EYEMAX
VISION PLAN

Provider Manual

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Chapter 1

Introduction

Why the Provider Manual is an important tool for you and how to use it.

This provider Manual is for you! We have created this Provider Manual (“Manual") for the sole purpose of assisting EyeMax providers. If information in this Manual is unclear, or you would like additional information included in the future, please let us know. We are here to help you!

Refer to this Manual to ensure that you are providing quality services to EyeMax Vision Plan, Inc. ("EyeMax" or "the Plan") members, the services you provide are covered benefits, and that you are paid promptly for your services.

You can always find the most recent version of the Provider Manual under the provider section of EyeMax’s website, www.eyemaxinc.com.

You are also welcome to contact EyeMax's Provider Relations by phone or email with any questions, concerns or feedback.

EyeMax is subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California Code of Regulations, and any provision required to be in the Provider Agreement by either of the above shall bind EyeMax whether or not provided in the Provider Agreement.

THIS DOCUMENT IS PROPRIETARY AND CONFIDENTIAL. NO PART OF THIS DOCUMENT MAY BE DISCLOSED IN ANY MANNER TO A THIRD PARTY WITHOUT THE PRIOR WRITTEN CONSENT OF EYEMAX VISION PLAN, INC. IF, FOR ANY REASON, THE MANUAL RECIPIENT DOCTOR NO LONGER PARTICIPATES ON THE EYEMAX PROVIDING NETWORK, THE DOCTOR HEREBY AGREES, AND IS DIRECTED, TO IMMEDIATELY DESTROY THIS MANUAL, ALL COPIES, AND ANY AND ALL AMENDMENTS AND ADDENDA THAT MAY BE ISSUED BY EYEMAX FROM TIME TO TIME. IN THE ALTERNATIVE, THE DOCTOR MAY RETURN ALL SUCH MANUALS, AND ANY AND ALL AMENDMENTS AND ADDENDA THERETO, TO EYEMAX’S MAIN OFFICE VIA REGISTERED MAIL, UPS AND/OR FEDERAL EXPRESS.

Chapter 2

Important Information and Quick Reference

How to contact EyeMax and quick guide on new EyeMax members.
Important phone numbers, email addresses, and websites for quick reference when contacting EyeMax for services are noted in this Chapter. EyeMax recommends that providers make this Chapter available to their staff.

Contacting EyeMax Vision Plan, Inc.
You can contact EyeMax Monday through Friday from 8:30 a.m. – 5:00 p.m. as follows:

530 S. Main Street, Orange, CA 92868
1-866-901-8610
Facsimile: 714-689-7575
www.eyemaxinc.com
operations@eye-maxinc.com
memberservices@eye-maxinc.com

In addition to calling EyeMax, providers can e-mail EyeMax anytime at operations@eye-maxinc.com. EyeMax's Provider Relations will respond to all e-mails within twenty-four (24) hours of receiving the e-mail.

Provider's New Member Quick Reference

1. When a patient calls for an appointment, the provider must attempt to determine if the member is an EyeMax member. The provider's office must ask for the group number, the member identification.
2. When a member arranges for an appointment, the provider's office must call EyeMax
3. EYEMAX IS UNDER NO OBLIGATION TO PAY A PROVIDER FROM THE EYEMAX PROVIDER NETWORK IF ELIGIBILITY HAS NOT BEEN CONFIRMED
4. At the time of the appointment, the provider must verify the identity of the EyeMax member (patient) by checking for a valid EyeMax identification card and for a valid picture identification such as a driver's license.
5. Provide the professional services requested by the member.
6. The provider can order any required materials from a lab of their choice.
7. After receiving the completed Rx from the laboratory, the provider must verify the accuracy of lenses and dispense the materials to the member. The provider must ensure the following:
   (a) The CMS-1500 claim is filled out completely including all relevant CPT/HCPCS codes
   (b) The provider must have collected all the Copayments and overages due from the member. The failure to do so will adversely affect the provider's final reimbursement. The completed form must be signed by the provider.
   (c) If applicable, the member must acknowledge any "Lens Upgrades, Services and Options" not covered by the EyeMax plan and the cost of such "Lens Upgrades, Services and Options”. The completed CMS-1500 and Material Invoice forms should be mailed to:

      EyeMax Vision Plan, Inc., P.O. Box 14227, Orange, CA 92863
      Attn: Claims Processing OR faxed to: 714-689-7575

8. Verify accuracy of lenses when received from contract laboratory.
9. Dispense the materials to the Patient

10. When performing an examination only or when providing contact lenses (either Medically Necessary or Non-Medically Necessary) submit the claim directly to EyeMax online at www.eyemaxinc.com. If a member chooses to order Non Medically Necessary Contact Lenses the provider must collect Contact Lens Exam Service Fees and Material Overage from the member at the time of service.

11. To submit a paper claim, make sure the CMS-1500 claim is filled out completely including all relevant CPT/HCPCS codes and that you have collected all the Copayments and overages due from the member. Failure to do so will adversely affect your final reimbursement. You must also sign and date the completed forms. Send the completed forms to:

    EyeMax Vision Plan
    P.O. Box 14227
    Orange, CA 92863
    Attn: Claims Processing
    Or Fax: 714-689-7575

12. EyeMax will pay the provider as outlined in the Provider Manual. For any exceptions or questions, please refer to the appropriate section of the Provider Manual. In the event EyeMax fails to pay the provider, the member shall not be liable to the provider for amounts owed by EyeMax. Upon termination of the Provider Agreement EyeMax shall be liable for covered services rendered to Members by the provider until covered services are completed, unless EyeMax arranges for covered services to be provided by a new contracting provider, as appropriate.

    If you cannot locate the necessary information or for any difficulties in providing services to EyeMax Members, please call the EyeMax office at 1-866-901-8610

Chapter 3

Benefit Plans

A description of the group and individual vision plans.

EyeMax provides prepaid vision coverage for the benefit of groups, associations, and individuals.
Under all programs administered by EyeMax, each member selects an optometrist or ophthalmologist from the list of contracted providers to receive vision care treatment and services. These services include a comprehensive vision exam, prescription glasses (lenses and frame), and contact lens coverage. If the member has a medical disease of the eye, the provider shall instruct the member toimmediately contact his or her primary care physician for medical care and treatment. **EyeMax does not cover ophthalmological medical or surgical conditions or services.**

Group and Individual Vision Care

Group vision benefits for employers

Group vision benefit products are sold by EyeMax to employers, associations, and union groups for the purpose of providing vision coverage to the individual members of the group. All group coverage includes member Copayments for many vision care services and eyewear.

Individual vision benefits for individuals and families

EyeMax provides individuals and families with individual vision plans. These individual plans provide coverage for individuals who do not have vision coverage and desire that type of coverage. All individual coverage includes member Copayments for many vision care services and eyewear.

EyeMax Benefit Plans

The benefits and Copayments for group and individual coverage are shown on the following pages.

Provider offices must submit electronically, or by mail a claim payment using the CMS-1500 Form l. A sample Standard CMS-1500 claim form is also included in this Provider Manual. A provider may obtain a CMS-1500 claim submission form from any medical forms supplier.

Copayments

Copayments are required for vision services. When receiving services, members must pay the Copayments at the time of service. Providers are responsible for collecting the Copayments.

How to Apply and Calculate the EyeMax Benefit

Copayment

Providers must collect all Copayments from EyeMax members at the time of service. Copayments may apply to any one or a combi nation of the exam, frame, lenses or contact lens benefits. A provider's reimbursement payment will be reduced by the amount of any specified Copayment paid by the member to the provider, according to the EyeMax plan provisions.

Comprehensive Eye Exam Policy

EyeMax will reimburse eye care professionals for providing a "healthy" routine comprehensive eye examination, annually or biannually depending on the member's contract. The medical exam records or electronic records need to be used to thoroughly document the testing and procedure results for each member on the date of service. Some members may require further testing beyond those included in the comprehensive eye exam. Members with eye medical health concerns requiring additional medical eye care testing should be referred through their medical insurance plan.

Comprehensive Eye Exam Required Procedures

- Case history and chief complaint
- Ocular and visual health history
- General medical status
- Current medication and medication allergies
- Ocular motility
- Visual acuity
- Pupil examination.
- Binocular examination.
- Objective refraction
- Visual fields (screening)
- Subjective refraction
- External examination and biomicroscopy
- Tonometry
- Ophthalmoscopy (with Dilation if indicated)
- Diagnosis
- Treatment plan

EyeMax Intermediate Eye Exam Policy

Members who do not require all of the procedures listed in the comprehensive eye exam or infant and preschool eye examinations.

Intermediate Eye Exam Required Procedures

- Case history and chief complaint
- Ocular and visual health history
- General medical status
- Current medication and medication allergies
- External examination
- Biomicroscopy
- Ophthalmoscopy
- Visual acuities R&L
- Objective refraction
- Subjective refraction
- Diagnosis and treatment plan

EyeMax Contact Lens Policy

This is for members interested in wearing contact lenses or established contact lens wearers that require additional tests and procedures beyond those procedures required in a comprehensive eye exam. These additional tests are not covered by **EyeMax** and the member is responsible for the additional cost. The requirements for supplying members with contact lens exam services including follow-ups and contact lens materials is specified in the section of this document titled “Contact Lenses”.

New Contact Lens Wearer Procedures

- Keratometry
- Biomicroscopy
- Trial fitting
- Over refraction
- Contact lens training
- Treatment plan

Existing Contact Lens Wearer Procedures

- Visual acuity with contact lens on R&L
- Over refraction
- Biomicroscopy
- Treatment Plan

Warranty

<u>Warranty</u>

For a period of <u>90 days from the date materials are dispensed.</u> Provider agrees to provide a guarantee to Member that all services and materials supplied under this agreement meet ANSI Z80 workmanship. Your provider will utilize the Contract Lab's Redo policies to honor this warranty- subject to the following time limitations:

First time Dr. Redos – *90 Days from lab invoice date Lab Redo - *90 days from lab invoice date Manufacturer's Warranty – 90 Days from lab invoice date
Progressive Non-Adapt Guaranty – 90 Days from lab invoice date
The 90-day timeframe referenced does not replace or supersede grievance policy.

EyeMax Redo Policy

Please refer to the section entitled "EyeMax Redo Policy" in this Provider Manual.

<u>Exclusions, Limitations of Benefits, and Patient Options</u>

Patient Options

EyeMax Vision Plan is designed to cover visual needs rather than cosmetic materials and extras, EyeMax will pay for the **basic** costs of the allowed lenses or frames, and the Member will be responsible to pay the provider for the additional costs for those options at 80% of usual & customary fees.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Polycarbonate lenses (except for pediatric patients)
- Oversize lenses
- Photochromic lenses
- Hi Index lenses
- Tinted lenses
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

Exclusions

Covered Services <u>exclude</u> the following:

- Services received before a Member's effective date of coverage or after coverage ends
- Eyewear that does not meet the minimum prescription requirements
- Vision care services, materials and/or treatments that are not specifically indicated in the Schedule of Covered Services
- Services or materials provided in connection with contact lenses, except those that are specifically listed in the Schedule of Covered Services
- Orthoptics or vision training and any supplemental testing, plano (non-prescription) lens, or two pairs of eyeglasses in lieu of bifocals or trifocals
- Medical or surgical treatment of the eyes
- An eye exam or corrective eyewear required as a condition of employment
- Any injury or illness covered under Workers' Compensation or similar laws, or which is work related except to the extent that The Plan is reimbursed for such Covered Services
- Safety eyewear. Safety eyewear is a class of lenses and frames that meet the most-current ANSI standard for safety in the workplace
- Sub-normal vision aids. Sub-Normal Vision Aids AKA Low Vision Aids are a group of devices that are prescribed by an optometrist/ophthalmologist to visually assist a Member
- Optical Aids. Optical Aids are lens based such as magnifiers, microscopes, or telescopes
- Electronic Aids. Electronic Aids are closed circuit television systems such as the Aladdin, the ELVIS, or even the Kindle

- Non-Optical Aids, which includes large print, check writing guides, felt tipped pens, acetate filters and special lighting
- Replacement of lenses or frames furnished under this plan, which are lost or broken, except at the normal Intervals when Covered Services are otherwise available
- Hospitalization services
- Corrective vision treatment of an Experimental or Investigational nature.
- Artistically painted contact lenses
- Plano (non-Rx) contact lenses

Limitations

EyeMax Vision Plan, Inc., ("EyeMax") has many standard plans. The primary difference among the Plans are member copayment amounts and plan 501 does not have elective contact lens coverage. Each Member is entitled to an examination once every twelve (12) months under all plans, EyeMax covers lenses and frames once every twelve (12) months or twenty-four (24) months, depending on the plan selected by the group.

All other Limitations, such as materials or fees Allowances, are described in the Schedule of Covered Services.

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Member Options, Exclusions, and Limitations of Benefits

Member Options

EyeMax Vision plan is designed to cover visual needs rather than cosmetic materials. If a Member elects any of the following extras, EyeMax will pay for the basic costs of the allowed lenses or frames, and the Member will be responsible to pay the provider for the additional costs for those options at 70% of usual & customary fees.

- Optional cosmetic processes
- Anti-reflective coating
- Blended Lenses
- Cosmetic lenses
- Photochromic lenses
- Progressive multifocal lenses
- Color coating
- Mirror coating
- Scratch coating
- Laminated lenses
- Hi Index lenses
- Tinted lenses
- UV (ultraviolet) protected lenses
- Oversize lenses
- Certain limitations on low vision care
- Polycarbonate lenses (except for Pediatric Members)

Exclusions

Covered Services exclude the following:

- Services received before a Member's effective date of coverage or after coverage ends
- Eyewear that does not meet the minimum prescription requirements
- Vision care services, materials and treatments that are not specifically indicated in the Schedule of Covered Services
- Services or materials provided in connection with contact lenses, except those that are specifically listed in the Schedule of Covered Services
- Orthoptics or vision training and are any supplemental testing, plano (non-prescription) lens, or two pairs of eyeglasses in lieu of bifocals or trifocals
- Medical or surgical treatment of the eyes
- An eye exam or corrective eye wear required as a condition of employment
- Any injury or illness covered under The Plan is reimbursed for such Covered Services
- Safety eyewear is a class of lenses and frames that meet the most-current ANSI standard for safety in the workplace
- Sub-normal vision aids. Sub-Normal Vision Aids AKA Low Vision Aids are a group of devices that are prescribed by an optometrist/ophthalmologist to visually assist an Enrollee
- Optical Aids are lens based such as magnifiers, microscopes, or telescopes
- Electronic Aids are closed circuit television systems such as the Aladdin, the ELVIS, or even the Kindle
- Non-Optical Aid, which includes large print, check writing guides, felt tipped pens, acetate filters and special lighting
- Replacement of lenses or frames furnished under this Plan, which are lost or broken, except at the normal intervals when services are otherwise available
- Hospitalization services.
- Corrective vision treatment of an Experimental Nature
- Artistically painted lenses
- Fundus photography

Limitations

Each Member on the Individual Plan is entitled to an examination once every twelve (12) months, and to receive covered frames and lenses once every twelve (12) months. All other limitations, such as materials Allowances, are described in the schedule of Covered Services.

