Proposal to Serve

New York State Department of Civil Service

New York State Vision Plan Services

ADMINISTRATIVE - REDACTED

January 1, 2022

Empire BlueCross

An Anthem Company

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New York State Department of Civil Service Administrative Proposal - **Redacted**

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Section 1

Administrative Proposal Requirements

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SECTION 4: ADMINISTRATIVE PROPOSAL

This section of the RFP sets forth the requirements for the Offeror's Administrative Proposal. The Department will consider for evaluation and selection purposes only those Proposals the Department determines to be in compliance with the requirements set forth in this section of the RFP. Any Offeror which fails to satisfy any of these requirements shall be eliminated from further consideration.

The Offeror's *Administrative Proposal* must respond to all of the following items as set forth below in the order and format specified and using the forms set forth in this RFP. Additional details pertaining to the required forms are found in Section 2 of this RFP.

Acknowledged.

4.1 Formal Offer Letter

The Offeror must submit a formal offer in the form of the *Formal Offer Letter* (Attachment 3). The formal offer must be signed and executed by an individual with the capacity and legal authority to bind the Offeror in its offer to the State. The copy of the Offeror's Administrative Proposal marked "ORIGINAL" requires a letter with an original signature; the remaining copies of the Offeror's Administrative Proposal may contain photocopies of the signature. Except as otherwise permitted under section 2.1(7), Bid Deviations, the Offeror must accept the terms and conditions as set forth in this RFP, *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), *Information Security Requirements* (Appendix C) and *Glossary for Appendix B and C* (Appendix C-1), and agree to enter into a Contractual Agreement with the Department containing, at a minimum, the terms and conditions identified in this RFP and appendices as cited herein. If an Offeror proposes to include the services of a Subcontractor(s) or Affiliate(s), the Offeror must be required to assume responsibility for those services as "Prime Contractor." The Department will consider the Prime Contractor solely responsible for contractual matters.

Confirmed. Please refer to Appendix A for the completed Attachment 3.

4.2 Offeror Attestation Form

The Offeror must complete and submit an executed copy of the *Offeror Attestations* Form (Attachment 13) attesting that it meets or exceeds the criteria for eligibility to bid as set forth in Section 1 of this RFP. A person legally authorized to represent the Offeror must execute this certification.

Confirmed. Please refer to Appendix B for the completed Attachment 13.

4.3 Subcontractors or Affiliates

The Offeror must complete the *Subcontractors or Affiliates* form (Attachment 9) to identify all Subcontractors or Affiliates with whom the Offeror subcontracts to provide Project Services. For purposes of reporting in the *Subcontractors or Affiliates* form (Attachment 9), Subcontractors include (1) all vendors who will provide $100,000 or more in Project Services over the term of the Contract that results from this RFP and (2) any vendor who will provide Project Services in an amount lower than the $100,000 threshold, and who is a part of the Offeror's Account Team (described in section 3.1, Account Team). For each Subcontractor identified, the Offeror must complete and submit the *Subcontractors or Affiliates* form (Attachment 9) and indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Subcontractor for services to be provided by such subcontractor relating to the RFP. For the purpose of this RFP, Affiliate is defined as a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent. On the *Subcontractors or Affiliates* (Attachment 9) form, the Offeror must:

1. Mark the applicable box if the Offeror will not be subcontracting with any Subcontractor(s) or Affiliate(s) to provide Project Services.
2. Indicate whether or not, as of the date of the Offeror's Proposal, a subcontract (or shared services agreement) has been executed between the Offeror and the Subcontractor or Affiliate for services to be provided by the Subcontractor or Affiliate relating to this RFP.
3. Provide a brief description of the services to be provided by the Subcontractor or Affiliate.
4. Provide a description of any current relationships with such Subcontractor or Affiliate and the clients/projects that the Offeror and Subcontractor or Affiliate are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

Confirmed. Please refer to Appendix C for the completed Attachment 9 forms.

4.4 New York State Standard Vendor Responsibility Questionnaire

The Offeror must complete and submit an executed copy of the New York State Vendor Responsibility Questionnaire. A person legally authorized to represent the Offeror must execute the questionnaire. The questionnaire must be completed by all Subcontractors as defined above.

The Department recommends each Offeror file the required Questionnaire online via the New York State VendRep System. To use the VendRep System, please refer to https://www.osc.state.ny.us./vendors/index.htm.

By submitting a Proposal, the Offeror agrees to fully and accurately complete the Questionnaire. The Offeror acknowledges that the State's execution of the Contract will be contingent upon the State's determination that the Offeror is responsible, and that the State will rely on the Offeror's responses to the Questionnaire when making its responsibility determination. The Offeror agrees that if it is found by the State that the Offeror's responses to the Questionnaire were intentionally false or intentionally incomplete, on such finding, the Department may terminate the Contract. In no case shall such termination of the Contract by the State be deemed a breach thereof, nor shall the State be liable for any damages for lost profits or otherwise, which may be sustained by the Contractor as a result of such termination.

Confirmed. As requested, we completed the New York State Vendor Responsibility Questionnaire and coordinated the completion of the questionnaire by our subcontractors.

4.5 New York State Tax Law Section 5-a

Tax Law § 5-a requires certain Offerors awarded state Contracts for commodities, services and technology valued at more than $100,000 to certify to New York State Department of Taxation and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to Contracts where the total amount of such Offeror's sales delivered into New York State is in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any Affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

An Offeror is required to file the completed and notarized Form ST-220-CA with the Department certifying that the Offeror filed the ST-220-TD with DTF. The Offeror should complete and return the certification forms within five Business Days from the date of request (if the forms are not completed and returned with bid submission). Failure to make either of these filings may render an Offeror non-responsive and non-responsible. The Offeror must take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

Website links to the Offeror certification forms and instructions are provided below.

1 Form ST-220-TD must be filed with and returned directly to DTF and can be found at http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the Offeror, its Affiliate(s), or its subcontractor(s), a new Form ST-220-TD must be filed with DTF.

   Confirmed. Per the instructions, we submitted Form ST-220-TD directly to The New York State Department of Civil Service (Department) on July 16, 2021.

2 Form ST-220-CA must be submitted to the Department. This form provides the required certification that the Offeror filed the ST-220-TD with DTF. This form can be found at http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf

   Confirmed. Please refer to Appendix D for the completed Form ST-220-CA.

4.6 Compliance with New York State Workers' Compensation Law

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any Contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a Contract with the Department, the selected Offeror and Subcontractor(s) or Affiliates, with more than $100,000 in expected expenses over the life of the Contract, if any, will be required to verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed in Compliance with *NYS Workers' Compensation Law* (Attachment 10). Any questions relating to either workers' compensation or disability benefits coverage should be directed to the New York State Workers' Compensation Board, Bureau of Compliance at 518-486-6307. You may also find useful information on their website: http://www.wcb.ny.gov.

Submission of the proof of workers' compensation and disability benefits insurance coverage is required at the time of Proposal submission. Failure to provide verification of either of these types of insurance coverage with the Offeror's Administrative Proposal may be grounds for disqualification of an otherwise successful Proposal.

To the extent that the Offeror is proposing the use of Subcontractors or Affiliates, the Offeror must verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that the Subcontractors or Affiliates are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

Confirmed. Please refer to Appendix E for evidence of workers' compensation and disability benefits coverage.

4.7 Insurance Requirements

Prior to the start of work the Offeror shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of any Contract resulting from this RFP, policies of insurance as required by this section, written by companies that have an A.M. Best Company rating of "A-," Class "VII" or better. In addition, companies writing insurance intended to comply with the requirements of this Section 4.7 should be licensed or authorized by the New York State Department of Financial Services to issue insurance in the State of New York. The Department may, in its sole discretion, accept policies of insurance written by a non-authorized carrier or carriers when certificates and/or other policy documents are accompanied by a completed Excess Lines Association of New York (ELANY) affidavit or other documents demonstrating the company's strong financial rating. If, during the term of a policy, the carrier's A.M. Best rating falls below "A-," Class "VII," the insurance must be replaced, on or before the renewal date of the policy, with insurance that meets the requirements above. These policies must be written in accordance with the requirements of the paragraphs below, as applicable.

An Offeror shall deliver to the Department evidence of the insurance required by this RFP and any Contract resulting from this RFP in a form satisfactory to the Department. Policies must be written in accordance with the requirements of the paragraphs below, as applicable. While acceptance of insurance documentation shall not be unreasonably withheld, conditioned or delayed, acceptance and/or approval by

the Department does not, and shall not be construed to, relieve an Offeror of any obligations, responsibilities or liabilities under this RFP or any Contract resulting from this RFP.

The Offeror shall not take any action, or omit to take any action that would suspend or invalidate any of the required coverages during the term of any Contract resulting from this RFP.

1 **General Conditions**

a All policies of insurance required by this Solicitation or any Contract resulting from this RFP shall comply with the following requirements:

i Coverage Types and Policy Limits. The types of coverage and policy limits required from the selected Offeror are specified in paragraph 12 *Specific Coverages and Limits* below.

[redacted]

ii Policy Forms. Except as may be otherwise specifically provided herein, or agreed to in any Contract resulting from this RFP, all policies of insurance shall be written on an occurrence basis.

[redacted]

iii Certificates of Insurance/Notices. The selected Offeror shall provide the Department with a Certificate or Certificates of Insurance, in a form satisfactory to the Department, as detailed below, and pursuant to the timelines set forth in paragraph 11 below. Certificates should reference the Solicitation or award number and shall name the New York State Department of Civil Service, Agency Building 1, Empire State Plaza, Albany, NY 12239, as the certificate holder.

[redacted]

b Certificates of Insurance shall:

i Be in the form acceptable to the Department and in accordance with the New York State Insurance Law (e.g., an ACORD certificate);

[redacted]

ii Disclose any deductible, self-insured retention, aggregate limit or any exclusion to the policy that materially changes the coverage required by this Solicitation or any Contract resulting from this Solicitation;

[redacted]

iii Be signed by an authorized representative of the insurance carrier of the referenced insurance carriers; and

[redacted]

iv Contain the following language in the Description of Operations / Locations / Vehicles section of the Certificate or on a submitted endorsement as applicable: Additional insured protection afforded is on a primary and non-contributory basis. A waiver of subrogation is granted in favor of the additional insureds.

[redacted]

c Only original documents (Certificates of Insurance and any endorsements and other attachments) or electronic versions of the same that can be directly traced back to the insurer, agent or broker via e-mail distribution or similar means will be accepted.

The Department generally requires an Offeror to submit only certificates of insurance and additional insured endorsements, although the Department reserves the right to request other proof of insurance. An Offeror should refrain from submitting entire insurance policies, unless specifically requested by the Department. If an entire insurance policy is submitted but not requested, the Department shall not be obligated to review and shall not be chargeable with knowledge of its contents. In addition, submission of an entire insurance policy not requested by the Department does not constitute proof of compliance with the insurance requirements and does not discharge an Offeror from submitting the requested insurance documentation.

Confirmed. Please refer to Appendix F for our insurance certificates and endorsements.

2 **Primary Coverage**

All liability insurance policies where the Department is required to be included as an additional insured, shall provide that the required coverage shall be primary and non-contributory to other insurance available to the Department and their officers, agents, and employees. Any other insurance maintained by the Department and their officers, agents, and employees shall be excess of and shall not contribute with the Offeror's insurance. Insurance policies that remove or restrict blanket contractual liability located in the "insured contract" definition (as generally stated in Section V, Number 9, Item f in the Insurance Services Offices (ISO) Commercial General Liability (CGL) policy) so as to limit coverage against Claims that arise out of the work, or that remove or modify the "insured contract" exception to the employers liability exclusion, or that do not cover the Additional Insured for Claims involving injury to employees of the Named Insured or subcontractors, are not acceptable.

