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November 2018

Proprietary and Confidential - For use by EyeMed network providers only
Introduction

The Provider Manual is part of your contract by reference, so be sure to take some time to familiarize yourself with its contents.

Use the navigation above to move through the manual.

This version of the EyeMed Vision Care Professional Provider Manual supersedes any prior manual you have received from EyeMed, The Eye Care Plan of America (ECPA) or Cole Managed Vision. The information contained in this manual is subject to change. EyeMed reserves the right to revise these policies and procedures at our sole discretion and at any time. EyeMed will notify participating providers of any such revision on our secure provider website prior to implementation. All applicable laws and regulations supersede the provisions of this manual. This Provider Manual is confidential and should not be shared with third parties. The provisions of this version of the Provider Manual are effective 9/7/2018, except in the states of Tennessee and Washington, where they will take effect the later of the effective date or 60 days from the production date whichever is greater.
Requirements

What are your requirements to be an eyemed provider?
As an in-network provider, you have obligations

As a participating provider, you’ve agreed to see our members and accept the negotiated rates detailed in the fee schedules that are part of your contract. You may be contracted for specific networks only, and you can request to participate in others. You’re expected to provide certain levels of service and follow rules for interacting with members.

EyeMed cares for vision and promotes utilization of benefits. In that regard, we work to support access for members, while protecting in-network provider’s volume.

We monitor both sides of the equation: membership growth and participating provider access level.

What does this mean for you?

- You can’t turn away members if you participate in their network and must represent yourself as an in-network provider to them.
- You can’t market directly to member groups and their employees as it relates to your participation in the network but can use EyeMed’s logo in your marketing as appropriate.
- You can request participation on other networks.
- You may be able to decline participation in specific plans that require additional administrative procedures. Call us at 888.581.3648 to request non-standard opt-out forms.
- You must meet all of our requirements to remain on the networks.
- You must make members aware of their costs when you’re providing services that are not covered under their plans.
- You must keep your information up-to-date by using our online form.
- There’s no guarantee we’ll add a new location you open, even if you currently have 1 or more participating locations.
- We’ll evaluate the need of every new location, even those operated by providers who already participate on the network.
- We’ll promote your practice on our member materials.
- We will address any issues through our Quality Assurance process.
- Network policies are at the sole discretion of EyeMed.

How does it work?

- You can’t submit claims for out-of-network services on behalf of members.
- You can’t charge members more than you would charge free-to-choose customers, and you can only use
1 price sheet.
- Don’t share your concerns/issues about EyeMed publicly. Instead, use our QA process.
- Complete and follow the conditions of our logo usage agreement for advertising your participation on the network.
- When EyeMed asks you to report or verify information through inFocus, you must report the information timely, accurately and completely.
- EyeMed has network rules of management in place. We monitor provider compliance in terms of access to members.
- If you’re interested in being on other networks, complete our online Network Request Form.
  - These requests may be related to provider directory information, email addresses, changes to your practice, diagnosis information on your claims, locations in which you practice, who is not accepting new patients and other information.
  - You may be asked to supply signed confirmation.
- For all members, a verbal notification is sufficient when their vision benefits don’t cover a service or item.
  - If the member is part of a Medicare plan, do not issue an Advanced Beneficiary Notice (or ABN form), as these do not apply to Medicare Advantage plans or protect you from liability.
- You need to have either a TPA certificate or DEA license.
  - You can use diagnostic pharmaceutical agents (DPAs) as long as the member’s age, condition type and severity and other contributing factors justify it.
  - Use therapeutic pharmaceutical agents (TPAs) as appropriate when a member has a condition that requires them, but get the member’s consent. You can also refer them to another health care professional as stated in their medical care plan. As with DPAs, document member refusals or referrals.
- To be eligible for participation on our networks, you have to be in good standing with Luxottica Group and all relevant subsidiaries. This includes being current with all financial obligations and complying with all contractual commitments and policies.
- If eligible to participate, you need to send your application to request participation. From there, EyeMed will evaluate our need for a new location in your area.
- Contracted eye care professionals and all affiliated eye care professionals must maintain professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate.
  - In states that have limitations on liability, state law applies.
  - An umbrella policy can meet these requirements.
  - Verify this through our credentialing and recredentialing process on inFocus.
- In-office signage and most advertising are fine, but we don’t permit direct contact with our members or clients who have not previously received care or purchased eyewear from you.

Best practices

- Providers must maintain complete and accurate clinical and financial records for 10 years.
- Verify you participate on the member’s network and plan before providing covered services.
- Note in the patient file that you had a conversation about what services are and are not covered by the member’s vision benefits.
- Document when a member refuses any DPAs you recommend.
- Verify your information when prompted, and alert us of changes using inFocus.

What if you don’t comply with guidelines?

- If you aren’t on the member’s network, we won’t pay the claim.
- We can deny out-of-network claims submitted for services performed by in-network providers.
- Our QA process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.
- If you are successfully accepted to the network, you will be credentialed and on-boarded.

Credentialing and staffing

Before providers can deliver service to members, they must complete credentialing, which verifies that the provider meets our participation requirements. These credentialing requirements apply to all doctors who will provide care to EyeMed members, including fill-in providers. This is a legal requirement.

What does this mean to EyeMed?

- We’re legally required to credential providers before they deliver service to members as a means of confirming providers meet our requirements.
- We use 2 companies to help us with credentialing:
  - The Council for Affordable Quality Healthcare (CAQH)
  - Aperture, a credentials verification organization (CVO)

What do you have to do?

- You must meet our credentialing requirements, including new doctors who join your practice, before seeing EyeMed members and submitting claims under their name.
- You must ensure your CAQH profile is up to date.
- Below are the credentialing requirements and documentation required.
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Documentation Required</th>
<th>Required for</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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<td>Satisfactory work history for prior 5 (initial credentialing) or 3 (recredentialing) years, with explanation of any gaps of 6 months or more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signed and dated attestation of completeness, accuracy and release of information</td>
<td></td>
<td></td>
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<tr>
<td>Valid, unencumbered license in state(s) of practice</td>
<td></td>
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<tr>
<td>Minimum professional liability insurance for all states in which provider practices, as indicated below, or state statutory cap, state regulations or as required by our contractual agreement with plan</td>
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<tr>
<td>- Optometrist or ophthalmologist – $1 million per occurrence and $3 million aggregate</td>
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<td>Requirement can be met with separate umbrella policy</td>
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<tr>
<td>No exclusion from Medicare/Medicaid in the last 5 years*</td>
<td></td>
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</table>
### Criteria

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Required for OD</th>
<th>Required for MD/DO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operation of all equipment (in clean and working condition) used in the course of patient care and management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No history of EyeMed chart/site evaluation failures in the past 5 years*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No more than 3 adverse events within the past 3 years*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice open to new members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduation from an accredited school or college of optometry (optometrists) or an accepted professional medical or osteopathic school and completion of an accredited residency program in ophthalmology (ophthalmologist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No history of insurance fraud*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List of other states where provider is or has been licensed, registered or certified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation of a practice with normal business hours and after-hours coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No office location subleased from or affiliated with a corporate-owned retail optical chain not accepted in our network (subject to state regulations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A valid TPA Certification and/or DEA Certification as indicated by state regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A valid DEA Certification or CDS Certification as indicated by state regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrated board certification (if applicable)</td>
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</tbody>
</table>

**Abbreviations:** OD = optometrist, MD/DO = ophthalmologist

- Verify your information and provide proof of your license, liability insurance and professional certifications to CAQH.
- The process can take up to 45 days.
- Credentialing does not apply to opticians.
How does it work?

- Once you’ve electronically signed your contract, you’ll be notified to begin credentialing.
- You’ll provide information to CAQH, and Aperture will verify your information.
- Our credentialing committee reviews all providers before approving them for credentialing.

Frequency/Timing

- Initial, credentialing takes up to 45 days. From there, unless specific state requirement, you’ll be recredentialed every 3 years.
- Initial credentialing is performed once – following that, providers will follow the needed process.

Best practices

- Make sure you’ve provided all of the required information to CAQH. Contact them at:
  
  888.599.1771
  
  866.293.0414
  
  https://proview.caqh.org/Login
  
  caqh.udphelp@acgs.com
  
- Use our online form to begin credentialing for new providers in your practice and/or to associate fill-in providers to your practice.
- Review your credentialing status through My Requests on the inFocus portal.
- You cannot serve EyeMed members UNTIL you are fully credentialed and approved. You’ll be notified by email when you can begin seeing members.

What happens if you don’t follow the guidelines?

- You will not be part of the EyeMed network and will not be able to file claims.

Your rights during credentialing

- During this process, you have the following rights:
  
  - Right to review information. You can request to review any information submitted with the application at any time. You can also request a copy of the credentialing information received from the CVO.
  - Right to correct erroneous information. If the information we receive from the CVO differs from what’s
on the application, we’ll contact you. You’ll have 15 business days from the date of receipt to respond. This lets you correct any inaccurate information from the CVO submitted by third parties through the primary source verification process.

- Right to be informed of your application status. You can request to be informed of the status of your application at any stage of the credentialing process. The CVO will respond by phone, fax or email.

Recredentialing

Providers complete recredentialing every 24 to 36 months so we can verify the validity of items that can change or expire over time. This is a legal requirement based on state legislation.

What does this mean to EyeMed?

- We are legally required to recredential providers so we can confirm they continue to meet our requirements.
- Our system will identify providers who are due for recredentialing.
- We use 2 companies to help us with credentialing:
  - The Council for Affordable Quality Healthcare (CAQH)
  - Aperture, a credentials verification organization (CVO)

What does this mean for you?

- You must verify your information and provide proof of your license, liability insurance and professional certifications.
- You have 90 days to complete the process.
- Recredentialing does not apply to opticians.
- You can check your progress on inFocus through My Requests.

How does it work?

- You’ll receive a letter and the online claims system will notify you when it’s time to begin recredentialing.
- Update CAQH, and Aperture will verify your information
- Our credentialing committee reviews all providers before they’re approved for recredentialing.
- You’ll need to meet all of our credentialing requirements:
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### Frequency/Timing

- The process begins 90 days prior to the recredentialing date.
- Recredentialing is required every 3 years.

### Best practices

- Keep CAQH up-to-date about changes to your practice information. Contact them at:
What happens if you don’t follow the guidelines?

- You’ll be removed from the network.
  - You’ll have an additional 30 days to provide missing information.
  - After 30 days, you will have to reapply to the network as a new provider.

Your rights during credentialing

- During this process, you have the following rights:
  - Right to review information. You can request to review any information submitted with the application at any time. You can also request a copy of the credentialing information received from the CVO.
  - Right to correct erroneous information. If the information we receive from the CVO differs from what’s on the application, we’ll contact you. You’ll have 15 business days from the date of receipt to respond. This lets you correct any inaccurate information from the CVO submitted by third parties through the primary source verification process.
  - Right to be informed of your application status. You can request to be informed of the status of your application at any stage of the credentialing process. The CVO will respond by phone, fax or email.
  - You can check the status of your recredentialing through “My Requests” on inFocus.
  - You can continue to provide in-network services if and only if your current credentialing period hasn’t expired.

Location requirements

Network providers must make sure all of their locations have all required instruments in working order and also meet hygiene and safety measures.

What does this mean to EyeMed?

- Our requirements align with those of the industry and the Centers for Medicare and Medicaid (CMS).
- We monitor compliance through routine audits and when we receive complaints from members or clients.
What does this mean for you?

- You must have a brick and mortar location.
- You must have all required instruments on site and in working order.
- Keep your office clean and safe for patients.
- Post important information, like your license, hours of operation and other policies, where your patients can see them.
- Secure and retain patient records for at least 10 years.
- You must arrange for back-up if you'll be out of the office for 7 consecutive days or more, and the fill-in doctor must be credentialed by EyeMed.
- You’re responsible for complying with any aspects of the Americans with Disabilities Act (ADA) that pertain to your business.

How does it work?

Required instruments

- We require participating provider locations to offer both exams and materials.
- You must have the following instruments on site and in working order:
  - Phoropter or trial lenses
  - Visual acuity testing distance and near charts and/or projector
  - Retinoscope, autorefractor or wavefront analyzer
  - Keratometer/ophthalmometer/ topographer
  - Ophthalmoscope: direct and binocular indirect with condensing lens
  - Tonometer
  - Biomicroscope
  - Lensometer
  - Radiuscope/keratometer attachment, if rigid contact lenses are prescribed or managed
  - Color vision testing system
  - Stereopsis testing
  - Diagnostic pharmaceutical agents within expiration dates

Office cleanliness requirements

- Properly clean exam rooms, laboratories, dispensing areas, offices and waiting areas.
  - Use gloves, biohazard disposal, trash receptacles and office disinfectant to reduce the spread of infection and ensure safe handling and disposal of medical waste.
  - Have staff wash their hands (in front of the member whenever possible) prior to examining the member, and use an alcohol-based hand sanitizer between interactions.
  - Keep exam lanes, the contact lens and eyewear dispensaries and public areas as clean and clear of
Clean clinical equipment with alcohol wipes in front of the member before each use.
Disinfect diagnostic contact lenses after each use.
Store pharmaceuticals in a secure, sanitary place away from food and beverages.
Discard contact lenses, contact lens solution, DPAs and TPAs after their expiration date.
Properly secure and maintain medical waste containers.

Safety and accessibility requirements

You’re required to operate a safe and secure environment. At a minimum, this includes having:
Adequate lighting in public area
Safe and secure flooring and fixtures
Hand-held fire extinguishers up to local and state fire codes with current inspection tags
A complete first-aid kit that includes at a minimum:
  - Adhesive bandages
  - Adhesive tape
  - Ammonia inhalants
  - Antibiotic ointment
  - Antihistamine
  - Antiseptic towelettes
  - Eye wash solution
  - First-aid/burn cream
  - Latex gloves
  - Pain reliever
  - Scissors
  - Sterile eye and guaze pads
A medical waste container
Any other safety equipment recommended by state or local emergency preparedness ordinances
Secure prescription pads.

Accommodate the needs of members with disabilities per the Americans with Disabilities Act (ADA) as applicable.

Miscellaneous

Maintain all member records (both clinical and financial) for 10 years (or longer if state or federal requirements say so). You can decide if you want to keep these electronically or in hard copy, as well as how long you want to keep them beyond the 10-year timeframe.
Provide seating for at least 5 patients in your reception area and provide an area that offers privacy and confidentiality for discussion of vision care or health information.
Post your license and certifications in plain sight or make them otherwise available to members per
state law.
   - Display and maintain reasonable business hours. If the doctor’s hours are different from the dispensary’s, post both sets of hours.
   - You must identify a fill-in doctor if you’ll be out of the office for more than 7 consecutive business days.
     - The doctor must be credentialed with EyeMed.
     - Use our online form to associate the doctor with your location.

Best practices

- Document your policies that demonstrate compliance with the requirements in this section so you can provide proof in writing should a member ever file a complaint against your practice.

What happens if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Access to care/emergencies

Network providers must accept new patients and must schedule appointments with EyeMed members within 2 weeks of the request. Specific policies help providers deliver necessary care during situations that are deemed emergencies. Practices in California must follow the requirements outlined in Senate Bill 137.

What does this mean to EyeMed?

- As part of our requirements for participating providers, we want network providers to be able to provide care in the event of emergencies.
- We define an eye care emergency as a physical condition involving one or both eyes which, if untreated or if treatment is delayed, may reasonably be expected to result in irreversible vision impairment.
- Eye care emergencies include:
  - Severe eye pain
  - Any penetrating injury to the eye
  - Chemical contact with the eye (particularly alkaline substances)
  - Sudden total loss of vision in one or both eyes
  - Sudden loss of vision to a degree that prohibits mobility
- Lost or broken eyeglasses or contact lenses, regardless of the strength of the prescription, do not constitute eye care emergencies.
What does this mean for you?

- Schedule non-urgent appointments within 2 weeks of the original request.
- If a member has an eye care emergency requiring eyewear, follow our emergency lab process.
- If you practice in California, make sure you follow the requirements in Senate Bill 137.

How does this work?

- Per California Senate Bill 137:
  - Urgent care appointments (no prior authorization required) must occur within 48 hours or 2 days.
  - Urgent care appointment (prior authorization required) must be made within 96 hours or 4 days.
  - Non-urgent doctor appointments must be scheduled within 15 business days (note that we require appointments within 14 business days).
- During normal business hours, the wait time for a patient to speak by telephone with a knowledgeable and competent staff person can’t exceed 10 minutes.
- Have (or arrange for) telephone triage or screening services on a 24/7 basis through which patients can get help to determine the urgency of their condition. Patients should receive return calls from this line within a reasonable timeframe, not to exceed 30 minutes.
- During non-business hours, have an answering service or a telephone answering machine that provides instructions on how patients can obtain urgent or emergency care including, when applicable, how to contact another vision provider who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care.
- Coordinate interpreter services with scheduled appointments to ensure interpretation is provided at the time of the appointment if needed.
- Perform urgent-care services the same day and offer after-hours support—via mobile phone, pager or an answering system—to members seeking emergency eye care. Have referral instructions on hand to give members who have an emergency eye care need outside your scope of practice during your office hours and after hours.

What if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Member confidentiality and privacy laws

Network providers must protect patient medical records and other confidential health information according to the state and federal laws restricting the release of patient information.
What does this mean to EyeMed?

- If we receive a report of a privacy complaint against you, we’ll forward it to you so you can address it within your privacy procedures.

What does this mean for you?

- You must follow all applicable state and federal guidelines restricting unauthorized access, use, destruction and the release of member information that includes Protected Health Information (PHI), Personally Identifying Information (PII) and credit card data.

How does it work?

- Member demographic and plan information displayed in our online claims system is proprietary and confidential.
- Keep medical records and other protected health information (PHI) confidential. Your procedures govern the use, collection, verification and removal of member information, as well as how and when to release this information.
- By law, you need a member’s written consent or permission from the member’s legal guardian before releasing PHI.
- You’re not permitted to use or re-disclose misdirected PHI.
  - If you happen to receive something from us that has PHI for a member you aren’t currently treating:
    - Destroy it immediately or safeguard it for as long as it’s in your possession.
    - Call us at 888.581.3648 to let us know you received the PHI in error.
    - If for some reason you can’t destroy the information, let us know.

Best practices

- When using the computer, protect the information by keeping the screen facing away from common areas and lock your screen when you need to step away.
- Sending patient charts to us for audit or other review purposes is not a violation of HIPAA confidentiality. You also don’t need to have the member sign a new form or otherwise give permission before you sending the charts to us.
- You can find more information about federal laws pertaining to medical information at hhs.gov/ocr/hipaa.
What if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Cultural competency and language assistance

You must provide services in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, physical and mental abilities and health conditions.

What does this mean to EyeMed?

- We want to make sure members from all backgrounds receive care that is consistent with their cultural norms.

What does this mean for you?

- Providers must complete cultural competency training annually to help all staff members understand how to deliver care across cultures.
- Respect and provide services in a manner that meets member cultural preferences and needs.
- Report all languages spoken in your office, including American Sign Language, in CAQH so we can include this information on our provider directory.
- Provide translation services for patients upon request.
- Provide language assistance to members with limited English proficiency.
- In California, comply with state laws pertaining to language assistance.

How does it work?

- Provide oral interpretation, American Sign Language interpretation and/or written translation of your practice materials and service delivery upon member request.
- Complete annual cultural competency training, which is part of our annual training module. See our Annual Training Requirements section for more details.
- In California:
  - Prominently post a language assistance notice in each of your locations.
  - Provide members with access to free highly skilled, qualified interpreters through our interpreter
service.

- Grievance forms and language procedures are available to members by emailing us through infocusdev.mowerinteractive.com/emailus. California members can contact the California Department of Managed Health Care’s Help Center at 888.HMO.2219 or TDD 877.688.9891. The Help Center is open 24 hours a day, seven days a week to answer questions.