Redo Policy

Please refer to the section entitled, "EyeMax Redo Policy" in this Provider Manual

Warranty

For a period of 90 days from the date materials are dispensed the Provider agrees to provide a guarantee to Member that all services and materials supplied under this agreement meet ANSI Z80.1-2005 Standards and are free from defects in materials and/or workmanship. Your provider will utilize the Contract Lab's Redo policies, Manufacturer warranties, and Progressive Lens Non-Adapt policies to honor this warranty- subject to the following time limitations:

First time Dr. Redos - *90 Days from lab invoice date
Lab Redo - *90 days from lab invoice data
Manufacturer's Warranty – 90 Days from lab invoice date
Progressive Non-Adapt Guaranty – 90 Days from lab invoice date

*The 90-day timeframe referenced does not replace or supersede the timeframe for a Member to file a grievance, as per EyeMax's grievance policy

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Chapter 4

Provider Requirements and Accessibility Standards

A guideline to member access.

EyeMax endeavors to provide not only efficient and quality of care, but care that is provided in a timely manner and is appropriate to the nature of a member's condition. As an EyeMax provider, you are required to provide timely access to members for vision care services. EyeMax follows the following guidelines for timely access and it requires its providers to follow the guidelines as well.

Type of Care	Response Time	Additional Notes
Routine Eye Examination and Eyeglass or Contact Lens Fitting and Dispensing	Within 10 business days.	
Routine Follow-Up Appointment	Within 10 business days.	
Urgent Care Appointment	Within 48 hours.	
Emergency Care	Immediately advise member to call 911 or go to the nearest emergency room.	Patient should be advised to call 911 or go to the nearest emergency room.
Non-Operational Hours Emergency Access	Access to 24/7 telephone instruction. Members should be advised to call 911 or go to the nearest emergency room.	
In-Office Wait Times	No more than 30 minutes.	
Speak to Plan Representative During Business Hours.	Within 10 Minutes of the Member contacting the Plan.	

During non-operational hours, providers are required to make available answering service or voice recording instructing members on how they can obtain care in urgent or emergency circumstances. The answering service or the voice recording must provide the following information:

- The name and location of the EyeMax provider;
- A description of the symptoms that the provider considers to be an emergency;
- An emergency contact number;
- Information on how to contact another provider who has agreed to be on-call to triage or screen by phone, or to provide the needed services;
- Instructions on contacting 911 and information that the member should go to the nearest emergency room; and
- A way the member can leave a voicemail for the provider

If a provider becomes aware that he/she cannot comply with the timely access requirements as set forth in this Manual, the provider must advise EyeMax's Provider Relations. EyeMax will work with the provider to ensure that the member is able to receive the services as needed. At all times, the appointments and services must be appropriate to the nature of member's condition and consistent with good professional practice.

Interpretation Services

In addition to providing care in a timely manner, EyeMax also requires its providers to comply with its language accessibility standards. EyeMax advises its members in its directory the language capabilities of its providers. EyeMax requires its providers to complete a language survey in order for EyeMax to have the most updated information on a provider's language capabilities. Please note, however, that while EyeMax collects information from the providers, EyeMax will be responsible for providing the interpretation services but requires that providers make the request for services in a timely manner as set forth in this Manual.

EyeMax also discloses to its members that free interpretation services are available for all members who have limited English proficiency. EyeMax discourages its members from using family and friends for interpretation services. When a member makes an appointment with the provider and requests language assistance, it is the responsibility of the provider office to coordinate the language services prior to the appointment.

EyeMax provides translation and interpretation services, which are available to EyeMax Providers and its Members at no charge. To access this service please contact the EyeMax Provider Relations department by calling 866-901-8610.

Monitoring Accessibility

EyeMax will periodically evaluate providers to ensure compliance with its timely access requirements. The evaluation will be as follows:

- **Random telephone calls to provider offices to schedule an appointment and evaluate the wait time and the response time.**
- **Periodic survey of its members to determine if members are being provided with timely access in compliance with EyeMax's requirements.**
- **Review of EyeMax's grievance reports to identify any access related concerns.**
- **Audit of EyeMax provider offices.**

Please refer to Chapter 12 regarding EyeMax's language assistance program.

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Chapter 5

Procedure Codes

A listing of procedure codes for completing encounter information and claims forms.

The following listing provides the procedure code and a description of each code for covered and non-covered benefits provided by EyeMax.

These codes must be used when reporting encounters, as described in Chapter 9.

Vision Care Procedures Codes

Examination	
92002	New Intermediate
92004	New Comprehensive
92012	Established Intermediate
92014	Established Comprehensive
S0620	Routine Ophthalmological - New Patient
S0621	Routine Ophthalmological - Established Patient
92015	Determination of Refractive State (Valid on certain plans)
92310	Prescription, fitting & dispensing of contacts by doctor
92314	Prescription, fitting & dispensing of contacts by tech
S0592	Comprehensive Contact Lens Evaluation

Contact Lens Materials	
S0500	Disposable Contact lens, per lens
S0512	Daily Wear Specialty Contacts, per lens
V2330	Contact Lens, Scleral, per lens
V2500	PMMA, Spherical, per lens
V2501	PMMA Toric or Prism Ballast, per lens
V2502	PMMA, Bifocal, per lens
V2503	PMMA, Color Vision Deficiency, per lens
V2510	Gas Permeable, Spherical, per lens
V2511	Gas Permeable, Toric, Prism Ballast, per lens
V2512	Gas Permeable, Bifocal, per lens
V2513	Gas Permeable, Extended, per lens
V2520	Hydrophilic, Spherical, per lens
V2520.1	Hydrophilic Asph. Color
V2521	Hydrophilic, Toric, or Prism Ballast, per lens
V2521.1	Hydrophilic Toric EW
V2522	Hydrophilic, Bifocal, per lens
V2523	Hydrophilic, Extended, per lens
V2531	Contact Lens, Scleral, Gas Permeable, per lens
V2599	Other Contact Lenses
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service
Frame Codes	
V2020	Standard Frame
V2025	Deluxe Frame

Contact Lens Materials	
Basic Single Vision Lens Codes (per lens)	
S0504	Single Vision Lens (Athletic, Sunglass)
V2100	PL/4.00D
V2101	4.12/7.00 D
V2102	7.12/20.00 D
V2103	PL/4.00 SPH; .12/2.00 CYL
V2104	PL/4.00 SPH; 2.12/4.00 CYL
V2105	PL/4.00 SPH; 4.25/6.00 CYL
V2106	PL/4.00 SPH; > 6.00 CYL
V2107	4.25/7.00 SPH; .12/2.00 CYL
V2108	4.25/7.00 SPH; 2.12/4.00 CYL
V2109	4.25/7.00 SPH; 4.25/6.00 CYL
V2110	4.25/7.00 SPH; > 6.00 CYL
V2111	7.25/12.00 SPH; .25/2.25 CYL
V2112	7.25/12.00 SPH; 2.25/4.00 CYL
V2113	7.25/12.00 SPH; 4.25/6.00 CYL
V2114	> 12.00 SPH
V2199	Specialty (explanation required)
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service

Basic Plastic Bifocal Vision Lens Codes (per lens)	
S0506	Bifocal Vision Lens (Athletic, Sunglass)
V2200	PL/4.00 D
V2201	4.12/7.00 D
V2202	7.12/20.00 D
V2203	PL/4.00 SPH; .12/2.00 CYL
V2204	PL/4.00 SPH; 2.12/4.00 CYL
V2205	PL/4.00 SPH; 4.25/6.00 CYL
V2206	PL/4.00 SPH; >6.00 CYL
V2207	4.25/7.00 SPH; 12/2.00 CYL
V2208	4.25/7.00 SPH; 2.12/4.00 CYL
V2209	4.25/7.00 SPH; 4.25/6.00 CYL
V2210	4.25/7.00 SPH; > 6.00 CYL
V2211	7.25/12.00 SPH; .25/2.25 CYL
V2212	7.25/12.00 SPH; 2.25/4.00 CYL
V2213	7.25/12.00 SPH; 4.25/6.00 CYL
V2214	> 12.00 SPH
V2299	Specialty (explanation required)
V2219	Seg width > 28mm (explanation required)
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service
Basic Plastic Trifocal Vision Lens Codes (per lens)	
S0508	Trifocal Vision Lens (Athletic, Sunglass)
V2300	PL/4.00 D

V2301	4.12/7.00 D
V2302	7.12/20.00 D
V2303	PL/4.00 SPH; .12/2.00 CYL
V2304	PL/4.00 SPH; 2.25/4.00 CYL
V2305	PL/4.00 SPH; 4.25/6.00 CYL
V2306	PL/4.00 SPH; >6.00 CYL
V2307	4.25/7.00 SPH; .12/2.00 CYL
V2308	4.25/7.00 SPH; 2.12/4.00 CYL
V2309	4.25/7.00 SPH; 4.25/6.00 CYL
V2310	4.25/7.00 SPH; > 6.00 CYL
V2311	7.25/12.00 SPH; 25/2.25 CYL
V2312	7.25/12.00 SPH; 2.25/4.00 CYL
V2313	7.25/12.00 SPH; 4.25/6.00 CYL
V2314	> 12.00 SPH
V2399	Specialty (explanation required)
V2319	Seg width > 28mm (explanation required)
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service

Progressive Lens Codes	
V2781	Standard Progressive Lens (per Lens)
V2702	Deluxe Lens Feature (Premium Progressives)
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service

Miscellaneous Codes	
V2199	Not otherwise classified, single vision lens
V2410	Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430	Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2499	Variable sphericity lens, other type
V2786	Specialty occupational multifocal lens, per lens
V2220	Bifocal Add >3.25D
V2320	Trifocal Add>3.25D
V2115	Lenticular, (myodisc), per lens, single vision
V2215	Lenticular (myodisc), per lens, bifocal
V2799	Vision item or service, miscellaneous
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service

Lens Add On and Material Codes	
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate
V2783	Lens, index greater than or equal to 1.66 plastic or 1.80 Glass
V2784	Lens, polycarbonate or equal, any index
V2780	Oversize
V2740	Solid or V2743 Gradient Plastic Rose Tint
V2745	Tint, any color, solid, gradient or equal, excludes photochromic
V2755	UV lens, per lens
V2715	Prism, per lens
V2744	Tint, Photochromic, per lens
V2700	Balance lens, per lens
V2710	Slab-Off, per lens
V2730	Special Base Curve, per lens
V2784	Polycarbonate or equal, any index, per lens
V2702	Deluxe lens feature
V2710	Slab off prism, glass or plastic, per lens
V2718	Press-on lens, fresnell prism, per lens
V2730	Special base curve, glass or plastic, per lens
V2744	Tint, photochromatic, per lens
V2750	Anti-reflective coating
V2756	Eye glass case
V2760	Scratch resistant coating
V2761	Mirror coating, any type, solid, gradient or equal, any lens material
V2762	Polarization, any lens material, per lens
V2770	Occlude lens, per lens
V2786	Specialty occupational multifocal lens, per lens
Modifiers	
KX	Specific required documentation on file
LT	Left Side
RT	Right Side
EY	No Physician or other healthcare provider for this item or service

Chapter 6

Member Rights & Responsibilities

For convenience of its providers, following is the list of member rights and responsibilities that EyeMax has provided to its members.

Member has the right to be treated equally:

EyeMax and EyeMax providers cannot discriminate against a member based on the member's:

- **Age, sex, race, skin color, religion, physical or intellectual impairment, or sexual orientation**
- **The country a member or members' ancestors came from**
- **Marital status (married, divorced, single, or in a domestic partnership)**
- **Health care needs and how often a member uses services**
- **History as a victim of domestic violence**
- **Genetic characteristics that may, under some circumstances, be associated with a disability**

EyeMax follows all State and Federal laws and regulations pertaining to discrimination.

Member has the right to informed consent:

Informed consent means that before a member agrees to a treatment or procedure, the member understands:

- What the treatment or procedure is
- The possible risks and benefits that exist and what their risks and benefits are
- Other treatments or procedures that exist and what their risks and benefits are
- What a member can expect if the member chooses not to have the treatment or procedure

Member has the right to refuse or accept a treatment or procedure:

The only exception to this right is when it is an emergency and there is not time to get a member's informed consent without risking the member's health.

Member has the right to have a copy of his/her medical records:

- It takes a few days to get the copy, and the member may be charged for the copying
- To get a copy of their medical records, a member should call his/her doctor's office or call EyeMax at 1-866-901-8610

Member has the right to keep his/her medical records private:

A member can ask EyeMax to send the member a statement that describes EyeMax's policies and procedures for keeping medical records private and confidential. EyeMax works to ensure that its privacy and confidentiality polices are in compliance with State and Federal laws. Call EyeMax at 1-866-901-8610 to request more information.

A STATEMENT DESCRIBING EYEMAX'S POLICIES AND PROCEDURE FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO THE MEMBER UPON REQUEST.

Member has the right to have an Advance Health Care Directive:

An Advanced Health Care Directive is a form that a member fills out to tell EyeMax, the member's doctor, family, and friends about the health care the members wants if he/she can no longer make decisions on their own.

- It explains the types of treatment the member wants or does not want
- It allows the member to name a person to be his/her health care agent. This person can be a spouse, family member, friend, or other person the member chooses. This person can make decisions for the member if the member can no longer make their own. A member's right as a member of EyeMax applies to his/her health care agent

To make an Advance Health Care Directive:

- Fill out an Advance Health Care Directive form
  - To get a form, follow this link: **http://loag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirective-Form-fillable.pdf**
  - A member can hire a lawyer to make the member's directive, if the member wishes

Member has the right to get information about how EyeMax does business:

A member has the right to request information about EyeMax's business practices. Call EyeMax at 1-844-393-6297 if you would like more information.

Member has the right to take part in making EyeMax's public policy:

EyeMax has a Public Policy Committee. This Committee includes providers, members, and a member of the Board of Directors. Members will be made aware of any material changes affecting public policy.

- This Committee advises the Board of Directors about how to assure the comfort, convenience, and dignity of our members
- The Committee may also review EyeMax's financial information and information about the complaints received by EyeMax

Complaints and Grievances

EyeMax makes every attempt to resolve member concerns quickly and to their satisfaction. Providers are responsible for making sure their staff knows EyeMax's complaint process and gives EyeMax's complaint/grievance form to members when they ask.

The provider can find a master copy of this form within the provider manual and can also be found on the EyeMax website at www.eyemaxinc.com.

Member Responsibilities

It is the member's responsibility to:

- Choose an optometrist or ophthalmologist within the EyeMax network who will provide the member and the member's dependents with Covered Services
- Get referrals and pre-approvals when the member needs them
- Pay the member co-payments at the time of service
- Give doctors and other providers all the information a member can to help them decide on the member's care
- A member should keep medical appointments; but if an appointment needs to be cancelled, a member should let the office know within 24 hours prior to the scheduled appointment
- A member should show respect to the providers, to the EyeMax staff, and to other members
- A member should let EyeMax know if their address or employment changes
- A member should let EyeMax know if there are any changes in the status of their dependents

Coordination of Benefits (applies to Group Members only):

Coordination of benefits occurs when an EyeMax member is covered and eligible for vision care benefits under another EyeMax plan from a different employer. In these situations, coordination of benefits will help the member maximize their covered benefit and reduce their out of pocket cost. This occurs most frequently when an employee is covered under their own plan and also as a dependent/spouse under their spouse's plan. If a member is covered by a plan other than EyeMax, there is no coordination of benefits.

In these cases, we must determine in what order to pay the claims. This is done by referring to the box on the benefit form labeled "Member Relationship to Employee".

(a) Member's own plan - the "SELF" box on the benefit form is checked
(b) Member's spouse plan - the "SPOUSE" box on the benefit form is checked
(c) Dependent children - Member's plan with the earliest birthdate is primary and the spouse's plan is secondary

1. SUBMITTING CLAIMS FOR PAYMENT

EyeMax will calculate the coordinated benefit amount subject to the plan limits.