Confirmed.

3 **Breach for Lack of Proof of Coverage**

The failure to comply with the requirements of this RFP at any time during the term of any Contract resulting from this Solicitation shall be considered a breach of the terms of any Contract resulting from this Solicitation and shall allow the Department and their officers, agents, and employees to avail themselves of all remedies available under any Contract resulting from this Solicitation, at law or in equity.

Confirmed.

4 **Self-Insured Retention/Deductibles**

Certificates of Insurance must indicate the applicable deductibles/self-insured retentions for each listed policy. Deductibles or self-insured retentions above $100,000.00 are subject to approval from the Department. Such approval shall not be unreasonably withheld, conditioned or delayed. An Offeror shall be solely responsible for all claim expenses and loss payments within the deductibles or self-insured retentions. If the Offeror is providing the required insurance through self-insurance, evidence of the financial capacity to support the self-insurance program along with a description of that program, including, but not limited to, information regarding the use of a third-party administrator shall be provided upon request.

[redacted]

5 **Subcontractors**

Prior to the commencement of any work by a Subcontractor, the Offeror shall require such Subcontractor to procure policies of insurance as required by this section and maintain the same in force during the term of any work performed by that Subcontractor. An Additional Insured Endorsement (ISO coverage form CG 20 38 04 13), or the equivalent, evidencing such coverage shall be provided to the Offeror prior to the commencement of any work by a subcontractor and pursuant to the timelines set forth in Section 4.7(11) of this RFP, as applicable, and shall be provided to the Department upon request. For subcontractors that are self-insured, the subcontractor shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the subcontractor would have been required to pursuant to this section had the subcontractor obtained such insurance policies.

[redacted]

6 **Waiver of Subrogation**

For all liability policies with the exception of professional and cyber liability, the Offeror shall cause to be included in its policies insuring against loss, damage or destruction by fire or other insured casualty a waiver of the insurer's right of subrogation against the Department and their officers, agents, and employees, or, if such waiver is unobtainable (i) an express agreement that such policy shall not be invalidated if the Offeror waives or has waived before the casualty, the right of recovery against the Department and their officers, agents, and employees or (ii) any other form of permission for the release of the Department any entity authorized by law or regulation to use any Contract resulting from this Solicitation and their officers, agents, and employees. A Waiver of Subrogation Endorsement shall be provided upon request. A blanket Waiver of Subrogation Endorsement evidencing such coverage is also acceptable.

[redacted]

7 **Additional Insured**

The Offeror shall cause to be included in each of the liability policies (except Professional Liability and Date Breach/Cyber Liability) required below coverage for on-going and completed operations naming as additional insureds (via ISO coverage forms CG 20 10 04 13 or 20 38 04 13 and CG 20 37 04 13 and form CA 20 48 10 13, or a form or forms that provide equivalent coverage): the Department and their officers, agents, and employees. An Additional Insured Endorsement evidencing such coverage shall be provided to the Department pursuant to the timelines set forth in Section 11 below. A blanket Additional Insured Endorsement evidencing such coverage is also acceptable.

For Offerors who are self-insured, the Offeror shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the Offeror would have been required to pursuant to this RFP had the Contractor obtained such insurance policies.

[redacted]

8 **Excess/Umbrella Liability Policies**

Required insurance coverage limits may be provided through a combination of primary and excess/umbrella liability policies. If coverage limits are provided through excess/umbrella liability policies, then a Schedule of underlying insurance listing policy information for all underlying insurance policies (insurer, policy number, policy term, coverage and limits of insurance), including proof that the excess/umbrella insurance follows form must be provided upon request.

Unrelated underlying policies included in the Schedule that are not required to meet the insurance requirements may be redacted from the Schedule.

[redacted]

9 **Notice of Cancellation or Non-Renewal**

Policies shall be written so as to include the requirements for notice of cancellation or non-renewal in accordance with the New York State Insurance Law. Within five Business Days of receipt of any notice of cancellation or non- renewal of insurance, the Offeror shall provide the Department with a copy of any such notice received from an insurer together with proof of replacement coverage that complies with the insurance requirements of this Solicitation and any Contract resulting from this Solicitation.

Confirmed.

10 **Policy Renewal/Expiration**

Upon policy renewal/expiration, evidence of renewal or replacement of coverage that complies with the insurance requirements set forth in this Solicitation and any Contract resulting from this Solicitation shall be delivered to the Department. If, at any time during the term of any Contract resulting from this Solicitation, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Solicitation or any Solicitation and any Contract resulting from this Solicitation, or proof thereof is not provided to the Department, the Offeror shall immediately cease work. The Offeror shall not resume work until authorized to do so by the Department.

Confirmed.

11 **Deadlines for Providing Insurance Documents after Renewal or Upon Request**

As set forth herein, certain insurance documents must be provided to the Department contact identified in the Contract Award Notice after renewal or upon request. This requirement means that the Offeror shall provide the applicable insurance document to the Department as soon as possible but in no event later than the following time periods:

a For certificates of insurance: five Business Days from request or renewal, whichever is later;

b For information on self-insurance or self-retention programs: fifteen Calendar Days from request or renewal, whichever is later;

c For other requested documentation evidencing coverage: fifteen Calendar Days from request or renewal, whichever is later;

d For additional insured and waiver of subrogation endorsements: thirty Calendar Days from request or renewal, whichever is later; and

e For notice of cancellation or non-renewal and proof of replacement coverage that complies with the requirements of this section: five Business Days from request or renewal, whichever is later.

Notwithstanding the foregoing, if the Offeror shall have promptly requested the insurance documents from its broker or insurer and shall have thereafter diligently taken all steps necessary to obtain such documents from its insurer and submit them to the Department, the Department shall extend the time period for a reasonable period under the circumstances, but in no event shall the extension exceed thirty Calendar Days.

Confirmed.

12 **Specific Coverage and Limits**

a Commercial General Liability

Commercial General Liability Insurance, (CGL) shall be written on the current edition of ISO occurrence form CG 00 01, or a substitute form providing equivalent coverage and shall cover liability arising from premises operations, independent contractors, products-completed operations, broad form property damage, personal & advertising injury, cross liability coverage, and liability assumed in a contract (including the tort liability of another assumed in a contract).

Policy shall include bodily injury, property damage, and broad form contractual liability coverage. The limits under such policy shall not be less than the following:

i Each Occurrence – $2,000,000

ii General Aggregate – $2,000,000

iii Products/Completed Operations – $2,000,000

iv Personal Advertising Injury – $1,000,000

v Medical Expense – $5,000

Coverage shall include, but not be limited to, the following:

i Premises liability;

ii Independent contractors/subcontractors;

iii Blanket contractual liability, including tort liability of another assumed in a contract;

iv Defense and/or indemnification obligations, including obligations assumed under any Contract resulting from this Solicitation;

v Cross liability for additional insureds;

vi Products/completed operations for a term of no less than 1 year, commencing upon acceptance of the work, as required by the Contract;

The CGL policy, and any umbrella/excess policies used to meet the “Each Occurrence” limits specified above, must be endorsed to be primary with respect to the coverage afforded the Additional Insureds, and such policy(ies) shall be primary to, and non-contributing with, any other insurance maintained by the Department. Any other insurance maintained by the Department shall be excess of and shall not contribute with the Contractor’s or Subcontractor’s insurance, regardless of the “Other Insurance” clause contained in either party’s policy(ies) of insurance, if applicable.

Confirmed.

b Business Automobile Liability Insurance

The Offeror shall maintain Business Automobile Liability Insurance in the amount of at least $1,000,000 each occurrence, covering liability arising out of any automobile used in connection with performance under any Contract resulting from this RFP, including owned, leased, hired and non- owned automobiles bearing or, under the circumstances under which they are being used, required by the Motor Vehicles Laws of the State of New York to bear, license plates.

Confirmed.

c Professional Errors and Omissions Insurance

The Offeror shall maintain Professional Errors and Omissions (Professional Liability) in the amount of at least $10,000,000 each occurrence, for claims arising out of but not limited to delay or failure in diagnosing a disease or condition and alleged wrongful acts, including breach of contract, bad faith and negligence. Such insurance shall apply to professional errors, acts, or omissions arising out of the scope of services.

i Such insurance shall include coverage of all professionals and technical personnel whose actions could be considered “professional services” arising out of the scope of services as additional named insureds.

ii If coverage is written on a claims-made policy, the Offeror warrants that any applicable retroactive date precedes the start of work; and that continuous coverage will be maintained, or an extended discovery period exercised, throughout the performance of the services and for a period of not less than three years from the time work under any Contract resulting from this Solicitation is completed. Written proof of this extended reporting period must be provided to the Department upon request.

iii The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of any Contract resulting from this Solicitation.

[redacted]

d Technology Errors & Omissions Insurance

The Offeror shall maintain, during the term of any Contract, Technology Errors and Omissions Insurance in the amount of at least $10,000,000 each occurrence, for claims for damages arising from computer-related services including, but not limited to, the following: consulting, data processing, programming, system integration, hardware or software development, installation, distribution or maintenance, systems analysis or design, training, staffing or other support services, any electronic equipment, computer software developed, manufactured, distributed, licensed, marketed or sold. The policy shall include coverage for third party fidelity including cyber theft if coverage is not met in a Data Breach and Privacy/Cyber Liability policy or a Fidelity/Employee Dishonesty policy.

If the policy is written on a claims-made basis, the Offeror must provide to the Department proof that the policy provides the option to purchase an Extended Reporting Period (tail coverage) providing coverage for no less than one year after work is completed in the event that coverage is canceled or not renewed. This requirement applies to both primary and excess liability policies, as applicable.

[redacted]

e Data Breach/Privacy/Cyber Liability Insurance

An Offeror is required to maintain during the term of any Contract and as otherwise required herein, Data Breach and Privacy/Cyber Liability Insurance in the amount of at least $10,000,000 each occurrence, including coverage for failure to protect confidential information and failure of the security of the Offeror's computer systems or the Department systems due to the actions of the Offeror which results in unauthorized access to the Department or their data. Coverage may be satisfied through alternative insurance policies.

Said insurance shall provide coverage for damages arising from, but not limited to the following:

i Breach of duty to protect the security and confidentiality of nonpublic proprietary corporate information;

ii Personally identifiable nonpublic information (e.g., medical, financial, or personal in nature in electronic or non-electronic form);

iii Privacy notification costs;

iv Regulatory defense and penalties;

v Website media liability; and

vi Cyber theft of customer's property, including but not limited to money and securities, unless coverage is provided under a Fidelity/Employee Dishonesty policy or bond (subject to verification by the State)

[redacted]

Section 2

Formal Offer Letter

Empire BlueCross

An Anthem Company

Empire BlueCross

An Anthem Company

Date: July 26, 2021

NYS Department of Civil Service
Agency Building #1, 17th Floor
Empire State Plaza
Albany, New York 12239

RE: Request for Proposals entitled:
"New York State Vision Plan Services"
Firm Offer to the State of New York

Empire HealthChoice Assurance, Inc. d/b/a Empire BlueCross hereby submits this firm and binding offer to the State of New York in response to the Department's Request for Proposals (RFP), entitled "New York State Vision Plan Services". The Proposal hereby submitted meets or exceeds all terms, conditions, and requirements set forth in the above-referenced RFP and in the manner set forth in this RFP.