Frequency/Timing

- Complete cultural competency training once per calendar year by December 31.

Best practices

- Customize, print and make available copies of section 1557 of Affordable Care Act’s Notice of Nondiscrimination and Statement of Nondiscrimination in the most common languages your practice encounters. Translated versions are available online at https://www.hhs.gov/civil-rights/fo-individuals/section-1557/translated-resources/index.html.
- In California:
  - Call us at 888.581.3648 during normal business hours (7:30 a.m. to 11 p.m. ET Monday through Saturday and 11 a.m. to 8 p.m. ET on Sunday) to access free interpreter services.
    - When using this service you’ll need the member’s first and last name and their date of birth or the member ID number and preferred language for the member (if known).
    - Our interpreters are trained in medical and insurance terminology as well as diverse ethnic and language nuances.
    - Members can use their family members as interpreters, but you still need to make them aware interpreter services are available to them. If they do opt for a family member or friend, this shouldn’t compromise the effectiveness of the service or violate a member’s confidentiality.
    - Capture known language preference in patient files. Should a member refuse access to offered language assistance services, make a note of it in the patient record.

What if you don’t follow the guidelines

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Sales tax

You’re required to follow your state laws regarding sales tax on eyewear purchases.
What does it mean for EyeMed?

- We follow state laws regarding the application of sales tax to eyewear purchases.

What does it mean for you?

- If you’re in a state or region that charges sales tax on eyewear, complete and return the Uniform Sales Tax and Use Certificate form.
  - Sales tax states include: AL, AR, CA, HI, ID, IL, KY, LA, MO, MS, NM, NV, OH, OK, SC, TN and UT.
  - Find more information about how to apply sales tax to member benefits in section 1.25 of our Provider Agreement.
- Pediatric Vision Benefits should not be treated differently in terms of sales tax.

Best practices

- Use your local tax authorities or work with a tax attorney for information.

What happens if you don’t follow the guidelines?

- If you don’t return the form, and you’re in a taxable region, you’ll be charged sales tax on your lab orders.

Medicare and Medicaid participation

EyeMed’s plans may enroll members who have benefits through Medicare and Medicaid, so we require network providers to be eligible to participate in federal healthcare programs.

What does this mean to EyeMed?

- We are subject to CMS rules and comply with state and federal rights related to network participation.
- To secure compliance, EyeMed conducts monthly reviews to determine whether network providers are included on Medicare’s opt-out lists or state or federal program participation exclusion lists.
- If you are participating in Medicaid plans through EyeMed, you must be enrolled with your state Medicaid agency, and we must have Medicaid ID number on file. We will request ID number during contracting.
What does this mean for you?

Medicare participation

- As an eye care provider, you can decide whether and how you choose to participate in federal health care programs, including Medicare. There are 3 basic categories of providers:
  - Medicare participating;
  - Non-Medicare participating; and
  - Opted out of Medicare.
- If you opt out of Medicare, you’re also opting out of EyeMed because EyeMed membership includes Medicare Advantage members.
  - Opting out of Medicare means Medicare will cover no services provided by you and no Medicare payment can be made to you.
  - While you can “opt out” of participating in federal programs, doing so means that under federal law you cannot be reimbursed for rendering services to Medicare members, including those enrolled in Medicare Advantage plans.

State Medicaid Agency Enrollment

- All providers that wish to participate in a Medicaid Managed Care plan served by an EyeMed network must be enrolled in the State Medicaid Agency.
- Your ID number will be key to participate in this program.

What happens if you don’t follow the guidelines?

- Pursuant to CMS requirements, if you opt out of Medicare, there is a 2-year waiting period before you can be reinstated.
- Providers who do not remain enrolled in Medicare will be immediately removed from the EyeMed provider panel. Providers excluded from participation in programs that receive federal funding cannot participate in EyeMed networks.

State laws

Should any state licensing or regulatory authority require specific tests, use of pharmaceutical agents or listed instrumentation not indicated in this manual, state statutes and regulations always prevail.

Arizona disclosure law

- According to state law, any optometrists or ophthalmologists practicing in Arizona must meet the
following requirements regarding disclosure of information to members:

- If a member asks for a list of direct pay prices (prices you would charge patients who have no vision benefits) for the 25 most commonly provided services you need to provide the list. If your practice is owned by an optometrist or ophthalmologist and you have fewer than 3 licensed doctors, you’re exempt from this requirement.
- When members choose to pay you directly for a service rather than have you submit claims on their behalf, you must have them sign a waiver stating they understand their rights as a member of the plan.

Non-traditional practice settings

EyeMed will contract with providers who practice in non-traditional only settings when specific requirements are met.

What does this mean to EyeMed?

We’ve established specific requirements for mobile providers and doctors who perform telemedicine.

Mobile providers

- We define a Mobile Provider as a third party who performs eye exams and/or dispenses materials at a location(s) other than a contracted brick-and-mortar location(s).
- Mobile Providers include, but are not limited to:
  - Vision vans
  - Temporary eye clinics
  - Those who serve patients at nursing homes or other care facilities.
- EyeMed has categorized Mobile Providers as:
  - Category 1: Those who increase access to care to otherwise underserved populations. EyeMed generally accepts Mobile Providers who fall in this category.
  - Category 2: Those who provide a service of convenience to members who already have adequate access to care. EyeMed only accepts providers in this category under certain circumstances.

Telemedicine

- We follow the Centers for Medicare and Medicaid Services (CMS) guidelines for member benefits. Telemedicine services are covered only when the member is located in a remote (non-metropolitan) area.
  - Telemedicine can open access to vision care through 2-way, real-time interactive communication between the patient and provider at a distant site.
What does this mean for you?

Mobile providers

- All Mobile Providers who want to participate in an EyeMed network must go through a Mobile Provider application and approval process.
- If approved, doctors performing exams will also need to be credentialed.

Telemedicine

- You must meet EyeMed’s requirements to receive approval to provide telemedicine as a covered benefit, including security and credentialing.
- Members must contact EyeMed before the telemedicine consultation to see if the benefits will be covered. If they are, you can file the claim online as you normally would.

How does it work?

Mobile providers

- You’re generally required to have a brick-and-mortar location that provides comprehensive eye exams in addition to any mobile services to ensure that members have access to continuity of care.
- You may not provide in-network covered services to EyeMed members prior to having your application approved, being credentialed and signing a participation agreement.
- Deliver/dispense all materials to members within 30 days of the exam date or notification of the need for new materials (loss, breakage, etc.).
- Leave clear, legible contact information, exam findings, follow-up notes and recommendations with the patient after every patient encounter.
- Provide/ensure appropriate medical eye care follow-up and/or ensure continuity of care with other medical providers, as indicated.
- Ensure that all HIPAA and medical records best practices are adhered to in the mobile setting and when traveling to and from the mobile setting.
- Ensure that all mobile service providers are and remain a credentialed provider in good standing with EyeMed in accordance with the terms and provisions contained in the credentialing policies and procedures, EyeMed provider agreement and Provider Manual.
- Have and maintain the required equipment at both the physical office location and mobile setting. We may request proof of equipment.
- Report any material changes within 30 days and provide written program and protocol revision descriptions.

Telemedicine
To be permitted to provide telemedicine services as a covered benefit, the provider must meet the below requirements:

- Have a fully licensed and accredited brick-and-mortar location.
- Have an established relationship with the patient before providing telemedicine, with at least 1 in-person comprehensive eye exam or consultation with a provider before the telemedicine services occur.
- Offer a level of care equal to in-person care, utilizing real-time, interactive audiovisual technology.
- The doctor providing the care must be licensed in the state where the member is located and must be credentialed with EyeMed.
- Your patient must sign an informed consent.
- You need to have privacy and security measures in place that meet HIPAA and HITECH standards.

Frequency/Timing

- Once a completed initial Mobile Provider Application package is received, it takes a minimum of 30-60 days to complete the process.
- Mobile Providers must recertify compliance with EyeMed’s requirements every 2 years.

Best practices

- Download a copy of the Mobile Provider Application and email it to us at provider@eyemed.com.

What happens if you don’t follow the guidelines?

- EyeMed will not permit mobile providers on the network who have not formally applied.
- Any finding of falsification of this information or failure to report material changes is grounds for immediate termination.
- We will deny claims submitted for either mobile providers or telemedicine services that have not been pre-approved through this process.

Network terminations

Providers can leave the network upon request, or they can be terminated by EyeMed for specific reasons.

What does this mean to EyeMed?

- Involuntary terminations occur when we terminate your participation immediately.
- Once you’re no longer participating on the network, we’ll remove your location(s) from our automated
locator services and exclude you from future member materials directories or mailings effective the day of termination.

- We will not terminate or refuse to renew a Provider agreement solely because the provider has advocated on behalf of a member, filed a complaint against EyeMed, appealed a decision of EyeMed, provided information to a Member regarding a condition or course of treatment, or made a report to an appropriate governmental body regarding the policies or practices of EyeMed that the provider believes may negatively impact upon the quality of, or access to, patient care or requested a fair hearing.
- We’ll process all claims submitted before the termination date and within claim-filing limits per the plan design.

What does this mean for you?

- You can request to be removed from the network, which we call a voluntary termination, usually with 60 days advance notice.
  - The amount of notice required to leave the network can vary; refer to Appendix 9 of your contract.
- Certain actions can result in involuntary termination.
- In the event of an involuntary termination, you’ll receive a written notice specifying the date of termination from the network, any applicable appeal rights and the appeal process.
- Your status will remain active during any appeal process unless the termination was based on loss of license, loss of insurance, evidence of physical or potential harm to a member or a reasonable suspicion of fraud.
- Notify your patients who have EyeMed benefits that you are leaving the network and explain how they can locate a new in-network provider if desired.
- Inform our members you’re no longer a participating provider before seeing them.

How does it work?

- Use the Termination of Tax ID or Location form to request removal from the network.
- EyeMed can involuntarily terminate you for the following reasons:
  - Lose or have your license suspended
  - Commit fraud, waste, or abuse
  - Fail to comply with insurance requirements
  - Submit false claims (which may include claims for services and/or materials not actually received and/or claims containing misleading or false information)
  - Have any legal or government action against your practice
  - No longer meet our contract requirements (which include provisions in this manual), including:
    - Providing false or misleading information upon contracting or renewal, credentialing or initial or subsequent application to participate in an EyeMed network or program
    - A pattern or practice of unprofessional or inappropriate conduct toward our members or clients
- Notification of a sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs against a provider, an affiliated eye care professional, tax entity or location
- When termination is deemed necessary to protect against the risk of imminent danger to the health or welfare of our members
- Bankruptcy filing
- In situations where involuntary terminations can be appealed, submit a fully documented, written statement, requesting reconsideration of the decision within 30 calendar days from the date of notification.
  - The Peer Review Subcommittee reviews involuntary termination appeals
  - You’ll receive written notification of their decision upon completion of their review.

Frequency/Timing

- You generally must notify us at least 60 days prior to leaving the network.
- You have 30 days to appeal an involuntary termination.

Best practices

- Common reasons for termination include not responding to credentialing requests prior to the termination date or opting out of Medicare or Medicaid.
- Provide referral instructions for follow-up care or clinical record requests when necessary.
- A common reason for termination is non-response to a corrective action plan after an audit.

What happens if you don’t follow the guidelines?

- You may be required to continue as an in-network provider for 60 days following notice.
Claims and payments
Reimbursements

Your total payment equals your reimbursement from EyeMed and, in some cases, member payment. If you use the lab network, the lab charges will be deducted from your EyeMed reimbursement.

Your eye exam reimbursement is provided in the fee schedule. The frame reimbursement is based on a frame factor detailed in your fee schedules. Your payments for progressive lenses and lens options are detailed in the Standard Lens Options Schedule. When using single vision in-office finishing, you’ll receive an additional $7 dispensing for single vision lenses.

Some special services, including low vision, safety eyewear and pediatric vision benefits, follow different schedules.

What does it mean for you? How does it work?

- When you don’t use a contracted lab to make eyewear, you’ll be paid according to the amounts listed under the Claims Submitted Outside of Our Claims System section on your fee schedules.

Frame reimbursements

- Frame reimbursements are composed of the following:
  - Frame dispensing amount listed on the fee schedule.
  - Frame retail amount or member allowance, whichever is less, divided by the frame factor on the fee schedule.
  - Member pays 80% of the balance over the frame allowance.

Lens reimbursements

- If you’re using our lab network, you’ll be paid a dispensing fee and be responsible for lab/lens charge backs according to our Lens and Options Charge Back Schedule.

Special services

- Retinal imaging
  - Some plans include a benefit or discount for retinal imaging.
  - When they do, members pay either:
    - $39 (or your standard office charge if it’s less) on a retinal imaging screening
    - A $0, $10, $20 or $30 copay (you’ll be reimbursed up to $39 after the copay)
- Diabetic eye care plans
  - You’ll be reimbursed according to the diabetic eye care plan fee schedule.
- Pediatric Vision Benefits
  - You’ll receive a flat payment for frames.
- See the Pediatric Vision Benefits fee schedule.

- **Safety Eyewear Program**
  - You’ll receive a $25 dispensing fee for each pair of complete safety glasses under this program.
  - You’ll receive your standard payments for lens options as listed in the standard Lens Options Schedule, except for polycarbonate.
  - There is no additional reimbursement for dispensing polycarbonate lenses in safety eyewear.
  - Lens and Options Charge Backs will apply for all safety eyewear orders placed through the lab network.
  - For complete information, see the Safety Eyewear Plan Fee Schedule for providers using the lab network and the Safety Eyewear Plan Fee Schedule for providers not using the lab network.

- **Medically necessary contact lenses (except Humana Vision plans)**
  - Reimbursement is based on the qualifying condition.

<table>
<thead>
<tr>
<th>Qualifying criteria</th>
<th>Provider reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>95% of U&amp;C up to $700</td>
</tr>
<tr>
<td>High ametropia</td>
<td>95% of U&amp;C up to $700</td>
</tr>
<tr>
<td>Keratoconus – Mild/Moderate</td>
<td>95% of U&amp;C up to $1,200</td>
</tr>
<tr>
<td>Keratoconus – Advanced/Ectasia</td>
<td>95% of U&amp;C up to $2,500</td>
</tr>
<tr>
<td>Vision improvement</td>
<td>95% of U&amp;C up to $2,500</td>
</tr>
<tr>
<td>Pediatric aniridia*</td>
<td>95% of U&amp;C up to $3,730</td>
</tr>
<tr>
<td>Pediatric aphakia*</td>
<td>95% of U&amp;C up to $5,800</td>
</tr>
<tr>
<td>Pediatric pathological myopia*</td>
<td>95% of U&amp;C up to $700</td>
</tr>
</tbody>
</table>

*Applicable only to members of Pediatric Vision Benefits in California. Pathological myopia pertains only to Health Net members. See information about medically necessary contact lens benefits for Pediatric Vision Benefits members, and details about Health Net’s unique benefit. View the process for obtaining authorizations and filing claims for these special medically necessary contact lens benefits.

- Non-standard plans pay according to the available plan benefit.
- Humana Vision medically necessary contact lenses
  - Contact lens fitting fee and materials are reimbursed on an invoice cost basis.
  - The reimbursement covers the initial fitting and materials only.
- Johnson & Johnson
  - You’ll be reimbursed 100% for ACUVUE® lenses up to MSRP.
  - Current year MSRP
- Low Vision Benefits
  - We’ll reimburse 100% of U&C up to the member’s allowance amount, which varies by plan.
• You can’t balance-bill the member for amounts over the allowance, unless the benefit indicates that you can.

• Visual Display Terminal (VDT) benefits
  • You’ll receive your contracted eye exam reimbursement for the additional refraction services required for VDT benefits.

• Medicaid plans
  • Your reimbursements for Medicaid plans will be based on your state’s Medicaid fee schedule.
  • When we enter a market, participating providers will receive contract amendments that include the Medicaid fee schedules for your state.

• Medical/Primary Eye Care Plans
  • Tufts Health Plan
    • Primary eye care plans follow the below fee schedules, which vary by state:
      • Connecticut
      • Massachusetts
      • New Hampshire
    • You’ll be paid according to the Tufts post-cataract benefits fee schedule for any claims for services or materials after cataract surgery.
  
  • Fallon Community Health Plan
    • Primary eye care plans follow the Fallon primary eye care fee schedules.
    • Members receive a separate reimbursement of $12.51 for refraction services performed during a comprehensive eye exam for members of Mass Health Routine (Group ID 9823253) and Navigare Routine (9823246) ONLY.
    • Medical/surgical eye care plans have specific fee schedules, which we’ll provide to participating providers when applicable.

Members with medical and vision benefits

Note: This policy is not intended to interfere or infringe on the professional judgment and decision-making of the participating eye care professional providing covered services as defined. All eye care professionals should adhere to their usual and customary coding and billing procedures in accordance with the American Medical Association’s Current Procedural Terminology (CPT) coding guidelines, consistent with evidence-based medicine and accepted standards of care for eye care professionals.

In situations where members have eye exam benefits through both their medical and vision plan, network providers should use their professional judgment combined with discussions with the patient to determine whether to file an eye exam claim or, potentially, other service(s), with us or through the patient’s medical carrier.
What does it mean for you?

- As a participating provider with EyeMed, you are under legal agreement with us to provide requested covered services and/or deliver materials to our members.
- If the patient initially lacks a specific complaint related to a medical condition, it is most appropriate to bill the vision plan (EyeMed) for the visit.
  - If during a visit where the patient presented without a medical-related complaint you discover the patient has a medical condition and your prescribed treatment plan would require medical eye care, inform the patient of their condition and their need for the diagnostic testing and/or treatment anticipated, then schedule the patient for a follow-up medical eye care visit.
  - Follow-up medical eye care should be billed to the patient’s medical plan.
- If the patient requests a vision plan examination based on a presenting problem, explain to the patient the needed care and coverage/billing options under their medical plan, possible out-of-pocket payments or possible referral options.
- Should an EyeMed member insist that a vision plan claim be submitted and the presenting problem, in your professional judgment, would indicate the need for another service and/or procedure, you may elect to refuse to provide the comprehensive eye examination under the vision plan.

How does it work?

- When the patient has no reported medical conditions, the coverage of services rendered by an eye care professional depends on the purpose of the examination or service and not the ultimate diagnosis of the patient’s condition.
- When a patient goes to his/her physician for an eye examination with no specific complaint related to a medical condition, the expenses for the examination are likely not covered under the patient’s medical benefit, even though a pathological condition was discovered as a result of the eye examination.
  - Under these circumstances, the eye examination should be billed to the vision plan if the patient presented without a specific complaint related to a medical condition.
  - If you recommend that the eye care service(s) provided be billed to the patient’s medical plan, it must be fully disclosed to the patient as to the reason for the recommendation to bill the medical plan and the possible deductible and/or copay out-of-pocket expenses.

Best practices

- Following your explanation of the entity to be billed, the patient should acknowledge this explanation by signing a Disclosure Form that states:
  - The medical reason (diagnosis) a claim is being filed with the medical benefit.
  - The potential cost (out-of-pocket expense), which would include the deductible and/or copay. It’s understood you may not be able to definitively determine the amount; therefore, listing your usual
and customary charges for the service(s) would be an acceptable disclosure.

- Clearly document the reasons for any refusal of care in the patient’s clinical record and contact us at 888.581.3648 to inform us of the refusal of care and the reason.
- If you deem the eye exam would be covered by the medical plan:
  - If you’re a participating provider for the patient’s medical plan, inform the patient of your participating status.
  - If you are not a participating provider, inform the patient that your practice’s usual and customary fees will be charged, and disclose those proposed fees.
- If the patient elects to be referred to a participating medical provider, make every effort to refer appropriately and provide the subsequent professional with all relevant information concerning your findings that will lead to the best possible outcome for the patient.

