses (Exam is additional reimbursement)	\$100.00
Total reimbursement SV Patient	\$142.00
Total reimbursement Bifocal Patient (Plus add-ons at provider's UCF)	\$152.00

All other add-ons are at provider's Usual Customary Fees (UCF); patient pays the difference.

NOTE: If you want to be paid electronically, please attach a blank voided check.

EXHIBIT “D”
CLAIMS SETTLEMENT PRACTICES
AND DISPUTE RESOLUTION MECHANISM

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This Exhibit sets forth Provider’s rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Claim Submission Instructions

A. Sending Claims to MVC. Claims for services provided to Members assigned to MVC must be sent to the following:

Via Mail: Max Vision Care, Inc.
6711 Comstock Ave.
Whittier, California 90601

Via Physical Delivery: Max Vision Care, Inc.
6711 Comstock Ave.
Whittier, California 90601

Via e-mail: www.maxvisioncare.com

Via Fax: 562-693-4418

B. Calling MVC Regarding Claims. For claim filing requirements or status inquiries, contact MVC by calling: 866-557-0518.

C. Claim Submission Requirements. The following is a list of claims timeliness requirements, claims supplemental information and claims documentation required by MVC:

1. Claims must be submitted within ninety (90) calendar days of the Date of Service or payment will be denied.
2. Claim statements must include the following: (1) the Member’s name and ID number, (2) provider’s name and Tax ID number, (3) date and place of service, (4) diagnosis code, (5) procedure code, (6) billed charges, (7) copies of any required referral or other authorization forms, and (8) any attachments and/or supplemental information or documentation which provides the relevant information necessary to determine payer liability. Supplemental reports shall include but are not limited to: (1) A copy of the emergency room report for emergency room physician billing, (2) any information related to coordination of benefits, and/or (3) supplemental

information necessary to support billing for services other than those authorized. Such billings shall be on the CMS 1500 or its successor format adopted by the National Uniform Claim Committee (“NUCC”) or the UB 92 form or its successor format adopted by the National Uniform Billing Committee (“NUBC”), as appropriate.

- D. Claim Receipt Verification. For verification of claim receipt by MVC, call the Claims Department at 866-557-0518.

II. Dispute Resolution Process for Contracted Providers

- A. Definition of Contracted Provider Dispute. A “contracted provider dispute” is a provider’s written notice to MVC and/or the Member’s applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider’s name; provider’s identification number, provider’s contact information, and:

if the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from MVC to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; if the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider’s position on such issue; and

if the contracted provider dispute involves a Member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the Date of Service and provider’s position on the dispute, and written authorization from the Member or Members for provider to represent said Member or Members.

- B. Sending a Contracted Provider Dispute to MVC. Contracted provider disputes submitted to MVC must include the information listed in Section II(A) above for each contracted provider dispute (see Exhibit D-1 of this Agreement). All contracted provider disputes must be sent to the attention of *Provider Dispute Resolution/Claims Department* as follows:

Via Mail: Max Vision Care, Inc.
6711 ComstockAve.
Whittier, Ca. 90601

Via Physical Delivery: Max Vision Care, Inc.

6711 Comstock Ave.

Whittier, Ca. 90601

Via e-mail: www.maxvisioncare.com

Via Fax: 562-693-4418

C. Time Period for Submission of Provider Disputes.

1. Contracted provider disputes must be received by MVC within three hundred and sixty-five (365) days from MVC's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
2. In the case of MVC's inaction, contracted provider disputes must be received by MVC within three hundred and sixty-five (365) days after MVC's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired. MVC's time for contesting or denying a claim expires forty-five (45) working days from the date of receipt of the claim by MVC.
3. Contracted provider disputes that do not include all required information as set forth above in Section II(A) may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to MVC within thirty (30) Working Days of the provider's receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. MVC will acknowledge receipt of all contracted provider disputes, as follows:

1. Electronic contracted provider disputes will be acknowledged by MVC within two (2) Working Days of the Date of Receipt by MVC.
2. Paper contracted provider disputes will be acknowledged by MVC within fifteen (15) Working Days of the Date of Receipt by MVC.

E. Contact MVC Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to MVC at: 866-557-0518.

F. Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format (see Exhibit D-2 of this Agreement):

1. Sort provider disputes by similar issue
2. Submit Provider Dispute Resolution Request (For use with multiple "LIKE" claims) form with each batch
3. Number each batch cover sheet
4. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered batches

- G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. MVC will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.
- H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, MVC will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

III. Claim Overpayments

- A. Notice of Overpayment of a Claim. If MVC determines that it has overpaid a claim, MVC will notify the provider in writing through a separate notice clearly identifying the claim, the name of the Member, the Date of Service(s) and a clear explanation of the basis upon which MVC believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.
- B. Contested Notice. If the provider contests MVC's notice of overpayment of a claim, the provider, within thirty (30) Working Days of the receipt of the notice of overpayment of a claim, must send written notice to MVC stating the basis upon which the provider believes that the claim was not overpaid. MVC will process the contested notice in accordance with MVC's contracted provider dispute resolution process described in Section II above.
- C. No Contest. If the provider does not contest MVC's notice of overpayment of a claim, the provider must reimburse MVC within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.
- D. Offsets to Payments. MVC may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse MVC within the time frame set forth in Section III(C), above, and (ii) MVC's contract with the provider specifically authorizes MVC to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, MVC will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

**EXHIBIT D-1
PROVIDER DISPUTE RESOLUTION REQUEST**

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Max Vision Care, Inc.
6711 Comstock Ave.
Whittier, CA 90601

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE MD Mental Health Hospital ASC SNF DME Rehab
 Home Health Ambulance Other _____
(Please specify type of "other")

* CLAIM INFORMATION Single Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute

* **DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	() Phone Number
Signature	Date	() Fax Number

**EXHIBIT D-2
PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple “LIKE” claims)**

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Page _____ of _____

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

(Please do not staple additional information)