Empire HealthChoice Assurance, Inc. accepts the terms and conditions as set forth in RFP and *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), *Information Security Requirements* (Appendix C), and *Glossary for Appendix B & C* (Appendix C-1), as modified by the Department and Offeror's negotiations in response to the *Non- Material Deviations Template* (Attachment 8) and agrees to satisfy the comprehensive programmatic duties and responsibilities outlined in this RFP in the manner set forth in this RFP.

Empire HealthChoice Assurance, Inc. agrees to execute a Contract that includes the terms and conditions set forth in the RFP, and accepts as non-negotiable the terms and conditions set forth in Standard Clauses for New York State Contracts (Appendix A), Standard Clauses for All Department Contracts (Appendix B), Information Security Requirements (Appendix C), and Glossary for Appendix B & C (Appendix C-1), except as modified by the Department and Offeror's negotiations in response to the *Non-Material Deviations Template* (Attachment 8).

Empire HealthChoice Assurance, Inc. further agrees, if selected as a result of the RFP, to comply with 1) the provisions of Tax Law Section 5-a, Certification Regarding Sales and Compensating Use Tax; and 2) the Workers' Compensation Law as set forth in Section 4.5 and 4.6 of the RFP.

This formal offer will remain firm and non-revocable for a minimum period of 180 days from the Proposal Due Date as set forth in the RFP. In the event that a contract is not approved by the NYS Comptroller within the 180 day period, this offer shall remain firm and binding beyond the 180 day period until a contract is approved by the NYS Comptroller, unless **Empire HealthChoice Assurance, Inc.** delivers to the Department of Civil Service written notice withdrawing its Proposal.

Empire HealthChoice Assurance, Inc.'s complete offer is set forth as follows:

Administrative and Technical Proposal:
Total of eight (8) electronic copies on a USB drive that each contain the Administrative and Technical Proposal and three (3) hard copy volumes, including one ORIGINAL hard copy.

Financial Proposal:
Total of eight (8) electronic copies on a USB drive and three (3) hard copy volumes, including one ORIGINAL hard copy.

Complete Electronic Master Proposal:
One (1) USB drive containing all three sections (Administrative, Technical AND Financial) of the Offeror's Proposal and electronic copies of all materials and documents present in the Original hard copies.

Offeror's Senior Officer Responsible for Account contact information

Name:
Alan Murray

Address:
14 Wall Street New York, New York 10005

Phone number:
[redacted]

Email address:
[redacted]

(Remainder of this page intentionally left blank)

The undersigned affirms and swears s/he has the legal authority and capacity to sign and make this offer on behalf of, **Empire HealthChoice Assurance, Inc.** and possesses the legal authority and capacity to act on behalf of **Empire HealthChoice Assurance, Inc.** to execute a contract with the State of New York.

The Offeror certifies that all information provided to the Department with respect to State Finance Law §139-k is complete, true and accurate. The undersigned affirms and swears as to the truth and veracity of all documents included in this offer.

Empire HealthChoice Assurance, Inc.

Signature: [redacted] **Title: President**

PRINT SIGNATORY'S NAME: Alan Murray **Date:** 7/17/21

INDIVIDUAL, CORPORATION, PARTNERSHIP, OR LLC ACKNOWLEDGMENT STATE OF }

Sworn Statement:

COUNTY OF }

On the 17 day of July in the year 20 21, before me personally appeared Alan Murray, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that he maintains an office at Town of New York
County of New York, State of New York; and further that:

____ **(If an individual):** he executed the foregoing instrument in his/her name and on his/her own behalf.

X **(If a corporation):** he is the President of Empire HealthChoice Assurance, Inc., the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

____ **(If a partnership):** he is the _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

____ **(If a limited liability company):** he is a duly authorized member of _____

_____, LLC, the limited liability company described in said instrument; that, _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public [redacted] Date: 07/17/2021

(x) Physically Appeared

NOTARY PUBLIC STATE OF FLORIDA

MUHAMMAD AAMIR
Commission # GG 942572
Expires April 25, 2024
Bonded Thru Budget Notary Services

Section 3

Offeror Attestations Form

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"

A representative of the Offeror who is legally authorized to bind the Offeror must complete and sign the Offeror Attestations Form and provide all requested information.

Name of Business Entity Submitting Bid:		Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross
Entity's Legal Form:		✓ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other _____
No.	**RFP Ref.**	**RFP Requirement:**
1.	Section 1.4(1)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ possesses ☐ does not possess the legal capacity to enter into a contract with the Department.
2.	Section 1.4(2)	At time of Proposal Due Date, the Offeror represents and warrants that it: ✓ possesses the authorization to conduct business in New York State. ☐ does not possess the authorization to conduct business in New York State. ☐ does not possess the authorization to conduct business in New York State, but the Offeror has filed an application for authority to do business in New York State with the New York State Secretary of State.
3.	Section 1.4(3)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ does not attest has completed, obtained or performed all registrations, filings, approvals, authorizations, consents and examinations required by any governmental authority for the provision of the delivery of Project Services (as detailed in Section 3 of this RFP) and agrees that it will, during the term of the Contract, comply with any requirements imposed upon it by law or regulation.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"**

4.	Section 1.4(4)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest is currently providing vision services, similar to those as set forth in the RFP, for a minimum of 500,000 covered lives in total and with at least one current client with at least 100,000 covered lives.
5.	Section 1.4(5)	At time of Contract Start Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest shall retain staff with the appropriate experience relevant to the duties and responsibilities outlined in Section 3 of this RFP; establish appropriate minimum qualifications for individuals filling positions slated to service the Vision Plan in the future; and possess the necessary account services, enrollment, claims processing, clinical management, and customer service staff levels, located in facilities within the Continental United States, to service the Vision Plan.
6.	Section 1.4(6)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest possesses adequate staffing resources, financial resources, and organizational capacity to perform the type, magnitude, and quality of work specified in the RFP.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"**

7.	Section 1.4(7)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest must agree to contractual provisions to maintain and make available as required by the State, a complete and accurate set of records for review by the State. Contractual provisions are set forth in the RFP and *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), and *Information Security Requirements* (Appendix C). Such records shall include any and all financial records deemed necessary by the State to discharge its fiduciary responsibilities to Program participants and to ensure that public dollars are spent appropriately.
8.	Section 1.4(8)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest agrees to comply with all specific duties and responsibilities set forth in Section 3.2 of this RFP, entitled "Implementation Plan," including Section 3.2(1)(d) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.
9.	Section 1.4(9)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest must administer the Vision Plan in accordance with all State and federal rules, laws and regulations.
10.	Section 1.4(10)	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest that the benefits design cannot deviate from that which has been collectively bargained.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"**

11.	Section 3.1	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.1 of this RFP, entitled "Account Team".
12.	Section 3.3	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.3 of this RFP, entitled "Participating Provider Network Management".
13.	Section 3.4	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.4 of this RFP, entitled "Customer Service".
14.	Section 3.5	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.5 of this RFP, entitled "Reporting Services".

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"**

15.	Section 3.6	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.6 of this RFP, entitled "Enrollee and Provider Communication Support".
16.	Section 3.7	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.7 of this RFP, entitled "Enrollment Management".
17.	Section 3.8	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.8 of this RFP, entitled "Claims Processing".
18.	Section 3.9	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.9 of this RFP, entitled "Occupational Vision Program".

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"**

19.	Section 3.10	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.10 of this RFP, entitled "Medical Exception Program".
20.	Section 3.11	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.11 of this RFP, entitled "Upgrade Program".
21.	Section 3.12	At time of Proposal Due Date, Offeror represents and warrants that it: ✓ attests ☐ acknowledges and agrees subject to the non-material deviation listed in Attachment 8 ☐ does not attest will comply with all specific duties and responsibilities set forth in Section 3.12 of this RFP, entitled "Transition and Termination of Contract".

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Offeror Attestations Form - RFP entitled: "New York State Vision Plan Services"

CERTIFICATION:
The Offeror: (1) recognizes that the following representations are submitted for the express purpose of assisting the State of New York in making a determination to award a contract; (2) ackn[redacted]y submitting the Attestation, that the State may at its discretion [redacted]curacy of all statements made herein; and (3) certifies that the [redacted]n this certification and any attached documentation is tru[redacted]ete

Signature: _____
Title: President

PRINT SIGNATORY'S NAME: Alan Murray
Date: 7/17/21

INDIVIDUAL, CORPORATION, PARTNERSHIP, OR LLC ACKNOWLEDGMENT
STATE OF }

Sworn Statement:

COUNTY OF }

On the 17 day of July in the year 2021, before me personally appeared Alan Murray, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that _he maintains an office at
Town
of New York

County of New York, State of New York; and further that:

____ **(If an individual):** _he executed the foregoing instrument in his/her name and on his/her own behalf.

X **(If a corporation):** _he is the
President of
Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

____ **(If a partnership):** _he is the
_____ of
_____, the partnership described in said

instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

____ (If a limited liability company): _he is a duly authorized member of _____ _____, LLC, the limited liability company described in said instrument; that, _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public: [redacted] Date: 07/17/2021

MUHAMMAD AAMIR
Commission # GG 942572
Expires April 25, 2024
Bonded Thru Budget Notary Services

(x) Physically Appeared

Section 4

Subcontractors or Affiliates

Empire BlueCross

An Anthem Company

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Subcontractors or Affiliates RFP entitled: "New York State Vision Plan Services"

INSTRUCTION: Prepare this form for each Subcontractor or Affiliate. Subcontractors include all vendors who will provide $100,000 or more in Project Services over the term of the Agreement that results from this RFP, as well as any vendor who will provide Project Services in an amount lower than the $100,000 threshold, and who is a part ofthe Offeror's Account Team.	
Offeror's Name:	Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

The Offeror:

- ✓ is
- ☐ is not

proposing to utilize the services of a Subcontractor(s) or Affiliate(s) to provide Project Services

Subcontractor or Affiliate's Legal Name:	EyeMed Vision Care
Business Address:	4000 Luxottica Place, Mason, Ohio
Subcontractor's Legal Form:	✓ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other

As of the date of the Offeror's Proposal, a subcontract or agreement

- ✓ has
- ☐ has not

been executed between the Offeror and the subcontractor(s) or Affiliate for services to be provided by such subcontractor(s) or Affiliate(s) relating to the Project.

In the space provided below, describe the Subcontractor's or Affiliate's role(s) and responsibilities regarding Project Services to be provided:
EyeMed Vision Care is the primary subcontractor for member services, eligibility management, claims processing, and network management.

Relationship between Offeror and Subcontractor or Affiliate for Current Engagements: (Complete items 1 through 5 for each client engagement identified)	
1. Client:	Empire BlueCross
2. Client Reference Name and Phone #	Angela Blessing [redacted]
3. Project Title:	New York State Vision Plan Services
4. Project Start Date:	January 1, 2022
5. In the space provided below, Project Status:	
Ongoing	
6. In the space provided below, describe the roles and responsibilities of the Offeror and Subcontractor or Affiliate in regard to the project identified in 3, above:	
Empire is responsible for administering vision benefits for NYS. EyeMed Vision Care is the primary subcontractor for member services, eligibility management, claims processing, and network management. Vendor partner service level agreements, performance guarantees or similar measures are between our parent company and its sourcing partners. We are solely responsible for performance levels.	