Coordination of Benefits Secondary Maximum Allowances (Plan Limits)			
	500	**501**	**515**
Eye Exam	$75.00 Less secondary Copays, if any	$70.00 Less secondary Copays, if any	$60.00 Less secondary Copays, if any
Lenses	$50.00 Less secondary Copays, if any	$50.00 Less secondary Copays, if any	$50.00 Less secondary Copays, if any
Frame	$45.00 Less secondary Copays, if any	$45.00 Less secondary Copays, if any	$45.00 Less secondary Copays, if any

Coordination of Benefit Rules for when a Member is Covered Under Two EyeMax Plans
Assuming a member is eligible for all services and materials under both plans, benefits will be coordinated as follows:

1. MEMBER IS RECEIVING AN EXAMINATION AND ONE PAIR OF GLASSES.
   - (a) All services and materials will be covered by using the Patient Record Report Form, except forany Copayments, lens options, or frame overages
   - (b) The Copayments, lens options, and frame overages will be covered under the secondary plan up to a plan limit
2. MEMBER IS RECEIVING AN EXAMINATION AND TWO PAIRS OF GLASSES
   - (a) The examination and materials for the first pair of glasses will be covered by using the primary benefit form, except for any copayments, lens options, or frame overages
   - (b) The frame and lenses for the second pair of glasses will be covered under the secondary plan, except for any copayments, lens options, or frame overages
   - (c) Any Copayments, lens options, or frame overages on both pair of glasses will be covered by using the examination eligibility under the secondary plan up to a plan limit
3. MEMBER RECEIVING COSMETIC (NOT MEDICALLY NECESSARY) CONTACT LENSES
   - (a) The allowance is payable under both the primary and the secondary plans subject to plan limitations.
   - (b) Member is responsible for the overage between the Combined Material Allowance from both plans and eighty-five percent (85%) of the Provider’s Usual and Customary Fees for materials
   - (c) If eighty percent (85%) of the provider's usual and customary fee for materials is less than the total of the combined allowances, the member must pay the Copayment under the secondary plan

4. THE MEMBER IS COVERED UNDER AN EYEMAX PLAN AND ANOTHER VISION CARE PLAN.
   - (a) EyeMax is the primary plan

Chapter 7

Emergency Vision Service

What to do in case of an emergency.

EyeMax advises its Members to call 911 or to go to the nearest hospital or urgent care facility if emergency or urgent care of a medical nature is needed. EyeMax does not cover any medical services.

EyeMax does cover Urgent Vision Care of a non-medical nature, such as lost, broken or stolen glasses. Urgent Vision Care is subject to the same benefit frequencies, plan Allowances, Copayments and exclusions stated herein.

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Chapter 8

Provider Responsibilities

A discussion of the responsibilities of each provider.

Each member who joins EyeMax selects an optometrist or an ophthalmologist who is responsible for providing or coordinating all Covered Services care for that member, including informing the member about the need for follow-up care.

Your Responsibilities

- You shall be duly licensed, registered and in good standing and shall maintain such licensure throughout the term of the Provider Agreement to practice medicine or optometry in the states where you provide services and ensure that such license and registration is not restricted, conditioned or limited in any way
- Comply with the Accessibility Standards and Grievance Procedures as set forth in this Provider Manual
- Comply with HIPAA, HITECH, and other federal and state law relating to confidentiality
- Comply with all state and federal requirements for safety and hygiene control as well as all requirements set forth in the Manual
- Provide or coordinate the vision care services provided by EyeMax.
- Perform an initial general vision assessment
- Participate in EyeMax's Quality Assurance Program (QAP) by cooperating with all QAP activities, recommendations and corrective actions, and adhering to all applicable program requirements.
- Participate in the grievance system by ensuring that staff are aware of EyeMax's complaint process and provide EyeMax's grievance form to members upon request
- Arrange for coverage by another provider when necessary (vacation, illness, etc.).
- Provide for availability or instructions on after-hours and emergency services.
- Provide encounter information for all Covered Services
- Maintain vision records for seven (7) years from the date of service and make vision records available during regular business hours
- Inform EyeMax of any changes to your license
- Inform EyeMax of any staff changes with regard to providers including new providers or providers leaving the location
- Inform EyeMax of any change in ownership of the provider office
- Keep current the provider profile by responding to the provider update request which is mailed to each provider every six (6) months. If a provider has updates between the six (6) month mailings the provider is responsible for notifying the plan immediately of the updates
- Inform EyeMax of any changes in business location within five (5) business days
- Provide EyeMax with your office language capability.

Initial Vision Assessment

Optometric providers are required to perform an initial vision assessment during the first appointment. Initial vision care assessment includes a vision history and clinical examination. Based upon the judgment of the provider, the vision care assessment can include any of the following: (i) refraction only, (ii) intermediate examination, or (iii) comprehensive eye examination. Providers shall additionally discuss general disease prevention and follow-up treatments, as necessary with members. Once contacted by the member, an appointment should be provided within the timely access requirements set forth in this Manual.

Safety and Hygiene/Infection Control and Safety

As part of EyeMax's Quality Assurance Program, provider office standards have been established to reflect the high quality required of EyeMax providers and to assure that EyeMax members and groups are receiving these high standards of quality care. The providers at minimum must meet the following standards:

- Every provider office must be equipped with the necessary instrumentation to provide all diagnostic procedures and tests required to meet the EyeMax criteria for a comprehensive vision examination
- Instrumentation in the provider office must be clean and maintained in proper working order
    1. Instrumentation that is in contact with patients including, but not limited to, face guards, must be cleaned with an antiseptic solution between patients.
    2. Sterility of contact lenses must be maintained.
    3. Provider offices must have easy access to a sink for doctor and staff use between patients.
- Patients must have access to a clean and properly functioning restroom

- Provider offices shall comply with local, state, or federal regulations including the Americans with Disability Act
- Provider offices must be clean, maintained in good repair, and provide for separate reception and examination rooms
- Provider offices must meet local, state, and federal health and safety codes regulations and provide a safe and hazard-free environment for patients
- Provider offices must provide for easy access to all records for EyeMax patients seen within the last seven (7) years. The provider understands and acknowledges that the provider must comply with HIPAA and HITECH with regards to member confidentiality including protected health information of the member
- EyeMax Providers and staff must maintain acceptable levels of personal hygiene and professional demeanor at all times

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EyeMax Redo Policy

Providers cannot charge a member for errors made by the provider, the provider's staff, or errors in processing the order by the contracted laboratory. Therefore, any redo which meets the criteria stated below should be processed under the EyeMax Redo Policy at no charge to the member. All Redo requests become private transactions between the doctor, lab and/or member. EyeMax is not involved in these transactions.

First Time Doctor Redo

Changes in the member's prescription such as power, axis, base curve, seg. height, lens style, material, etc., which require a remake of the original lenses, will be remade one time only at no charge within ninety (90) days of the Contract Lab invoice date. However, the same provider and lab must be used for any redo. A request for a doctor redo must be submitted to the lab according to the labs preferred method, clearly stating the reason for the redo along with the original invoice, lenses, and frame. Upgrades to lens style, material, or lens options *not* ordered on the original Rx order, become a private transaction between the provider and member, and will be billed at the contracted lab's published Lab Price List.

Second and Subsequent Doctor Redo's

Second and subsequent doctor redos are not covered under the EyeMax Redo Policy, and will become a private transaction between the provider and the lab. Such redos will remain the sole responsibility of the provider.

Lab Redo

If the provider receives an order from the lab which fails to meet ANSI Z80.1-2005 Standards or is cosmetically unacceptable, a request for lab redo must be submitted according to the labs preferred method, clearly stating the specific reason for the return and accompanied with the original invoice, lenses, and frame. The contracted lab must be in full agreement of the provider's specific reason for return, and if dispute arises, the contracted lab's decision will be final and unchallengeable. The lab redo will be processed at no charge. If the original lenses and frame are not returned, the lab will reprocess at full charge.

Upgrades to lens style, material, or lens options *not* ordered on the original Rx order are not allowed.

Manufacturer's Lens Warranties

Lenses submitted for a no charge warranty remake must be submitted according to the labs preferred method along with the original lenses, frame, and a copy of the original invoice, for consideration under the same contracted lab's Manufacturer's Warranty Policies and/or Anti-reflective Coating Patient Satisfaction Guarantee Policy. The remake will be made to the original Rx specifications. **No changes are allowed.** If any dispute arises as to whether or not lenses are covered under the Manufacturer's Warranty Policies and/or the contract lab's Anti-reflective Coating Patient Satisfaction Guarantee Policy, the final decision will be made by the same contract lab and their decision will be final and unchallengeable. **Any financial issues or disputes resulting from the manufacturer's warranties must be handled between the provider and the contracted lab.**

Progressive Lens Non-Adapts

If a member cannot adjust to the member's new progressive lenses, the contracted lab will replace and/or remake the lenses **one time only** at no charge by remaking the lenses into Single Vision, Bifocal, Trifocal or the same tier Progressive lenses in the same material. However, the following conditions must be met:

1. The replacement is ordered within ninety (90) days from the Contract Lab Invoice date.
2. Provider must return a copy of the original invoice with the original lenses and frame.
3. All extras ***not*** billed on the original order, will be charged at the contracted lab's published Lab Price List. These lab charges will remain the sole responsibility of the provider.

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Chapter 9

Claims Submission Requirements

A guide to how EyeMax pays providers.

Providers are required to submit a clean CMS 1500 claim form no later than 180 Days from the Date of Service. The provider can access a CMS 1500 form on the EyeMax website: www.eyemaxinc.com. The provider can fax or mail the completed CMS 1500 claim to:

EyeMax Vision Plan Services, Inc. 530 S. Main Street
Orange, CA 92868
Fax Number:714-689-7575

The provider will receive an Explanation of Payment with the payment.

When a provider performs the services listed and submits a clean claim form to EyeMax, the provider will be paid within thirty (30) days of receipt.

Claims Processing/Provider Dispute Resolution Mechanism

I. **CLAIM SUBMISSION INSTRUCTIONS**

A. Sending Claims to EyeMax. Claims for services provided to members must be sent to the following: Via Mail: EyeMax Vision Plan, Inc.

Claims Processing
530 S. Main St. Orange, CA 92868

B. Acknowledgement of Claims. EyeMax will verify and acknowledge the receipt of each claim within thirty (30) days. If you want to verify, EyeMax's receipt of your claim you can do so by contacting EyeMax at 1-866-901-8610.

C. Claim Submission Requirements. The following is a list of claim timeliness requirements required by EyeMax:

1. All claims must be submitted to EyeMax for payment for services no later than six (6) months (or one hundred eighty (180) days) after the date of service. Include the name of the member, the date services were provided, and the care provided, including any glasses or contact lens prescriptions ordered.
2. EyeMax will reimburse all Clean Claims within thirty (30) business days. A Clean Claim is a claim that is complete and has all of the required information.
3. If the claim is not completed and EyeMax denies the claim, or portion thereof, EyeMax shall notify the claimant by mail within thirty (30) business days after receipt of the claim. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, and the specific information needed from the provider to reconsider the claim. If a completed claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the thirty (30) business day period, EyeMax shall pay, in addition to the claim, fifteen percent (15%) per annum for the period of time that the payment is late. If a completed claim involves emergency care, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the thirty (30) business day period, EyeMax shall, in addition to the claim, pay the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof on a non-prorated basis or fifteen percent (15%) per annum for the period of time that the payment is late. If EyeMax fails to automatically include the late payment interest amount, the claimant will receive, in addition to claim and the interest amount, an additional ten dollars ($10) for each claim.

D. Fee Schedules. EyeMax will disclose the complete Fee Schedule for contracted providers within the provider manual.

II. **CLAIMS OVERPAYMENT.**

A. Notice of Overpayment of a Claim. If EyeMax determines that it has overpaid a claim, EyeMax will notify the

B. provider in writing through a separate notice clearly identifying the claim, the name of the member, the date of service(s), and a clear explanation of the basis upon which EyeMax believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

C. Contested Notice. If the provider contests EyeMax's notice of overpayment of a claim, the provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, must send written notice to EyeMax stating the basis upon which the provider believes that the claim was not overpaid. EyeMax will process the contested notice in accordance with EyeMax's contracted provider dispute resolution process.

D. No Contest. If the provider does not contest EyeMax's notice of overpayment of a claim, the provider must reimburse EyeMax within thirty (30) business days of the provider's receipt of the notice of overpayment of a claim. In the event that the provider fails to reimburse EyeMax within thirty (30) business days of the receipt of overpayment of claim, EyeMax is authorized to offset the uncontested notice of overpayment of a claim from the provider's current claim submissions.

E. Offsets to Payments. EyeMax may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when (i) the provider fails to reimburse EyeMax within the required timeframe, and (ii) EyeMax's contract with the provider specifically authorizes EyeMax to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, EyeMax will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims

III. DISPUTE RESOLUTION PROCESS FOR CONTRACTED PROVIDERS.

A. A contracted provider dispute is a provider's written notice to EyeMax challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim. A copy of EyeMax's Provider Dispute Form is included in this Manual. If EyeMax offsets prior claim adjustment against your current monthly payment, it will be itemized in the Summery Sheet of the Explanation of Payment. Each contracted provider dispute must contain, at a minimum contain the following: provider's name; license number, contact information, and if applicable:

1. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from EyeMax to a contracted provider the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.
2. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.
3. If the contracted provider dispute involves a member or group of members: the name and identification number(s) of the member(s), a clear explanation of the disputed item, including the date of service and the provider's position thereon. Note: EyeMax will resolve any provider dispute submitted on behalf of a member treated by the provider in EyeMax's Member Services and not in EyeMax's Provider Relations.

B. Sending a Contracted Provider Dispute to EyeMax: Via Mail: EyeMax Vision Plan, Inc.

Attn: Provider Relations 530 S. Main St Orange, CA 92868

Via Email: operations@eye-maxinc.com Fax: 714-689-7575

C. Time Period for Submission of Provider Disputes.

1. Contracted provider disputes must be received by EyeMax within three hundred sixty-five (365) days from EyeMax's action that led to the dispute (or the most recent action if there are multiple actions).,

2. Contracted provider disputes that do not include all required information as set forth above, may be returned to the submitter for completion EyeMax will clearly identify in writing the missing information

necessary to resolve the dispute. An amended contracted provider dispute which includes the missing information shall be submitted to EyeMax within thirty (30) business days.

D. Acknowledgment of Contracted Provider Disputes: EyeMax will acknowledge receipt ofall contracted provider disputes as follows:

1. Contracted provider disputes submitted via mail (i.e., paper disputes) will be acknowledged by EyeMax within fifteen (15) business days of the date of receipt by EyeMax.
2. Contracted provider disputes submitted electronically will be acknowledged by EyeMax within two (2) business days of the date of receipt by EyeMax.

E. Contact EyeMax Regarding Contracted Provider Disputes: All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to EyeMax Provider Relations at: 1-844- 393-6297.

F. Instructions for Filing Substantially Similar Contracted Provider Disputes: Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

Provide cover sheet for each batch describing each provider dispute.

G. Time Period for Resolution and Written Determination of Contracted Provider Dispute: EyeMax will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) business days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, EyeMax will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) business days of the issuance of the written determination.

IV. DISPUTE RESOLUTION PROCESS FOR NON-CONTRACTED PROVIDERS

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to EyeMax challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested or disputing a request for reimbursement of an overpayment of a claim. A non-contracted provider must use the EyeMax Provider Dispute form. Each non- contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

1. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from EyeMax to provider the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.
2. If the non-contracted provider dispute involves a member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service, provider's position on the dispute, and a member's written authorization for provider to represent said members.