What if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Coordination of benefits

The majority of our plans do not allow coordination of benefits.

What does it mean to EyeMed?

- We’re considered the primary payer.
- We don’t reimburse separately for any services included in a comprehensive eye exam (including dilation and refraction) unless the contract with the client specifically permits it.

What does it mean for you?

- Claims for refraction only will be denied unless they are for members of groups that have specific contract provisions for coordination of benefits.
- You cannot submit dilation only claims.

How does it work?

- We’ll coordinate benefits only for the following plans as long as you submit the proper paperwork (including an EOB or remittance from another carrier showing non-payment of a portion of the claim):
When a Medicaid member has benefits through multiple plans or “dual coverage,” you’ll need to know what plan is primary and what plan is secondary or tertiary.

- Medicaid is always the payor of last resort.

- File the claim with the primary plan first, then submit the claim to EyeMed as the secondary plan using a CMS 1500 form once an explanation of payment (EOP) and possibly a payment is received from the primary plan. Include a copy of the EOP from the other plan.

- For members of the Federal Employees Dental & Vision Insurance Program (FEDVIP) program through Aetna, the medical plan is primary.
  - If you see the member is part of either the Aetna FEDVIP Standard 2 or the Aetna FEDVIP High 2 plans, you’ll know the person has Aetna for medical and vision. In this situation, you’ll file the claim with us through our online claims system.
  - Should the member give you a medical ID card other than Aetna, or the person’s plan is called Aetna FEDVIP Standard Plan or Aetna FEDVIP High Plan (Plan IDs 9885963 and 9885971 respectively), the member has medical benefits through a company other than Aetna.
  - The member’s medical benefits are primary if you participate on the medical network. You can file claims for any denied services with us using a CMS 1500 form as long as you attach the medical plan’s denial.
  - You can then submit any denied portion of the claim to us on a hard copy CMS 1500 form (be sure to attach the denial), and we’ll coordinate benefits.
  - If you’re not on the medical plan network, just file the claim with us.

*Humana Vision Insight plans do not allow refraction only claims/coordination of benefits. If you’re unsure what plan the member is part of, contact us at 888.581.3648.*
Best practices

- Refer to the [Special Claims Processes section](#) for more information about submitting claims for refraction only when permitted by the plan.
- The [Medicaid](#) section further explains requirements related to Medicaid members.

What happens if you don’t follow guidelines?

- Your claim will be denied and you may be responsible for returning money to the member.

Submitting claims

Providers use the online claims system to file claims, except when the benefits are excluded from the lab network, need special processing or are for an emergency pair of eyewear. Or, providers can submit non-lab claims electronically using 837 inbound format through outside clearinghouses.

We require participating providers to submit all applicable ICD-10 diagnosis codes when filing a claim.

For most plans, you have 180 days from the service date to submit the claim or file corrected claims. Some plans have other filing limits per their contract terms.

We don’t coordinate benefits unless the group’s contract specifically allows for it.

What does it mean to EyeMed?

- We use CPT codes 92004 and 92014 for eye exams because they describe specific definitions of what a comprehensive eye exam should include.
  - We don’t work with employer groups that recognize S0620 or S0621 codes, because their definition of an eye exam is limited to the title.
- We consider the refraction (CPT 92015) part of a comprehensive eye exam.
  - The only time we’ll reimburse you for refraction by itself is when we’re contracted to coordinate benefits for the group.
  - The [Coordination of Benefits](#) section has a list of groups refraction only claims apply to.

What does it mean for you?

- You’ll submit most claims online using our online claims system or via 837 electronic data interface (EDI).
- For most plans, you have 180 days from the service date to submit the claim or file corrected claims.
- For Medicare members, you have 12 months to file the claim.
- If you don’t file the claim in time, you can’t go back to collect the money from the member.
- Some plans have other filing periods as detailed below.

<table>
<thead>
<tr>
<th>Plan name</th>
<th>Filing limit</th>
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<tbody>
<tr>
<td>AT&amp;T Plan IDs:</td>
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<tr>
<td></td>
<td>9825449</td>
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<td>9825530</td>
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<td>9727058</td>
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<td>9727181</td>
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<td>90 days after the end of calendar year</td>
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<td>AT&amp;T Plan IDs:</td>
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<td></td>
<td>9727199</td>
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<td></td>
<td>9727027</td>
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<td></td>
<td>15 months from date of service</td>
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AT&T Plan IDs:
- 9825449
- 9825530
- 9727058
- 9727066
- 9727074
- 9727082
- 9727090
- 9727108
- 9727173
- 9727181

90 days after the end of calendar year

Time Warner 2 years from date of service

(This list is subject to change.)

- Medicaid claims must be filed within 90 days, and corrected claims must be submitted within 45 days of denial.
- If you decide to use electronic data interface (EDI), you’ll need to accept an alternative fee schedule, as you can’t submit lab orders using 837. To begin the process, contact us at 888.581.3648.

How does it work?

- Submit all claims requiring lab orders directly through our online claims system.
  - Use CPT codes to indicate the services performed. We do not accept S codes.
  - Also submit all applicable ICD-10 diagnosis codes when filing a claim.
- The online claims system lets you note primary and high-risk diagnoses, including abnormal pupil, ARMD, cataract, diabetes, diabetic retinopathy, glaucoma, hypercholesterolemia and hypertension.
- You can also use CPT II codes to denote the patient’s risk for diabetic retinopathy.
- For hard copy claims and special processes, use our Preferred Claims Codes. We might also deny codes not on this list, based on the member’s plan and benefits.
  - Any plans, services or materials requiring a CMS 1500 hard copy submission are not eligible for lab ordering.
  - Fax hard copy claims to 866.293.7373, or mail them to:
EyeMed/FAA
PO Box 8504
Mason, OH 45040-7111

- You can use electronic data interface (EDI) claims submission, but labs cannot accept orders using EDI.
- You should file Aetna and Anthem (Blue View Vision) claims through EyeMed’s online claims system.
- You cannot submit a separate claim for the refraction service (unless it’s a VDT plan or one of the groups on our coordination of benefits exception list).
- You can submit claims for medically necessary contact lenses, VDT benefits and some primary/medical eye care benefits through the normal process. Refer to Special Claims Processes for instructions for submitting claims that fall outside our normal process.

Best practices

- Check the plan’s claim filing period when you confirm benefits and eligibility.
- We’re not an authorized forms supplier, so we can’t give you CMS 1500
- Labs can’t accept hard copy, manual or paper orders.
- Include primary and secondary diagnosis codes on hard copy claim forms. We need these to comply with HEDIS reporting requirements. Using other codes can delay your payment.
  - Report these based on information from the patient’s history, any reported medications and your clinical findings during your evaluation.
  - **Select the appropriate code(s) even though you are providing routine vision care services. The diagnosis codes are not tied to the services you provide.**
  - These codes don’t impact how members apply their benefit or what we reimburse you, but they do help us add a more thorough approach to health and wellness for employer groups.
- Make sure you haven’t already started the claim online. Even if you haven’t hit the Submit button, we’ll deny hard copy claims when an online claim is already in-process for the same transaction.

What happens if you don’t follow the guidelines?

- If you send us a hard copy claim for materials that should have been submitted to a lab through our online claims system, we’ll reimburse you according to the Claims Submitted Outside of Our Claims System fee schedule on your network schedules. You’ll be responsible for all lab and eyewear fabrication costs, and you can’t bill the member for the balance.
- Billing the same service on the same date of service to multiple entities is not appropriate.
  - We’ve discovered this billing practice is common in some offices who then request a withhold if both the medical and vision plan approve and pay the claims.
  - We understand errors can occur, however, if we see a pattern of this billing practice, we’ll report it to
the medical plan in question to be investigated. We’ll also place the practice in a level of non-compliance that could lead to termination from the network. Refer to our Quality Assurance Process for more details about disciplinary actions.

- If labs receive claim forms, they’ll return them to you unprocessed.
- Refraction only claims submitted for any groups other than those on our exception list will be denied.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Claim payments and withholds

A wholly owned subsidiary of EyeMed, First American Administrators, Inc. (FAA), processes all claims. We pay claims within 30 business days of receiving a clean claim.

Withholds are applied to collect money owed for corrected claims or payment adjustments.

What does it mean for EyeMed?

- We’ll pay you no later than 30 business days from when we receive a “clean” claim.
  - For lab orders, 30 days begins when the lab lets us know the order has shipped.
  - Exam portions of claims are not paid until the materials are shipped from the lab.
- We’ll pay shipping charges from the lab to your office for the initial order and any subsequent transactions covered by our remake policy.
- We’ll adjust the claims process timing as required by state law.
- If we overpay you as part of a claim correction or complaint resolution, we’ll withhold the overage from a future payment.

What does it mean to you?

- You’ll be paid within 30 business days of submitting a clean claim.
- Claims are paid electronically by FAA at least once per week.
- If you choose to receive paper checks instead of electronic payments, a fee could apply.
- Remittance advices summarize your payments and will also show any withholds applied because of incorrect or voided claims.
- You’ll be responsible for any shipping charges outside of the remake policy.

How does it work?

- FAA generates payments weekly.
EyeMed pays claims by electronic funds transfer (EFT).

Electronic payments may appear on your statement under different names. Any of the below names are payments for EyeMed claims:

<table>
<thead>
<tr>
<th>Aetna Life</th>
<th>EyeMed MVC IPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem/IBM</td>
<td>Fidelity Security Life</td>
</tr>
<tr>
<td>Assignment</td>
<td>Fidelity Security Life New York</td>
</tr>
<tr>
<td>Blue Cross Blue Shield Arizona</td>
<td>Heritage Vision Plans Inc.</td>
</tr>
<tr>
<td>Blue Cross Blue Shield North Carolina</td>
<td>Holding for Humana</td>
</tr>
<tr>
<td>Combined of America</td>
<td>Humana VCP</td>
</tr>
<tr>
<td>Combined of America New York</td>
<td>Sierra</td>
</tr>
<tr>
<td>EIC Resellers</td>
<td>Security Life</td>
</tr>
<tr>
<td>Eyexam</td>
<td>Standard Security Life New York</td>
</tr>
<tr>
<td>EyeMed MVC</td>
<td>Texas HMO- Cole</td>
</tr>
</tbody>
</table>

- Use our [online form](#) to change any of your direct deposit details, like account number.

- You can have checks mailed to you, but you could be charged a 5% administrative fee for this service, per section 1.6 of your provider contract, except for tax entities contracted in Alabama, Maryland or Oregon.
  - If you’re still getting paper checks, you’ll receive a Remittance Advice (RA). You can also view RAs online through the Payment History section of the online claims system.
  - Enroll in direct deposit by completing our [online form](#).
  - You’ll see withholds reflected on remittance advices.
  - Refer to our [fraud warning statements](#).

**Best practices**

- Register for EFT by completing our [online request form](#). You’ll need your bank account number, routing number, provider ID number and federal tax ID number.
  - It takes about a month to set up and test direct deposit.
  - Once we receive your completed direct deposit form and test the electronic payment, we’ll start depositing payments into your account beginning on the next reimbursement cycle.
- Your bank may charge a fee for services related to direct deposits.
- You can access RAs for direct deposit payments through our online claims system.
- Some of our health plan clients may request withholds if they find errors during audits. We’ll notify you if this happens.

## Voiding and correcting claims

You can correct eye exam and contact lens claims by submitting a CMS 1500 form to us. To correct claims for eyewear orders, providers need to contact the lab before work on the job begins.

If you used the lab network and need to cancel the materials portion of a claim, you must void the entire claim. Claims for non-lab transactions can be voided by sending a corrected claim using a CMS 1500 form.

### What does it mean for you?

- You’ll use CMS 1500 forms to submit corrected claims.
- You can’t correct or void claims for eyewear if the lab has already started the order.
- Submit a corrected claim to void a claim for an eye exam or non-lab eyewear.
- If a member returns eyewear, the member may be eligible for a free remake depending on the reason for the return.

### How does it work?

- You can correct or void claims for eye exams and contact lens services and materials by faxing a corrected CMS 1500 form to us at 866.293.7373 with “CORRECTED CLAIM” written on the top. You can mail corrected CMS 1500 forms to:
  
  EyeMed/FAA
  
  PO Box 8504
  
  Mason, OH 45040-7111

- You can void claims for eye exams and contact lens services or materials by contacting the call center.
- When you need to make a change to a lab order:
  - Call the lab to cancel the order. The lab will confirm if a cancellation is required and process the cancellation if needed. If the lab determines the order doesn’t need to be canceled, no further action is needed.
  - Allow 24 hours for the cancellation to flow through our system. If you don’t see the member eligibility reopen after 2 business days, please contact the lab to escalate the issue.
  - Once the eligibility is reset to “Yes,” proceed by refiling the claim and submitting the correct order.
• If you didn’t use the lab network, submit a corrected claim, indicating that the materials were returned, and we’ll void it.
• Returns, exchanges and voids are not processed as part of the Safety Eyewear Program, with the exception of voids in the case a member cancels his or her order before the order is in the manufacturing process. In this case, follow our normal void process.
• When members return their glasses, we need to know why.
  • **Returns for poor quality or non-adapt** – Refer to our remake policy to replace the glasses.
  • **Change in frame style or “no questions asked” return policy** – Call us at 888.581.3648 if the member is taking advantage of your practice’s “no questions asked” satisfaction guarantee or simply wants to change the frame. We can reinstate the member’s benefits at your request, but you’ll be charged for the lab work based on the Lens and Options Charge Back Schedule.
  • **Medicaid medically necessary replacements** – Some Medicaid members are eligible for medically necessary eyewear replacements. Refer to the Medicaid section for more details.

**Best practices**

• Keep a written policy on remakes and refunds so members know up-front that they could be financially responsible for returned glasses or changes to orders after the claim has been submitted.
  • In the event of a member complaint about charges for base lenses in the event of a canceled order, we’ll ask you to show us this policy.

**Claims appeals rights**

**State of California**

Your request for a review of an adverse benefit determination must be submitted within 180 days of the date of your Explanation of Payment.

A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative.

You may also review the documents relevant to your claim.

You may seek review by the California Department of Insurance of a claim that an insurer has contested or denied by contacting the California Department of Insurance Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, or call the Consumer Hotline:

• 800.927.HELP (4357)
• Out-of-State Callers: 213.897.8921
• TDD: 800.482.4TDD (4833)
Internet: [insurance.ca.gov](http://insurance.ca.gov)

You have a right to enter into the dispute resolution process described in Section 10123.13 of Article 1. General Provisions – California Insurance Code.

You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the California Department of Insurance.

**State of Delaware**

You have the right to seek review of our decision regarding the amount of your reimbursement.

The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us.

You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: DOIarbitration@state.de.us. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final.

**State of Illinois**

If you are not satisfied with a coverage decision, you are entitled to a review (appeal) of the benefit determination. To obtain a review, you or your authorized representative should submit your request in writing to:

Member Appeals Coordinator  
EyeMed Vision Care  
4000 Luxottica Place  
Cincinnati, OH 45040

Your request for a review of an adverse benefit determination must be submitted within 180 days of the date of your Explanation of Payment.

A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also review the documents relevant to your claim.

Notice of Availability: Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 (312-814-2420) and in Springfield at 320 West Washington Street, Springfield, Illinois 62767 (217-78-
You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the Illinois Department of Insurance.

**Utilization Management appeals**

Refer to the [Medical/Surgical Plan section](#) for information about appealing utilization management decisions.

**Claim denials**

When a claim is denied, we’ll let you know the reason why, and you’ll have up to the [claims filing limits](#) to correct the claim.

**What does it mean to EyeMed?**

- If a claim is denied, we’ll send you a letter within 30 days explaining why we denied it, and request that you correct and resubmit it.

**What does it mean for you?**

- For most plans, you’ll have up to 180 days from the service date to return the corrected claim. See [claims filing limits](#) to double-check the filing limit for specific plans.

**How does it work?**

- When a claim is denied, you’ll be paid only when you resubmit the claim within the appropriate timeframe, and it’s accepted.
- You can collect payment from members for denied claims only if we determine they weren’t eligible for benefits at the time of service.
- If you used the lab network and the materials portion of your claim is denied, you’ll be billed for the cost of the materials and any associated lab charges.
Plan benefits
Eye exam services

*Note: This policy is not intended to interfere or infringe on the professional judgment and decision-making of the participating eye care professional providing covered services as defined.*

Eye exam benefits cover the components listed in our Comprehensive Exam Guidelines, including refraction and dilation. You must follow FTC guidelines regarding eyeglass prescriptions, and you should refer patients appropriately for any follow-up care resulting from your exam findings.

What does this mean to EyeMed?

- Our eye exam benefits cover comprehensive eye exams instead of focusing only on the refraction. Refraction is a component of the covered services available to eligible EyeMed members and must be performed in conjunction with a comprehensive examination. Refraction will not be reimbursed separately.
- Dilation is included in the eye exam benefit whenever professionally indicated.
  - We follow industry standard language related to service definitions, such as that defined by CPT-92004/14 for a Comprehensive Eye Exam. The EyeMed Quality Improvement Committee believes several member characteristics and conditions typically require dilation, including diabetes.

What does it mean for you?

- The eye exam must include the components in our Comprehensive Eye Exam Guidelines.

<table>
<thead>
<tr>
<th>Case history</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chief complaint</td>
</tr>
<tr>
<td>• Ocular disease history (including prescriptive and non-prescriptive medications)</td>
</tr>
<tr>
<td>• Family history: general and ocular</td>
</tr>
<tr>
<td>• Occupational/lifestyle: use of vision; glasses or contact lense</td>
</tr>
<tr>
<td>• General medical history (including medications)</td>
</tr>
<tr>
<td>• Allergies, including medication allergies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General patient observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Neurological: orientation (time/place/person)</td>
</tr>
<tr>
<td>• Psychiatric: mood and effect</td>
</tr>
<tr>
<td>(depression/anxiety/agitation)</td>
</tr>
</tbody>
</table>

Clinical and diagnostic testing and evaluation
• Examination of orbits
• Test visual acuity
• Gross visual field testing by confrontation or other means
• Ocular motility
• Binocular testing
• Slit lamp examination of irises, cornea(s), lenses, anterior chambers, conjunctivae and sclera
• Examination of pupils

• Measurement of intraocular pressure
• Ophthalmoscopic examination with pupillary dilation, as indicated, of the following:
  • Optic disc(s) and posterior segment
  • Macula
  • Retinal periphery
  • Retinal vessels
  • Vitreous
  • Other examinations (must specify)

Note: Pupillary dilation is required for members with diabetes.

**Refraction**

• Objective refraction (retinoscopy or auto-refraction) and/or subjective refraction*
• Resultant best (corrected) visual acuities, distance and near

**Color vision testing***

**Stereopsis testing***

**Case presentation**

• Assessment
• Management plan
• Professional reports* (i.e., driver’s license, health physical)

Note: If you don’t include all applicable ICD-10 diagnosis codes when filing a claim, you’ll fail a clinical records evaluation and be placed in noncompliance.

**Diagnosis (ICD) codes**

It’s important to list all applicable diagnosis codes for each patient when filing a claim to comply with current HEDIS and other future reporting requirements. ICD-10 diagnosis codes should include diagnosis from the patient’s history, the patient’s reported medications and/or your clinical findings. List the primary diagnosis first followed by all secondary diagnosis codes determined in the exam (especially those including diabetes, diabetic retinopathy, hypertension and glaucoma).

*As indicated

Note: Payment of 92004 and 92014, the comprehensive eye exam, includes refraction and dilation. Note: In some cases, exam may be completed with other instrumentation because of member limitations.