Clarity

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Subcontractors or Affiliates
RFP entitled: "New York State Vision Plan Services"

INSTRUCTION: Prepare this form for each Subcontractor or Affiliate. Subcontractors include all vendors who will provide $100,000 or more in Project Services over the term of the Agreement that results from this RFP, as well as any vendor who will provide Project Services in an amount lower than the $100,000 threshold, and who is a part ofthe Offeror's Account Team.	
Offeror's Name:	Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

The Offeror:

- ✓ is
- ☐ is not

proposing to utilize the services of a Subcontractor(s) or Affiliate(s) to provide Project Services

Subcontractor or Affiliate's Legal Name:	Clarity Software Solutions Inc.
Business Address:	92 Wall Street, Suite 1, Madison, Connecticut 06443
Subcontractor's Legal Form:	✓ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other

As of the date of the Offeror's Proposal, a subcontract or agreement

- ✓ has
- ☐ has not

been executed between the Offeror and the subcontractor(s) or Affiliate for services to be provided by such subcontractor(s) or Affiliate(s) relating to the Project.

In the space provided below, describe the Subcontractor's or Affiliate's role(s) and responsibilities regarding Project Services to be provided:
Clarity Software Solutions supports document management, form creation, and fulfillment (ID cards).

Relationship between Offeror and Subcontractor or Affiliate for Current Engagements: (Complete items 1 through 5 for each client engagement identified)	
1. Client:	Empire BlueCross
2. Client Reference Name and Phone #	Angela Blessing [redacted]
3. Project Title:	New York State Vision Plan Services
4. Project Start Date:	January 1, 2022
5. In the space provided below, Project Status:	
Ongoing	
6. In the space provided below, describe the roles and responsibilities of the Offeror and Subcontractor or Affiliate in regard to the project identified in 3, above:	
Empire is responsible for administering vision benefits for NYS. Clarity Software Solutions supports document management, form creation, and fulfillment (ID cards). Vendor partner service level agreements, performance guarantees or similar measures are between our parent company and its sourcing partners. We are solely responsible for performance levels.	

Section 5

New York State Tax Law Section 5-a: Form ST-220-CA

Empire BlueCross

An Anthem Company

New York State Department of Taxation and Finance

Contractor Certification to Covered Agency

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-CA (12/11)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help?* on back).

Contractor name Empire HealthChoice Assurance, Inc.				*For covered agency use only* *Contract number or description*
Contractor's principal place of business 14 Wall Street	City New York	State NY	ZIP code 10005	
Contractor's mailing address *(if different than above)*				*Estimated contract value over the full term of contract (but not including renewals)* $
Contractor's federal employer identification number (EIN) 23-7391136	Contractor's sales tax ID number (if different from contractor's EIN)			
Contractor's telephone number [redacted]	Covered agency name New York State Department of Civil Service			
Covered agency address Empire State Plaza, Agency Building 1, Floor 17, Albany, NY 12239				*Covered agency telephone number* [redacted]

I, Tyler P. Juckem *(name)*, hereby affirm, under penalty of perjury, that I am Tax Officer *(title)* of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an **X** *in only one box)*

☒ The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.

☐ The contractor has previously filed Form ST-220-TD with the Tax Department in connection with _____ *(insert contract number or description)* and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this 14 day of July, 20 21

[redacted] *(sign before a notary public)*

Tax Officer *(title)*

Instructions

General information

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency,* with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. See *Need help?* for more information on how to obtain this publication. In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

Note: Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

When to complete this form

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);

ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and

iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of $100,000 and (b) is a contract for *commodities* or *services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned *on or after April 26, 2006* (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF Indiana }
: SS.:
COUNTY OF Marion }

On the 14 day of July in the year 2021, before me personally appeared Tyler P. Juckem,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
_he resides at 220 Virginia Ave,
Town of Indianapolis,
County of Marion,
State of Indiana; and further that:

[Mark an ***X*** in the appropriate box and complete the accompanying statement.]

☐ (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.

☒ (If a corporation): _he is the Tax Officer of EHCA, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ (If a partnership): _he is a _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

☐ (If a limited liability company): _he is a duly authorized member of _____, LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited

[redacted]

Rita F. Gentry
Notary Public
SEAL
Johnson County, State of Indiana
My Commission Expires January 17, 2029
Commission No: NP0641321

Registration No. NP 0641321

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Manager of Document Management, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone (518) 457-5181.

Need help?

Visit our Web site at ***www.tax.ny.gov***
- get information and manage your taxes online
- check for new online services and features

Telephone assistance

Sales Tax Information Center: (518) 485-2889

To order forms and publications: (518) 457-5431

Text Telephone (TTY) Hotline (for persons with hearing and speech disabilities using a TTY): (518) 485-5082

Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, call the information center.

Section 6

Compliance with New York State Workers' Compensation Law

Empire BlueCross

An Anthem Company

Workers' Compensation Evidence of Coverage

Empire BlueCross

An Anthem Company

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/30/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur J. Gallagher & Co.
Insurance Brokers of CA Inc.
505 N. Brand Boulevard, Suite 600
Glendale CA 91203

License#: 0726293

CONTACT NAME: Stephanie Powell
PHONE (A/C, No, Ext): [redacted] **FAX (A/C, No):** [redacted]
E-MAIL ADDRESS: [redacted]

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ACE American Insurance Company	22667
INSURER B : American Zurich Insurance Company	40142
INSURER C : Zurich American Insurance Company	16535
INSURER D : Great American Insurance Company of NY	22136
INSURER E : National Union Fire Insurance Co of LA	32298
INSURER F :	

INSURED
Anthem, Inc. And Its Subsidiaries
2015 Staples Mill Road
Mail Drop VA2001-N350
Richmond VA 23230

ANTHINC-02

COVERAGES **CERTIFICATE NUMBER:** 7597866 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [X] LOC [ ] OTHER:			HDO G72483625	5/1/2021	5/1/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Per Occurence Ded	$ 2,000,000 $ 1,000,000 $ 25,000 $ 2,000,000 $ 25,000,000 $ 2,000,000 $ 2,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS X HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			ISA H25546891	5/1/2021	5/1/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Per Accident Ded	$ 3,000,000 $ $ $ $ 3,000,000
D E	X **UMBRELLA LIAB** [X] OCCUR **EXCESS LIAB** [ ] CLAIMS-MADE DED X RETENTION $ $10,000			UMB 3555292 21335634	5/1/2021 5/1/2021	5/1/2022 5/1/2022	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
B C C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WC9299269-20 EWS5347154-16 WC9376766-19	1/1/2021 1/1/2021 1/1/2021	1/1/2022 1/1/2022 1/1/2022	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 2,000,000 $ 2,000,000 $ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Subject to policy terms, conditions and exclusions.

CERTIFICATE HOLDER

Evidence of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
[redacted]

Proof of Disability Coverage

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

ANDREW M. CUOMO
GOVERNOR

CLARISSA M. RODRIGUEZ
CHAIR

NOTICE OF COMPLIANCE

AS SELF-INSURER UNDER THE NEW YORK STATE
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

Disability Benefits ☑ **Paid Family Leave** ☑

Employer:	Empire HealthChoice Assurance, Inc.
Carrier ID #.:	B903508
FEIN:	23-7391136
Qualification Date (DB):	1/1/2007
Qualification Date (PFL):	7/24/2018

The above named employer is in compliance with the New York State Disability and Paid Family Leave Benefits Law with respect to all of his or her employees by approved self-insurance or a combination of self-insurance and insurance with an authorized carrier(s).

Self-Insurance coverage for the program(s) checked above was effective as noted and remains in full force.

Status Confirmed By

[redacted]

7/16/2021

Section 7

Insurance Requirements

Empire BlueCross

An Anthem Company

General Liability, Automobile Liability, Umbrella Liability, and Workers' Compensation Evidence of Coverage

Empire BlueCross

An Anthem Company

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/30/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur J. Gallagher & Co.
Insurance Brokers of CA Inc.
505 N. Brand Boulevard, Suite 600
Glendale CA 91203

License#: 0726293

CONTACT NAME: Stephanie Powell
PHONE (A/C, No, Ext): [redacted] **FAX (A/C, No):** [redacted]
E-MAIL ADDRESS: [redacted]

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ACE American Insurance Company	22667
INSURER B : American Zurich Insurance Company	40142
INSURER C : Zurich American Insurance Company	16535
INSURER D : Great American Insurance Company of NY	22136
INSURER E : National Union Fire Insurance Co of LA	32298
INSURER F :	

INSURED
Anthem, Inc. And Its Subsidiaries
2015 Staples Mill Road
Mail Drop VA2001-N350
Richmond VA 23230

ANTHINC-02

COVERAGES **CERTIFICATE NUMBER:** 7597866 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [X] LOC [ ] OTHER:			HDO G72483625	5/1/2021	5/1/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Per Occurence Ded	$ 2,000,000 $ 1,000,000 $ 25,000 $ 2,000,000 $ 25,000,000 $ 2,000,000 $ 2,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS X HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			ISA H25546891	5/1/2021	5/1/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Per Accident Ded	$ 3,000,000 $ $ $ $ 3,000,000
D E	X **UMBRELLA LIAB** [X] OCCUR **EXCESS LIAB** [ ] CLAIMS-MADE [ ] DED X RETENTION $ $10,000			UMB 3555292 21335634	5/1/2021 5/1/2021	5/1/2022 5/1/2022	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000 $
B C C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WC9299269-20 EWS5347154-16 WC9376766-19	1/1/2021 1/1/2021 1/1/2021	1/1/2022 1/1/2022 1/1/2022	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 2,000,000 $ 2,000,000 $ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Subject to policy terms, conditions and exclusions.

CERTIFICATE HOLDER

Evidence of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
[redacted]

Errors and Omissions Evidence of Coverage

Empire BlueCross

An Anthem Company

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 04/23/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER	CONTACT NAME: Willis Towers Watson Certificate Center
Willis Towers Watson Southeast, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	PHONE (A/C, No, Ext): [redacted] FAX (A/C, No): 1-888-467-2378 E-MAIL ADDRESS: [redacted]

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ACE American Insurance Company	22667
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Anthem, Inc. and It's Subsidiaries
2015 Staples Mill Road
Mail Drop VA2001-N350
Richmond, VA 23230

COVERAGES **CERTIFICATE NUMBER:** W20719629 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Managed Care E&O			MSPG21816097015	01/31/2021	01/31/2022	Aggregate	$10,000,000
	Managed Care E&O Retentions						SIR - Each Claim	$10,000,000
							SIR- Class Action	$50,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Evidence of Coverage

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
[redacted]

FI Bond Evidence of Coverage

Empire BlueCross

An Anthem Company

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/09/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER	CONTACT NAME: Chelsea Laing
License #0726293 Arthur J. Gallagher & Co Ins Brokers of CA, Inc. 0726293 505 N. Brand Blouvevard, Suite 600 Glendale CA 91203	PHONE (A/C, No, Ext): [redacted] FAX (A/C, No): (818) 539-1505 E-MAIL ADDRESS: [redacted]

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Fidelity and Deposit Company of Maryland	39306
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Anthem, Inc.
& Its Subsidiaries
220 Virginia Avenue
Indianapolis IN 46204

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE OCCUR N/A N/A GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			N/A	N/A		EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG N/A	$ N/A $ N/A $ N/A $ N/A $ N/A $ N/A $ N/A
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS N/A N/A			N/A	N/A		COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) N/A	$ N/A $ N/A $ N/A $ N/A $ N/A
	UMBRELLA LIAB OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			N/A	N/A		EACH OCCURRENCE AGGREGATE N/A	$ N/A $ N/A $ N/A
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		N/A	N/A		WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	N/A $ N/A $ N/A $ N/A
A	FI Bond			FIB 8722945-00	11/16/2020	11/16/2021	Limit Aggregate	$10,000,000 $20,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Evidence of Coverage Only. This certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend or alter the coverage afforded by the policy to which the certificate of insurance makes reference.