B. Dispute Resolution Process. The dispute resolution process for non-contracted providers is the same as the process for contracted providers as set forth in this section.

Encounter Information

Encounter information must be reported to reflect all services provided to EyeMax members. Providers will be provided with a claim form to report encounter information to EyeMax.

Encounter information is required for all benefit programs, including Individual Plan members and is an important source of information regarding the quality of care that EyeMax providers deliver to the members.

Second Opinion

A member may ask for a second opinion from another provider about a condition that the member's provider diagnoses or about a treatment that the member's provider recommends. Below are some reasons a member may want to ask for a second opinion:

- The member questions about treatment that their provider has recommended.
- The member has questions about a serious optometric condition.
- There is disagreement regarding a member's routine vision care.
- The member's vision is not improving with the member current treatment plan.
- The member's provider is unable to diagnose the problem.
- The member is having difficulty with their current prescription either spectacles or contacts.

Chapter 10

Quality Assurance Program

Working with EyeMax to ensure care provided meets the professional standards.

I. PURPOSE

EyeMax and its participating vision care providers are committed to delivering the highest quality of care in the prepaid vision care industry. Accordingly, EyeMax has developed a Quality Assurance Program (QAP). This section of the Provider Manual describes the various elements of the QAP, including the overall structure and responsibilities of people that implement the QAP. The QAP policies and procedures are reviewed and revised (when needed) annually to identify additional opportunities for improvement and the means by which that improvement is achieved and monitored. Elements of the QAP are as follows:

II. GOALS AND OBJECTIVES

A. To assess the quality of vision care and service in the EyeMax delivery system, thereby identifying opportunities for improvement
B. To assure that the professional performance of participating providers and administrative practices of EyeMax are regularly and reliably evaluated
C. To monitor the services provided to members and implement changes that will improve the overall provision of quality vision care, and to timely address member and provider complaints
D. To assure compliance with standards and regulations of vision plan accrediting and regulatory agencies
E. To develop, implement, and monitor quality improvement initiatives where opportunities for improvement are
F. identified
G. To maintain effective systems to assure current credentialing and re-credentialing of all participating
H. optometrists and ophthalmologists
I. To provide a peer review structure for the monitoring and evaluation of quality of care issues and the procedure for assessing interventions
J. To assure that quality improvement activities are meaningful and relevant to the member population
K. To develop and/or adopt clinical practice guidelines that are consistent with professionally recognized standards of care and to monitor practitioner performance against standards

III. AUTHORITY/RESPONSIBILITY

The EyeMax Board of Directors has the ultimate authority and responsibility for the overall Quality Assurance Program including but not limited to the appointment of the formal Quality Assurance Committee; approval of the Quality Assurance Program; and evaluation of the Quality Assurance Committee reports. The Board of Directors meets on a quarterly basis and is responsible to take action regarding quality assurance activities when appropriate, and for adequately documenting its actions in the Board minutes. The Board of Directors delegates responsibility for day-to-day management of the quality assurance activities to the on- site Optometric Director who is the chairman of the Quality Assurance Committee. The Optometric Director is aided in this task by the EyeMax's Vice President of Grievance Resolution/Provider Relations. The Optometric Director works in close coordination with senior management staff to ensure that all EyeMax's quality assurance objectives with regards to plan design, provider credentialing, provider performance and quality of care are monitored and maintained throughout EyeMax's provider network. The overall functioning of the Quality Assurance Program is delegated to the Quality Assurance Committee which is responsible for issuing a yearly Quality Assurance Committee report to the Board of Directors. This report will include recommendations from the Quality Assurance Committee for further improvement of EyeMax and an evaluation of the overall effectiveness of quality assurance activities.

IV. SCOPE

The Quality Assurance Program includes all internal EyeMax departments, as well as all services rendered by participating providers. It is comprehensive in scope; ongoing and includes effective mechanisms to monitor, identify, evaluate, and resolve problems that impact the accessibility, availability, continuity and quality of vision plan services provided to EyeMax members.

V. QUALITY ASSURANCE PROGRAM STAFF AND STRUCTURE

Board of Directors

- Reviews quarterly quality assurance reports.
- Recommends action as appropriate to address areas for improvement.
- Maintains documentation of all board actions and meeting minutes.

Optometric Director

- Reports to the EyeMax Board of Directors on all quality assurance/improvement activities and member grievances.
- Works with the senior management staff to assure coordination of company-wide quality initiatives.
- Chairs the Quality Assurance Committee.
- Coordinates the Quality Assurance Committee meeting agenda to assure follow-up on relevant issues.
- Implements the Quality Assurance Program as it concerns clinically related services.
- Facilitates involvement of participating providers in the Quality Assurance Program.
- Assists in the selection and design of quality improvement studies and "best practices."
- Coordinates, oversees and communicates information to providers to manage their clinical behavior to improve quality, service, access, and cost outcomes.
- Responsible for selection and design of clinical quality improvement studies.
- Directs efforts to collect, report, and evaluate data and implement improvement plans as indicated.
- Presents Board of Directors with reports on all quality improvement activities.
- Makes recommendations to the Board of Directors regarding committee appointments.
- When needed, performs annual on-site audits of provider offices.

Vice President of Quality Management

- Assists the Optometric Director to effectively conduct the Quality Assurance Program.
- Provides feedback to providers regarding results of on-site audits.
- Provides oversight to the review of member complaints and grievances in accordance with approved policies.
- Provides input to the review of member grievances.
- Monitors EyeMax's response times to ensure compliance with the law.
- Monitors correspondence to members and/or providers regarding outcome of grievance cases.
- Monitors the maintenance of the grievance log, including review outcomes and categories.
- Provides tabulated grievance information to the Public Policy Committee and the Board of Directors.

VI. COMMITTEE STRUCTURE

Quality Assurance Committee (QAC)

A. Objective: Serves as the governing body for EyeMax's Quality Assurance Program directing all aspects of quality assurance and improvement processes for both quality of vision care and quality of service. Responsible for the overall effectiveness of the quality assurance plan in providing for quality vision care to members of EyeMax.

B. Composition: The membership of the QAC shall consist of the following:

- Optometric Director (Chair)
- Vice President of Quality Management
- Two EyeMax providers

Duties and Responsibilities:

1. Review and analyze data including:
    - Quality improvement study results.
    - Member grievances and appeals.
    - Member survey results.
    - Provider survey results.
    - Subscriber survey results.
    - Utilization data (encounter data).

- Denial of service trending.
- Treatment authorization/referral timelines.
- Access and availability study results.
- Evaluation of grievance and appeal trending.
- On-site survey report results.
- Group transfer rate/disenrollment data.
- Geographical access study data

2. Approve Quality Assurance Program policies/ procedures.
3. Review the quality assurance plan and revise as needed.
4. Coordinate activities related to clinical guidelines and parameters of care.
5. Evaluate participating provider's compliance with clinical guidelines and parameters of care.
6. Recommend quality improvement activities and plans.
7. Develop reports for submission to top senior management and the Board of Directors, including the Quality Assurance Program evaluation and work plan
8. Coordinate communications of quality assurance activities to EyeMax staff, providers, and members.
9. Oversee the training of quality assurance activities for EyeMax managers, staff, and provider advisors.
10. Identify "best practices" and provide feedback to plan providers regarding best practices.
11. Convene in ad hoc session as needed to review significant quality of care issues uncovered in the process of peer review or through monitoring of member grievances. . If necessary, take appropriate corrective action, including, but not limited to, the following (note that, where appropriate, the QAC may delegate responsibility for corrective action to Optometric Director):
    - Further education and assistance to the provider.
    - Requiring the provider to submit and follow through with an appropriate corrective action plan.
    - Provider counseling.
    - Provider probation.
    - Suspension of new member assignments.
    - Transfer of patient(s) to another EyeMax provider.
    - Contract termination for continuing noncompliance

    After an appropriate interval of time, to be determined by the Optometric Director and/or the QAC, the Optometric Director and/or the QAC will re-evaluate the provider to determine whether the actions taken were effective, and to determine if further actions such as termination of the provider from the network need to be taken.

12. Develop and approve credentialing and re-credentialing policies and procedures.
13. Review applicants and approve for initial credentialing and re-credentialing.
14. Review cases identified through quality monitoring activities
15. Recommend corrective action as deemed necessary.
16. Evaluate/develop and adopt clinical standards or parameters of care.
17. Issue recommendations regarding correction of provider performance deficiencies and monitor progress of any recommended correction action plans.
18. Refer possible violations of the state's practice laws and regulations relating to vision care providers or other criminal or civil statutes to the proper state authorities following approval from the QA committee.
19. Implement procedures for continuously reviewing the utilization of services and facilities.
20. Review utilization data for general utilization and accessibility of Optometric services.
21. Evaluate appropriateness of Emergency Vision Service referrals by providers.
22. Establish benchmarks for utilization patterns.

23. Review provider appeals of denied services.
24. Make recommendation for specific interventions to assure efficient use of resources.
25. Review and approve policies and procedures as they affect utilization management.
26. Review appeals of benefit denials.
27. Establish criteria for, and evaluate appropriate use of new vision care technologies or new applications of established technologies

VII. STATEMENT OF CONFIDENTIALITY

Due to the highly confidential nature of clinical information reviewed for the Quality Assurance Program, all necessary precautions shall be taken to protect members, providers, and EyeMax. To ensure the confidentiality of the Quality Assurance Program, the following will be observed:

- Statements of confidentiality will be signed by all committee members.
- Quality assurance materials will be collected from committee members at the end of the meeting.
- Vision care records and peer review information shall be confidential and available only to those persons actively participating in the quality review.
- The business portion of committee minutes shall be separated from any "peer review minutes."
- Original copies of QAC minutes shall be maintained in a locked file in the Optometric Director's office, all other copies of minutes shall be destroyed promptly following meetings.
- When a case is reviewed by EyeMax a separate file containing peer review forms, correspondence to and from the provider, peer review determinations and the results of recommended corrective action will be maintained in the Optometric Director's office in a locked file.
- Access to peer review files shall be for the sole purpose of discharging vision care staff responsibilities, and subject to the requirement that confidentiality be maintained.
- Information disclosed to the Board of Directors of EyeMax shall be maintained by that body as confidential.
- Any person who participates in QAC activities shall be made an ex officio member of the committee until their work with the committee is concluded.
- Any and all documents and records that are part of the internal Quality Assurance Program as well as the proceedings, reports, and records from any committee shall be confidential and shall be protected under federal and state peer review protection statutes.
- Disclosure of confidential medical record information to persons other than the contracted providers except where required by state or federal law is prohibited.
- If a provider utilizes a third party for billing, the provider must inform EyeMax of any such arrangements. Also, the third party shall comply with all state and federal law, including HIPAA, HITECH, and agree to enter into a Business Associate Agreement, which will include indemnification provision against any disclosure

VIII. STATEMENT OF CONFLICT OF INTEREST

No provider may participate in the peer review and evaluation of cases or clinical activities in which he or she has been professionally involved or where judgment may be compromised

IX. ONSITE AUDIT

As part of its quality of care review program, EyeMax will conduct in-office audits of EyeMax network providers as needed. During the visit, the reviewing optometrist will select a random sample of EyeMax member (patient) files and review the files for specific items, including but not limited to:

- Eye examination and patient files
- Equipment & instrumentation
- Quality of frames dispensed
- Quality of lenses dispensed
- Service time intervals
- Compliance with EyeMax referral procedures
- Network provider office standards as set forth in this Manual.
- Compliance with EyeMax policy and procedure for charges made to EyeMax members as set forth in this Manual
- Material dispensing time requirements as set forth in this Manual

Following the review of the provider's office, a letter will be sent to the provider indicating the results of the review. Subsequent reviews (if any) are determined by the results of previous reviews and the number of EyeMax Members that are seen at the provider's office. Review findings are evaluated by EyeMax's Quality Assurance Committee and any action taken is communicated to the provider.

Some optometrists will receive an office site visit as part of initial credentialing. When a review is conducted, it will include, at a minimum:

- Adequacy of waiting and examining room space;
- Physical accessibility;
- Physical appearance;
- Availability of appointments;
- Adequacy of record keeping practices; and
- Clinical appropriateness of the Optometric care provided.

At the time of an office site audit, any deficiencies noted will be discussed with the provider during an exit interview. At that time, the specific nature of the deficiency will be discussed and suggestions/recommendations for improvement will be identified. Within ten (10) business days following the audit, written correspondence will be forwarded to the provider which will identify any deficiencies noted. A score of seventy-five percent (75%) of total points is required by a facility to gain and maintain credentialed status in the network. Facilities achieving a score of fifty to seventy-four percent (50%-74%) of total points will be notified of their deficiencies and will have a re-audit scheduled in three to six (3-6) months to evaluate if improvements have been implemented.

In instances where the care is substantially below recognized standards, less than fifty percent (50%) of total points, or when there are significant issues that must be addressed to assure patient health and safety, the correspondence will outline any corrective measures (if needed), and the timeframe for completion. The provider will be requested to submit in writing a commitment to the corrective action plan. In addition, if a re-audit is determined to be required, the date of the follow-up audit will be given. The timeframe for re-audit will be determined by the Optometric Director and/or Quality Assurance Committee and will be based upon the severity of the deficiencies. If a provider fails to respond to a request for a corrective action plan, or continues to deliver care below recognized standards, he/she will be referred to the Quality Assurance Committee for appropriate action. If needed, an ad hoc meeting of the Quality Assurance Committee will be scheduled. Possible actions of the committee include:

- Optometric Director to schedule meeting with provider to discuss requested corrective action plan;
- Immediate re-audit of office to determine if corrective measures have been implemented; and
- Termination from network.

Refer to the credentialing/re-credentialing policy/procedure for information regarding termination of a provider from the network.

X. PEER REVIEW PROCESS (WHEN NEEDED)

Cases are referred for peer review for a number of reasons including: evaluation of member grievances, review of potential quality of care issues identified during an on-site audit, evaluation of a provider with aberrant utilization patterns, evaluation of a provider who is charging members fees inconsistent with established Copayments, evaluation of state board actions, etc. When there is a concern regarding the quality of vision care provided to a member, the medical record and other pertinent information will be referred to the Optometric Director for review. Questions regarding the quality of care may include:

- All quality of care issues contained in member grievances;
- The vision care necessity of specific treatments, diagnostic tests, or other procedures provided (especially services not covered by EyeMax);
- The omission of necessary vision care services that are covered benefits;
- Delays in diagnosis or treatment;
- Improperly performed procedures or treatments;
- Lack of follow-up care following a procedure;
- Inadequate access to a provider;
- Unethical behavior;
- Refusal to provide services;
- Failure to obtain complete history and physical information; and
- Failure to follow appropriate standards and procedures in providing vision care services.

The Optometric Director will evaluate the provider/chart information provided to determine if the member received services that were appropriate to the member's vision care condition and whether the services met professionally recognized standards of ca re.

The specific question(s) regarding the quality of care will be answered and a determination will be made as to whether a potential or confirmed quality of care issue exists. The Optometric Director should refrain from stating personal comments regarding the vision care and should provide clinical comments based upon accepted standards of care.

Answers to the questions posed regarding the care provided will be documented by the Optometric Director. In addition to answering the questions, the Optometric Director is encouraged to cite reference sources utilized in making the quality of care determinations. The Optometric Director is also encouraged to add additional quality of care concerns that he/she identifies. Once a concern is identified, the Optometric Director must select a category of concern, a type of grievance, and a severity level (all 3 if applicable). See below for category and severity level selections.