• Refraction will not be reimbursed separately from the eye exam, except in the case of clients for whom we coordinate benefits.
• The eye exam benefit includes dilation performed within 30 days of the initial eye exam.
  • Retinal imaging doesn’t replace dilation.
  • You must dilate all EyeMed members who have diabetes.
• According to FTC guidelines, you must provide members with copies of their eyeglass prescriptions at no
cost after performing eye exams.
- When members require further diagnostic testing or treatment you don’t offer, refer them to a physician or other health care professional for follow-up care.

How does it work?

- If a client contracts with us to perform refraction, you can submit a claim for the refraction only, along with a copy of an EOB or claims denial. Please refer to Coordination of Benefits for the list of participating groups.
- If the plan includes benefits for Visual Display Terminal (VDT) eyewear, the member will have an additional eye exam benefit to cover the separate refraction.
- If the patient returns to your office for dilation after the 30 days have elapsed, you can charge the member your normal U&C for the dilation.
- The FTC requires you to provide (at no cost) a copy of the eyeglass prescription immediately after you complete an eye exam.
  - You cannot require members to purchase eyewear or contacts from you just because you conducted the eye exam.
  - You cannot place disclaimers or waivers of liability on the prescriptions you give to your patients.

Best practices

- If the member refuses to be dilated, document the refusal in their file.
- If a referral is required, refer the member to a physician or other professional who is part of their health plan whenever possible.
  - Note the referral and any follow-up communication in the member’s record.
  - Keep a referral log separate from your patient records and provide it to us upon request.
- If the member doesn’t have any benefits or discounts for retinal imaging and you want to recommend this service, make sure the member is aware of any additional costs before performing the service.
  - Clearly state their benefit does not cover this service.
  - Note your conversation in the member’s file.

What happens if you don’t follow the guidelines?

- Claims submitted for refraction or dilation separate from the eye exam will be denied, except for refraction only claims for clients on our Coordination of Benefits exception list.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.
Contact lens evaluations

EyeMed’s contact lens fit and follow-up benefits include training and a complete lens evaluation as well as up to 2 follow-up visits (in addition to the standard eye exam). The member may have different benefits for premium versus standard lenses.

What does it mean to EyeMed?

- The contact lens fit and follow-up benefit varies slightly depending on whether the member is a new or existing contact lens wearer.
  - A “new contact lens wearer” is a new patient at your practice, or a patient who hasn’t worn contact lenses in the past 12 months.
  - An “existing contact lens wearer” is a patient who has worn contact lenses within the last 12 months and is an established patient at your practice.
- Some plans have different benefits for premium versus standard contact lens fittings.

What does it mean to you?

- When treating contact lens patients, perform compatibility tests, diagnostic evaluations and diagnostic lens analyses to determine if contact lenses are right for a member, or if their contact lens prescription has changed.
- Our benefit covers contact lens training and instruction.
- Your contact lens evaluation should follow our guidelines depending on whether the patient has worn contact lenses in the past.

|                               | New Wearer | Existing Wearer |
|                               |            |                 |
| Required Test (√)             |            |                 |
| 1. Contact lens-related history| √          | √               |
| 2. Keratometry and/or corneal topography | √          | √               |
| 3. Anterior segment analysis with dyes | As Indicated | As Indicated |
| 4. Biomicroscopy of eye and adnexa | √          | √               |
| 5. Biomicroscopy with lens. Fluorescein pattern (rigid lenses) orb. Movement and/or Centration (soft lenses) | √          | As Indicated |
| 6. Over-refraction            | As Indicated | As Indicated |
7. Visual acuity with diagnostic lenses √ As Indicated

8. Determination of contact lens specifications determined to obtain the final prescription As Indicated As Indicated

9. Member instructions and consultations √ √

10. Proper documentation with assessment and plan √ √

If a member files a complaint about the evaluation process, we'll look for supporting documentation as outlined in the contact lens audit scorecard.

- Contact lens fittings
  - The contact lens fit and follow-up billing should generally follow the type of lens you dispense.
  - You can also bill the following as premium contact fittings:
    - Contact fittings started as a toric fit with multiple visits due to astigmatism, in which you ultimately prescribe spherical lenses
    - Toric soft lens fittings
    - Fitting of spherical lens(es) used in a monovision application
    - Prescribing or dispensing an extended-wear lens to a member who intends to wear the contact lens as extended wear
  - Except for package plans, the contact lens fitting should be initiated during the same visit as the exam.
  - Any situations outside the definition of premium fittings are considered standard.
- Follow-up services
  - Complete fit and follow-up services within 45 days.
  - The benefit covers up to 2 follow-up visits.
  - Medically necessary contact lens benefits cover unlimited follow-up visits.

How does it work?

Standard vs. premium contact lens fittings

- “Standard contact lens fit” lenses are clear, soft, spherical, daily wear contact lenses for single vision prescriptions (astigmatism less than .75D). This doesn't include extended/overnight wear.
“Premium contact lens fit” lenses are more complex contact lenses, including but not limited to toric, multifocal/monovision, post-surgical and gas permeable contact lenses (astigmatism .62D or higher). This includes extended/overnight wear for any prescription.

**Follow-up services**

- You can’t charge members additional fees for training and education, which should include written instructions on how to handle, clean, maintain and wear their contact lenses.
- If the member requires more than 2 follow-up visits (excluding insertion and removal training), you may charge them for the extra visits.

**Best practices**

- Indicate in your paperwork if the patient is a “new” or “existing” lens wearer.
- Let the member know in advance if you intend to charge them for additional visits and note the conversation in the member’s file.
- Consider using a contact lens care and handling agreement form to document the member received this information.
- If a member files a complaint about the evaluation process, we’ll look for supporting documentation that you followed our guidelines.

**What if you don’t follow the guidelines?**

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

**Special claims processes**

Certain benefits and plans require unique claims filing processes.

**What does this mean for EyeMed?**

- We will notify you if the claims process for any of our services changes, or if new groups or products require unique processes.

**What does this mean to you?**

- Follow the special processes to ensure claims are paid correctly.
How does it work?

Refraction only claims (for groups who have coordination of benefits exceptions)

- Collect only the medical carrier’s eye exam copay from the member, if applicable. Don’t collect any exam copays that would apply under our plan.
- After you’re paid by the medical carrier, submit a CMS 1500 form with only the refraction code (leave the exam off) and attach a copy of the EOB from the primary payer showing that an exam was rendered. We’ll reimburse you your U&C for the refraction up to the maximum exam reimbursement.
- Filing the claim will make the member ineligible for eye exam benefits until the next benefit cycle.

Medically necessary contact lens claims (excludes Humana plans)

- The materials and fit and follow-up services for medically necessary contact lens benefits must be submitted on 1 claim. File the claim in hard copy following the process below:
  - Complete our Medically Necessary Contact Lens Form.
    - Enter a single contact lens fitting code to indicate the qualifying condition.
    - Include a material contact code on the same claim and same date of service.
    - Include the applicable vision and high-risk diagnosis codes.
    - When filling out the claim, use these codes to indicate the qualifying condition:

<table>
<thead>
<tr>
<th>Qualifying criteria</th>
<th>Medically necessary contact lens codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>92310AN</td>
</tr>
<tr>
<td>High ametropia</td>
<td>92310HA</td>
</tr>
<tr>
<td>Keratoconus</td>
<td>92072</td>
</tr>
<tr>
<td>Vision improvement</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric aniridia*</td>
<td>92310AI</td>
</tr>
<tr>
<td>Pediatric aphakia*</td>
<td>92310AP</td>
</tr>
<tr>
<td>Pediatric corneal and post-traumatic disorder (filed as vision improvement)*</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric pathological myopia*</td>
<td>92310PM</td>
</tr>
</tbody>
</table>
*Applies only to members of Pediatric Vision Benefits in California. Pediatric corneal and post-traumatic disorder and pediatric pathological myopia pertain only to members of Health Net’s PPO in California.

- If you put more than 1 diagnosis on the claim, we’ll reimburse based on the lowest paying condition.
- Fax the completed form and copies of the patient’s medical records showing justification for medically necessary contact lenses to 866.293.7373. Make sure you’ve completed everything we need, including:
  - Fitting code indicating the qualifying condition.
  - Material code.
  - Diagnosis code(s).
  - Your provider and location information.

**Humana medically necessary contact lenses**

- This section applies to all Humana Vision members, whether part of Humana Vision Insight or Humana Vision VCP.
- You must obtain prior authorization for Humana members to qualify for medically necessary contact lenses.

1. Complete a [Humana Medically Necessary Contact Lens Prior Authorization Form](#).
2. Submit the form with a copy of the patient’s Humana Vision ID card, a copy of the patient’s complete medical records and the contact lens manufacturer’s wholesale invoice or cost estimate to Humana Vision Utilization Management Department via fax to 866.685.2759.
3. The Humana Vision Utilization Management Department will return the Authorization Notification form, indicating approval and reimbursement amounts and authorization number or denial to the provider.
4. Order and dispense materials after receiving the returned Authorization Notification form.

- After you receive approval and provide service to the member, submit the CMS-1500 form and a copy of the authorization approval:
  - via fax to: 866.293.7373
  - via mail to: Humana Specialty Benefits, PO Box 8504, Mason OH  45040
- Use the below codes to indicate the qualifying condition:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure or HCPC Code</th>
<th>Modifier</th>
<th>Expected Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Necessary Contact Lens Fitting (General)</td>
<td>92310</td>
<td>22</td>
<td>H52.31</td>
</tr>
<tr>
<td>Anisometropia</td>
<td>92310</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Code</td>
<td>Tiers</td>
<td>Code Range</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>--------</td>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>Ametropia</td>
<td>92310</td>
<td>22</td>
<td>H52.0x, H52.1x</td>
</tr>
<tr>
<td>Keratoconus</td>
<td>92072</td>
<td></td>
<td>H18.601—H18.629</td>
</tr>
<tr>
<td>Contact lens fitting for aphakia, one eye (monocular)</td>
<td>92311</td>
<td></td>
<td>H27.00—H27.03</td>
</tr>
<tr>
<td>Contact lens fitting for aphakia, both eyes (binocular)</td>
<td>92312</td>
<td></td>
<td>H27.00—H27.03</td>
</tr>
</tbody>
</table>

| Medically Necessary Contact Material (General)       |        |       |             |
| —Contact Lens, GP, Spherical, Per Lens              | V2510  | P2    |             |
| —Contact Lens, GP, Toric, Per Lens                  | V2511  | P2    |             |
| —Contact Lens, GP, Bifocal, Per Lens                | V2512  | P2    |             |
| —Contact Lens, GP, Extended Wear, Per Lens          | V2513  | P2    |             |
| —Contact Lens, Hydrophilic, Spherical, Per Lens     | V2520  | P2    |             |
| —Contact Lens, Hydrophilic, Toric, Per Lens         | V2521  | P2    |             |
| —Contact Lens, Hydrophilic, Bifocal, Per Lens       | V2522  | P2    |             |
| —Contact Lens, Hydrophilic, Extended Wear, Per Lens | V2523  | P2    |             |
| —Contact Lens, GP, Scleral, Per Lens                | V2531  | P2    |             |
| —Contact Lens, Other Type                           | V2599  | P2    |             |

*Submit 1 fit code and 1 material code per claim with 1 date of service.*

- If a claim is filed without the approved Humana Authorization Notification, standard or premium fit will be paid at the provider’s contracted rate and the provider MAY NOT balance bill the member.
- Claims for follow-up visits and diagnostic tests (e.g., corneal topography) should be submitted to the patient’s medical insurance

Contact lenses when the allowance includes both fit and follow-up and materials
- Contact lens benefits for some plans combine the fit and follow-up and materials into 1 allowance. How you file the claim depends on how you and the member decide to handle the allowance.
- If you’re going to use the full allowance for materials
  - Collect your full U&C from the member.
  - The provider dispensing the contact lenses will collect any copayments and obtain the authorization/file the claim for the materials.
- If you’re splitting the allowance between the fit and follow-up and materials
  - Submit the fit and follow-up with the eye exam claim.
  - The materials provider will submit the claim for the contact lenses based on the remaining allowance amount.
  - To make this work, both the exam and materials providers need to communicate with each other about the amount of the allowance used for the fit and follow-up.

**Safety Eyewear Program powered by EyeMed**

- If using the EyeMed lab network
  - Submit lab orders to the safety-certified lab you selected through our online claims system.
    - Choose “Frame at Lab.”
  - Select the member record associated with the plan and with the word “SAFETY” in the name.
  - Select one of the labs with SAFETY in the name.
  - Do not send frames to the lab, as safety-certified labs carry all safety frames.
  - Use a CMS 1500 claim form with the applicable service codes to submit an Emergency Service claim. The member must qualify for emergency eyewear according to our standard Emergency Service lab policy.
    - Indicate the word “SAFETY” at the top of the form and include a valid diagnosis code based on their prescription, so we pay you correctly.
    - Fax the completed form to 866.293.7373.
    - Diagnosis codes are not specific to safety. If the word “SAFETY” doesn’t appear at the top of the page, your claim could be denied.
  - If using the lab of your choice:
    - You must have an existing assortment of ANSI-certified safety frames and place the order with a safety-certified lab partner to fulfill safety eyewear orders. See the Safety Eyewear Program section for full details.
    - File the claim through the online claims system.
    - You can submit claims using 837 inbound format as long as you aren’t using the lab network.

**Post-cataract eyewear benefits**

- File claims for post-cataract eyewear through the online claims system.

**Railroad Employees National Health Plan post-cataract claims process**
- Submit a CMS 1500 form.
- Write “Railroad Employees Post-Cat Plan” on the top of the form.
- Put the date of the surgery on the claim form.

Fallon Community Health Care Plan MassHealth and NaviCare refractions

- File the refraction claim on our online claims system. Select “Refraction” as a service provided when filing the exam claim.
- If you need to file a hard copy claim, use CPT code 92015.
- File the refraction claim at the same time as the eye exam claim.

Tufts Health Plan – Therapeutic/Post-Cataract Lens Benefit

- The first time a Tufts Health Plan commercial member uses the therapeutic/post-cataract lens benefit, there’s no pre-authorization required. Complete and fax a CMS 1500 claim form to 866.293.7373.
- If a member wishes to use the therapeutic/post-cataract lens benefit for a second time in a calendar year, obtain prior authorization from Tufts Health Plan, unless the member is requesting the lens post-cataract surgery.
- To request pre-authorization, fax a letter of medical necessity to the Tufts Health Plan Pre-certification Department at 617.972.9409.
- If you receive approval for the benefit, complete a CMS 1500 claim form for the service and fax it with a copy of the pre-authorization letter from Tufts Health Plan to 866.293.7373.

Tufts Health Plan – Vision Therapy

- The vision therapy CPT code is 92065.
- Submit one claim per visit.
- Fax the completed CMS 1500 claim form to 866.293.7373.

Telemedicine claims

- If you meet the requirements to provide telemedicine services, the member must get approval for the claim before you provide services.
- Once approved, you can submit the claim through the online claims system.

Medicaid medically necessary claims

- When filing medically necessary claims for Medicaid:
  - Always include a reason code
  - Indicate the appropriate diagnosis code for a qualifying condition
  - When filing paper claims, use the RP reason code modifier only.
  - Use the Medically Necessary tab in the online claims system for contact lenses, additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.
• Use the Routine tab in the online claims system for medically necessary lens options on the member’s first pair of glasses.
• If you’re submitting a paper claim that includes medically necessary lens options, include the modifier “RP” along with the V-code.
• To file the claim online for additional eye exams, use the Medically Necessary tab on the Member Benefits page and be sure to enter a medical necessity reason code on the U&C page of the claims filing process.
• When submitting a claim online that includes medically necessary lens options, enter a medically necessary reason in the system on the U&C page for it to be paid.
• Submit claims for replacement eyewear in the online claims system under the “Medically Necessary” tab.
  • Select the appropriate diagnosis code and reason code on the U&C page of the claims submission process.
  • For replacement eyewear, use the ST code.
  • If you’re submitting a paper claim for a covered pair of replacement eyewear, please add the modifier “RP” even if the replacement is due to a diopter change.
  • Discard broken or returned glasses.

Medical/Surgical eye care claims

• We recommend using standard 837 electronic claims submission for medical/surgical eye care claims.
  • If you aren’t set up for 837, you can submit the claim through the Medical tab in the online claims system.
• You can submit multiple dates of service and multiple service lines on the same claim, but only 1 provider should be listed on each claim.
• For services that do not require pre-authorization, we’ll match the procedure and diagnosis codes for relevance.
• When providing routine vision care services, you’ll use the online claims system like you normally do, but you should file routine vision claims separately from medical/surgical eye care services.
  • Do not file medical eye care and routine vision services on the same claim.

Low vision claims

• We don’t accept low vision claims online, and you can’t use our lab network.
• Low vision claims require pre-approval.
  • To obtain pre-approval, fax the Low Vision Request form with the invoice or catalog sheet to 866.552.9115, or email it to medexceptions@eyemed.com.
  • If we approve the form, you’ll receive an approval letter and authorization.
  • If we don’t approve the form, you’ll receive an explanation why.
• Once you receive approval for low vision benefits, you can go ahead and submit the low vision benefit claim by faxing a completed CMS 1500 claim form to 866.293.7373.
• Sign the form and be sure to include the following information on the claim:
  • Your provider information.
  • Proper diagnosis codes.
  • Proper material codes.
  • Authorization number.
  • Stamped or handwritten line indicating “Low Vision Exam or Aids.”
  • Your fax, phone and email address.
  • Copy of the low vision approval letter.
• Anthem Blue View Vision requires a slightly different process for submitting low vision claims. Please refer to the Anthem section for more details.

What happens if you don’t follow guidelines?

• Your claims will be denied.

Frame benefits

We require providers to display a minimum of 100 frames priced at $130 or less to ensure members have a wide choice of frames within our typical frame allowance amounts. You do not have to display specific brands or manufacturers. All frames must meet current ANSI standards.

Our plans don’t cover sports goggles or over-the-counter readers, and you’re responsible for complying with any manufacturers’ restrictions on discounting of frames.

Some plans, including our Safety Eyewear Plan and Pediatric Vision Benefits, have other specific frame requirements.

What does it mean to EyeMed?

• EyeMed’s requirements ensure members receive quality eyewear when using their frame benefits.
• Plans like Pediatric Vision Benefits and the Safety Eyewear Program have separate requirements due to the unique nature of the programs.

What does it mean for you? How does it work?

• When you use our lab network, you’ll supply your own frames.
• Dispense only frames that meet ANSI Z80.5 Spectacle Frame Standard.
  • Safety eyewear dispensed under the Safety Eyewear Program must meet ANSI Z87.1 safety standards.
• Maintain/display at least 100 prescription frames priced $130 or less, from any manufacturer.
- The EyeMed reimbursement includes the eyeglass case and any postage.
- Many high-end brands have restrictions on which frames can be discounted.
  - Most of the time, these restrictions apply only to true discounts (not funded plans like our benefits).
  - Ultimately, it’s up to you to be aware of restrictions on the frames you carry.
- Frames designed for use as protective eyewear in sports (often called sports goggles) are not part of our standard benefit. Members receive a 20% discount off the purchase of sports goggles as part of their discount on additional services.
- Prescription spectacles for reading, where the lenses are fabricated by a network laboratory, are covered under the EyeMed benefit. Over-the-counter readers are not covered.
- Refer to the Safety Eyewear Program section for unique requirements for safety frames.
- To receive fully covered corrective eyewear, members of Pediatric Vision Benefits must choose from a frame selection that you make available to the member.
  - You’ll need a minimum of 35 frames in your dispensary that meet the following criteria for Pediatric Vision Benefits members to choose from:
    - A total wholesale acquisition cost of at least $19
    - 20% to 40% (or at least 5 units) each of girl, boy and unisex styles
    - Eye size assortment as follows:

<table>
<thead>
<tr>
<th>Eye size</th>
<th>Minimum # of units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 46</td>
<td>6</td>
</tr>
<tr>
<td>46 to 47</td>
<td>6</td>
</tr>
<tr>
<td>48 to 49</td>
<td>2</td>
</tr>
<tr>
<td>50 to 51</td>
<td>1</td>
</tr>
<tr>
<td>52 and higher</td>
<td>1</td>
</tr>
</tbody>
</table>

Best practices

- If your dispensary doesn’t permit our members to apply a discount to a manufacturer’s frames, provide the member with a written policy from the manufacturer that explicitly states the brand is excluded from managed vision care members.
- In most cases, if a Pediatric Vision Benefits member chooses a frame outside of your designated selection, the frame is not covered by the plan and becomes a free-to-choose transaction (meaning you can charge the member your regular retail price, and you won’t file a claim).
What if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Contact lens materials

Contact lens benefits provide an allowance members use toward the retail price of the materials. You must follow the FTC Fairness to Contact Lens Consumers Act when dispensing contact lenses. Pediatric Vision Benefits have a different contact lens benefit that is based on an annual supply of lenses.