CERTIFICATE HOLDER

EVIDENCE OF COVERAGE ONLY

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

[redacted]

Security & Privacy Liability Evidence of Coverage

Empire BlueCross

An Anthem Company

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 04/08/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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PRODUCER	CONTACT NAME: Willis Towers Watson Certificate Center
Willis Towers Watson Southeast, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	PHONE (A/C, No, Ext): [redacted] FAX (A/C, No): 1-888-467-2378 E-MAIL ADDRESS: [redacted]
	INSURER(S) AFFORDING COVERAGE / NAIC #
	INSURER A : National Union Fire Insurance Company of P — 19445
INSURED Anthem, Inc. and It's Subsidiaries 2015 Staples Mill Road Mail Drop VA2001-N350 Richmond, VA 23230	INSURER B :
	INSURER C :
	INSURER D :
	INSURER E :
	INSURER F :

COVERAGES **CERTIFICATE NUMBER:** W20669255 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Security & Privacy Liability			08-067-49-12	03/31/2021	03/31/2022	Limit	$10,000,000
	Including Media Content						Excess of an SIR of	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Evidence of Coverage

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE [redacted]

General Liability Additional Insured Endorsement

Empire BlueCross

An Anthem Company

POLICY NUMBER: HDO G72483625 Endorsement Number: 36

COMMERCIAL GENERAL LIABILITY
CG 20 26 04 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s): Any person or organization whom you have agreed to include as an additional insured under a written contract, provided such contract was executed prior to the date of loss.
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

A. **Section II – Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

1. In the performance of your ongoing operations; or
2. In connection with your premises owned by or rented to you.

However:

1. The insurance afforded to such additional insured only applies to the extent permitted by law; and
2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or
2. Available under the applicable Limits of Insurance shown in the Declarations;

whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.

General Liability Waiver of Transfer Endorsement

Empire BlueCross

An Anthem Company

COMMERCIAL GENERAL LIABILITY
CG 24 04 05 09

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

SCHEDULE

Name Of Person Or Organization: Any person or organization against whom you have agreed to waive your right of recovery in a written contract, provided such contract was executed prior to the date of loss.
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

The following is added to Paragraph **8. Transfer Of Rights Of Recovery Against Others To Us** of **Section IV – Conditions:**

We waive any right of recovery we may have against the person or organization shown in the Schedule above because of payments we make for injury or damage arising out of your ongoing operations or "your work" done under a contract with that person or organization and included in the "products-completed operations hazard". This waiver applies only to the person or organization shown in the Schedule above.

Appendix A

Non-Material Deviations Template

Empire BlueCross

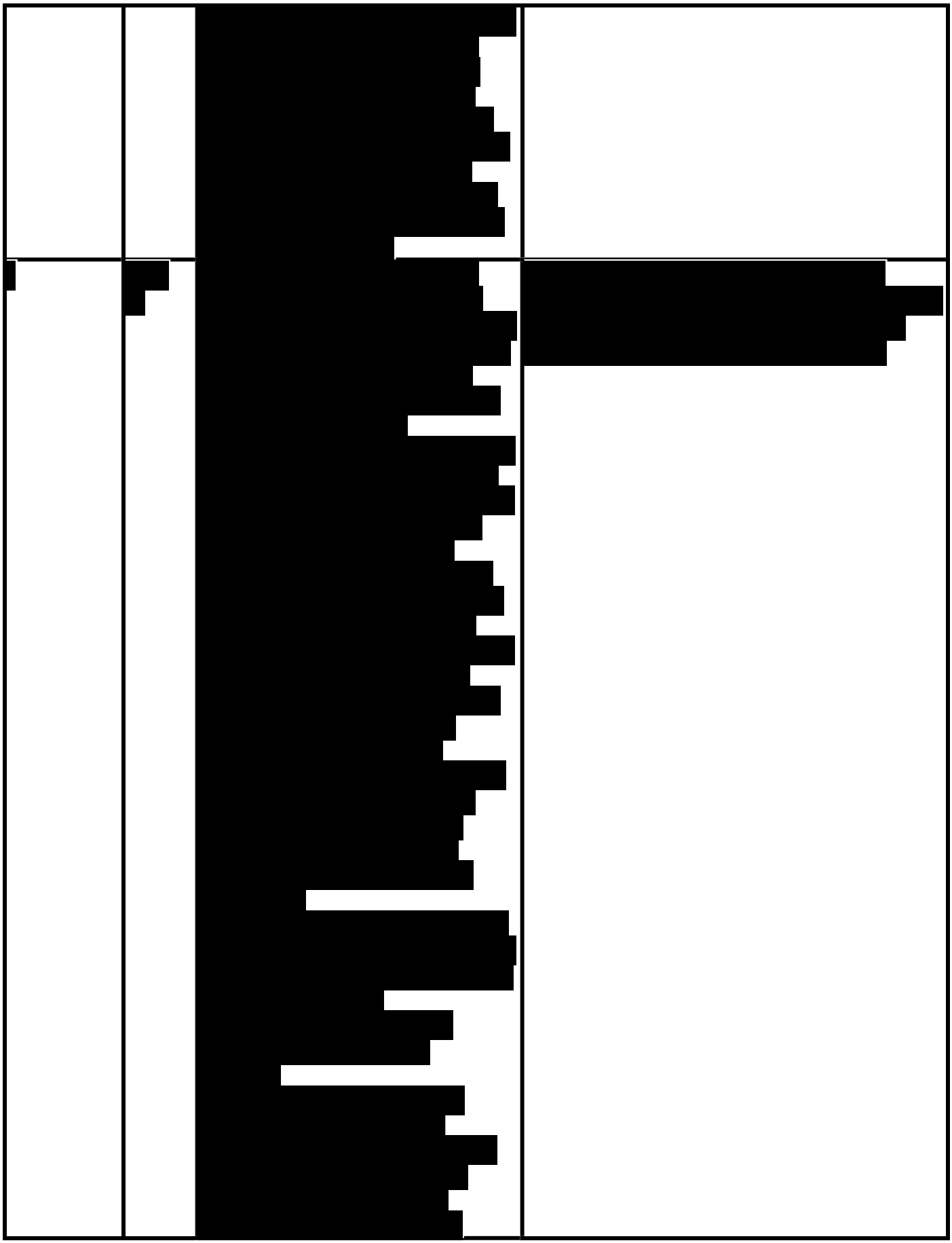
An Anthem Company

ATTACHMENT 8

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Non-Material Deviations Template - RFP entitled: "New York State Vision Plan Services"**

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Deviation Number	RFP Page #	Section Reference	Proposed Deviation with Detailed Explanation



		[redacted]	

An Offeror is required to use this **Non-Material Deviations Template** when submitting any proposed non- material deviations and/or alternates. Offeror's proposed deviations must be submitted with its Proposal.

Appendix B

New York State Required Certifications

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

New York State Required Certifications RFP entitled "New York State Vision Plan Services"

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

NON-DISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND MACBRIDE FAIR EMPLOYMENT PRINCIPLES

In accordance with Chapter 807 of the Laws of 1992 the Contractor, by submission of this Certification, certifies that it or any individual or legal entity in which the Contractor holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the Contractor, either (answer "yes" or "no" to one or both of the following, as applicable):
Have business operations in Northern Ireland. Yes_____or No X____

If yes:

Shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such Principles. Yes_____or No _____

NON-COLLUSIVE BIDDING CERTIFICATION

By submission of this Certification, the Contractor and each person signing on behalf of the Contractor certifies, under penalty of perjury, that to the best of his knowledge and belief:

1. The prices in this Agreement have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition, as to any matter relating to such prices with any other competitor;

2. Unless otherwise required by law, the prices which have been quoted in this Agreement have not been knowingly disclosed by the Contractor and will not knowingly be disclosed by the Contractor prior to contract approval, directly or indirectly, to any other competitor; and

3. No attempt has been made or will be made by the Contractor to induce any other person, partnership or corporation to submit or not to submit a price quote for the purpose of restricting competition.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

New York State Required Certifications RFP entitled "New York State Vision Plan Services"

EXECUTIVE ORDER NO. 177 CERTIFICATION

The New York State Human Rights Law, Article 15 of the Executive Law, prohibits discrimination and harassment based on age, race, creed, color, national origin, sex, pregnancy or pregnancy-related conditions, sexual orientation, gender identity, disability, marital status, familial status, domestic violence victim status, prior arrest or conviction record, military status or predisposing genetic characteristics.

The Human Rights Law may also require reasonable accommodation for persons with disabilities and pregnancy-related conditions. A reasonable accommodation is an adjustment to a job or work environment that enables a person with a disability to perform the essential functions of a job in a reasonable manner. The Human Rights Law may also require reasonable accommodation in employment on the basis of Sabbath observance or religious practices.

Generally, the Human Rights Law applies to:

- all employers of four or more people, employment agencies, labor organizations and apprenticeship training programs in all instances of discrimination or harassment;
- employers with fewer than four employees in all cases involving sexual harassment; and,
- any employer of domestic workers in cases involving sexual harassment or harassment based on gender, race, religion or national origin.

In accordance with Executive Order No. 177, the Contractor hereby certifies that it does not have institutional policies or practices that fail to address the harassment and discrimination of individuals on the basis of their age, race, creed, color, national origin, sex, sexual orientation, gender identity, disability, marital status, military status, or other protected status under the Human Rights Law.

Executive Order No. 177 and this certification do not affect institutional policies or practices that are protected by existing law, including but not limited to the First Amendment of the United States Constitution, Article 1, Section 3 of the New York State Constitution, and Section 296(11) of the New York State Human Rights Law.

SEXUAL HARASSMENT PREVENTION CERTIFICATION

State Finance Law §139-l requires bidders on state procurements to certify that they have a written policy addressing sexual harassment prevention in the workplace and provide annual sexual harassment training (that meets the Department of Labor's model policy and training standards) to all its employees.

By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies its own organization, under penalty of perjury, that the bidder has and has implemented a written policy addressing sexual harassment prevention in the workplace and provides annual sexual harassment prevention training to all of its employees. Such policy shall, at a minimum, meet the requirements of section two hundred one-g of the Labor Law.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

New York State Required Certifications RFP entitled "New York State Vision Plan Services"

(Note: Bids that do not contain this certification will not be considered for award; provided however, that if the bidder cannot make the certification, the bidder may provide a signed statement with the bid detailing the reasons why the sexual harassment prevention certification cannot be made.)

PUBLIC OFFICER LAW REQUIREMENTS AND CONFLICT OF INTEREST DISCLOSURE

The New York State Public Officers Law ("POL"), particularly POL Sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establish ethical standards for current and former State employees. In submitting its Proposal, the Offeror must guarantee knowledge and full compliance with such provisions for purposes of this RFP and any other activities including, but not limited to, contracts, bids, offers, and negotiations. Failure to comply with these provisions may result in disqualification from the procurement process, termination, suspension or cancellation of the contract and criminal proceedings as may be required by law.