Severity Levels

Level 0 - No quality of care issue, care provided meets standard of care.
Level 1 - Confirmed quality issue with minimal or moderate potential for adverse effects. Level 2 - Confirmed quality issue with significant potential for adverse effects.
Level 3 - Confirmed quality issue meeting the definition of egregious violation.

Definitions

Adverse effect is defined as performance of an unnecessary vision care procedure, unnecessary prolonged treatment, vision care complication, avoidable additional vision care exam procedure, or physiological anatomical impairment or disability.

Egregious violation is defined as a violation representing gross misconduct and/or actions which pose an imminent danger to the health, safety, or well-being of a member or placed the member unnecessarily in a high-risk situation.

Quality Categories

Q1 - Failure to obtain pertinent history and/or findings from examination. Q2 - Failure to make appropriate diagnosis.
Q3 - Failure to establish/develop an appropriate treatment plan.
Q4 - Failure to carry out an established plan in a competent and/or timely fashion.
Q5 - Failure to establish adequate clinical justification for a procedure which was performed. Q6 - Failure to perform

appropriate follow-up care.
Q7 - Failure to obtain appropriate specialty consultation. Q8 - Failure to provide emergent care in a timely fashion.

The Optometric Director assigns a potential level of quality and category of concern to the case. Correspondence is then developed to the responsible provider requesting information regarding the potential quality concern. The provider is given fifteen (15) calendar days to respond to the quality concern. At the end of the fifteen (15) day timeframe the record and any additional information is evaluated by the Optometric Director and a final determination regarding the level of quality concern and category of concern is made. Correspondence regarding the outcome of the final review is forwarded to the provider along with an explanation of any quality concerns and accompanying educational information as appropriate. All follow up recommended for confirmed quality of care issues must be documented. Possible interventions to be taken are as follows:

- Level 0 - No action.
- Level 1 - Notice of confirmed issue and written educational feedback to the provider. Follow up will be made to see if there are further occurrences. A referral is made to the Peer Review Committee.
- Level 2 - Notice of confirmed issue and written educational feedback to provider. A referral is made for review and/or action. There will be follow-ups to ensure no further occurrences.
- Level 3 - Refer to an Ad Hoc Committee for immediate attention.

Actions taken by an Ad Hoc Committee as a result of confirmed quality issues include but are not limited to: Written educational feedback, verbal educational feedback, intensification of review, onsite audit of provider's office, request for continuing vision care education, formal meeting between provider and the Optometric Director, referral to state licensing board or termination from network.

XI. COMPLAINT AND APPEAL REVIEW SUMMARY

Complaints

Providers may file a complaint if they are dissatisfied with EyeMax. Complaints may be either oral or written; complaint forms, and copies of EyeMax's complaint procedures, are available at all EyeMax facilities.
Complaints must normally be resolved within thirty (30) days of receipt. The provider who filed the complaint will be sent a written resolution letter that explains how the complaint was resolved, and explains how to appeal the resolution internally, and how to file a complaint with the Department of Managed Health Care.

Appeals

If a provider is not satisfied with the way their complaint was resolved, they may file an appeal. Where the original determination of the complaint was made by a vision care professional, the appeal must be performed by a different vision care professional. Written notice of the final determination of the appeal will be sent to the provider; the written notice shall include information on how to file a complaint with the Department of Managed Health Care.

Monitoring Complaints and Appeals

Outcomes of complaints and appeals will be tracked by EyeMax and reported to the QAC as an information item. If a complaint or appeal is also determined to represent a quality of care issue, the case will be forwarded in accordance with EyeMax's policies. In addition, patterns of confirmed complaints for the same provider will be forwarded for discussion and/or appropriate action, as they are identified and/or at the time of provider re-credentialing. In addition, a written record of tabulated complaint will be prepared by EyeMax staff.

XII. DELEGATION

EyeMax may choose to delegate certain functions. The QAC and BOD are responsible for the oversight of delegated activities.

XIII. PROGRAM EVALUATION

The QAC will issue a report that will provide an assessment of EyeMax's activities. At a minimum, this report includes completed quality improvement/ assurance activities, trending of clinical and service indicators and other performance data and demonstrated improvements in quality of care and service. The Quality Assurance Program description and procedure for the upcoming year are developed based on this evaluation.

XIV. PROGRAM APPROVAL

The EyeMax Board of Directors review and approve the Quality Assurance Program evaluation, the proposed Quality Assurance Program description and the proposed quality assurance policy for the upcoming year.

XV. INTEGRATING QUALITY IMPROVEMENT PLAN-WIDE

All activities that are designed to improve the processes by which vision care and service are delivered to members and are coordinated throughout the Quality Assurance Program. The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of quality assurance initiatives are documented and reported to appropriate individuals within the organization through established quality assurance channels.

Quality assurance initiatives are coordinated with other departments and the Quality Assurance Program utilizes performance monitoring information from other parts of the organization, including but not limited to utilization management, credentialing, monitoring and resolution of member complaints and appeals, assessment of member satisfaction and record review.

Quality assurance initiatives are coordinated with other management functions including, but not limited to the use of quality assurance information in re-credentialing and re-contracting, provider profiling, risk management, complaint resolution, network changes, benefit changes, changes in vision management systems, practice feedback to providers, and patient education.

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Chapter 11

Credentialing

How EyeMax credentials providers.

EyeMax maintains a policy and procedure for initial credentialing and continued re-credentialing of licensed independent providers with whom it contracts with to care for its members. This procedure will ensure that only those providers who demonstrate professional competence and meet or exceed EyeMax's credentialing standards, qualifications and requirements deliver optometric services to EyeMax members. In addition, the credentialing and re-credentialing procedure ensures that EyeMax does not incur unnecessary legal liability resulting from the optometric care practices of its network providers. The scope of the policy will apply to all contracted optometrist and ophthalmologist providers.

All providers that meet the criteria listed within the scope of this policy will undergo an initial credentialing process prior to being contracted with EyeMax. All providers are notified of their right to review information obtained by EyeMax to evaluate their credentialing application. This evaluation includes information obtained from any outside primary source (e.g., malpractice insurance carriers and state licensing boards). In the event that credentialing information obtained from other sources varies substantially from that provided by the provider, EyeMax will notify the provider in writing and allow the provider the right to correct erroneous information submitted by another party.

Active participating providers will undergo a re-credentialing process at least every three (3) years. EyeMax will evaluate, in accordance with legal and regulatory requirements, the clinical competence and responsiveness of applicants and participating providers to ensure that they can meet or exceed EyeMax's standards for quality care and service.
EyeMax will maintain credentialing standards that meet or exceed those required by regulators and subscribers-employer groups. At no time will EyeMax's credentialing standards be less than those required to meet state or federal requirements. EyeMax will maintain documentation of current state licensure and required permits to undertake the re-credentialing process.

Should EyeMax decide to grant credentials to a provider whose practice is currently restricted or who has significant past malpractice claims or other questionable history, EyeMax will provide additional oversight to that provider or similarly restrict his/her practice. If there is a need to expedite the credentialing of a provider, the Optometric Director has the authority to approve a provider's application prior to presentation to the Quality Assurance Committee (QAC) provided that all required standards have been met. Providers will not be listed in EyeMax internal or external provider directories until the credentialing approval has been granted and the contract has been executed and is on file with EyeMax.

I. **CREDENTIALING STANDARDS**

A. EyeMax will establish credentialing standards for participating providers listed within the credentialing scope.
B. EyeMax will conduct annual reviews of all credentialing standards, categories and policies to ensure that they meet or exceed legal, regulatory, and quality standards for which EyeMax is accountable.
C. The following credentialing standards apply to all participating providers, except as noted:

1. Available to provide patient care during regular office hours at least four (4) days a week.
2. No unexplained gaps more than thirty days in work history for the past five (5) years.
3. Successful completion of appropriate professional education for their requested/licensed area of practice for which they are contracting with EyeMax to provide.
4. Current, valid, unrestricted license to practice in the State of California verified by the California State Board of Optometric Examiners or the California Medical Board.
5. Current malpractice insurance coverage with limits in accordance with the Provider Agreement.
6. No unexplained actions, lawsuit, malpractice claim, or plea of nolo contendere, or Section 809 reports and/or allegations.

Note: Verification of state sanctions, restrictions and/or limitations in the scope of practice, will be done by a review of the quarterly bulletin distributed by the California State Board of Optometric Examiners and Medical Board.

7. Adherence to the lawful ethics of his/her profession.
8. No refusal by a malpractice carrier to issue coverage.
9. No prior history of sanction, termination, or other peer review action by a hospital or other professional review body.

10. No history of any incident that raises issues of competence, adherence to professional ethics, character, reputation, or ability to work effectively with other professionals on a health care team.
11. Absence of present physical or mental impairments from alcohol abuse, chemical dependency, or substance abuse that could impair the ability to effectively function as a health service provider in the chosen area of practice. If the provider has a prior history of alcohol abuse, chemical dependency, or substance abuse, but is not currently impaired, he/she may be granted full, unrestricted credentials if:
    - The provider can document successful participation in a treatment program; and
    - The provider can provide documentation that he/she has maintained recovery for five (5) years
    - Absence of sanctions from Medicare, Medicaid or other managed care organization;
12. Note: If sanctions are more than five (5) years old and did not involve criminal action, the provider may be given unrestricted credentials.
13. No peer review or malpractice actions of significance listed in the NPDB.
14. Adequate liability coverage for participation in EyeMax's product with the minimum limits ofone million/three million dollars ($1,000,000/$3,000,000) for all providers.

D. EyeMax will not consider age, sex, religion, race, creed, color, or national origin when determining a provider's qualifications, or when deciding whether to approve or deny credentials to any provider.

E. The credentialing criteria, standards and requirements set forth in this policy are not intended to limit EyeMax's discretion in any way, nor to create rights for providers who seek to provide services to EyeMax members.

F. The QAC may amend the credentialing standards to accommodate new categories of providers who may have additional or different standards commonly applied to their credentials.

II. CREDENTIALS CATEGORIES

A. There are three possible credentials categories for approved providers:
1. Full credentials, unrestricted.
2. Full credentials with oversight.
3. Denial.

Providers approved for unrestrictive full credentials meet all EyeMax credentialing standards. They may be issued a contract with no restrictions or qualifications to their practice.

Providers approved for full credentials with oversight meet the following criteria:
1. They meet all of criteria as stated in credentialing standards.
2. They have some previous history in the last five (5) years related to:
    - License to practice.
    - Malpractice coverage.
    - Hospital privileges (if applicable).
    - Peer review action, and
    Competence, professional ethics, character, or reputation.
3. In the presence of significant history, providers must submit letters of recommendation from providers familiar with their current level of practice. The letters must demonstrate that the provider is regarded as competent to practice in the area for which he/she is applying for credentials.

Note: Providers granted full credentials with oversight may be issued a contract with EyeMax. Their contracts, however, must outline any special conditions or actions pertinent to provider's practices, including non-standard utilization management requirements, to ensure that the providers understand the scope of their practice with EyeMax and the conditions for maintaining their credentials.

4. Applicants may be denied credentials under the following circumstances:
    - Unable to meet one or more of the criteria stated in the "Credentialing Standards"
    - No active license
    - No malpractice coverage
    - Currently impaired and not in active treatment
    - Deselected by another managed care organization
    - Under active Medicare or Medicaid sanction, especially if criminal action is pending.
    - Under active sanction by the state licensing board.
    - Under active prosecution for a felony, or
    - Under active investigation for a charge of moral turpitude, especially if the action originates with a patient

III. INITIAL CREDENTIALING

The procedure for provider credentialing is as follows:

A. The provider must submit a completed application/contract to EyeMax. The form must include: applicant's full name, address where practice is located, telephone number, fax number, business hours, California State provider's License number, board certification, date of birth,W9, DEA or DEA waiver(if applicable), malpractice insurance with required coverage, hospital privileges, NPI number, and social security number. Managed practice facilities must furnish name, address where services are rendered, type of entity, and number of doctors at the respective facilities.

B. EyeMax maintains an electronic flow sheet to track application advancement towards initial credentialing. This database will include:
   1. Provider name and title.
   2. Date initialization requested.
   3. Date completed application and verification received, and
   4. Date the attestation was signed by the provider.

C. If EyeMax has a recent credentialing application with an attestation signed within the last ninety (90) days, that application will be used to initiate the credentialing process. If, however, the application EyeMax has on file is greater than ninety (90) days old, a new application will be printed from EyeMax's database and will be sent to the provider for completion.

D. The provider must submit a fully completed, signed and dated application to EyeMax. The provider will also furnish any other information requested by EyeMax and/or EyeMax designee to verify and evaluate the provider's legal authority to practice, professional training and experience, work history background, demonstrated abilities, physical and mental health status, and/or issues that may affect member care. The provider must furnish all information needed to resolve any doubts about his/her qualifications. By completing a credentialing application, the provider:
   1. Authorizes EyeMax and/or EyeMax designee to consult with managed care companies, hospitals, or other health care facilities, persons or entities who have been associated with the provider, or who may have information bearing on the provider's competence and qualifications or that is otherwise relevant to the pending review.
   2. Consents to the inspection and copying, by EyeMax, of all records and documents that may be relevant to the pending review, including optometric records.
   3. Certifies that he/she will report any changes to the information submitted on the application form to the credentialing staff.
   4. Releases from any and all liability, EyeMax and its officers, directors, employees, representatives, and agents (including without limitation, the members of the QAC) for acts performed in connection with evaluating the provider's application.
   5. Releases from any and all liability all individuals and organizations who provide information concerning the provider, including otherwise privileged or confidential information to EyeMax representatives.
   6. Authorizes and consents to EyeMax and other organizations delegated credentialing activities on behalf of EyeMax to obtain information from the California State Board of Optometric Examiners/Medical Board, the NPDB (if indicated) and any other relevant information EyeMax may have concerning the provider.
   7. If issued full credentials with oversight, understands that any participating provider contract offered will require corrective action(s) or other restrictions to remain in good standing with EyeMax; and signifies his or her willingness to accept new patients.

E. EyeMax reviews the application for completeness.

F. If EyeMax determines that the application is incomplete, the provider is notified.
   1. If the provider fails to return the completed application back to EyeMax within forty-five (45) days, EyeMax will terminate the provider's request to participate in the EyeMax network.

G. When EyeMax receives a completed application from the provider, the verification process is initiated.

H. EyeMax is required to verify the following:
   1. Current California State Optometric License/Medical Board.
   2. Board certification, if applicable.

3. Current malpractice coverage, meeting adequate amounts previously noted.
4. Malpractice history for the past five (5) years via attestation questions and a copy of NPDB query report (if indicated);
5. Medicaid and Medicare sanction reports via a copy of NPDB query report (if indicated);
6. Censure by either state board of Optometric Examiners or county optometric society via query report from the California State Licensing Board.
7. Work history for past five (5) years via application and/or applicant's Curriculum Vitae. A gap in work history longer than thirty (30) days will require a written explanation, and
8. Application review to include a signed and dated attestation.

I. Upon completion of the credentials verification process and return of the provider's file, EyeMax will:
   1. Create and maintain a file for each provider to include:
      - Provider application.
      - Provider licensure, and
      - Provider verifications and any other documentation related to the credentials process.