What does it mean for you?

- Make sure the member’s prescription hasn’t expired and still meets the member’s eye health and vision needs before dispensing contact lenses.
- Follow the FTC Fairness to Contact Lens Consumers Act.

How does it work?

- The FTC Fairness to Contact Lens Consumers Act includes the following provisions:
  - What you have to do for members:
    - Give them a copy of their contact lens prescription after completing a contact lens fitting and/or follow-up.
    - Provide or verify their prescription via electronic or other means.
  - What you can’t require members to do:
    - Purchase lenses from you.
    - Pay for the release or verification of a prescription.
    - Sign a waiver or release to obtain a prescription.
    - Pay up-front for the eye exam (for those members who want their prescriptions).
  - You must verify a member’s prescription before selling contact lenses. The FTC requires you to verify this prescription in one of the following ways:
    - Get confirmation from the prescriber that the prescription is accurate.
    - If the prescriber verifies the prescription is inaccurate, they must provide the accurate prescription.
    - If the prescriber fails to communicate with you within 8 business hours (or as defined by the FTC), verification is assumed.
  - You can’t alter a prescription; however, you can exchange a private-label lens with an identical lens from the same manufacturer.
Consider the contact lens prescription valid for at least 1 year or longer from the “issue date,” depending on state law or other medical condition.
- Any changes to the Fairness to Contact Lens Consumers Act will supersede this manual.

What if you don’t follow the guidelines?
- Violations of the FTC Fairness to Contact Lens Consumers Act are considered unfair or deceptive trade practices and are subject to FTC enforcement.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Lens requirements

Our lens benefit applies to prescription lenses that improve members’ vision. We don’t have a minimum prescription requirement, but at least 1 lens (in a pair) has to have a prescription to qualify for the benefit.

EyeMed’s plans cover standard and premium lenses, progressive lenses and various lens options and add-ons. Refer to the Product Catalog section for information about the lens products available for order through EyeMed’s lab network.

What does this mean to EyeMed?
- We consider standard lenses to be uncoated, CR-39 plastic single vision, bifocals (ST 25 and 28) and trifocals (7×28). Any other lens types are considered premium lenses.
- Some plans’ benefit structures further segment premium progressive lenses and anti-reflectives into tiers. We reserve the right to make changes to the products on each tier and member out-of-pocket costs.

What does this mean for you?
- Unless your contract allows otherwise, you’re required to use our contracted labs (or, when applicable, you may provide single vision in-office finishing) to produce eyewear for members.
  - If you use another lab or in-office finishing to produce eyewear, lenses must meet current ANSI standards
  - Our product catalogs define the lenses and treatments available through our lab network.
- Member out-of-pocket costs for progressives and anti-reflectives depend on whether the lenses are classified as standard or premium. These lists include most available brands.
Progressive classification list

(Not all progressives listed are available through the EyeMed lab network.)

**Standard Progressive** (Add-on to Bifocal)

|---------|---------------|------------------|------------------|---------|-----------|----------------|---------|--------------|-----------|---------------|----|--------------|------------|----------------|-----------------------|-----------------|------------|----------|------------|---------|-----|----------------|-----------|-------------|------------|---------|----------|--------------|----------------|----------------|----------------|----------------|

**Premium Progressives** (Add-on to Bifocal)

| Tier  | Adapter Digital | Adataar Digital Short | Natural Digital | Ovation Digital | Small Fit | Small Fit Digital | Amplitude BKs | Amplitude Mini BKs | Amplitude IQ | Amplitude IQ Mini | GP Wide | Tact BKs | Navigator FBS | Navigator Short FBS | Proceed II | Proceed III | Gradal Top | Instictive HD | AO Easy | Synchrony | Synchrony Easy S | Adage | Concise | Illumina | Image /Image Wrap | Novel | Novella | Precise | Precise Short | Xplorer | Shaimir 1st Pal | MVP | Premium Progressive | Short Fit Progressive | LC Design 1.0 |
|-------|-----------------|----------------------|-----------------|-----------------|----------|-------------------|--------------|------------------|-------------|----------------|---------|---------|----------------|------------------|-------------|------------|-----------|------------|---------|------|------------|--------|----------|----------|----------------|-------|----------------|---------|----------------|------------------|----------------|
### Plan benefits

November 2018

Please see the [Luxottica Lab Services and Essilor product catalogs](#) for a list of lenses available by schedule through network labs.

**Anti-reflective classification list**

(Not all anti-reflectives listed are available through the EyeMed lab network.)

#### Standard Anti-Reflective Coating


#### Premium Anti-Reflective Coatings

**TIER 1** - Crizal Easy w/UV / Crizal Prevencia Kids / Xperio Sun UV / Xperio Sun UV w/Mirrors / VIS0 / HiVision / Hoya Premium w/ViewProtect / BluCrystal / Kodak CleAR / RF Endura EZ / Zeiss DuraVision Chrome

**TIER 2** - Crizal Alize w/UV / Crizal SunShield w/UV / VIS0 XC / HiVision w/ViewProtect / Allure AR / Zeiss DuraVision Silver / Custom CleAR Plus / Custom CleAR Plus Sun / Clean Shield Elite AR / Clean Shield Elite Sun AR / ECC AR / Kodak Clean’N CleAR / Kodak Clean’N Clear AR UV / Kodak Total Blue AR / Vivid AR / RayBan Premium AR / Synchrony HMC+ / Premium AR / EasyCare Premium AR / EZ Premium CleAR

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Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

- Some lens manufacturers offer anti-reflective lenses with backside UV. We consider this an additional lens add-on. Charge the member the appropriate member out-of-pocket cost as well as the $15 for the UV coating.
  - Crizal Easy UV
  - Crizal Alize UV
  - Crizal Avance UV
  - Crizal Sapphire 360 UV
  - Crizal SunShield UV (with or without mirrors)
  - Crizal Prevencia
  - Xperio UV (with or without mirrors)
  - VISO XC+ w/UV
  - VISO Prevencia
  - Glacier Plus UV
  - Synergy Crystal UV

- Members pay a fixed amount for common lens options.
- If you sell lenses as packages that bundle multiple add-ons with the lens, make sure you’re charging the member for each of the individual lens add-ons (unless the add-on is inherent to the lens material).

- When the lens add-on material automatically includes some other lens add-on — like scratch-coating inherent in polycarbonate or UV and scratch-resistant coating in a photochromic lens — the member only has to pay for the main add-on.
- We cover only specific medically necessary lens options for Medicaid members.
- When dispensing safety eyewear, lenses will need to meet different standards. Refer to the Safety Eyewear Program section for more information on safety lens requirements.
- Some plans offer post-cataract eyewear benefits, which cover additional pairs of glasses after cataract surgery.

Please see the Luxottica Lab Services and Essilor product catalogs for a list of anti-reflectives available by schedule through network labs.
How does it work?

- If you dispense a progressive lens not on our list (including “house brands”), charge the member based on the lens that most closely matches the features and benefits of the lens you’re dispensing.
- The chart below shows the member cost for each type (tier) of progressive lenses.

<table>
<thead>
<tr>
<th>Plan benefits</th>
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<tbody>
<tr>
<td>November 2018</td>
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### Progressive lenses

<table>
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<tr>
<th>Plan benefits</th>
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<td>November 2018</td>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Member out-of-pocket (excludes bifocal lens copay)</th>
<th>Corresponding service code for claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progressive - standard</td>
<td>$65</td>
</tr>
<tr>
<td>Progressive - Premium tier 1</td>
<td>$85</td>
</tr>
<tr>
<td>Progressive - Premium tier 2</td>
<td>$95</td>
</tr>
<tr>
<td>Progressive - Premium tier 3</td>
<td>$110</td>
</tr>
<tr>
<td>Progressive - Premium tier 4</td>
<td>80% of charge less $55, plus bifocal copay</td>
</tr>
</tbody>
</table>

- The chart below shows the member cost for each type (tier) of anti-reflective lenses.

<table>
<thead>
<tr>
<th>Plan benefits</th>
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<tbody>
<tr>
<td>November 2018</td>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Member out-of-pocket (excludes lens copay)</th>
<th>Corresponding service code for claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-reflective coating - standard</td>
<td>$45</td>
</tr>
<tr>
<td>Anti-reflective coating - Premium tier 1</td>
<td>$57</td>
</tr>
<tr>
<td>Anti-reflective coating - Premium tier 2</td>
<td>$68</td>
</tr>
<tr>
<td>Anti-reflective coating - Premium tier 3</td>
<td>80% of charge</td>
</tr>
</tbody>
</table>

- The standard member payments for common lens options are:

<table>
<thead>
<tr>
<th>Lens option</th>
<th>Standard member cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>UV coating</td>
<td>$15</td>
</tr>
<tr>
<td>Tint (solid or gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>Plan benefit</td>
<td>Cost</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Standard scratch-resistant coating</td>
<td>$15</td>
</tr>
<tr>
<td>Standard polycarbonate</td>
<td>$40</td>
</tr>
</tbody>
</table>

*(Member payments for Insight plans will differ.)*

- For other lens options, the member receives a 20% discount off your U&C.

- **Polycarbonate lenses**
  - Polycarbonate lenses are often funded, especially for children under age 19. In those cases, the member pays a copay or has no charge, and we pay you $40 (less any member copay) when you file the claim.
  - Polycarbonate is typically a covered benefit for safety eyewear. There is no additional reimbursement for dispensing polycarbonate on [Safety Eyewear Program](#) claims.

- **Digital single vision lens with boost power for digital eyestrain**
  - New digital single vision lens designs provide at least a 0.25 power boost or greater to single vision Rx to help address digital eyestrain.
  - Any of the lenses below are covered under a member’s funded lens benefit even if there is no vision correction in the lenses.
    - Essilor EyeZen +
    - Hoya SYNC BKS
    - Zeiss Digital Smart Lens
    - Shamir Relax
  - **Materials with blue light filtering**
    - The following lens materials offer better balances of clarity and blue light filtering, which generate a tint benefit for the member.
      - Essilor Essential Blue Series
      - Blu Tech Ultra, Classic or Max
      - Ray-Ban Blue
    - If you don’t use the lab network, check the tint box if these lens materials are dispensed.
    - All other blue light filtering materials will follow the base materials reimbursement and member out of pocket.

- Always check the member’s benefits for their exact payments; some plans have “non-standard” or funded lens options, or the member may be covered by a different type of plan. The [online claims system](#) displays the member responsibility for each claim you submit.
- If a member asks for a lens recheck, verify the lenses and, if necessary, the refraction, within the first 45 days of receiving new eyewear based on that prescription, at no additional charge to the member.

**Best practices**

- Because UV protection is already included in premium products (such as polycarbonate and high-index...
members don’t pay a separate $15 charge for UV coating. However, for backside UV products, members are charged $15 for the additional coating.

- Youth packages available through Essilor labs use Crizal Kids UV or Crizal Prevencia Kids.
- Both include backside UV, but don’t charge extra for the coating when members choose these packages.

To calculate member payment, add the charges for any lens options to the copayment for the base lens.

- For add-ons eligible for the 20% discount, charge the member the base lens copay, then figure out how much the add-on would cost after the discount and add that to the member copay.
- If a lens material claim is submitted, only approved blue light filtering materials will qualify for proper reimbursement and member benefit.

What if you don’t follow the guidelines?

- Claims submitted for plano lenses will be paid only if the lenses qualify as single vision boost for digital eyestrain.
  - Failure to provide proper documentation of an approved design dispensed may result in recoupment and/or notification of non-compliance during an audit.
  - Failure to provide proper documentation of an approved blue light material dispensed may result in recoupment and/or notification of non-compliance during an audit.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Plano sunglasses

EyeMed’s frame eyewear allowance only applies towards the purchase of eyewear with prescription lenses. Members can’t use our lens benefit for plano sunglasses unless the member’s plan explicitly includes such benefits. It’s possible for members to use their 20% discount on non-covered items toward the purchase of plano sunglasses.

What does this mean to EyeMed?

- Our benefits do not cover plano lenses.

What does this mean for you?

- In general, members can’t use benefits on plano sunglasses.
- It’s possible members will want to use their frame allowance to purchase frames for prescription sunglasses, which is okay.
  - Members can only use the frame benefit to purchase frames that hold a prescription lens.
RXable sun frames with plano sun lenses – whether or not the lenses were obtained using their lens benefit – are plano sunglasses, and are not covered.

Your detailed requirements

- If the member doesn’t purchase prescription lenses at the same time they purchase the RXable frame, you must remove the plano lenses from the frame before selling them.
- If you remove the lenses, from the frame the member must sign an acknowledgment that the plano lenses were removed and that removing them may void the manufacturer’s warranty. Keep a copy of the signed acknowledgment on file.
- If the member has already used their benefit for lenses or contact lenses, but still has the frame benefit available, he or she can use the additional pair discount, but only to purchase a complete pair of eyewear (frame and prescription lens at the same time). Plano sunglasses are not eligible for the complete pair discount. Instead, apply a 20% discount, since this is a non-covered item.

Best practices

- Health plan audits, member complaints or trends that make us suspect abuse could trigger evaluations. If that happens, we’ll ask you for a copy of the transaction and the lab invoice to make sure you followed our guidelines.

What happens if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Discounts

All members are also eligible for additional, unlimited savings on vision-related purchases from in-network providers after they use their initial benefit. Some groups also offer just discounts on eye exams and/or eyewear.

What does this mean to EyeMed?

- Discounts are standard parts of our vision plans.
What does this mean for you?

- You’re required to provide point-of-sale discounts to members.
- Some states may prohibit eye care plans from requiring eye care providers to accept these discounts on non-covered services. If you practice in any of these states, you may contact the call center to opt out of providing discounts on non-covered services.

How does it work?

- Unless your state law allows otherwise, you should offer the following discounts to members after they have used their initial benefit, or if their plan provides a discount only.
  - 35% or 40% off additional complete pairs of glasses (frames, lenses and lens options purchased together at the same time), except with the Safety Eyewear Program, where additional complete pairs are 20% off
  - 20% off frames, lenses or lens options purchased separately
  - 20% off non-covered items such as cleaning cloths and contact lens solution
  - 15% off conventional contact lenses
- Members can use discounts any time during the plan year.
- If the member received their initial exam or materials at a different provider, you still need to honor these discounts.
- Members can use their discount to save 20% off plano sunglasses.
- For Aetna plans, follow Aetna’s discount schedule.
- If you practice in Nevada, additional discounts are available to Health Plan of Nevada members:

<table>
<thead>
<tr>
<th>Additional services</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Balance over $5</td>
</tr>
<tr>
<td>Lens (Standard)</td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$55 Copay</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$90 Copay</td>
</tr>
<tr>
<td>Standard progressive lens</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Premium progressive lens</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$90 Copay</td>
</tr>
</tbody>
</table>
## Plan benefits

<table>
<thead>
<tr>
<th>Other lens types</th>
<th>80% of Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame</td>
<td></td>
</tr>
<tr>
<td>Frame</td>
<td>Retail price of $0 - $130: 55% of Charge</td>
</tr>
<tr>
<td></td>
<td>Retail price over $130.01: $71.50 Copay + 80% of balance over $130</td>
</tr>
<tr>
<td>Lens options (in addition to standard lenses)</td>
<td></td>
</tr>
<tr>
<td>Standard polycarbonate</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Standard plastic scratch coating</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tint</td>
<td>$12 Copay</td>
</tr>
<tr>
<td>UV treatment</td>
<td>$12 Copay</td>
</tr>
<tr>
<td>Standard anti-reflective (A/R) Coating</td>
<td>$45 Copay</td>
</tr>
<tr>
<td>Other coatings</td>
<td>80% of Charge</td>
</tr>
<tr>
<td>Glass</td>
<td>80% of Charge</td>
</tr>
<tr>
<td>Other lens options</td>
<td>80% of Charge</td>
</tr>
<tr>
<td>Contact lenses</td>
<td></td>
</tr>
<tr>
<td>Contact lens – conventional</td>
<td>85% of Charge</td>
</tr>
<tr>
<td>Contact lens – disposable</td>
<td>100% of Charge</td>
</tr>
<tr>
<td>Standard fit &amp; follow up</td>
<td>Balance over $5</td>
</tr>
<tr>
<td>Non-scheduled items</td>
<td></td>
</tr>
<tr>
<td>Non-scheduled Item – Retail</td>
<td>80% of Charge</td>
</tr>
</tbody>
</table>

### Best practices

- Some states may prohibit eye care plans from requiring eye care providers to accept these discounts on non-covered services. If you practice in any of these states, you may contact the call center to opt out of providing discounts on non-covered services.
What happens if you don’t follow guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Eyewear warranties and return policies

Our benefits don’t cover product warranties, but you’re welcome to offer members the option to purchase an extended protection plan through your office.

What does this mean for you?

- Honor manufacturer and lab warranties when it comes to defective lenses and frames.
- Contracted labs will honor all manufacturer warranties.
  - Contact the lab that manufactured the materials for further information.
- Specific return policies apply to eyewear manufactured through the lab network.

Best practices

- If you offer warranties, keep a copy of the warranty and the member’s signature on file in case of a complaint. Warranties should clearly identify the timeframe, terms and conditions.
- Have a return policy in place and share it with your patients when you dispense the eyewear.

Medically necessary contact lens benefits

Many plans include benefits for contact lenses when the member’s vision correction needs meet specific requirements that make the use of contact lenses a medical necessity.

Anthem Blue View Vision calls these non-elective contact lenses.

What does this mean to EyeMed?

- Our expectation is that the documented spectacle prescription supports the qualifying condition submitted.

- To help prevent abuse of the benefit and make sure you’re paid appropriately for your time, reimbursements for medically necessary contact lenses vary depending on the member’s condition.
- Members can’t use this benefit for conditions not listed, even if you determine that contact lenses are
necessary to correct other vision issues.

- We review the fee schedule at least once a year.

What does this mean for you?