The Offeror hereby submits its affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations.

Please provide below an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations. Please attach additional pieces of paper as necessary.

As an incumbent carrier for NYSHIP, Empire HealthChoice Assurance, Inc. hereby submits to the best of our knowledge there is an absence of conflict of interest on the part of Empire HealthChoice Assurance, Inc. because of prior, current, or proposed contracts, engagements or affiliations.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

New York State Required Certifications RFP entitled "New York State Vision Plan Services"

Signature: [redacted] **Title:** President

PRINT SIGNATORY'S NAME: Alan Murray **Date:** 7/17/21

INDIVIDUAL, CORPORATION, PARTNERSHIP, OR LLC ACKNOWLEDGMENT

STATE OF }

Sworn Statement:

COUNTY OF }

On the_____day of_____in the year 2021, before me personally appeared Alan Murray, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that _he maintains an office at
Town of New York
County of New York, State of New York; and further that:

____ **(If an individual):** _he executed the foregoing instrument in his/her name and on his/her own behalf.

X **(If a corporation):** _he is the President of Empire HealthChoice Assurance, Inc., the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

____ **(If a partnership):** _he is the _____ ____of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.

____ **(If a limited liability company):** _he is a duly authorized member of_____ _____, LLC, the limited liability company described in said instrument; that, _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public [redacted] Date: 07/17/2021

(x) Physically Appeared

NOTARY PUBLIC STATE OF FLORIDA

MUHAMMAD AAMIR
Commission # GG 942572
Expires April 25, 2024
Bonded Thru Budget Notary Services

Appendix C

Offeror Affirmation of Understanding and Agreement

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Offeror Affirmation of Understanding and Agreement

08/26/2020

As a prerequisite for participating in this Request for Proposals entitled: "**New York State Vision Plan Services**", an Offeror must provide the following Affirmation of Understanding and Agreement to comply with these procurement lobbying restrictions in accordance with State Finance Law §§139-j and 139-k. Attachment 1 should be completed by the Offeror and emailed and/or mailed to the Designated Contact as set forth in Section 2 of the RFP.

Offeror Affirmation and Agreement

The Offeror affirms that it understands and agrees to comply with the procedures of the Department of Civil Service relative to permissible Contacts as required by State Finance Law §139-j(3) and §139-j(6)(b). The Department's procedures are set out in Attachment 2.

Name of Offeror:	Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross
By:	[redacted]
	(Signature)
Name:	Jason O'Malley
Title:	Regional Vice President, Sales
Email:	[redacted]
Address:	15 Plaza Drive
	Latham, NY 12110
Date:	6/14/2021

A note about our binders and tabs: Our binders and tabs are made from Premium Grade polypropylene, which is an environmentally friendly material. Polypropylene is produced without using water and no harmful emissions are released.

Additionally, Polypropylene is:

- A strong, non-toxic, durable material
- 100% recyclable and biodegradable
- Free from chlorine and harmful additives

Since Polypropylene is up to 35 percent lighter than many traditional plastics, this helps to reduce transportation costs and the output of carbon dioxide. In a world where more companies are increasingly aware of the need to reduce our environmental impact, Polypropylene is considered the natural choice.

Proposal to Serve

New York State Department of Civil Service

New York State Vision Plan Services

TECHNICAL - REDACTED

January 1, 2022

Empire BlueCross

An Anthem Company

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New York State Department of Civil Service Technical Proposal - Redacted

Empire BlueCross

An Anthem Company

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Empire BlueCross

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Section 1

Technical Proposal Requirements (Section 5)

Empire BlueCross

An Anthem Company

SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

The purpose of Section 5 of the RFP is to set forth the submissions required of the Offeror. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror may submit only one Technical Proposal. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of this RFP.

An Offeror must not include any cost information in the Technical Proposal, including attachments. Specific savings estimates (dollars or percentages) must not be quoted in the Technical Proposal or in any attachments submitted with the Technical Proposal.

Acknowledged.

Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross (Empire) as the offeror has responded to the below items related to our Technical Proposal. Empire is presenting our Blue View Vision plan in partnership with our independent vendor EyeMed Vision Care (EyeMed) to meet The New York State Department of Civil Service's (the Department) needs. The proposed Blue View Vision plan delivers cost-effective and inclusive benefits, from a broad range of eye care providers and locations. The plan is designed to be user-friendly and aims to provide savings beyond basic coverage.

We recognize the eyes provide a unique and direct view of blood vessels, which allows vision providers to detect and diagnose serious health conditions—like high blood pressure, high cholesterol, and heart disease. Early detection can help avoid more serious problems and reduce health care costs for the Department.

We understand the importance of administering the benefit design in a manner consistent with your collectively bargained benefit structure. We have developed both systematic and administrative flexibility to align with your union-negotiated benefit designs. We can deliver best-in-class vision benefits for healthier outcomes and are uniquely positioned as the leading partner to achieve these results based on our existing relationship with the Empire Plan as the Hospital Program administrator, our unique capabilities and provider collaborations, unmatched technology and data, and a member-centric view known as the Whole Health Connection.

Empire serves more than seven million members and insures over 100,000 employer groups. We administer multiple states' vision benefits, each with their own unique customizations and nuances. Additionally, our vision care partner, EyeMed, administers vision plans for more than 22,000 clients and 62 million members, including more state governments than any other vision benefits provider in the country.

5.1 Executive Summary

1 In an Executive Summary, the Offeror must describe its capacity and proposed approach to administering the Vision Plan, which covers over 240,000 lives and incurs claims costs of over $10 million annually. The Offeror must have the ability, experience, reliability, and integrity to fulfill the requirements of this RFP. As such, the Executive Summary must include:

a A description of the Offeror's understanding of the requirements presented in the RFP and how the Offeror can assist the Department in accomplishing its objectives;

b A statement explaining the Offeror's experience managing the vision plans of other state or local government employers or any other organizations with over 100,000 covered lives; and a list of client organizations to clearly demonstrate and support how the Offeror meets the 500,000 minimum covered lives requirement. In determining covered lives, the Offeror should count all lives (i.e., an employee, a spouse, and two eligible dependents counts as four covered lives); and

c A description of the Offeror's experience managing a vision plan similar to the Plan described in this RFP, including details on how this experience qualifies the Offeror to undertake the functions and activities required by this RFP.

Confirmed. Please refer to our executive summary located in Section 2.

5.2 Account Team

1 The Offeror must complete the *Biographical Sketch Form* (Attachment 14) for all key personnel including Subcontractor provided key staff, if any, of the proposed Account Team.

Confirmed. Please refer to Section 3 for the completed Attachment 14 documents.

2 The Offeror must also provide:

a The name and address of the Offeror's main and branch offices, and the name of the senior officer(s) who will be responsible for this account;

The Account Team is located at Empire's new office at 15 and 17 Plaza Drive, Latham, New York 12110. Alan Murray, President and CEO, will have responsibility for strategic direction and oversight of the account and is located at Empire's office at 14 Wall Street, New York, New York 10005. In addition, Jason O'Malley, Regional Vice President of Sales, will provide leadership and direction of all account management activities and has the authority to command the appropriate resources necessary to deliver program services. Jason is located at the Latham, New York office.

b An organizational and staffing plan that describes the roles and responsibilities of key personnel involved in administering the Vision Plan, their planned level of effort, their anticipated duration of involvement, and their daily level of availability. An organizational chart must be included in the proposal which identifies the Offeror's staff and staff from any Subcontractor, including their name and title, to be used in delivering the Project Services.

Empire's relationship with the Department is our top priority and one we never take for granted. Our focus has always been, and will continue to be, to consistently serve you and your Plan members and provide the highest level of service every day. Accordingly, we will provide the Department with an enhanced cross functional sales and operational teams that report up to Alan Murray, President and CEO and John Thorp, Staff Vice President Vision Services. Alan and John's leadership teams are committed to the success of the New York State Vision Plan and providing the Department with the exceptional service you deserve as our largest client. To ensure we provide the highest level of service and expertise, our vision care administrator for nearly 20 years, EyeMed, has been and will continue to be working with us side by side to ensure your Plan is implemented to meet all your specifications as required.

Below are the key members of your Empire Account Team:

Your Empire Account Team	
Empire Blue Cross	**EyeMed**
Jason O'Malley Executive leader responsible for leadership, direction, and oversight responsibility for all account management activities.	**Jim Wright** Executive leader responsible for direction and any executive-level support needed for the ongoing administration of the Plan.
Angela Blessing Account Team leader responsible for ensuring all Plan expectations are being met or exceeded. Angela will also formulate strategies to improve Plan administration, control or reduce cost and ensure member satisfaction.	**Dawn Richards** Lead EyeMed representative with extensive experience in State vision plan new business and implementation. Dawn will continue to be involved through implementation to ensure all commitments within our proposal are installed and functioning as promised.
Anthony Savignano As account manager, Anthony will support Angela in all activities involved in administration of the Plan and work directly with EyeMed to ensure all Plan expectations are being met or exceeded.	**Leslie Nathan** As Empire's account manager, Leslie will remain involved through the entirety of the contract. She will assist the Empire Account Team with the ongoing administration of the Plan.
	Joe Wende, O.D. As EyeMed's medical director, Joe will consult on the medical exception program. He will also aid in the development of provider communications about the Plan.

The above individuals are the key points of contact who will work directly with the Department.

Please refer to Section 3 for the Organizational Chart including your entire Empire Account Team and the Staffing Plan.

c A description on how the Account Team interfaces with senior management and ultimate decision-makers within Offeror's organization; and how the Account Team will interact with other departments such as the call center, quality assurance, reporting, and network management within Offeror's organization.

The organizational model we are proposing capitalizes on our current structure for the Empire Plan Hospital Program and integrates several operational areas into a dedicated model for the Vision Plan. We are expanding the current team structure to provide you with the additional resources to reduce administrative burdens for the Department. The Account Team reports up to Empire's President and CEO, Alan Murray and John Thorp, Staff VP Vision Services. The Account Team will have direct access to Alan and John to ensure we are providing excellent service that meets or exceeds the Department's expectations.

Empire is proposing an Extended Account Team comprised of EyeMed resources. Collaborating with EyeMed brings over 60 years of vision care experience, 35 of which are with EyeMed. Angela will have daily access to these resources and will meet with them regularly to ensure all lines of communication are open. This model will ensure Empire maintains the superior level of service you have become accustomed to while easing administration for the Department through a single point of contact for the Empire Plan Hospital Program and the New York State Vision Plan. The Account Management team will respond quickly and accurately to inquiries and act in a consultative manner with the Department of Civil Service, the Governor's Office of Employee Relations, and other New York State entities involved in the administration of the Plan.

The Account Team will have access to, and the cooperation of, all operational areas throughout both organizations, including the call center, reporting, auditing, compliance, claims and network management. In keeping with our existing process for the Hospital Program, Empire will facilitate monthly meetings with leaders from EyeMed's operational areas. The objective of these meetings is to review current service levels, discuss areas of concern and mitigation strategies, and identify enhancements or process improvements, trends, and any topic that could potentially impact the Plan. These meetings ensure visibility, accountability, and support within the organization, from executive management to our extended service team.

We recognize and value the importance of our relationship and understand what is required at all levels of our organization. We are committed to meeting your expectations and all requirements outlined in the RFP.

d An explanation of how the Offeror's Account Team will be prepared to administer the operational and clinical aspects of the Vision Plan.