J. Stamp EyeMax credentials worksheet and all supporting documentation with the date received.

K. Place EyeMax application and all supporting documentation in a provider credentialing file, and

L. Document on the Credentialing Flow Form exactly what was verified by EyeMax to include:
   1. Date of receipt of verification of each required element.
   2. Expiration dates.
   3. History of malpractice cases.
   4. History of pending malpractice cases, and
   5. History of incidents related to competence and professional ethics.

M. Any files with potential problems are clearly identified for the QAC prior to their review.

N. EyeMax forwards the completed provider file to the Optometric Director, or her assistant, for review

O. Once the final decision is reached by the OAC, EyeMax will update the current provider database to reflect the following:
   1. The dates and results of actions taken by the QAC.
   2. Licensure and expiration dates to include California provider's license, liability face sheet, and DEA and CPR licenses (if applicable) for each provider
   3. Board license and expiration date (if applicable), and
   4. Education information.

P. Written notice of reasons for denial of initial application is given to providers.

Q. EyeMax will monitor the current provider database to obtain licensure updates for each provider file as it expires, to include the California provider's license, liability face sheet, DEA, and CPR licenses (if applicable).

R. EyeMax will refresh the licensure expiration dates within the database to replace those which have expired.

IV. RE-CREDENTIALING

A. EyeMax will monitor the database used to hold the credential dates of all providers and determine the providers due for re-credentialing within one hundred eighty (180) days prior to the provider's re-credentialing due date.

B. EyeMax will prepare a list of those providers identified for the re-credentialing procedure.

C. One hundred fifty (150) days prior to the date that a participating provider's credentials are due to expire, EyeMax will prepare a list of providers to be re-credentialed. This list will include:
   1. The full name and degree of provider.
   2. Current provider address.
   3. Office contact.
   4. Telephone and fax number, and
   5. Business hours.

D. During the credential's verification process, the following information is verified by EyeMax staff using the same approved primary sources as stated in "Initial Credentialing":
   1. Continued board certification or eligibility, if expired.
   2. A valid unrestricted state license to practice.
   3. Status of clinical privileges at the primary admitting facility, if applicable.
   4. Valid DEA and CPR certificate(s), if applicable.

5. Current, adequate malpractice coverage in limits that meet EyeMax standards.
6. Professional claims liability history for the past three (3) years.
7. An attestation as to the provider's ability to perform his/her duties.
8. A statement regarding the provider's present use of illegal drugs.
9. Sanctions in Medicaid, Medicare or other managed care program(s).
10. History of incidents related to competence, adherence to professional ethics, character, reputation or ability to work effectively with other professionals, and
11. NPDB query

E. EyeMax will determine the information to review during the re-credentialing process. Such information may include:
    1. Quality improvement information such as results of quality screenings, quality issues, optometric record audits, special studies, and outcome reviews.
    2. Results of member satisfaction surveys, service audits, and access standards audits.
    3. Complaints and grievances from members, providers, and/or EyeMax staff.

F. Once all verification and re-credentialing reports have been obtained and once the information in the participating provider's file is complete, EyeMax will ensure that all completed files are available for review by the QAC during its next scheduled meeting.

G. Once the final decision is reached by the QAC, EyeMax will update the current provider database to reflect, at a minimum, the dates and results of actions taken by the QAC.

H. EyeMax will record the QAC's actions within the meeting minutes and present these for approval at the QAC's next scheduled meeting.

V. ACCOUNTABILITY STRUCTURE

A. Participating Providers:
    1. Actively participating providers will undergo re-credentialing at least every three (3) years.
    2. Actively participating providers will provide any additional information requested by EyeMax to facilitate an accurate and timely credentials verification process.
    3. Actively participating providers will ensure that their offices and staff are available for an office site review if one has not been performed within the previous twenty-four (24) month period, if applicable.

VI. QUALITY ASSURANCE COMMITTEE (QAC):

The Quality Assurance Committee (QAC) is responsible for the development, implementation, and revision of all credentialing program policies and procedures and has full authority to grant credentials to any provider meeting the EyeMax standards. The QAC is chaired by the Optometric Director and its membership includes at least two (2) additional licensed providers. The QAC directs the investigation of the credentials of potential or currently contracted providers and determines whether or not an applicant/participating provider fulfills EyeMax's credentialing standards. The QAC reviews all providers/participating providers prior to issuing or renewing their contracts/agreements. Under no circumstances will the QAC be composed of only one optometrist or only EyeMax staff (regardless of the professional training of said staff). The QAC has full authority to approve the credentials of any provider under review.

A. The QAC is responsible for the development, implementation, evaluation, and revision of those policies and procedures that guide the credentialing and re-credentialing processes.

B. The specific duties of the QAC include, but are not limited to:
    1. Review and evaluate the application and supporting documentation to determine whether the provider seeking new or renewed credentials as a participating provider meets the criteria and qualifications as stated in "Credentialing Standards" for providing optometric care services to EyeMax members.
    2. Approve, with or without restrictions, or deny credentials for network providers.
    3. Review and expand or restrict the credentials of participating providers.
    4. Establish EyeMax's credentialing and re-credentialing standards to ensure that providers are able to deliver quality, effective optometric services within the framework of a managed care organization.
    5. Review EyeMax's credentialing standards on an annual basis to ensure that they continue to support EyeMax's quality and service performance objectives.

C. The QAC will meet at least quarterly to conduct credentialing-related activities, or more frequently if needed to meet the one hundred eighty (180) day requirement.
D. A quorum of sixty-seven percent (67%) plus at least two (2) optometrist members must be present to recommend changes to policies and procedures, or to recommend approval or denial of a provider's credentials.
E. At no time will the QAC base a credentialing decision on provider's information that is more than one hundred eighty (180) days old at the time of the credentialing decision.
    1. The QAC may request additional information on a provider prior to making a decision on the type of credentials to recommend.
    2. At its discretion, the QAC may invite the provider to meet with the committee to provide additional
    3. information.
    4. If the provider has disclosed on the application, malpractice claims or lawsuits against him/her, the QAC will evaluate the malpractice claims history.

F. The Optometric Director must consult with EyeMax legal counsel to obtain an opinion on the legal or risk management implications of any credential’s exception.
    1. The QAC may not grant credentials in a category other than the one that the provider appears qualified to meet, whether that category is more or less restricted.
G. The QAC will keep minutes of all its meetings in order to ensure appropriate documentation and communication of its decision-making process.

Note: All minutes and documents related to the credentialing and re-credentialing processes are confidential, in accordance with EyeMax's policies and procedures on peer review information.

VII. BOARD OF DIRECTORS

The Board of Directors delegates responsibility for the implementation of the quality assurance program to the Optometric Director. The Board of Directors, however, retains ultimate accountability for the quality of optometric services and the health plan operations.

VIII. OPTOMETRIC PLAN LEGAL COUNSEL:

A. Legal counsel is knowledgeable about all pertinent contract provisions, state and federal regulations, codes and laws, NCQA standards, and related risk management practices that govern credentialing activities in managed care organizations.
B. Legal counsel reviews and approves all credentialing and re-credentialing policies and procedures prior to their presentation to the QAC and the QAC for approval.
C. When appropriate, legal counsel will review significant histories and advise the QAC of the degree of legal risk that might be incurred if EyeMax approves the provider/participating provider's credentials.

Note: A summary of legal counsel's review and opinion will be documented in writing and will be placed in the provider's/participating provider file.

IX. OPTOMETRIC DIRECTOR (OD):

The Optometric Director is ultimately accountable for ensuring the appropriateness and accuracy of each provider file that is submitted to the QAC for review. The Optometric Director reviews all potential providers and participating providers' credentials prior to their presentation to the QAC and makes recommendations on the action required by the QAC. This review will include: all malpractice issues, board certification issues, state board sanction issues, and any other issues that involve the quality of care to EyeMax's members. If necessary, the Optometric Director personally interviews the potential provider or participating provider to determine his/her fitness for participating in EyeMax's network(s). The Optometric Director will document the results of any interviews conducted and present such documentation to the QAC when appropriate.

A. EyeMax documents the results of any inquiry into the provider's file and places it in the provider's file. Documentation will include, at a minimum:

1. Date and type of contact with the provider. Note: The OD may telephone or meet in person with the provider.
2. Provider's explanation of questionable incidents, as determined by the QAC, the investigation of which defines the degree of significance.
3. Number of suits per year of practice (when malpractice claims exist); provider's malpractice risk relative to those of same or similar specialty (a peer comparison).
4. The severity of any malpractice claims; note will be made whenever a claim involved the death of a patient.
5. Average amount of malpractice judgment or settlement, and
6. Any written response on the part of the provider regarding a significant history.

B. The OD will ensure that participating providers whose performance resulted in a change in credentials category during the re-credentialing process are given priority attention during the QAC review process.

X. CONFIDENTIALITY

A. Credentialing information is handled in a confidential manner and will be used strictly for peer review and quality management purposes.

B. All credentialing files and related information will be secured during non-business hours. Information will be secured in designated locked filing cabinets with access only by specific individuals.

C. Each individual involved with the use and/or viewing of the credentialing files must sign the "EyeMax Vision Plan, Inc.'s Statement of Confidentiality/Conflict of Interest" on or shortly after the date of hire (temporary employees included).

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Chapter 12

Language Assistance Program

A guide in dealing with limited English proficiency members.

As required by the California Department of Managed Health Care, EyeMax offers language assistance services to members with limited English proficiency. EyeMax requires all of its providers to be in compliance with the language assistance requirements. Language services include oral interpretation services as well as documentation translation free of charge.

In order to ensure compliance, EyeMax's Language Assistance Program includes the following:

- Member surveys relating to linguistic needs.
- Updating its demographic profile every three (3) years.
- Providing members with information on provider offices with bilingual staff.
- Free interpretation services.
- Translation of member documents.
- Staff training.
- Provider compliance.

What Providers Need to Do:

- Ensure members are provided with interpretation services even if a member has a friend or a family member who can translate.
- Inform members that interpretation services are free.
- Post notice in your waiting room regarding the availability of interpretation services.
- Make the grievance form and process available in different languages. Provider is welcome to contact EyeMax for translated grievance form and process that are currently available in both English and Spanish
- Provide member with efficient and competent interpretation services. If a provider needs assistance with arranging an interpreter for an EyeMax member, provider must advise EyeMax of such forty-eight (48) hours in advance
- Document in the member's records if a member refuses interpretation services.
- Inform EyeMax of any language capability changes in the provider office.
- Cooperate with EyeMax by providing any information necessary to assess Language Assistance Program compliance.

Providing Service to Members

EyeMax does not require its providers to provide interpretation services themselves. This includes circumstances where the provider's office is bilingual.

EyeMax provides interpreting and translation services telephonically to its providers and members. To access the language assistance services providers are directed to contact the EyeMax Provider Relations Department by calling 866-901-8610. This service is available to EyeMax Providers and its Members at no charge.

If a member requires interpretation services or refuses interpretation services, it is best practice to document this in the Member's record, as well as the Member’s preferred language.

Translation of Written Material

EyeMax has identified the following documents as vital documents that a member may request to be translated:

- Applications.
- Consent Forms.
- Certificate of Coverage.
- Standard letters that are sent to members.
- Grievance and Appeals process materials.
- Letters pertaining to eligibility and to participation criteria.

- Notices reducing, denying, modifying, or terminating services or benefits.
- Marketing information.
- Disclosure Forms.
- Letter sent to specific members requiring a response from the members.
- Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to members.

If a member requests a provider for translated documents, please call EyeMax at 1-844-393-6297. EyeMax will ensure that translated documents are provided to the member within twenty-one (21) days of the request.

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Chapter 13

Confidentiality

Working with EyeMax to ensure member confidentiality.

EyeMax takes confidentiality of members very seriously and expects its providers to do the same. EyeMax makes every effort to release only the amount of information necessary to meet the needs of a request. Additionally, when a request is made for confidential information, EyeMax removes identifiable information from the member's records whenever possible. To ensure confidentiality of members' records, EyeMax takes the following steps:

1. EyeMax ensures all employees are trained on EyeMax's confidentiality policies and procedures at the time of hire as well as annually.
2. EyeMax restricts access by employees to members' medical information to only those employees who need the information.
3. EyeMax requires its employees to sign a confidentiality agreement upon completion of their training to ensure that employees understand EyeMax's policies and procedures.
4. EyeMax requires all employees to report any violations of its confidentiality policies and procedures.
5. All EyeMax employees who have access to EyeMax's computer system are required to have a unique and secure login name and password.
6. EyeMax does not share any specific or identifying medical information with any person who is not directly concerned with the member's care or involved in the payment without the member's written consent, unless required by law.
7. EyeMax requires its network of providers to follow EyeMax's confidentiality policies and procedures, Health Insurance Portability and Accountability Act ("HIPAA") and Health Information Technology for Economic and Clinical Health Act ("HITECH Act").
8. EyeMax conducts periodic data security audits and risk assessments.
9. EyeMax reviews its policies and procedures on confidentiality periodically to ensure compliance under HIPAA and HITECH Act.
10. EyeMax provides its members with access to their records, provides accounting of disclosure when requested by a member, and retains all requests for information in the records.

To request a copy of EyeMax's policies and procedures on confidentiality, please call EyeMax at 1-844-393-6297

Chapter 14

Glossary

How EyeMax defines certain terms.

ACUITY - The clearness or sharpness of vision.
ADDITIONAL PAIR DISCOUNT – Second and additional pair discounts (varies by plan).
AMBLYOPIA - Reduced visual acuity not correctable by refractive means and not attributable to obvious structural or pathological ocular anomalies.
ANGLE KAPPA - The angle between the visual axis and the pupillary axis of the eye, measured at the nodal point.
ANISOMETROPIA - A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction from the other.
ANTI-REFLECTIVE - A specialized lens coating which optimizes the transmission of light through a lens. ASPHERIC - A lens design which increases the visual field area and reduces peripheral distortion.
ASTIGMATISM - A condition of refraction in which rays emanating from a single luminous point are not focused at a single point by an optical system, but instead are focused as two line images at different distances from the system at right angles to each other.
BACKSIDE UV - A coating added to the backside of the lens to protect from UV radiation. This is considered a lens add-on.
BASE LENS – See “Standard EyeMax Plan and its Intervals”.
BINOCULAR - Pertaining to both eyes; the use of both eyes simultaneously. BVA - Best Visual Acuity.
C.C. - Chief Complaint.
CLINICAL RECORDS EVALUATION - A review of clinical records to confirm that members received eye exams according to EyeMax standards and guidelines and that all necessary items were documented.
C.O.B. – See the “Coordination of Benefits” section of the Provider Manual.
COMPLICATED CONTACT LENS EXAM – More complex lenses, including but not limited to toric, multifocal / monovision, post- surgical and gas permeable contact lenses. These types of fittings are reimbursed differently under the Standard EyeMax Plan. COMPREHENSIVE EYE EXAM – The requirements for this level of examination are defined in the Standard EyeMax Plan and your Provider Manual.
CONTRAST - The manifestation or perception of difference between two compared stimuli.
CREDENTIALING - The process of verifying that providers meet our minimum requirements for participation. Please see the Credentialing section of the Provider Manual.
CYCLOPLEGIC - (Cycloplegia) Paralysis of the ciliary muscle and the power of accommodation, usually accompanied by a dilated pupil.
DILATION – Is a component of the Comprehensive Eye Examination (as indicated) and is required for all diabetic members. Retinal Imaging is not a substitute for Dilation and cannot be billed separately.
DX - Diagnosis.
ELECTRO-OCULOGRAM - A record of eye position made by recording, during eye movements, the difference in electrical potential between two electrodes placed on the skin at either side of the eye. The potential difference is a function of eye position and changes in the potential difference are due to changes in alignment of the resting potential of the eye in reference to the electrodes. ELECTRO RETINOGRAM - The electrical effect recorded from the surface of the eyeball and originated by a pulse of light. It is usually recorded as a monophasic or a diphasic wave but may be more complex.
E.O.C. – Combined Evidence of Coverage and Disclosure Form.
ESTABLISHED CONTACT LENS WEARER - A patient who has worn contact lenses in the last 12 months or who is an established patient at your practice.
FAR SIGHTED - See Hyperopia.
FEE SCHEDULE – The contracted fees you agree to accept for services and materials covered by EyeMax plans.
FIXATION DISPARITY - A condition in which the images of a bifixated object do not stimulate exactly corresponding retinal points, but still fall within Panum's areas, the objects thus being seen singularly.
FRAMES QUARTERLY – A market publication used in EyeMax frame reimbursement calculation. FUNDUS - The interior lining of the eyeball, including the retina, optic disc, and the Macula.
HI INDEX - A lens material which bends light more rapidly allowing for thinner lens profiles on hi-power lenses. HX - History.
HYPEROPIA - Far-sightedness.