- You’re responsible for determining if members qualify based on your exam and evaluation.
- A member’s vision and spectacle prescription must meet the below criteria to qualify for medically necessary contact lens benefits:
  - **Anisometropia** of 3D in meridian powers.
  - **High Ametropia** exceeding –10D or +10D in meridian powers.
  - **Keratoconus** when the member’s vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses. For the purposes of our benefit, there are 2 types of keratoconus as defined in our [ectasia scale](#).
    - **Emerging/Mild**: Contact lenses in this tier are anticipated to include, however not be limited to, soft toric, rigid gas permeable, scleral, semi-scleral and hybrid designs/materials. The below severity scale applies:
      - Multiple spectacle remakes
      - Unstable topography
      - Light sensitivity/glare issues
      - Signs including Fleischer ring, Vogt’s striae and scissor reflex with retinoscopy
      - No scarring
      - Topography (steep K <53D)
      - Corneal thickness >475 microns
    - **Moderate/Severe**: Patients who begin in the emerging or mild categories and are not successful with contact lens materials and keratoconus designs may be elevated into this moderate/severe tier. Contact lenses in this tier are anticipated to include however not be limited to scleral, semi-scleral and hybrid designs/materials. Patients who qualify as moderate/severe will have all of the emerging/mild symptoms, plus:
      - Mild to no scarring or some scarring
      - Topography (steep K of 53D or higher)
      - Corneal thickness up to 475 microns
      - Refraction not measurable
    - **Vision improvement other than keratoconus** for members whose vision can be corrected by two lines or more on a standard visual acuity chart when compared to the best corrected standard spectacle lenses.
  - This bundled benefit covers materials, fitting and unlimited follow-up visits.
  - Include the appropriate diagnosis code when submitting the medically necessary contact lens claims. We may also ask you for additional supporting documentation.
  - You can submit cases for fee review to our Quality Assurance department at [eyemedqa@eyemed.com](mailto:eyemedqa@eyemed.com). Include supporting statements, lab fee documents and clinical
How does it work?

- Members who qualify can use the benefit once a benefit year based on member’s eligibility and can’t exceed annual supply limits defined by contact lens manufacturer replacement guidelines.
- The following have different medical necessity requirements:
  - Tufts Health Plan members
  - Humana Vision members
  - Members of Pediatric Vision Benefits plans in California
  - Medicaid members
- When filling out the claim, use these codes to indicate the qualifying condition:

<table>
<thead>
<tr>
<th>Qualifying criteria</th>
<th>Medically necessary contact lens codes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>92310AN</td>
</tr>
<tr>
<td>High ametropia</td>
<td>92310HA</td>
</tr>
<tr>
<td>Keratoconus</td>
<td>92072</td>
</tr>
<tr>
<td>Advanced keratoconus</td>
<td>92072AD</td>
</tr>
<tr>
<td>Vision improvement</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric aniridia**</td>
<td>92310AI</td>
</tr>
<tr>
<td>Pediatric aphakia**</td>
<td>92310AP</td>
</tr>
<tr>
<td>Pediatric corneal and post-traumatic disorder (filed as vision improvement)**</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric pathological myopia**</td>
<td>92310PM</td>
</tr>
</tbody>
</table>

*Submit a single fit code with a material code on 1 claim with 1 date of service.

**Applies only to members of Pediatric Vision Benefits in California. Pediatric corneal and post-traumatic disorder and pediatric pathological myopia pertain only to members of Health Net’s PPO in California.

- Along with the claim, you must submit the patient’s medical records showing justification for medically necessary contact lenses.
- We’ll pay you standard contact lens fit and follow-up reimbursements if the claim doesn’t include one of the condition-related fitting codes.
  - CPT procedural codes for contact lens fitting are limited to kerataconus (92072). CPT has not
designated codes for anisometropia, high ametropia and vision improvement.
- If the covered condition is either keratoconus or anisometropia, submit the applicable diagnosis codes listed in ICD-10.
- Include the applicable refractive and high-risk diagnosis codes on all claims.
- You may not bill members for any difference between your U&C fees and the plan’s reimbursement unless the plan benefits specifically say the member is responsible for payment above the allowance.

Best practices

- Dispense contact lenses that have been manufactured to meet the most current industry standards.
- Make sure your claim form includes all of the information we need, including:
  - Fitting code consistent with justification for medical necessity.
  - Material code.
  - Diagnosis code(s).
  - Your provider and location information.
- When filling an existing contact lens prescription, make sure the prescription is current and meets the member’s vision needs prior to supplying contact lens materials.
- When a member’s vision impairment doesn’t meet one of the conditions, you may suggest an alternative solution to the member. For instance:
  - Using the standard contact lens benefit up to the limits of coverage
  - Submitting a claim to the member’s medical coverage
- Use your best judgment to provide the appropriate materials/design for the best quality eye health, comfort and vision for patients who have previously worn contact lenses for keratoconus but who are not successful with their current contact lenses.
  - It’s expected that many new keratoconus contact lens patients will fall into the emerging/mild tier.
  - Patients who have been successful and satisfied with contact lens designs and/or materials that are not in the moderate/severe tiers will likely remain in contact lenses in the emerging/mild tier.
  - If you initially fit a keratoconus patient in an emerging/mild tier keratoconus contact lens but it is not possible to achieve quality eye health, comfort and/or vision, refit the patient with contact lenses in the moderate/severe tier and submit a corrected claim reflecting the moderate/severe keratoconus fee. We will adjust the claim and pay the difference, if any, under the medically necessary contact lens benefit guideline.
- If you put more than one diagnosis on the claim, we’ll reimburse based on the lowest paying condition.
- In most cases, you can’t bill the member for the amount over your reimbursement for medically necessary contact lenses.

What happens if you don’t follow the guidelines?

- We’ll periodically review clinical records to make sure you’re correctly applying the medically necessary
contact lens benefit.

- We’ll be checking whether the documented prescription supports the qualifying condition submitted. If the record doesn’t support this condition, we’ll recoup any overpayment by withholding payment on future claim(s) where law permits.
- We can consider any inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network.
- If we believe you’ve filed a false claim, we might also have to report it to regulatory and law enforcement agencies as appropriate.

Humana Vision Medically necessary contact lens benefits

Humana Vision is a routine vision plan that provides coverage for medically necessary contact lenses as an additional coverage option for your patients. You’re responsible for determining the patient’s eligibility before proceeding with any contact lens fitting.

What does this mean for you?

- Humana Vision will cover, in lieu of eyewear or elective contacts, initial fitting and medically necessary contact lens material for the following conditions:
  - **Monocular aphakia or binocular aphakia** where the doctor certifies that contact lenses are medically necessary for safety and rehabilitation to a productive life
  - **Anisometropia** of greater than 3.00 diopters and asthenopia or diplopia, with spectacles
  - **High ametropia** of either +10D or -10D in any meridian
  - **Keratoconus** supported by medical record documentation consistent with a 2-line improvement of visual acuity with contact lenses as the treatment of choice
  - When **visual acuity cannot be corrected to 20/70** in the better eye except through the use of contact lenses (example: nystagmus and/or other ocular diseases or conditions that meet these criteria)
- Coverage for medically necessary contact lenses is limited to the conditions listed above. Humana Vision’s medically necessary contact lens benefits do not cover the following:
  - Patients with a history of corneal or elective refractive surgery (ie. LASIK, PRK, RK)
  - Plano lenses to change eye color cosmetically
  - Artistically painted lenses
  - Additional office visits associated with contact lens pathology.
  - Contact lens modification, polishing or cleaning
How does it work?

- For the patient to be eligible for Medically Necessary Contact Lenses, they must be currently eligible for both exam and full contact lens benefits.
- The benefit covers the initial fitting and materials only.
- There’s no copayment for the initial fitting and materials.
- You may not charge the patient the difference between your usual and customary fees for contact lens services and the amount Humana Vision reimburses for the initial fitting and materials.
- Medically necessary contact lens benefit covers the first pair of lenses. Members may purchase additional or companion lenses at your usual and customary fee less a 20% discount, as applicable by state.
- You must obtain pre-authorization for these services. Refer to the Special Claims Processes section for details.

Best practices

- Submit claims for follow-up visits and diagnostic tests (e.g., corneal topography) to the patient’s medical insurance.

What happens if I don’t follow the guidelines?

- If a claim is filed without the approved Humana Authorization Notification, standard or premium fit will be paid at the provider’s contracted rate and the provider MAY NOT balance bill the member.
- We’ll periodically review clinical records to make sure you’re correctly applying the medically necessary contact lens benefit.

KidsEyes

Groups can choose to provide additional coverage for children age 18 and under through KidsEyes plans.

What does it mean for EyeMed?

- Clients can add the KidsEyes benefits to any plan.

What does it mean for you?

- Children covered by these plans receive:
- 2 comprehensive eye exams in the same benefit year.
- 1 additional covered pair of eyeglass lenses, if the child’s vision changes within the same benefit year.
- Funded polycarbonate lenses.
- 40% off additional pairs of glasses.
- 20% off plano sunglasses.

Best practices

- You’ll be able to tell if the member is eligible because plan frequencies and benefit levels will be based on age.
- Follow what displays on the Member Details page of our online claims system.

What if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Diabetic Eye Care plans

Clients can include benefits for medical eye care services for members with type 1 or type 2 diabetes as an add-on to routine vision plans.

What does this mean to EyeMed?

- Our diabetic benefits allow for consistent member eye care, even if the participating provider who completed the eye exam is not on the member’s medical plan.
- Members diagnosed with type 1 or type 2 diabetes, or who have diabetic eye disease (such as diabetic retinopathy), are eligible for additional services when their plan sponsor includes the benefits.

What does this mean for you?

- Members who have type 1 or type 2 diabetes may be eligible to receive benefits for the below follow-up diagnostic services:
  - Fundus Photography – bilateral
  - Extended ophthalmoscopy – unilateral
  - Gonioscopy – bilateral
  - Scanning laser – bilateral
Members might have coverage for the same follow-up services through both a Diabetic Eye Care plan and their medical plan.

How does it work?

- For the member to qualify for our Diabetic Eye Care plan, a diagnosis within the following range must be present:
  - E08.XX – E13.XX
- When members meet these criteria, they’ll receive benefits for these diagnostic services:

<table>
<thead>
<tr>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
<th>Code 5</th>
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<td>99215</td>
</tr>
</tbody>
</table>

Best practices

- If you don’t offer these services or want to refer the member for follow-up care, you can do so; note the referral in the member’s record.
- If you also participate on the member’s medical network, please discuss billing options with the member. Members are ultimately responsible for deciding which plan to bill and will pay any applicable copayments, allowances and/or deductibles.

What if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Low vision benefits

Some plans include a low vision benefit for members who have severe eye health and visual problems not correctable with conventional techniques.
What does it mean to EyeMed?

- Our low vision benefit covers supplemental testing and spectacle-mounted magnifiers, hand-held or spectacle-mounted telescopes, hand-held or stand magnifiers or video magnification, with pre-approval.

What does it mean for you?

- Benefits cover both supplemental testing and low vision aids when the member meets certain criteria.
- Low vision supplemental testing consists of a diagnostic evaluation beyond a comprehensive eye exam.
- To be added to our list of providers who provide low vision services to members, complete and submit a Low Vision Provider Notification form.

How does it work?

- To qualify for low vision, the member must meet 1 of these criteria:
  - Best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription.
  - A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point.
  - The widest diameter subtends an angle less than 20 degrees in the better eye.
- Low vision supplemental testing should include a history of difficulties related to:
  - Reading
  - Activities in the kitchen
  - Glare problems
  - Travel vision
  - Workplace
  - Viewing television
  - School requirements
  - Hobbies and interests
- Preliminary tests may include assessments such as color vision and contrast sensitivity.
- The following low-vision aids are covered:
  - **Spectacle-mounted magnifiers.** A magnifying lens mounted in spectacles (called a microscope) or on a special headband, which allows use of both hands to complete close-up tasks such as reading.
  - **Hand-held or spectacle-mounted telescopes.** Miniature telescopes used for seeing longer distances such as across the room to watch television, or that can be modified for near tasks such as reading.
  - **Hand-held and stand magnifiers.** Tools that help with short-term reading, such as price tags, labels and instrument dials. These magnifiers can be equipped with lights.
  - **Video magnification.** Tabletop (closed-circuit television) or head-mounted systems that enlarge
reading material on a video display. Some systems can be used for distance applications. Image brightness, size, contrast and foreground/background color and illumination can be customized.

- Anthem has different processes for low vision benefits. Refer to the Anthem section for more information.

### Best practices

- See the list of clients who have low vision benefits riders.
- When conducting low vision supplemental testing, take measurements of the member’s visual acuity using low-vision test charts with a larger range of letters or numbers to more accurately specify a starting point for determining impairment.
- You can also evaluate visual fields by performing a specialized refraction, and you may prescribe various treatment options, including low vision aids, as well as inform the member of other resources for vision and lifestyle changes.
- We consider low vision aids other than the above on a case-by-case basis. To request other low vision aids, email the Low Vision Service/Materials Approval Request form to medexceptions@eyemed.com or fax it to 866.552.9115.

### What happens if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

### Safety Eyewear Program powered by EyeMed

The Safety Eyewear Program Powered by EyeMed offers vision benefits to employees needing on-the-job protective eyewear. It’s sold separately to new and existing clients in addition to their routine vision plan.

### What does this mean to EyeMed?

- A few existing groups allow members to use their routine benefits on safety eyewear.
  - You won’t use the lab network for these groups.
    - American Greetings
    - National IAM Benefits Trust
    - Northern Michigan University
    - Quad Graphics
    - Railroad Employees national vision plan
- Vibracoustic
- EyeMed will contact you to inform you of the demand for safety eyewear in your geography, and you may be sent a safety frame kit to keep in your practice depending on your geographic proximity to the employees who have the benefit.

What does this mean for you?

- If you’re contracted to use the lab network, you’ll order from a selection of ANSI-certified safety frames available from the participating network of labs.
  - The full list of available frames is provided in the Safety Frame Catalog.
  - Sample frame kits may be provided depending on the expected volume of members in your practice.
- If you don’t use the EyeMed lab network, members with safety eyewear benefits may choose from the selection of safety-certified frames you offer.
  - You must offer a frame selection of at least 8 ANSI-approved frames that meet the following criteria:
    - Unisex or at least 4 men’s frames and 4 women’s frames
    - Varied material types
    - Varied eye sizes
    - Complimentary side shields
    - Complimentary eyeglass case
    - Manufactured at a safety-certified lab
    - Include the ANSI required markings
  - Provide complimentary side-shields and a frame case with every safety eyewear purchase.

How does it work?

- Only the employee who is enrolled in the Safety Eyewear Program is eligible. Dependents are not eligible.
- Safety plans include the following coverage:
  - A frame allowance – If members buy a frame that exceeds the allowance, apply a 20% discount to the overage, and collect the remainder from the member, as you would with routine vision care.
  - Lens copay – Refer to the Member Benefits Display in the online claims system for the member’s specific copay amounts, if any.
  - Lens add-ons – Lens add-ons are available and will vary depending on the member’s benefit. If the patient chooses an option that’s covered under their plan, charge the plan copay amount, otherwise follow the standard Lens Options Schedule for member payment. Polycarbonate is typically a covered benefit for safety eyewear.
  - Additional pair discount – Members receive 20% off additional complete pairs of safety eyewear. This can’t be submitted through the system. Simply apply the discount at the point of sale as you do for other EyeMed discounts.
The following are excluded and are not covered under the Safety Eyewear Benefit:

- Plano safety glasses
- Contact lenses
- Everyday eyewear instead of safety certified frames and lenses
- Any frame, lens or lens option that does not meet current ANSI Z87.1 safety standards
- Materials obtained by other means than those approved as part of the program

- The patient’s prescription must be valid (<2 years old).
- All prescribed materials must meet current American National Standards Institute (ANSI) Z87.1 standards for safety.
- Lens add-ons will vary depending on the member’s benefit.
  - If the patient chooses an option that’s covered under their plan, charge the plan copay amount; otherwise, follow the standard [Lens Options Schedule](#) for member payment.
  - Polycarbonate is typically a covered benefit for safety eyewear.
- Employers may have specific guidelines regarding allowable safety materials for their employees based on work conditions or specific job functions. See the notes in the Service Restriction Section in the Member Details page in the [online claims system](#) for plan specific information.
- If you’re contracted to use the lab network, order all Safety Eyewear Program frames through participating labs.
  - Have your patient choose a frame from the [Safety Frame Catalog](#).
  - The frame will be supplied by the labs.
  - All safety frames come with side shields (built-in or removable) at no additional charge. For replacement side-shields, call Hilco OnGuard at 800.955.6544.
- You can request a first-time remake from the network lab at no charge within 6 months of the date of delivery for the reasons stated in the Provider Manual under the [Refunds, Returns and Remakes](#) section.
  - Process a remake or redo as a lens-only order.
  - If a member wants to change a frame only, he or she is responsible for the cost to change the frame, and you’ll handle it as a private pay transaction.
  - Work with the lab for remake procedures to find out if you need to return the frame with the remake.
  - Eyewear can be remade in the case of damage or quality issues with the frame at no cost as part of the manufacturer’s product warranty.
- Returns, exchanges and voids are not processed as part of the Safety Eyewear Program.
  - The only exception is when the member cancels his or her order before the order is in the manufacturing process.
  - In this case, follow our [normal void process](#).
- You can’t use in-office finishing or uncut lenses to fulfill a safety order.

**Best practices**

- The Safety Eyewear Program is typically a materials-only benefit, so an eye exam is usually not covered.
  - If employers choose, they can add an exam benefit to the program.
- You’ll be reimbursed your standard contracted eye exam rate for the network.
- In most cases, safety patients will be eligible for a comprehensive eye exam under other sources, such as medical coverage or routine vision benefits. Double-check exam eligibility under any available plan for that member. If the member is still eligible for eye exam coverage through a different plan, and you accept that plan, you can bill the eye exam to the other plan.
- If a member received an eye exam elsewhere, they will present their prescription. Based on your professional judgment, you can require a new exam prior to dispensing the safety eyewear.
- When filing the claim online, the system will calculate the member out-of-pocket.
- The current frame and lens catalogs are available on inFocus.
- Before you place an order, note that frames in the frame kit are for display only and should not be sent to the lab.
  - The kit includes a sampling of available frames.
  - Refer to the Safety Frame Catalog for the full list of available frames, materials and colors.
- Hilco OnGuard offers qualifying safety eyewear frames. Call them at 800.955.6544 for more information.

What happens if you don’t follow the guidelines?

- Claims could be denied, and you could be responsible for lab charges.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Medical/Surgical Eye Care

EyeMed administers the medical and surgical eye care benefits for some health plans. Doing so gives you the opportunity to practice to the full extent of your license and to be part of more coordinated patient care. You’ll be able to file claims with us for these expanded services for members without having to schedule additional appointments or work with a different carrier.

Fallon Community Health Care Plan (FCHCP) and Tufts Health Plan cover primary eye care services, but their programs are not part of Medical/Surgical Eye Care. Please refer to the Client-Specific Requirements for more information.

What does this mean to EyeMed?

- Some medical and surgical procedures require review and pre-authorization through our utilization management process
  - Utilization management (UM) is the evaluation and determination of medical necessity, appropriateness and efficiency of health care services, procedures or a course of treatment based on clinical criteria or protocols.
  - We’ll work with the health plan to secure any required facility authorizations for the services.
What does it mean for you?

- You’re required to obtain pre-authorization for the below 6 surgical procedures and injections.
  - Intravitreal injections: J0178, J0585, J0586, J0588, J2778, J3396, J3490, J7313, J7316, J2503
  - Blepharoplasty and ptosis repair: 15822, 15823, 67900-67914
  - Botulinum toxin (Botox): J0585, J0586, J0588:
  - Cataract surgery: 66982 & 66984
  - Glaucoma Surgery: 65850 & 65855
  - Unlisted procedures 66999, 67299, 67399, 67999, 68399, 68899, 92499
- Clinical guidelines for each are available on inFocus.
- Expedited pre-authorizations are available only if the standard UM decision turnaround time:
  - Could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function
  - Would, in the opinion of a physician with knowledge of the consumer’s medical condition, subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

How does it work?