Empire has been administering benefits for the State of New York for nearly 65 years. The experience we have drawn from this long-term relationship will be invaluable and directly applied to our administration of the Vision Plan. We recognize the importance of having the State of New York as a client and are fully committed to meeting your expectations. The account team will meet deliverables, act consultatively and engage Senior Management as needed to ensure the Department's expectations are met. The operational and clinical teams will have accountability to the Account Team, who will be responsible for oversight of the entire Plan. All key account areas will participate in regularly scheduled meeting with the Department, with the understanding that they are accountable for their various areas of operation. Providing direct access and interaction with the operational leadership creates a collaborative environment and open communication resulting in higher client satisfaction.

We will outline in detail throughout the proposal our approach to actively manage all aspects of the program but some of these activities include:

- Regular discussions to explore coverage options and their impact on costs, quality, outcomes, and the overall best use of health care dollars
- Continued review of member and provider experiences to identify opportunities for service improvement and Plan development
- Communicating performance measures
- Fully cooperating in any program audits
- Review of utilization trends through claims data to evaluate program performance
- Collaborating on member communications

We acknowledge there are unique aspects to the Department's Vision Plan and that union contracts require the plan be administered exactly as stated within the RFP. Empire has experience in administering similar requirements for other State vision plans. We are committed to the overall satisfaction of the Department and have proposed the resources and administrative model that best accomplishes this goal.

e A description of how the Offeror proposes to ensure that responses are provided within one Business Day to administrative concerns and inquiries.

Angela Blessing, Account Executive has more than 12 years' experience supporting the Department and over 30 years in the health care industry. She has the necessary institutional knowledge across all areas of operation, direct access to Senior Level Management, and the authority to command the resources within the Department's Account Team.

Anthony Savignano, Specialty Account Manager has more than 20 years of industry experience. He has in-depth knowledge of vision plan benefit design and administration. Anthony will provide Angela the support necessary to ensure administrative concerns and inquiries are responded to within one business day.

f A description of the protocols that will be put into place to ensure the Department will be kept abreast of actual or anticipated events impacting costs and/or delivery of services to Enrollees, including a representative scenario.

We propose establishing monthly meetings with the Department to discuss various topics and deliverables associated with the Vision Plan. If the Department prefers, we could instead increase the frequency of our current bi-monthly meeting cadence to include discussion regarding the Vision Plan. Either approach will ensure we are continually sharing information regarding the Plan's performance as well as quickly addressing any questions or issues that may arise.

Some topics and deliverables that may be discussed include:

- Analysis of utilization of the Occupational Vision Program, Medical Exception Program, and the Upgrade Program
- Support with reporting and recommendations during union contract negotiations
- Discussion of any feedback, call center or operational topics that have arisen
- Inclusion of key subject matter experts to share vision trends

In addition, we will conduct an in-depth Plan review annually. During this meeting the following will be provided:

- Year in review of Plan performance, experience, and emerging trends
- Roll up analysis of the Plan's utilization compared to book of business results
- Benchmark analysis comparing your program against other State clients
- Discussion of upcoming key events for the Department and how we can support you in those endeavors

In 2020 there are two specific examples where we proactively communicated time-sensitive information to our members:

1 COVID-19 brought many challenges, especially in communicating benefits as in-person benefits fairs were cancelled. Therefore, we introduced online benefit fairs to ensure members had access to important information. Our Virtual Benefit Fairs will provide a one-stop shop for members to be educated regarding their vision benefit options, locate a network provider nearby, and find answers to frequently asked questions. We also developed a pre-packaged email our clients were able to use to communicate this experience to members.

2 Our laser vision partner, LCA Vision recently acquired another laser vision network. This resulted in a significant expansion to in-network options for our members. Although this information was automatically reflected in our online directories, we also proactively communicated this to our clients and members.

g A description of the corporate resources that will be available to the Account Team to ensure compliance with all legislative and statutory requirements.

Our Public Affairs team monitors proposed and actual legislation on a state and federal level. The Account Team along with our Legal team works in conjunction with Public Affairs to analyze new laws and regulations that affect or could potentially affect our customers. The Account Team meets routinely with the Public Affairs and Legal teams and actively participates in discussions to identify potential impact to the Plan. In addition, our internal compliance team who is responsible to ensure compliance with all applicable legislative and statutory requirements today on the Empire Plan Hospital Program will have oversight responsibility for the Vision Program as well. The Account Team will ensure the Department is kept fully abreast of potential or actual operational, procedural, and/or financial impact to the Plan.

In addition, the Account Team closely monitors impacted business areas to ensure timely and accurate implementation of any operational, procedural, and/or system changes required to ensure compliance with all legislative and statutory requirements.

5.3 Implementation Plan

The Offeror must provide a detailed Implementation Plan in narrative, diagram, and timeline formats, designed to meet the implementation by the required Service Start Date of January 1, 2022. The Implementation Period shall be a minimum of 30 Business Days. Specifically, the Implementation Plan must include:

1 Roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected.

Confirmed. Empire will implement the Plan on our enterprise eligibility processing platform to leverage the latest technology and enhancements to bring you and Plan members an experience that will continue to evolve in anticipation of your needs and the needs of Plan members. Our longstanding relationship provides the foundation for ongoing success– one that engages Plan members and eases the administrative burdens of Department staff.

Our implementation plan addresses the key activities you reference above as well as all other key deliverables to ensure a smooth transition to our vision plan. We are committed to ensuring Plan members receive the level of service they have come to expect with Empire and will leverage our experience and expertise in implementing large, complex clients to ensure success. Comprehensive testing will occur prior to the effective date and is an integral part of the overall implementation plan. We understand the expectation of having certain aspects of the Plan (i.e. custom website, Sydney mobile app, and Alexa app) available in advance of the effective date, as well as the importance of enrollee communication and education. We have incorporated these requirements into our implementation guide provided in Section 4.

Team Approach

A dedicated implementation team will manage all implementation activities and will be comprised of resources from various areas including but not limited to account management, operations, eligibility and billing, underwriting, reporting, marketing, communications, and network teams. These departments will work together and directly with you to ensure a seamless implementation. Empire commits to having a contracted network, member services, and claims processing fully functioning by the target date of January 1, 2022.

Angela Blessing and a dedicated implementation coordinator will lead a cross-functional implementation team that will include but not be limited to resources such as:

- A technical project manager to coordinate all IT and website development activities
- A dedicated marketing manager to assist in the development and execution of member communication materials
- A call center manager to support scripting and training
- A network manager to oversee custom network implementation

This team will work closely with you to ensure that we complete all implementation activities according to plan and will be available to address ongoing needs and issue resolution.

Implementation Plan, Tools, and Data Requirements

An experienced project leader will be assigned and responsible for developing an implementation plan and managing the team through the implementation. Generally, our implementation staff may meet with clients several times throughout the implementation process.

These activities include:

- Third-party vendor interfaces
- Website, Sydney mobile app, and Alexa app
- Financial and backend reporting requirements
- Acclimation of claims, and service representatives in Plan-specific workflows

Our team will use the following implementation tools:

- Formal project plan
- Group structure document
- Benefit summaries
- Communication deliverables/issues document
- Formal meeting and reporting structure

Operational Readiness

We will be prepared for an operational readiness review from the Department 30 days prior to the contract effective date and will make our systems, processes, and staff available to you for review. This will provide the Department with the opportunity to conduct a review of documentation, as well as policies and procedures required to assess our readiness in the areas of call center scripting, IT systems connectivity, website/microsite development, and claims processing. Following the readiness review, we will provide a timeline and correction plan if any issues are identified. We will provide the Department with ongoing reviews at an agreed upon frequency, which can be bi-weekly, weekly, and then daily as we near the 1/1/2022 effective date.

Our Management Approach Ensures Success

With our seasoned team, knowledge of Plan requirements, proven process, and the experience of many successful implementations, we are confident that we will develop and execute your implementation plan to meet your objectives. We have a long track record as a reliable and committed benefits administrator, not only for the Department, but also for many state health plans, which extends back decades. We have proven experience implementing vision programs.

Please refer to Section 4 for the implementation guide, which includes the timeline and diagram.

2 Key activities such as:

a Establishing a Participating Provider Network;

b Establishing a Participating Provider Laser Vision Network;

c Enrollee and Provider communications;

d Training of customer service staff;

e Report generation; and

f Eligibility feeds and testing claims processing.

The implementation guide in Section 4 includes the key activities performed and addresses all of the key items above.

3 Implementation Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all of the Implementation requirements listed in Section 3.2 will be in place on or before December 31, 2021.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each Calendar Day or part thereof, that all Implementation requirements are not met. The forfeited amount (Standard Credit Amount) for each Calendar Day that all Implementation and Start-Up requirements are not met is $1,000. However, an Offeror may propose a higher amount.

Confirmed. [redacted] Please refer to Section 10 for the completed Attachment 6.

5.4 Participating Provider Network Management

1 The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in participating provider network management as specified in Section 3.3 of this RFP, including the following:

a Propose access standards for the Vision Plan's Participating Provider Network that meet or exceed the Minimum Access Standard set forth below. The access standard must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the Minimum Access Standards stipulated below.

NYS Enrollee Location	Access Standard – At least 1 Provider within
Urban	5 miles
Suburban	15 miles
Rural	30 miles

We use Quest Analytics, a GeoAccess analysis program, to determine how many employees would have access to our providers within a certain distance. All calculations are based on estimated driving distance calculations, as this provides a more accurate representation of a member's access to providers.

Our network accessibility results for the Department are as follows:

NYS Enrollee Location	Access Standard – At least 1 Provider within	Percentage of Enrollees with Access
Urban	5 miles	[redacted]%
Suburban	15 miles	[redacted]%
Rural	30 miles	[redacted]%

i To demonstrate satisfaction of this requirement, the Offeror must submit all required Attachments below based on the Geo-Coded Census file provided in *Enrollment Counts by Zip Code* (Attachment 20).

1. *Offeror's Participating Provider Network Access Summary* (Attachment 17). This attachment summarizes the number of Enrollees with and without access to network providers in urban, suburban, and rural areas;

Confirmed. Our network provides access to nearly [redacted]% of Plan members. Empire's completed Participating Provider Network Access Summaries are in Section 5.

2. *Offeror's Current Participating Provider Network File* (Attachment 18). Offeror should list every provider that will be included in their network as part of their Technical Proposal responses. This attachment contains the required file layout; and

   Confirmed. Empire's proposed network includes nearly 4,200 in-network participating provider locations throughout New York State vs. the stated incumbent network's 2,300 – an increase of 81%. Our national network includes more than 19,000 locations and consists of 68% independent provider locations and 32% retail locations including LensCrafters, Target Optical, America's Best, Sterling Optical, and Pearle Vision. Empire's completed Participating Provider Network File is in Section 5.

3. *Offeror's Participating Provider Quest Analytics Report* (Attachment 19). Offeror must provide a detailed GeoAccess report from Quest Analytics. The Quest Analytics report should include every ZIP Code that is in the demographic file; even ZIP Codes with no access should be included. Offeror should use Estimated Driving Distance from the employee's home ZIP code for calculating distance. The most current version of Quest Analytics software should be used to create these reports.

   Confirmed. Empire's completed Participating Provider Quest Analytics Reports are included in Section 5.

b Confirm that if selected, the Offeror shall provide an updated *Participating Provider Network Access Summary* (Attachment 17) on December 1, 2021 confirming that the proposed Participating Provider Network will be implemented as required on January 1, 2022.