INVOLUNTARY TERMINATION – The removal of a provider from our network due to violation of our policies. (See Auditing Procedure section of the Provider Manual.)
KERATOMETRY - Measurement of the anterior curvatures of the cornea with a keratometer.
LENTICULAR - A form of cataract lens design in which the front curves are confined to a 38-40mm bubble which is molded on top of a flat carrier base.
MACULA – The interior lining of the eyeball, including the retina, optic disc and the Macula. MEDICALLY NECESSARY CONTACTS – This criteria is defined in the Standard EyeMax Plan.
MEMBER – Anyone covered under EyeMax's plans. Could be a spouse or dependent of the primary member as defined in the Combined Evidence of Coverage and Disclosure Form.
MINIMUM LENS PRESCRIPTION - The Rx must contain a minimum of .50 Diopters of power in sphere, cylinder, or add, in at least one eye.
MYO-DISC - A specialized method of grinding to reduce the edge thickness of Hi-Minus lenses. MYDRIATIC - Pertaining to increase in pupil size.
MYOPIA - Near sightedness.
NCT – Noncontact tonometry or air puff test. NPC - Near Point of Convergence.
NEAR SIGHTED - See Myopia. OCULAR - Pertaining to or of the eye. OD - Oculus dexter, or right eye.
OS - Oculus Sinister or left eye. OU - Oculus Uterque or both eyes.
PLAN CHARGE – The amount deducted from your claim payment for the cost of materials ordered through a contract laboratory and other costs such as shipping, administrative fees, etc.
PLANO SUNGLASSES – Sunglasses without a corrective lens. These are only covered under the "Second Pair Benefit" and are provided to the patient at a contracted discount from U&C by the Provider.
PROGRESSIVE LENSES (PAL) – Terms used by labs to refer to lenses that produce a gradual change in focus without lines or junctions and fall within the EyeMax Progressive Lens Tiers. (See "Lens Upgrades, Services and Options Tables 1 through 5" section of the Standard EyeMax Plans.)
PHORIA - The direction or orientation of one eye, its line of sight or some other reference axis or meridian.
PHOTOCHROMIC - Pertaining to substances which change in color and in light transmission properties upon exposure to a change of light intensity.
POLARIZED - A lens which inhibits the transmission of indirect light through the lens thus reducing glare.
PRESBYOPIA - A reduction in accommodative ability occurring normally with age and necessitating a plus lens addition for satisfactory vision at near.
REFRACTIVE STATUS - See Hyperopia, Myopia, Astigmatism, Presbyopia. RX - Prescription.
SLAB-OFF - A special form of grinding to reduce an imbalance in prism in the near (reading) portion of the lens. SLE - Slit Lamp Examination.
STEREOPSIS - Binocular visual perception of three-dimensional space based on retinal disparity; visual perception of depth or three-dimensional space.
STRABISMUS - The condition in which binocular fixation is not present under normal seeing conditions. SUBJECTIVE REFRACTION - The refractive state of the eye as determined by visual judgment of the patient.
SUBSCRIBER – An Employer which pays premiums to EyeMax to cover their employees for vision services and materials.
TA – Tonometry by applanation.
TONOMETER - An instrument for determining ocular tension, usually by measuring the impressibility of the tunics of the eye, so as to evaluate intraocular pressure.
TONOMETRY - Measurement of ocular tension with a tonometer. TX - Treatment.
VISUAL ACUITY (VA) - Acuteness or clearness of vision (especially of form vision) which is dependent on the sharpness of the retinal focus.

Chapter 15
Attachments

Sample Standard CMS-1500 Form

Member Grievance Form

Provider Dispute Resolution Request

Exhibit A – Quality Assessment Form

Exhibit B – Suspected Fraud Report

Exhibit C – Fraud Investigation Report

Exhibit D – Member ID Card

Exhibit E – Provider Survey

Exhibit F – Peer Review Form

Exhibit G – Provider Update Form

Exhibit H – Language Assistance Poster

Exhibit I – 500 EyeMax Provider Reimbursement Explanation

Exhibit J – 501 EyeMax Provider Reimbursement Explanation

Exhibit K – 515 EyeMax Provider Reimbursement Explanation

Fillable PDF form: http://www.ahcipa.com/NEWsite/wp-content/uploads/2015/11/CMS1500.pdf

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA — CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) — 1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — 3. PATIENT'S BIRTH DATE MM DD YY SEX M F — 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) — 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other — 7. INSURED'S ADDRESS (No., Street)

CITY STATE — 8. RESERVED FOR NUCC USE — CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( ) — ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) — 10. IS PATIENT'S CONDITION RELATED TO: — 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER — a. EMPLOYMENT? (Current or Previous) YES NO — a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE — b. AUTO ACCIDENT? PLACE (State) YES NO — b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE — c. OTHER ACCIDENT? YES NO — c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME — 10d. CLAIM CODES (Designated by NUCC) — d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. — 15. OTHER DATE QUAL. MM DD YY — 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI — 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) — 20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN — 26. PATIENT'S ACCOUNT NO. — 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO — 28. TOTAL CHARGE $ — 29. AMOUNT PAID $ — 30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) — 32. SERVICE FACILITY LOCATION INFORMATION — 33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE — a. NPI b. — a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB 0938 1197 FORM 1500 (02 12)

EYEMAX VISION PLAN

Grievance Form

IMPORTANT: If you cannot read this letter in English or Español, you can call 1-844-393-6297 and ask for help to complete it and/or ask that this letter be translated to your language, at no cost to you.

Member Name (Last) (First)	Birth Date: Mo. Day Yr.	Effective Date of Enrollment: Mo. Day Yr.
(Address) (City) (State)		(ZIP Code)
Telephone (Home)	(Work)	Member ID #
Name of person completing form/relationship, if different from member		(Daytime Telephone)
Name of Optometrist or Ophthalmologist		Medical Group/Clinic
Where did the problem occur? (Name of Clinic)	Date of Incident: Mo. Day Yr	Time of Incident:
Inaccurate Directory? Yes ☐ No ☐		
Correct Address: Who was involved beside yourself ? (Give names of involved staff, if possible.)	Phone Number:	
Who was involved beside yourself? (Give names of involved staff, if possible.)		
Please mail this completed form to:	**EyeMax Vision Plan, Inc.** **Attn: Grievance Dept.** **P.O. Box 14227** **Orange, CA 92863**	

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-844-393-6297** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online."

Grievance Received By:	By Fax ☐	
Date Received: Time Received:	By Mail ☐ By Telephone ☐ Online ☐	______________________ Member's Signature (optional) Date I UNDERSTAND THAT THE PLAN WILL CONTACT ME WITHIN THIRTY (30) DAYS TO GIVE ME A REPORT ON ITS INVESTIGATION AND/OR ACTION

EYEMAX
VISION PLAN

Grievance Form

DESCRIBE WHAT HAPPENED: (Please describe what happened as specifically as possible. Include the sequence of events and how the problem affected you).

ACTION REQUESTED: (What would you like to see done about this problem).

(Official Use Only)

OUTCOME/Resolution:

Acknowledgement sent within (5) days: ☐ Yes ☐ No sent by: ___________________

Member was acknowledged verbally and notified of the 72 hours appeal process: ☐ Yes ☐ No (Complete only if expedited Appeal)

Grievance Received by: ______________________________________ Date Received: ____________

Provider Dispute Resolution Request

EyeMax Vision Plan welcomes your call to our Provider Relation Department, prior to submitting this form.

Please send this for to EyeMax Vision Plan, Inc.

Via Mail: EyeMax Vision Plan, Inc.
Attn: Provider Relations
530 S. Main St
Orange, CA 92868

Via Email: operations@eye-maxinc.com

Fax: 714-689-7575

Please be as complete as possible and submit any additional information to support the dispute. No need to send the original claim.

Provider's Name: ______________________ **Phone:** ______________________

Provider's Address: ______________________

Email: ______________ **Provider's EyeMax ID:** ______________ **Provider's NPI#:** ______________

CLAIM INFORMATION: ☐ Single Claim ☐ Multiple "Like" Claims Number of Claims: __________

PATIENT INFORMATION: Name: ______________________ DOB: __________

EyeMax Member ID#: ______________________

Date(s) of Service: From: ______________ To: ______________

Original Claim #: ______________ EyeMax Authorization #: ______________

Original Claim Amount Billed: $ ______________ Amount Paid: $ ______________

DISPUTE TYPE:

- ☐ Appeal of Medical Necessity/Utilization Management
- ☐ Claim
- ☐ Contract Dispute
- ☐ Request for Reimbursement of:
- ☐ Member Complaint
- ☐ Other

DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (Print): ______________________ **Title:** ______________

Signature: ______________________ **Date:** ______________

Phone: ______________________ **Fax:** ______________

☐ **Additional information is attached**

EYEMAX USE ONLY

DATE RECEIVED: ______________ **RECEIVED BY:** ______________

OUTCOME: ______________________

RESOLUTION DATE: ______________________

EYEMAX
VISION PLAN

Quality Assessment Form

Member Name:______________________ DOB.:__________ Member ID No:____________

Provider Name:______________________ NPI Number:______________________

Provider Address: ____

Phone Number: ____

Group /Plan: ______________________ Phone Number:______________________

Referred By:______________________ Diagnostic Code:______________________

PLAN QUALITY ASSURANCE COMMITTEE REFERRAL BECAUSE (Check all that apply):

- ☐ WAS THERE A DIAGNOSIS ERROR?
- ☐ WAS THERE A TREATMENT ERROR?
- ☐ WAS THERE AN UNEXPECTED TRAUMA OR SAFETY ISSUES DURING HEALTH CARE VISIT?
- ☐ WAS THERE A LACK OF REQUIRED MEDICAL RECORD DOCUMENTATION?
- ☐ WAS THERE A COMPLAINT ABOUT ACCESSIBILITY TO CARE?
- ☐ WAS THERE A COMPLAINT ABOUT A DELAY IN OBTAINING AN APPOINTMENT OR SERVICES?
- ☐ WAS THERE A POTENTIAL QUALITY OF CARE ISSUE?
- ☐ OTHER- PLEASE SPECIFY: ____

Brief Summary of Events(Include date of service. Attach additional pages as needed):

____
Referring Staff Signature

____
Department

____
Date

____
Phone Number

Please send the complete form to: ***EyeMax Vision Plan, Inc. Attn to Provider Relations, 530 S. Main St., Orange, CA 92868.***

EYEMAX
VISION PLAN

Suspected Fraud Report

Date of Report:______________________________

Name of Person Making Report: **______________________________

*** Preferred. EyeMax Vision Plan, Inc. encourages all of its employees and providers to report suspected incidents of fraud and will not retaliate against for making such a report. If desired, however, reports maybe made anonymously.*

Description of Suspected Fraudulent Activity: (In order to facilitate an appropriate investigation, please provide as much information as possible on the suspected fraudulent activity. Attach additional pages if necessary.)

Name of Person involved:

A copy of this form should be forwarded to the Anti-Fraud Committee as soon as possible.

Date Received by EyeMax Anti-Fraud Committee: ______________________________

Action Taken:

(Attach additional pages if necessary)

Note: Attach the Fraud Investigation Report to this form.

EYEMAX
VISION PLAN

Fraud Investigation Report

EXHIBIT G

Name of Investigator :____

Date Investigation Completed:____

List of Witnesses Interviewed *(Copies of interview notes or summaries of interviews should be attached to this Report)*:

Lists of Documents Reviewed *(Copies of all documents reviewed, or a summary of all documents reviewed, should be attached to this Report)*:

Description of other Investigative Activities undertaken:

Summary of Investigation Findings:

(Attach additional pages if necessary)

MEMBER
IDENTIFICATION CARD
MBR# 00000-9919002
PLAN 500

Member Name
EFF DATE: 7/1/2019

Questions Call 844-393-6297

INSTRUCTIONS FOR OBTAINING VISION CARE SERVICES

1. Visit www.eyemaxinc.com to locate an EyeMax provider location closest to you.
2. Call an EyeMax Panel Provider for an appointment. Refer to list of providers for contact information of provider located most conveniently for you. Mention that you are an EyeMax Vision Plan Enrollee.
3. Present this card and/or Benefit Form to the Provider's office at the time of appointment.

EYEMAX VISION CUSTOMER SERVICE (844) 393-6297

Provider Satisfaction Survey

Thank you for being a provider for EyeMax Vision Plan. Please take a moment and check the corresponding boxes for the survey.

Questions	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
When I call EyeMax Provider Services I am happy with the wait time and the quality of the information I receive.					
EyeMax's claims process and turnaround is generally accurate and timely.					
The information in the Provider Manual is helpful and I am familiar with EyeMax's Language Assistance Program.					
EyeMax's overall compensation is comparable to other plans I participate within California.					
Overall I am satisfied with EyeMax Plan and would recommend the plan to my colleagues.					

Please return this survey:

By fax to: 714-689-7575

By Mail to: 530 S. Main St., Orange, CA 92868

Thank you.

EYEMAX
VISION PLAN

EyeMax Peer Review Form

EXHIBIT R

Provider: ______________________ Pt Name.: ______________________
Dates of Care: ______________________
File#: ______________ Pt. ______________ Sex: ______________ Age: ______
Trigger for Review: ______________________

OVERALL OPTOMETRIC CARE *(check only one)*

- ☐ Appropriate
- ☐ Questionable
- ☐ Not Appropriate

PROCEDURE JUSTIFICATION *(check only one if appropriate)*

- ☐ Documentation ***clearly*** supports need for procedure
- ☐ Documentation ***questionably*** supports need for procedure
- ☐ Documentation ***does not*** support need for procedure

DIAGNOSIS CONFIRMED *(check only one)*

☐ Yes ☐ No

PROVIDER CARE ISSUES *(if treatment and overall management = Appropriate, check* **NONE**; *otherwise check all that apply)*

- ☐ None
- ☐ Diagnosis Acuracy
- ☐ Clinical Judgement
- ☐ Technique/Skills
- ☐ Policy Compliance
- ☐ Knowledge
- ☐ Other
- ☐ Delay in Diagnosis or Treatment
- ☐ Delay in Follow-up/Follow-through
- ☐ Communication/Responsiveness
- ☐ Coordination of Care/Planning
- ☐ Pre-procedure work-up

GENERAL DOCUMENTATION ISSUES *(check all that apply)*

- ☐ Documentation acceptable
- ☐ Documentation illegible
- ☐ Documentation not timely
- ☐ Documentation does not substantiate course or treatment

REVIEWER COMMENTS:

ACTION TAKEN *(if necessary)*:

EYEMAX REVIEWER SIGNATURE: ______________________ **DATE:** ______________

DATE

«Facility_Name»
«Address_Line_1»
«City_Name», «State_ID» «Zip_Code»

Dear Dr. «Last_Name_»,

EyeMax Vision Plan Services, Inc., is required to display an accurate provider directory for contracted facilities and associate providers to comply with California Senate Bill 137. Please review the information below for accuracy and update appropriately leaving no item blank. Once all information is reviewed and/or updated, please sign the form and fax it to 714-689-7575 oremail it to providerrelations@eye-maxinc.com.