- You’ll request pre-approval through the Utilization Management form available on our online claims system.
  - You’ll be notified of approval or denial for standard, non-urgent requests within 14 calendar days.
  - If any of the services/injections also requires a facility authorization, we’ll obtain that for you.
- You can request expedited decisions, which are rendered within 72 business hours, by indicating that it’s an expedited request on the pre-authorization form.
- Emergency services do not require pre-authorization.
  - Notify us by completing the pre-authorization online request form on the next business day following the emergency care or by calling 866.652.0038.
  - Attach to the form any medical records related to the emergency care.
- When you or your patient are not satisfied with a denied UM decision, you can request an appeal along with additional medical information.
  - The request will be reviewed by a clinical peer reviewer not involved in the initial denial determination and not a subordinate of the initial clinical peer reviewer. Follow the instructions on the determination letter.
  - Standard UM appeals are determined within 30 calendar days of the receipt of the request. Expedited appeal requests will be reviewed and determined within 72 hours of receipt.
  - Both you and the patient will receive notification of the appeal decision.
- Co-management is allowed as long as the surgeon who receives pre-authorization for the surgery uses the co-management modifiers.
  - These modifiers need to be on the claims submitted by both the surgeon and optometrist.
Co-management guidelines are the same as Medicare.

Frequency/Timing

- We deliver determinations for standard pre-authorizations within 14 business days.
- Expedited requests are processed within 72 business hours.
- Standard UM appeals are determined within 30 calendar days of the receipt of the request. Expedited appeal requests will be reviewed and determined within 72 hours of receipt.

What if I don’t follow the guidelines?

- Your claim will be denied if you do not obtain pre-approval for medical/surgical eye care services as required.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Client-specific rules

CareMore

- If you need a facility authorization for services other than those processed through EyeMed, you’ll need to obtain it directly from CareMore. Contact CareMore’s Utilization Management department at 888.291.1358 (Option 3, Option 3, Option 2).

Limitations and exclusions

Plan limits and exclusions include:

- Orthoptic or vision training, low vision aids and any associated supplemental testing, unless specifically covered by the plan.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- An eye or vision exam, or any corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under a plan. Some clients may offer the Safety Eyewear Program Powered by EyeMed in addition to their routine vision plan.
- Services provided as a result of any workers’ compensation law or similar legislation or required by any governmental agency or program, whether federal, state or subdivisions.
- Plano lenses and plano sunglasses (except for 20% discount).
- 2 pairs of glasses instead of bifocals (does not apply to D or C plan members).
- Services or materials provided by any other group benefit plan providing vision care.
• Services rendered after the date and insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days of such an order.
• Lost or broken lenses, frames, glasses or contact lenses, until the benefit resets.
• Not all materials are available at all provider locations.
• Members can’t combine benefits with any discount, promotional offer or other group benefits plans.
• Allowances are one-time use benefits unless otherwise noted.
• Members can’t use remaining balances for additional pairs unless the plan provides a declining balance benefit.

We’ll notify you of any changes to this list. Insurance companies who underwrite our plans may have additional limitations and exclusions.
Pediatric Vision Benefits

Insurance carriers may be required to provide coverage for Essential Health Benefits (EHBs) identified by the government. One of the EHBs for children is vision care. The EHB differs somewhat by state but generally includes eye care and corrective eyewear as needed. We refer to these benefits as Pediatric Vision Plans.

What does this mean to EyeMed?

- Pediatric vision benefits must be embedded in a medical plan rather than offered as a standalone vision plan offered by companies like EyeMed.
- Several health plans who already use our network for vision benefits use our network to provide the vision care EHB to medical members.

What does this mean for you?

- To meet the ACA requirements and ensure consistency of eyewear products, members will have to select from a specific selection of frames. See the details of our Pediatric Vision Benefits frame inventory requirements.
  - Members will have no out-of-pocket cost if they choose from the inventory selection.
  - If they decide they want a frame outside the selection, they’ll have to pay your regular U&C, and the transaction will be considered “free to choose.”

<table>
<thead>
<tr>
<th>Replacement frequency</th>
<th>Amount dispensed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>6 month supply</td>
</tr>
<tr>
<td>2-week</td>
<td>6 month supply</td>
</tr>
<tr>
<td>Daily disposable</td>
<td>3 month supply</td>
</tr>
<tr>
<td>Conventional</td>
<td>Annual supply (one pair)</td>
</tr>
</tbody>
</table>

- For contact lenses, members will receive a 6-month, 3-month or annual supply of contact lenses, depending on the modality, at no cost.
How does it work?

- Members with Pediatric Vision Benefits present medical plan ID cards instead of EyeMed ID cards.
- You’ll look up members the same way you would any EyeMed member. You’ll know it’s a Pediatric Vision Benefits plan because the Member Details page will include a note like the one below.
- Health plans may require members to meet deductibles before qualifying for Pediatric Vision Benefits.
  - Before they meet the deductibles, members will be placed in pre-deductible plans, and the member will pay you in full based on your negotiated rates with us.
  - You’ll know a member is part of a pre-deductible plan because the note on the Member Details screen will say so.
  - Health plans need to track the members’ spending, so file the claim like you normally would. However, you won’t receive any reimbursement from us for pre-deductible plans.
- The Member Details page for the member will tell you exactly what the member owes you.

Plan-specific requirements

- Multiple-pair benefits (Kansas, Kentucky and New York only)
  - Some health plans cover a medically necessary second pair of eyewear for Pediatric Vision Benefits members in Kansas, Kentucky and New York.
  - In Kentucky and New York, the vision change/loss must be due to one of the following conditions:
    - Diabetes
    - Keratoconus
      - Significant Rx Change/Progressive myopia/astigmatism
      - .75D sphere
      - 00D cylinder
      - For NY only: any significant Rx change/progressive myopia
    - Cataracts
    - Post-cataract surgery
    - Prescription medication
    - Other medical conditions that after review could reasonably cause a change in refractive status
  - You’ll need to provide documentation of the vision change/loss each time a new prescription is needed sooner than the standard 12-month interval.
- Kentucky multiple-pair benefits
  - Qualifying members in Kentucky receive one additional pair of prescription spectacle lenses of the appropriate power to provide the best possible visual acuity.
  - The frame can be the current frame, if usable, or a new frame that meets the benefit guideline.
- New York multiple-pair benefits
  - The benefit covers prescription spectacle lenses or contact lenses in New York.
  - The member is not restricted to 2 pairs only and can receive new glasses or contact lenses for each prescription change.
- Kansas multiple-pair benefits
  - Members of Pediatric Vision Benefits plans in Kansas receive additional pairs of covered eyewear based on the doctor’s recommendation. There are no special criteria or processes.
- Additional covered conditions for medically necessary contact lenses (California only)
  - Members of Pediatric Vision Benefits plans in California can qualify for medically necessary contact lenses if they have the following conditions:
    - Pediatric aniridia
    - Pediatric aphakia

**Best practices**

- If the member’s cost for contact lenses is more than the $140 allowance, please charge the member the remaining amount in a separate transaction.
  - Because the benefit is based on amount dispensed rather than an allowance, do not balance bill the member if you dispense more than the indicated amount of contact lenses (for instance, an annual supply of monthlies).
  - Instead, submit the claim for the allowed amount only.
  - The remaining supply should be handled in a separate transaction that is not covered by the EyeMed benefit.
- In California and Washington, some health plans cover an entire annual supply of any type of contact lens. Be sure to read the notes in the online claims system to make sure you’re giving the member the correct benefits.

**What happens if you don’t follow the guidelines?**

- Claims could be denied.
- You may not receive the appropriate payment if you do not follow the inventory requirements.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

**Medicaid**

EyeMed administers Medicaid plans for specific health plans in certain states. Not all providers on the EyeMed network participate on Medicaid networks, and participation is dependent on acceptance of a contract amendment and fee schedules specific to the plan or state and enrollment in the applicable state Medicaid agency.

If you’re part of a Medicaid program we administer, these additional requirements pertain to your care of Medicaid members.
What does it mean to EyeMed?

- EyeMed offers vision benefits for members of Medicaid plans through health plans we contract with.
- We proactively communicate new Medicaid plans in advance and assist providers in preparing for serving these members.

What does it mean for you?

- As a member of the Medicaid network, you need to follow both EyeMed and the State Medicaid agency processes and requirements.

How does it work?

- All providers (both the rendering provider and the billing provider) must be an enrolled Medicaid provider in good standing and have an active Medicaid ID prior to providing services to a Medicaid member. The Medicaid agency in your state assigns this ID.
- Medicaid network participation requires that you’re “member ready” before we activate your participation on the locator. Member readiness requires that you:
  - Are enrolled in your State Medicaid program in good standing with Medicaid ID
  - Are registered with a participating Medicaid lab for the plan
  - Have a Medicaid frame kit at your location and ready for use by members
- Medicaid members cannot be charged any out-of-pocket cost for covered services.
- Members can request services not covered or fully covered under the Medicaid plan.
  - You can bill the member, provided the member agrees in writing that s/he is willing to accept payment responsibility.
  - If a member chooses non-covered materials, the member is fully responsible for the cost.
- When a Medicaid member has benefits through multiple plans or “dual coverage,” you need to know what plan is primary and what plan is secondary or tertiary.
  - **Medicaid is always the payor of last resort.**
    - File the claim with the primary plan first, then submit the claim to EyeMed as the secondary plan once an explanation of payment (EOP) and possibly a payment is received from the primary plan.
- Medicaid claims must be filed no later than 90 days from the date of service.
  - Rejected or denied claims can be corrected and resubmitted for provider payment within 45 days of denial.
- Other requirements of the Centers of Medicare and Medicaid Services Part C (Medicare Advantage & Managed Medicaid Plans) may exist.
- If you want to opt out of a Medicaid network you’re currently participating in, complete our online Network Request form.
Frames and lenses

- To comply with the Medicaid benefit requirements, members choose from a specific selection of frames, provide their own frame or purchase a new frame from your dispensary.

  - **Using EyeMed’s lab network**
    - Members must choose from the pre-selected frames from the Medicaid frame catalog.
    - You’ll receive a Medicaid Frame Kit for participating in the Medicaid Network at no cost after you register for a Medicaid-participating lab. The frames in the frame kit are for display only and shouldn’t be sent to the lab when placing orders. They represent a selection of the frames available in the Medicaid frame catalog.
    - Eyewear orders for Medicaid members will be manufactured at a specific network of labs equipped to carry the eligible frames and process frame at lab claims.
      - You must register for a Medicaid lab before you can service Medicaid patients.
      - Once you register, you’ll receive your Medicaid frame kit within approximately 2 weeks.
    - When placing orders for Medicaid members, you’ll use a specific product catalog of lenses, options and add-ons.
    - The first-time doctor-redo policy at network labs does not apply to Medicaid members. If glasses need to be remade due to error during the ordering process, contact the lab directly to make arrangements to have the glasses remade at your cost.

  - **Using the lab of your choice**
    - Medicaid members may choose from a selection of frames you offer. Your frame selection must include at least 36 ANSI-approved frames that meet the following criteria:
      - 12 girls’ frames, varied materials
      - 12 boys’ frames, varied materials
      - 6 women’s frames, varied materials
      - 6 men’s frames, varied materials
      - Eye size assortment between 42 and 57
    - **Patient-supplied frame**
      - Members may supply their own ophthalmic frames, provided the frames are in good repair and able to hold the new lens.
      - Members may purchase a new frame in a separate transaction from their benefit transaction.
      - The lab liability is limited to a maximum of $50 in the event a frame in a “frame to come” order is damaged, lost in transit back to the provider, or during the production process.
    - **Polycarbonate lenses** may be covered as the standard material for all eyewear. Refer to the plan-specific guidelines for more information.
    - The plan may cover 2 pairs of glasses in lieu of bifocals. Refer to the plan-specific guidelines to see the exact benefits.

**Additional eye exams**

- Many Medicaid plans include additional eye exams when medically necessary due to a change in vision
of greater than 0.50 diopter. Refer to the plan-specific guidelines for more information.

**Lens options**

- Some lens options are covered only when medically necessary. Refer to the plan-specific guidelines for the plan’s covered options and benefits.
- Medical necessity can be met for any of the below reasons.
  - Prescription (RX) – Patient has a prescription strength or medical condition that necessitated a medically necessary lens option for adequate vision correction.
  - Situational (ST) – Patient has a circumstantial clinical need that required a specific treatment for adequate vision correction.
  - Previous Order (PO) – Patient is unable to wear multi-focal lenses.

**Replacement eyewear**

- Medicaid covers replacement eyewear for members.
- Replacement eyeglasses due to loss or breakage must duplicate the original prescription and frames.
- Coverage also includes the repair or replacement of eyeglass parts when the damage results from causes other than defective workmanship.
- Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.

**Contact lenses**

- Contact lenses may be covered for patients with a medical necessity that precludes them from wearing glasses.
- You’ll be paid for medically necessary contact lenses based on your Medicaid fee schedule.

**Best practices**

- Order frame and lenses when placing the lab order through the online claims system using the “Lab Supplied” frame option.
- The frame kit is the lab’s property and should be used only in conjunction with Medicaid plans.
  - If you leave the program, return the kit to the lab at your expense.
  - Additional kits and replacement frames can be ordered directly from the lab.
- If the member elects to provide their own frame, indicate “Patient Supplied” in the frame source field and “Frame to Come” or “Lens Only w/Trace” as the job type. Also enter the frame information as part of the order.
- If you are sending the order as “Frame to Come,” send the frame to the lab using a shipping service with tracking capabilities and signature required, to show the lab received the frame prior to filing any claim loss.
- Inform the member prior to rendering the non-covered service that the service is not covered, and they will be financially responsible.
- Failure to notify members at the time of service could result in you being financially responsible for the services, even if the member verbally agreed to those services or paid for them up front.
- To protect your practice from financial responsibility, have the member sign a waiver specifically listing the materials, services and costs not covered under Medicaid coverage, and acknowledge that they are financially responsible for those items.
  - Make sure the date of service, your practice information and a reason for the visit is listed.
  - Give the member a copy and keep the original in the patient’s file.
- EyeMed expects you to have appropriate documentation to support medically necessary claims.
  - Maintain up-to-date, detailed and organized medical records documenting clinical findings.
  - We may request access to records as part of our audit process. We’ll be looking to see that the documented prescription supports the qualifying condition submitted.

What happens if you don’t follow the guidelines?

- If documentation doesn’t support qualifying conditions for medically necessary claims, we’ll recoup any overpayment by withholding payment on future claim(s) where law permits.
- If you dispense a frame not supplied from the frame kit, the frame will not be covered.
- We can consider an inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. If we believe you’ve filed a false claim, we might also have to report it to regulatory and law enforcement agencies as appropriate.

TRICARE through Humana Military

Some EyeMed network providers are part of the optical network for TRICARE through Humana Military via an addendum to their current EyeMed provider contract and acceptance of the TRICARE fee schedule.

TRICARE providers are obligated to abide by the rules, procedures, policies and program requirements as specified in the TRICARE provider handbook and the TRICARE regulations and manual requirements related to the program. TRICARE regulations are available on the TRICARE website at TRICARE.mil. Additional information is also available at HumanaMilitary.com.

“TRICARE” is a registered trademark of the Defense Health Agency (DHA). All rights reserved.

You agree to accept the rates and terms of payment specified in your agreement with EyeMed as payment for a covered service.

You’ll use Humana Military’s provider self-service to look up eligibility and file electronic claims.
You must be TRICARE-certified through Wisconsin Physicians Service (WPS), Humana Military’s claims processing partner to receive payment for TRICARE services.
Compliance and quality assurance
Quality Assurance (evaluations, audits and disciplinary action)

Our Quality Assurance (QA) team reviews any member or participating provider complaints or appeals of clinical issues. We review all complaints or appeals about claims, application of benefits, plan benefits or other non-clinical issues. The QA process includes complaints, appeals and audits.

Please see the Medicaid section of the provider manual for specific quality assurance policies related to that plan. Medical/surgical program utilization management also has unique quality assurance processes, which are detailed in that section of the manual.

What does this mean to EyeMed?

- Clients require us to demonstrate that their employees receive quality eye care. Audits and associated reporting let us provide data that demonstrates consistent eye care that meets specific standards.
- We use an independent review process with different subject matter experts at each level of the claim appeal or complaint.
- We’ll work to resolve all member complaints using all the information submitted by both parties.
- From time to time, our QA group selects participating providers and/or locations for facility, clinical, financial and/or process audits.
  - An audit can also be triggered by suspicious claim activity and/or a complaint of alleged fraud, waste or abuse about a participating provider and/or location.
- A subcommittee composed of individuals not involved in the original resolution reviews the complaint appeals.
- Professional reviewers score each clinical record to determine an average.
- We help health plan clients collect Healthcare Effectiveness Data and Information Set (HEDIS) data through HEDIS audits. HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA), that allows consumers compare health plan performance to other plans and to national or regional benchmarks.
- When a member files a complaint against a lab making their materials, the QA team will work with you, the lab and the member to resolve the complaint.

What does this mean for you?

- You’ll be involved in resolving member complaints related to care you provided.
  - You must cooperate and participate in helping us resolve member complaints, and if we rule in the member’s favor, you must comply with our determination.
You may be able to appeal decisions.
- File formal complaints through the QA department.
- You are subject to audits of your facility, your records and your processes.
- Quality Assurance activities could result in disciplinary actions.
- When you’re asked to submit copies of patient records, you must do so at no charge to EyeMed.

How does it work?

Member complaint process

- Member submits written complaint to our QA team.
- The team reviews the complaint. They may request additional explanation and information from the member. If we feel the member hasn’t informed you of the complaint, we’ll recommend the member reach out to you to work things out.
- You’ll receive a summary of the complaint via email, fax or mail.
- Our QA team collects supporting information from you and the member and recommends a resolution. If you don’t respond to our requests for information, or if you don’t give us what we need, we’ll pursue disciplinary action.
- The team determines the resolution and notifies you and the member in writing within 30 days.

Second opinions

- When members submit written requests for second opinions, we’ll ask for your perspective and any supporting evidence or clinical records pertaining to the case.
- We’ll resolve the dispute and notify both parties.

Provider complaint process

- If you or your staff has a complaint about how we handle something or about our services and plans in general:
- Call us at 888.581.3648. For most situations, our customer service team can help.
- If they can’t help, they’ll ask you to submit your complaint in writing to our QA team, along with any supporting documentation.

Audits and evaluations

- We conduct the following audits:

<table>
<thead>
<tr>
<th>Evaluation type</th>
<th>What we’re looking for</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Facility
- Areas of physical access, instrumentation and overall facility condition
- 2 sections: Required equipment and facility environment

Required equipment:
100% required to pass

Facility section:
- 100 – Excellent
- 99 to 80 – Satisfactory
- Less than 80 – Progressive Disciplinary Action

Clinical records
- Assessment of member records
- Financial evaluation

- 100 to 90 – Good to Excellent
- 89 to 80 – Satisfactory
- 79 to 0 – Fail: Progressive Disciplinary Action

Financial
- Financial document evaluation reviews claims against payment and member records
- Financial claim evaluation reviews a provider and/or location’s claim history to reveal billing patterns

- 100 – Excellent
- 99 to 80 – Satisfactory
- 79 to 0 – Fail: Progressive Disciplinary Action

Process
Review of clinical and business practices for a specific reason, such as adherence to clinical coverage criteria or application of a benefit and compliance with lab ordering, In-Office Finishing and emergency service policies

80% required to pass

HEDIS
Collection of HEDIS data to assess and compare quality of care

NA

Best practices
- Respond quickly to requests for follow-up information to ensure the QA team has all of the facts.
- If you don’t respond to our requests for information within the specified time, we’ll resolve the member complaint without your comments or perspective.
- If you receive a request for clinical records for a HEDIS audit, respond promptly to the address listed on the request and include all clinical documents relating to the patient.
- You can’t charge us or a member for the cost of making copies of your records when we request them.
- You must make members’ clinical and all administrative records available to us or other authorities that are reviewing quality of care or investigating a member complaint or appeal. In the event of a member complaint or an audit, you must also provide members’ clinical and financial records upon request.
- If you leave your practice or our network, provide us with a forwarding address so members can get copies of their clinical and administrative records if needed.