Please respond by **DATE**

Failure to respond may result in your facility being removed from our provider directory.

Please review the information below and make any necessary corrections.

Facility ID «Facility_ID»	**Current Facility Information**	**New/Revised Information; if applicable**
Practice Phone Number	«Phone_Number»	
Practice Email Address	«Email»	
Office Hours	«mon» «tue» «wen» «thu» «fri» «sat» «sun»	
Languages Spoken	«l1», «l2», «l3», «l4», «l5», «l6», «l7», «l8», «l9», «l10», «l11», «l12»	
Facility Street Address	«Address_Line_1»	
Accepting New Patients	«Accepting_New_Members»	

Facility ID «Facility_ID»	**Current Associate Information Below**	**Indicate Yes or No that Associate is still affiliated with this facility**
Associate Name	«Fist_Name_» «M» «Last_Name_», «TYPE»	
Associate License #	«License_»	
Associate NPI Number	«NPI»	
Specialty Type	«Speciality»	
Board Certification	«SpecialtyBoardCertified»	
Other Accreditation		

Hospital Admitting Privileges Yes No
Hospital Name:
____

Please provide a list of any associates(s) at this location currently not listed above, if necessary, attach a separate sheet.

Our records indicate that your facility is currently OPEN to enrollment for the following Benefit Plans:

«Plan_»

YES, I confirm the above information is accurate. INITIAL____________________NO, the above information is incorrect, see corrections below:

____

____INITIAL
____

Attestation:
By signing this form, you are acknowledging you have reviewed the above information and have made any necessary changes.

______________________________ ______________________________ ______________

Name of Owner Optometrist/ Authorized Person Signature Date

Please return this entire form including the signature page to EyeMax Vision Plan Services, Inc., either by fax or email. If you have questions regarding the credentialing of new associates, please call us at 866-901- 8610.

Scan and email to: providerrelations@eye-maxinc.com Or Fax to: EyeMax Vision Plan Services, Inc. Provider Relations: 714-689-7575

Sincerely,

Cassandra Bredek
Senior Manager
EyeMax Vision Plan Services, Inc.

Language Assistance Poster

EXHIBIT T

	FOR EXAMPLE: ☛	**ENGLISH** I speak English
SPANISH Yo hablo español	**CHINESE** 我說中國話	**VIETNAMESE** Tôi nói tiếng Việt
FARSI/PERSIAN من فارسی صحبت می کنند	**TAGALOG/Filipino** NAGSASALITA AKO Ginagamit ko Pilipino	**KOREAN** 나는 한국어를
ARMENIAN Ես խոսում եմ հայերեն	**RUSSIAN** Я говорю по-русски	**ARABIC** انا اتحدث العربية
KHMER/CAMBODIAN ខ្ញុំនិយាយកម្ពុជា / ខ្មែរ	**LAO** ຂ້າພະເຈົ້າເວົ້າພາສາລາວ	**YIDDISH** איך רעד יידיש
ITALIAN Lo parlo italiano	**FRENCH** Je parle français	**HMONG/MAIO** Kuv hais lus Hmoob
GREEK Μιλάω ελληνικά	**GERMAN** Ich spreche Deutsch	**HEBREW** אני מדבר עברית
HINDI मैं हिंदी बोलते हैं	**TAMIL** நான் தமிழ் பேச	**MALAY** Saya bercakap MELAYU
CROATIAN Ja govorim hrvatski	**BENGALI** আমি বাংলা বলতে	**URDU** میں نے اردو بولتے ہیں
THAI ผมพูดภาษาไทย	**POLISH** Ja mówie po polsku	**PORTUGUESE** Eu falo português
JAPANESE 私は日本語を話します	**PUNJABI** ਮੈਂ ਪੰਜਾਬੀ ਦੀ ਗੱਲ ਕਰ	**GUJARATI** હું ગુજરાતી વાત

PLAN 500 PROVIDER Reimbursement Explanation

Benefit Intervals

Description of Coverage	Frequency
Eye Exam, Ophthalmic Lenses, Contact Lens Fitting and Lenses	Once every 12-months, renewing January 1st
Ophthalmic Frames	Once every 24-months, renewing January 1st

Eye Examination Benefit

Eye Examination	TOTAL EXAM BENEFIT TO PROVIDER
Comprehensive Examination + Refraction (New or Established Member)	**$70 ($45 EyeMax Reimbursement + $25 Patient Exam Copay)**
Fundus Photography or OCT (Digital Retinal Imaging)	Available to Members at **70% of YOUR U&C** Payable to provider at time of service. All other procedures must still be performed. This is not a substitute for dilation if indicated (diabetes, etc.).

Dispensing/Lab Fees – Paid Directly to Provider by EyeMax

	Dispensing Fee – 1 Pair	Lab Fee – 1 Pair
SV – Lenses Only	**$15.00**	**$15**
BiFocal – Lenses Only	**$20.00**	**$20**
Trifocal & Progressive – Lenses Only	**$20.00**	**$30**

Basic Lens Coverage (excludes Progressive Lenses)

Single Vision, Bifocal, Trifocal, - Clear *	**Only CR39 Covered (Polycarbonate Covered** *for pediatric patients*

Frame Benefit

Frame covered up to $75 retail allowance. (Provider Receives $45 towards frame from EyeMax)
Member pays provider additional 70% of the difference between the U&C Frame Retail and the $75

Upgrades, Premium Lenses, Coatings, and any uncovered materials or service

Including, but not limited to: High-Index Lenses, Polycarbonate, Specialized Coatings, Extra Options, Custom Jobs, Drill Mounts, Prism, etc.	**Member pays Provider:** 70% of the Usual and Customary Fee for non-covered upgrades.

Contact Lenses

(No additional coverage for Medically Necessary Contact Lenses)

	Services	Materials
Contact Lens Fitting and Evaluation and Contact Lenses (in lieu of eyeglasses)	**Member Pays Provider 70% of U&C for CL fitting**	**Member has $70 material allowance – which is reimbursed to provider by EyeMax** **Member pays Provider 70% of difference between lens cost and $70 allowance**

No Material Copays for Frames or Lenses.
Provider collects 70% of the U&C difference between Covered U&C and Purchased Material U&C
Any overage charges + Exam Copay + Imaging Fees are due at the time of visit and/or order by the member.

*Standard SV, bifocal, and trifocal lenses within Rx power up to +/- 7.00ph with -4.25 cylinder and up to +3.00 add power are included in Plan 500.
** Pediatric Patients are dependents age 18 and under.
**CA Prop. 65 Warning: Polycarbonate product contains a chemical known to the State of CA to cause birth defects or other reproductive harm.

PLAN 501 PROVIDER Reimbursement Explanation

Benefit Intervals

Description of Coverage	Frequency
Eye Exam, Ophthalmic Lenses	Once every 12-months, renewing January 1st
Ophthalmic Frames	Once every 24-months, renewing January 1st

Eye Examination Benefit

Eye Examination	TOTAL EXAM BENEFIT TO PROVIDER
Comprehensive Examination + Refraction (New or Established Member)	**$70 ($45 EyeMax Reimbursement + $25 Patient Exam Copay)**
Fundus Photography or OCT (Digital Retinal Imaging)	Available to Members at **70% of YOUR U&C** Payable to provider at time of service. All other procedures must still be performed. This is not a substitute for dilation if indicated (diabetes, etc.).

Dispensing/Lab Fees – Paid Directly to Provider by EyeMax

	Dispensing Fee – 1 Pair	Lab Fee – 1 Pair
SV – Lenses Only	**$15.00**	**$15**
BiFocal, Trifocal – Lenses Only	**$20.00**	**$20**

Progressives NOT Covered – Member Pays 70% of your U&C

Basic Lens Coverage (excludes Progressive Lenses)

Single Vision, Bifocal, Trifocal - Clear *	**ONLY CR39 Covered (Polycarbonate Covered** *for pediatric patients*

Frame Benefit

Frame covered up to $75 retail allowance. (Provider Receives $45 towards frame from EyeMax)

Upgrades, Premium Lenses, Coatings, and any uncovered materials or service

Including, but not limited to: High-Index Lenses, Polycarbonate, Specialized Coatings, Extra Options, Custom Jobs, Drill Mounts, Prism, etc.	**Member pays Provider:** 70% of the Usual and Customary Fee for non-covered upgrades

This plan has no coverage for Contact Lenses Services, Contact Lens Materials, or Medically Necessary Contact Lenses.

Patient pays U&C for all CL Services and Product

No Material Copays for Frames or Lenses.

Provider collects 70% of the U&C difference between Covered U&C and Purchased Material U&C

Any overage charges + Exam Copay + Imaging Fees are due at the time of visit and/or order by the member.

***Standard SV, bifocal, and trifocal lenses within Rx power up to +/- 7.00ph with -4.25 cylinder and up to +3.00 add power are included in Plan 501.**

**** Pediatric Patients are dependents age 18 and under.**

****CA Prop. 65 Warning: Polycarbonate product contains a chemical known to the State of CA to cause birth defects or other reproductive harm.**

EYEMAX 515 PROVIDER Reimbursement Explanation

Benefit Intervals

Description of Coverage	Frequency
Eye Exam, Ophthalmic Lenses, Contact Lens Fitting and Lenses	Once every 12-months, renewing January 1st
Ophthalmic Frames	Once every 24-months, renewing January 1st

Eye Examination Benefit

Eye Examination	TOTAL EXAM BENEFIT TO PROVIDER
Comprehensive Examination + Refraction (New or Established Member)	**$70 ($60 EyeMax Reimbursement + $10 Patient Exam Copay)**
Fundus Photography or OCT (Digital Retinal Imaging)	Available to Members at **70% of YOUR U&C** Payable to provider at time of service. All other procedures must still be performed. This is not a substitute for dilation if indicated (diabetes, etc.).

Dispensing/Lab Fees – Paid Directly to Provider by EyeMax

	Dispensing Fee – 1 Pair	Lab Fee – 1 Pair
SV – Lenses Only	$15.00	$15
BiFocal – Lenses Only	$20.00	$20
Trifocal & Progressive – Lenses Only	$30.00	$30

Lens and Coating Coverage

Single Vision, Bifocal, Trifocal - Clear Basic Scratch Resistant Coating included.	**Only CR39 Covered** **(Polycarbonate Covered** *for pediatric patients only)* 1

Frame Benefit

Frame covered up to $130 retail allowance. (Provider Receives $50 towards frame from EyeMax)

Member pays provider additional 80% of the difference between the U&C Frame Retail and the $130 allowance. No Material Co-Pay from the Patient.

Upgrades, Premium Lenses, Coatings, and any uncovered materials or service

Including, but not limited to: High-Index Lenses, Polycarbonate, Specialized or Upgraded Coatings, Polarization, Photochromic, Extra Options, Custom Jobs, Drill Mounts, Prism, etc.	**$25 material Copay** **Member lower negotiated plan fees for upgrades according to the Additional Options Sheet.**

Contact Lenses

CL Fitting Services	CL Materials (in lieu of glasses)

EYEMAX VISION PLAN

Standard CL Fitting Member Pays $25 copay	Member has $130 material allowance - reimbursed to provider by EyeMax Member pays Provider 85% of difference between lens cost and $130 allowance
Specialty CL Fitting Member Pays $25 copay + 85% of U&C for all charges over $60 EyeMax Pays $35 to Provider	Member has $130 material allowance - reimbursed to provider by EyeMax Member pays Provider 85% of difference between lens cost and $130 allowance

EYEMAX 515 PROVIDER Reimbursement Explanation

Provider collects 85% of the U&C difference between Covered U&C and Purchased Material U&C

Any overage charges + Exam Copay + Imaging Fees are due at the time of visit and/or order by the member.

ADDITIONAL OPTIONS

LENS OPTIONS AND ADD-ONs	MEMBER COST for UPGRADE
LENS MATERIAL UPGRADES	
Polycarbonate Lenses for age 19 and up (18 and under, included at $0 cost) [1,2]	$30
High-Index Lenses	$55
AR ADD-ONs	
Standard Anti-Reflective Coating (AR)	$35
Premium Anti-Reflective Coating (AR)	$48
Ultra-Anti-Reflective Coating (AR)	$60
PROGRESSIVE ADD-ONs	
Standard Progressive Lenses	$50
Premium Progressive Lenses	$90
Ultra-Progressive Lenses	$140
MISCELLANEOUS ADD-ONs	
Photochromic Lenses	$65
Polarized Lenses	$75
Ultra-Violet Coating	$12
Tinting	$30

1 **Pediatric Patients are dependents age 18 and under.**
2 **CA Prop. 65 Warning: Polycarbonate product contains a chemical known to the State of CA to cause birth defects or other reproductive harm.** 3 **Discounts may not apply at Walmart, Costco, Sam's Club, or other big box corporate locations.**

EyeMax Vision Plan, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION III – QUALITY MANAGEMENT	
III.H – Encouraging Nonpharmacological Treatments	Exhibit Type: J-9
QAC Chair:	Approved on:

III.H1- PURPOSE

Nonpharmacological therapies seek to give patients a sense of control and decrease fear, distress, anxiety, and pain without the use of medications. Nonpharmacological therapies are relatively inexpensive and safe when compared with traditional pharmacological treatments. Pursuant to AB 2585, as codified in Health & Safety Code § 124962, EyeMax Vision Plan, Inc. ("EyeMax" or the "Plan") encourages the use of evidence-based non-pharmacological therapies for pain management.

III.H2- SCOPE & RESPONSIBILITIES

This policy applies to all network providers and staff who work for or with the Plan and their network providers. The Optometric Director and/or SVP of Quality Management and Plan/Network Operations shall be responsible for the development and implementation of this policy.

1. Policy & Procedures

EyeMax encourages providers to use evidence-based, nonpharmacological therapies when addressing patients' pain management. Whenever possible, Plan providers should coordinate with a patient's primary care provider before prescribing any Schedule II prescription medications, and work with the primary care provider to identify appropriate evidence-based nonpharmacological therapies that may help the patient.

Examples of nonpharmacological treatments that a provider may discuss with their patients include, but are not limited to, education, acupuncture, psychological conditioning, biofeedback, electrical stimulation, meditation, and psychotherapy. However, not all therapies may be appropriate for a patient's condition. In accordance with the accepted standards of care, providers should give consideration to a patient's age, development level, medical history, prior experiences, current degree of pain, and/or anticipated pain when determining a course of treatment.

All newly-contracted Plan providers shall be given a copy of this policy. Providers should contact the Plan if they need additional information or support in encouraging patients to pursue nonpharmacological therapies. Providers are also encouraged to stay up-to-date on new developments in nonpharmacological therapies by participating in continuing education on the topic.

2. Additional Resources for Providers

Additional information and resources can be found at:

- https://medlineplus.gov/nondrugpainmanagement.html
- https://www.cdc.gov/opioids/patients/options.html
- https://stanfordhealthcare.org/medical-conditions/pain/pain/treatments/non-pharmacological-pain-management.html