**Frequency/Timing**

**Complaints**

- QA will investigate your complaint and provide a written resolution within 30 days for most situations, but absolutely no later than 60 days.
- You must provide copies of the member’s file and a response to a complaint within 5 business days.

**Appeals to determinations**

- You or the member must submit a written appeal to us within 30 business days from the original decision date.
- The subcommittee will make its appeal decision in writing within 30 days.

**Audits/evaluations**

- If you fail an equipment evaluation, you’ll have 10 business days to correct any issues or face disciplinary action.
- We’ll remove you from the network if you don’t respond or correct equipment issues within 30 days.

**What happens if you don’t comply with the guidelines?**

- If you don’t assist during the investigation, we’ll hold you in “noncompliant” status.
- If we determine the member is due a refund, and you don’t reimburse the member or reinstate their benefit, we may reimburse them on your behalf and deduct the amount from future payments to your account, where permitted by law.
- You may be subject to re-evaluation or a corrective action plan if you fail or score less than “excellent” on audits. Facility audit failures are subject to accelerated disciplinary action, and the corrective action plan must be completed within 30 days.
- In most cases, we apply the following disciplinary process.
  - For suspected fraud, waste or abuse, additional actions, including involuntary termination, may be taken.
<table>
<thead>
<tr>
<th>Noncompliance level</th>
<th>Reasons</th>
</tr>
</thead>
</table>
| Level 1 noncompliance | • Non-response to QA request or notice  
• Billing and/or claim filing errors  
• Lower than expected quality of service and/or materials, standards of optometric care and/or professional behavior  
• Failure to follow our quality, contractual or administrative protocols  
• Violating the terms of our Provider Agreement |
| Level 2 noncompliance | • Continued Level 1 noncompliance  
• Provider/member conflict: if your practice requires Provider Appeal, Peer Review or QA intervention |
| Level 3 noncompliance | Continued noncompliance with our rules and standards that includes a “notice of involuntary termination” review from the Peer Review |

- If we find any overpayments during a financial record audit, we’ll collect the overage from future claim payments as allowed by law.

**Annual training requirements**

Network providers must comply with Centers for Medicare and Medicaid (CMS) annual training requirements.

**What does this mean to EyeMed?**

- We must report compliance with CMS requirements to health plan clients and insurers.  
- We offer modules that cover the required annual training topics.  
- We track provider attestation that they have completed the annual training.

**What does it mean for you?**

- You’re required to attest once a year by December 31 that you have completed the CMS training requirements.  
- All staff members in your practice must complete training about:  
  - Fraud, waste and abuse prevention
- Compliance Program Effectiveness (federal)
- HIPAA (federal and state privacy)
- Information Security (federal OCR & state)
- Cultural competency
- Human trafficking
- Additional topics could be added in compliance with CMS requirements or state law.

How does it work?

- We’ll notify you when the annual tracking period is open.
- Once the training has been completed by everyone in your practice, you must attest that you meet the

Best practices

- You can download training from our communications portal or use another source that meets CMS requirements.

Frequency/Timing

- You must attest that you meet training requirements by December 31 each year.

What happens in you don’t follow guidelines?

- You could be subject to disciplinary action.
- You’ll also be out of compliance with CMS or state regulatory agencies.

Fraud, waste and abuse prevention

EyeMed’s membership includes Medicare Advantage and Managed Medicaid members. EyeMed follows Centers for Medicare and Medicaid Services (CMS) requirements and other industry standards related to preventing fraud, waste and abuse (FWA).

What does this mean to EyeMed?

- Our FWA prevention goals are:
  - To effectively pursue the prevention, investigation and prosecution of health care fraud, waste or abuse.
  - To recover overpayments on behalf of our clients.
To comply with state and federal regulations and clients’ requirements for preventing fraud.
- EyeMed conducts audits and other measures to monitor and correct potential fraud, waste and abuse.

What does this mean for you?
- You must complete annual training about preventing FWA.
- No one in your practice can be on an exclusion list.
- If you’re found in violation of FWA policies, you will be subject to disciplinary action ranging from corrective action plans to termination from the network depending on the severity.
- EyeMed will report suspected fraudulent activity to comply with state and federal regulations and/or clients’ requirements.

How does it work?

Annual training
- The Centers for Medicare and Medicaid Services (CMS) requires you to complete at hire and annually thereafter compliance training related to fraud, waste and abuse (FWA) awareness.
- The requirement applies to:
  - Everyone working within your location.
  - Anyone who has at least a 5% ownership in your business.
  - If you also subcontract work to other suppliers or vendors, they must complete CMS FWA & Compliance annual training.
- Refer to our Annual Training Requirements for more information.

Exclusion screening and documentation
- You must make sure any individual or entity you intend to hire, sub-contract or add into your practice ownership is not excluded from receiving federal funds. If they appear on any of the exclusion lists below, they will not be able to provide services to EyeMed members.
- The Office of Inspector General’s List of Excluded Individuals and Entities or LEIE at https://exclusions.oig.hhs.gov/
- System for Award Management or SAM at https://www.sam.gov/, see “search records”

Frequency/Timing
- Fraud, waste and abuse training is required once per calendar year by December 31.
- Check websites monthly for the exclusion status of any current or prospective team members.
Best practices

- Complete training and attest to your compliance as soon as possible after receiving notice from EyeMed that it is available.
- Keep records of your exclusion screening effort and training, and be able to produce supporting documentation if requested.

What happens if you don’t follow the guidelines?

- Identified fraud, waste or abuse may result in some or all of following:
  - Provider education and warning
  - Monitoring of the provider’s submitted claims activity and/or implementation of a Corrective Action Plan
  - Comprehensive provider audit and/or quality review of the provider’s claim activity
  - Withholding of the provider’s claim payments or demand for restitution for recovery of overpayments
  - Termination of the provider from the network
  - Reporting of suspected fraudulent activity to comply with state and federal regulations and/or clients’ requirements
- Refer to our Quality Assurance Program for detailed descriptions of disciplinary action.

Returning to the network after involuntary termination

If you’re involuntarily terminated from the network and wish to reapply, you can do so after 1 year subject to approval by our Quality Assurance committee and a probationary period.

What does this mean to EyeMed?

- Our Peer Review Subcommittee reviews reapplication requests from providers who were previously involuntarily terminated.
- We will explain any reason for denying a request to rejoin the network.

What does this mean for you?

- Request to reapply to the network in writing, acknowledge the reason for your termination and provide evidence of how you’ve addressed the issue that caused your removal from the network. You must also be in good financial standing with EyeMed and all affiliated entities.
If approved, you will:
- Need to reapply to the network.
- Be subject to network and credentialing rules and requirements at the time of reapplication.
- Be under probation for 12 months following reinstatement.
- If your request to reapply is denied, we’ll let you know why and explain the requirements to successfully re-enter the network. You may reapply again after 1 year.

How does it work?

- During the 12-month probationary period:
  - You must participate in the EyeMed Dispensing Model, and you will not be eligible to participate in the In-Office Finishing program to the extent permitted by applicable law.
  - You agree to additional audits at your expense to monitor compliance with all EyeMed participation criteria and your corrective action plan.
  - You must attest annually to having completed a minimum of 10 hours of continuing education related to proper coding, billing and/or Fraud, Waste and/or Abuse prevention.
  - If you don’t comply with all rules and standards during this period, the subcommittee can immediately terminate you from the network.
  - If you do comply with all rules and standards during this period, the subcommittee will readmit you to the network in the same manner as all providers.
  - Some situations prohibit re-entry, including evidence of physical or potential harm to a member or alleged fraud and/or billing abuse.

Frequency/Timing

- You can reapply to the network 1 year after involuntary termination.

What happens if you don’t follow the guidelines?

- You will not be able to rejoin the network.
Lab network

Unless your contract states otherwise, you must use our network labs or single vision In-Office Finishing program (if applicable) for all EyeMed member eyewear.

What does it mean for EyeMed?

- EyeMed’s lab network includes labs across the country, including Essilor labs, Walman labs and Luxottica Lab Services (LLS).
  - Eyewear for Medicaid and Safety Eyewear Program members are available only at certain labs.

What does it mean to you?

- You can choose to fulfill orders at any of the labs on EyeMed’s lab network.
- Stay in good financial standing with the network labs you use for non-EyeMed orders.

How does it work?

- Submit lab orders through our online claims system at the same time you file the claim and send the frame to the lab (except for eyewear covered under Medicaid and the Safety Eyewear Program).
- The lab will make lenses based on the member’s prescription and options indicated on the claim, insert the lens into the frame you provided and ship the completed pair back to your office.
- When you place an order with a network lab, send the frame to the chosen lab.
  - If you’re sending the frame(s) directly from your location, always include a copy of the order confirmation. You can request a confirmation from the lab in our online claims system.
  - If you don’t send the frame to the lab within 90 days of the order, the lab will cancel the job and void the claim. You’ll need to re-enter the claim if you end up sending the frames after the 90-day period has elapsed.
- You will not use the lab network for the below situations. Instead, submit a CMS 1500 form.
  - Standalone discount programs, materials only discount plans and discounts on additional purchases after use of the funded benefit (although you can order eyewear materials for members with discounted materials through our lab network if you choose)
  - Low vision materials
  - Pediatric Vision Benefits pre-deductible plans (all other plans use the lab network)
  - Pediatric Vision Benefits medically necessary multiple pairs
  - Any other benefit that requires the submission of a CMS 1500 form
  - Any plans or groups specifically excluded
  - Emergency services/situations
- Safety Eyewear Program orders are treated as frame at lab. Refer to the Safety Eyewear Program section for available frames catalogs and requirements.

Best practices

- If you’re drop-shipping the frame from the manufacturer, make sure to include the member’s name with the frame order.
- When sending the frame(s) to the lab, always include a copy of the order confirmation.

Frequency/timing

- Our goal is for the lab to ship the product back to you within 1 week from the time the lab receives the frame.

What happens if you don’t follow the guidelines?

- If you don’t stay in good financial standing with labs, your claim may be paid according to the fees listed under the heading Claims Submitted Outside of Our Online Claim System on the back of your fee schedules.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

What if my state laws allow me to utilize the lab of my choice?

- Contact the call center to receive a form to complete to update your agreement with us.

Product catalog requirements

When using the lab network for eyewear orders, you’re required to order lenses listed in the Essilor or Luxottica Lab Services product catalogs for EyeMed when members use their funded benefits, except for certain situations that require the use of a hard copy CMS 1500 form.

What does it mean for EyeMed?

- Product catalogs include lenses and treatments to meet members’ many lifestyles – and we have complete product catalog listings for all labs in our network.
- We update catalogs periodically to ensure access to the latest technologies.

What does it mean to you?

- Product catalogs include all products available for order through the lab network.
  - You can find more information on lab charges for specific lenses, lens options and finishing services in the [Lens and Options Charge Back Schedule](#).
  - Refer to the [Safety Eyewear Program](#) section for specific safety lens product information.

How does it work?

- When filing the claim online, you’ll select the lenses and lens options you wish to order in the lab order section.
- Drop-downs for each lens, treatment and option will include the products available for the lab you choose at the beginning of the lab order process.
- You can access full product catalogs on [inFocus](#).

Frequency/timing

- We update product catalogs periodically to reflect changes in technology and new products. We’ll notify network providers when new catalogs are available.

What happens if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. [Refer to that section for our formal disciplinary process](#).

Emergency lab processes

You may use a non-contracted lab to meet urgent member needs when, in your professional judgment, there’s a critical patient visual need that cannot be addressed through normal contract lab services.

What does this mean for you?

- The below situations qualify as emergencies for which you can use a non-contracted lab.
  - A member’s safety and/or well-being is at risk without the immediate delivery of prescription eyewear.
  - The member is unable to function at work or school and doesn’t have an alternate pair of glasses or contact lenses.
• Lenses or lens options not in our product catalog that you deem necessary based on your professional judgment. When filing an emergency service claim, you’ll need to explain your professional justification.
• The member suffers a loss, theft or breakage of prescription eyewear, has no alternate pair and can’t wear contact lenses.

How does it work?

• Send the job to the lab of your choice; it will be treated as a private pay lab transaction.
• Submit a CMS 1500 form in hard copy to receive payment according to the amounts listed under the Claims Submitted Outside of Our Online Claims System section on your fee schedules.
• Don’t balance bill the member for any difference in reimbursement from the schedule if you order a lens that’s not in one of our catalogs.

Best practices

• Requests for faster turnaround time for convenience (such as to accommodate trips, vacations or other events), a desire for faster service, or when the member has another serviceable pair of glasses or contact lenses, aren’t considered emergencies.

What happens if you don’t follow guidelines?

• Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Lab order refunds, returns and remakes

If you’re not satisfied with the end product from the lab, or the member has problems adapting to progressive lenses, the lab will correct reasonable remake requests as outlined below.

What does this mean for you?

• You can request a no-charge remake from a network lab 1 time per job within 6 months of the date of delivery for the following reasons:
  • Power changes (excludes power changes resulting in plano lenses).
  • Axis changes.
  • Base curve changes.
  • Segment height/segment style changes due to non-adaptation (i.e., FT28 to Executive).
- Lens style change (except when going from a lower to higher technology like from a bifocal to a progressive)
- Transcription errors (not including transcription errors involving tints, photochromics, frames or coatings).
- Material change (i.e., glass to plastic, plastic to poly, plastic to high index plastic or glass, etc.)
- Lab errors.
- Progressive lenses under warranty.
- You can’t receive a free lens remake for the following:
  - Frame change remakes without a change in lens prescription
  - Subsequent remakes after the first 1 (excludes lab errors)
  - Patients’ upgrade requests
  - Lost materials
  - Materials broken or damaged by the member
  - Any lenses with upgrades
  - Changes requested after 6 months of delivery
- Labs won’t do free remakes for changes to the frame only.

How does this work?

- Remakes for lab errors are processed free of charge.
- For a free first-time remake, return the lenses to the same lab (within 6 months of the original delivery date) along with the original invoice/shipping slip, an explanation of why you’re returning the lens and any supporting documentation.
- Members are responsible for the cost to change a frame.
  - Handle it as a private pay transaction.
  - Fax the request to the lab and ship the new frame to the lab with the existing pair of glasses.
- If a member wants to change to a lesser technology from a more advanced lens type (for instance, from a progressive lens to a bifocal), work with the lab to determine applicable charges. Members are expected to pay any charges above and beyond the original order.
- For progressive lenses:
  - When a member can’t adapt to progressive lenses while they’re under warranty, the lab will remake the lenses 1 time at no charge in the same design and material (or lesser-priced design and material).
  - If the member still can’t adapt to the second (remade) glasses with progressive lenses, request another remake to switch the member back to lined bifocals, but you’ll have to pay full invoice cost for this additional remake. If this happens, follow the same remake/return process outlined above.
Best practices

- The first-time remake/re-do policy doesn’t cover frame changes if the error is your fault or if the member doesn’t like the frame.
- Any financial issues resulting from the manufacturer’s product warranty should be handled between you and the lab.
- After your first request for a free remake, or requests submitted to the lab after 6 months from the original delivery, additional requests must be handled as a private pay transaction between you and the lab.

What happens if you don’t follow guidelines?

- You could be charged for lab services.
- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Single Vision In-Office Finishing Program

Our single vision In-Office Finishing program lets you offer same-day service by purchasing finished single vision lenses directly from Nassau Vision Group and using your in-house edging equipment.

What does it mean for you?

- To participate in the program, you must:
  - Order all lenses from Nassau Vision Group using our Lens Ordering link (iof.mylensorder.com).
  - Have In-Office Finishing capabilities.
  - Produce eyewear that meets ANSI standards.
  - Complete eyewear within 7 business days

How does it work?

- Use lenses purchased through our Lens Ordering link. Orders from other outlets are not compliant with the ordering requirement.
  - Orders can be placed for individual replenishment or via bulk orders. You also don’t need to replace the lenses you use with the exact lens style used.
  - You can’t use in-office finishing to fulfill a safety eyewear order.
What happens if you don’t follow the guidelines?

- Your IOF claim count will be compared with your orders through our Lens Ordering link. If we notice a discrepancy between the two, we will provide you with notice of the non-compliance. If you do not explain or correct the discrepancy, we may remove your access to the IOF program.
- Refer to our Quality Assurance Program section for our formal disciplinary process.

Lens Only Program

EyeMed’s lens only program lets network providers receive surfaced, edged lenses directly from contracted network labs without sending a frame. You can use the Lens Only program for most jobs.

What does it mean for you?

- You’ll need a tracer calibrated within manufacturer tolerances and according to manufacturer-suggested schedule, with the ability to download and transmit trace data in the Vision Council standard format.

How does it work?

- Submit lens only lab orders through our online claims system. Upload a trace file in either text (.txt) or .xml format using the Vision Council standard format.
- You can send a lens only job using a reference to an archived trace file.
  - Put a prior order or invoice number in the reference field in the online system.
  - If the lab needs an updated trace file, send it separately from the original order.
- Changes to Lens Only orders, once submitted to lab, may result in a private pay transaction if the order has been started.
- Our standard remake policy applies to lens only orders, with the following exceptions:
  - Lens fitting issues due to tracer calibration that exceed manufacturer tolerances or are outside the suggested calibration schedule.
  - Damage or breakage during lens fitting.
  - Fitting issues related to the trace data supplied for lens only jobs, unless caused by lab error.
- Some frames or lens edging may necessitate sending the frame to the lab. If a submitted lens only order cannot be filled for a specific frame or lens, the lab may notify you if identified prior to starting the lens order. Examples of exclusions include:
  - Three-piece/drilled rimless
  - Wrap frames (those with a base curve higher than 6)
  - In-line/double-groove frames
  - U-bevel frames (zyl frames with deep groove)
Mini/shallow-bevel frame (too small for standard bevel)

Best practices

- Look for the “Lens Only w/ Trace” button in the online claims system.
- We may request tracer and calibration records during our Quality Assurance process.
- Due to tracer variances, minor finishing may be required to fit the lens.

What happens if you don’t follow guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.

Uncut lens program

EyeMed’s uncut lens program lets network providers receive surfaced lenses directly from EyeMed-contracted network labs, so you can control quality and complete the edging and mounting in-office.

What does this mean for you?

- To participate, you need an edger and must have the ability to edge and mount frames within manufacturer tolerances.
- The program is available through Luxottica Lab Services (LLS).
- You can’t use uncut lens ordering for:
  - Tint
  - Mirror
  - Lab-applied UV
  - Glass
  - Balanced lenses
  - Slab off
  - Certain complex frames that require specific mounting or bevels

How does this work?

- Submit uncut lens lab orders through our online claims system.
- When you submit an uncuts job, choose “uncut” as the job type from the available job type list. As other labs that you are already registered for have this service available, “uncut” will appear as a job type for those labs.
Our standard remake policy applies to uncut lens orders, with the following exceptions:
- Damage or breakage during edging and/or mounting of the lens.
- If you’re unable to complete the edging or mounting of the frame, causing you to send a frame to the lab to complete the job.

Best practices

- If you provide an edge-treatment service like a polish edge or a roll and polish, choose that option in the available treatments when placing the uncut order.
  - This will generate the member benefit for the service where you can enter in the Usual and Customary charge.
  - This will not trigger a charge back, as this service will be provided by you.
- Choose a frame type for every uncut order placed through the online claims system. This is important for frame types such as drill mounts and semi-rimless groove to ensure the member benefit is applied correctly.
- If you decide to complete a drill mount or semi-rimless frame, you’ll see these options on the Usual & Customary screen. This will also ensure a charge back is not assigned to these frames, as you’re performing the mounting.

What happens if you don’t follow the guidelines?

- Our Quality Assurance (QA) process monitors compliance with these and other requirements. Refer to that section for our formal disciplinary process.
Client specific requirements