Confirmed.

c Describe the approach(es) the Offeror would use to solicit additional providers to enhance its proposed Participating Provider Network or to fulfill a request to add a Participating Provider.

With 4,170 provider access points at 1,285 locations in New York, 81% more than your current vision provider, our network will deliver greater access and choice for the Department's members. Our Network Management team leads recruitment activities, crafting strategic network development efforts to identify key providers necessary to enhance the network. They also remain active in conferences, expos, professional associations, and other network events to stay close to their constituents and maintain positive communication throughout the optometric community.

If a member desires a specific doctor that is not in the network, we welcome provider nominations.

The process to nominate a provider is simple:

1 Members should ask their eye care professional to complete the online interest form on EyeMedInfocus.com (EyeMed's provider website)

2 EyeMed will send a recruitment packet to the nominated provider, containing network participation benefits and requirements

3 EyeMed will work to recruit the nominated provider

While there is no guarantee that a provider will join the network, EyeMed will assert good faith effort to recruit nominated providers.

Our Vision Plan Provider Relations department is responsible for the quality network of providers delivering services and products to members, they oversee the credentialing of all providers, regardless of their mode of practice. It is imperative that each provider meet the eligibility requirements and standards set forth by the industry and adopt them into policy prior to practicing within a network.

d Explain whether Members traveling or residing outside of New York State will have access to the same level of benefits as those offered by Participating Providers located in New York State if a national network of Participating Providers is proposed.

Confirmed. Members traveling or residing outside the state of New York will have access to the same level of benefits.

We hold 100% of our network providers to the same contract, credentialing, and quality assurance standards. Therefore, Plan members can always feel confident, they will receive the exact same benefit and level of service regardless of the state in which care is accessed.

e Describe in detail how the Offeror proposes to develop and maintain the three levels of Vision Plan frames required under the Vison Plan frame selection and/or allowance method, a description of the variety of frame options, and the minimum contractual and average number of frames available in each level including how Enrollees will be made aware of the available Vision Plan frame selection when receiving services from a Participating Provider (i.e., separate location of frames, color coding of UPC codes, price tag).

Based on our most recent data, the chart below reflects the average selection across our proposed network:

Frame Level	Retail Allowance	Percent of Frames	Number of Frames
Basic	[redacted]	[redacted]%	[redacted]
Standard	[redacted]	[redacted]%	[redacted]
Enhanced	[redacted]	[redacted]%	[redacted]

Empire's network will provide Plan members with freedom and flexibility in the products they buy. With the exception of pediatric vision plans and safety eyewear plans, we do not restrict members' choices to a limiting frame tower or frame selection. In order to ensure high member and provider satisfaction, all frames at all provider locations are available to members through their frame allowance.

Providers are also required to carry a minimum of 100 frames that cost $130 or less. The benefits are based upon retail pricing and applied consistently at all network provider locations, allowing members to easily understand and anticipate any out-of-pocket costs. This approach eliminates frame 'selections' and 'wholesale conversions' that may appear to provide consistency.

All providers guarantee a frame assortment that meets the lifestyle and budgetary needs of their local consumer base, and all providers maintain a proper frame stock for the markets they serve. Network providers carry the frame assortment that meets the lifestyle and budgetary needs of their local consumer base.

If a member chooses a frame that exceeds their frame allowance, they will receive 20% off the remaining frame balance for an even greater savings.* Members can also apply their frame allowance toward the purchase of prescription sunglasses. Lastly, once the funded frame benefit has been exhausted, members will receive 40% off unlimited additional complete pairs of prescription eye wear - the largest and most flexible additional pair discount in the industry.*

Each population within the Vision Plan will be set up in the system for the retail frame allowance that is covered under their specific benefit design. For example, the SEHP (GSEU and CUNY) Plan design only covers the Basic level of frames. This population will be set up with an $80 frame allowance. Using the retail price tag on the frame, they will know if their allowance will cover that frame. Once the frame allowance has been applied; members will receive 20% off any remaining frame balance for additional savings.

Currently, [redacted]% of claims where members utilized their standard benefits are auto adjudicated.* Our fully integrated claims system compares the charges by the provider to the specific population's benefits configured in the system.

* *EyeMed Book of Business, 2020*

f State the retail price points for a standard collection and/or the Offeror's proposed allowances for frames covered at each of the three levels. If an allowance method is proposed, confirm the allowances are adequate to ensure that Participating Providers stock the minimum contractual number of frames.

We have duplicated the frame price points of the incumbent as shared in Section 3: Project Services, #3.3 on page 28.

Frame Level	Retail Allowance	Percent of Frames	Number of Frames
Basic	[redacted]	[redacted]%	[redacted]
Standard	[redacted]	[redacted]%	[redacted]
Enhanced	[redacted]	[redacted]%	[redacted]

With an average of 100 frames available at the Basic frame level, we are confident all Plan members will have an adequate selection to choose from.

Empire understands that members want freedom of choice. Therefore, we empower members to choose from any frame available at any network provider, avoiding the limiting frame towers or collections. Providers are permitted to carry a frame assortment that meets the lifestyle and budgetary needs of their local consumer base, which ensures a diverse selection of frames for the Department's members. Because of this, providers offer high quality frames at a variety of price points, including nationally recognized designer brands such as Prada®, Ray-Ban®, Versace®, Oakley®, Brooks Brothers® and Ralph Lauren®.

EyeMed relies upon the economic efficiencies of the market to determine frame pricing. Their retail-based frame pricing model eliminates 'wholesale conversions' that may appear to provide consistency but are confusing for members. This approach has resulted in extremely high member satisfaction ([redacted]%) and enables both the member and provider to calculate coverage that they can actually understand.

While frame pricing may hold slight variance from provider to provider, members are able to easily identify frames that are fully paid for by their plan. Additionally, our network providers must "maintain and display" at least 100 frames at a $130 or lower price point ensuring a broad selection at value price points. Once the frame allowance is applied, members receive 20% off any remaining frame balance and 40% off unlimited additional complete pairs of prescription eye wear purchased throughout the plan year.

g Describe in detail how lens types and lens options will be classified as either Standard (covered) material or premium material, eligible for the upgrade program.

Empire will replicate the discounted surcharges and retail discounts as outlined in the Upgrade Program. For progressive lenses and anti-reflective coatings, we provide a detailed list of those lenses which are considered standard vs. premium. We will cover in full standard and Tier 1 progressive lenses which includes over 65 brands. Having this level of detail allows members to understand what out of pocket responsibility they may have based on the lens options they choose. These are reviewed annually to ensure new technology is being included as it becomes available.

i Provide a listing of the currently manufactured lens products that are/will be classified as Standard or premium for the following categories of lens types: polycarbonate, high index, photochromatic and progressive.

A detailed list of standard and premium lens options is in Section 5.

While brand names are not provided, standard polycarbonate lenses will be covered based on the benefits specified for each population. Most of the current plans cover high index and photochromic lenses in full. Member communications will specify any member out of pocket cost for their selected lenses and options. For any option not specifically listed, members will receive a 20% discount.

ii Confirm which covered lens options will be available in both basic and premium classifications.

The following lens options contain both basic and premium choices:

- Progressive lenses
- Anti-reflective lenses
- Polycarbonate lenses
- Scratch coating

We have duplicated coverage based on benefits specifications provided in Attachment 24.

iii Confirm that Enrollees eligible for multiple covered lens types and options will be able to select a combination of covered eyewear with no out-of-pocket cost. For example, a photochromatic single vision high index lens with Standard scratch-resistance and ultraviolet coating.

Confirmed. Benefits for each population will be set up to ensure members receive the covered-in-full lens options as per their selected vision benefit. Please see Attachment 24 for complete details. All network providers have access to the covered-in-full lens options from which members may chose.

h Describe the Offeror's proposed product guarantees for Vison Plan frames and lenses dispensed by a Participating Provider including how the Offeror will ensure that Participating Providers perform product repairs and replacements for eyewear which are under warranty.

Our network providers are required to honor all manufacturers' product warranties. In fact, manufacturer product warranties (one year to the lifetime of the product) may be better than breakage protection programs. We invest heavily in the satisfaction of members and have received high member satisfaction ([redacted]%) with very few complaints around eyewear breakage. Last year, out of more than 20 million claims, we received approximately [redacted] formal complaints and of those, less than [redacted] were for eyewear quality issues.

i The Offeror must provide a narrative describing prior experience administering an annual contact lens examination benefit of this design, and how it will ensure this benefit is accurately programmed into their eligibility system.

We have administered similar differing benefit frequencies for other clients based on utilization. Using the historical data provided by the incumbent carrier, we will identify and code those members who have already met the requirements for the additional exam. Ongoing, our claims system can identify members who have utilized their contact lens benefit to ensure they are set up for the annual benefit going forward.

j The Offeror must detail how they will communicate the annual contact lens examination benefit to providers and eligible members through print materials and through call center inquiries.

Empire knows how important it is that all parties understand any unique attributes of their benefits. While the restriction in coverage for the contact lens fit and follow up is not common, we are able to configure multiple plan benefits within our fully integrated claims system. All standard benefits are auto-adjudicated (currently [redacted]%*) comparing charges by the provider to the member's specific plan benefits.

With the member's name and birthdate, in network providers can quickly and easily confirm their available benefits via an automated IVR or an online claim and membership system. The member's next eligible date of service and benefit is displayed, ensuring that the member receives the appropriate services and materials.

Members can also view their available benefits by registering and logging into the member website at empireblue.com or calling Member Services.

To ensure the call center and providers are familiar with the unique aspects of the Department's vision plan, providers receive a New Client Introduction with an overview of your benefits, highlighting unique components of the plans and any special processes that may be required.

When receiving calls, Member Services representatives access a sophisticated system, which provides a pop-up screen that makes them aware of any unique or important details of the Plan's benefits. This allows us to effortlessly communicate personalized benefit information to the Department's members. In addition, all representatives will be trained on specific details of the Plan's benefits to ensure they are familiar with the contact lens benefit and other unique features of your vision program. By training all representatives on the Plan's benefits, EyeMed provides fast and accurate service to your members. All representatives are 100% dedicated to answering vision questions only - unlike competitors who also administer dental or medical benefits through the same call center. In addition, our automated system allows calls to be routed based on need level. Therefore, complex, or escalated member and provider calls are forwarded to more experienced representatives.

k State whether a Standardized contact lens selection and/or contact lens allowance is proposed.

i If a Standardized contact lens selection is proposed:

1. Describe how the Offeror will develop and maintain the selection of Vision Plan contact lenses. Complete *Summary of Contact Lenses Covered by the Plan* (Attachment 33), to detail the Vision Plan contact lenses the Offeror is proposing.

   Not applicable.

   With our Blue View Vision benefit, members can consult with their provider to choose the contact lens type and brand that best meets their needs. We do not use confusing formulary benefits and there are not any limiting manufacturer lists to choose from.

2. State the Offeror's proposed criteria for classifying contact lenses as either standard or premium (which are subject to the higher copay level for PEF, GSEU, M/C and unrepresented employee and their covered dependents).

   We use the following criteria to classify contact lenses:

   - Conventional: Intended for ongoing, daily-wear use. These lenses are not labeled with the expectation of replacement at specific intervals, but are replaced when the lenses become overly soiled or damaged, or present health risks as indicated by the provider
   - Disposable/Frequent replacement: Designed and labeled to be replaced at specific time intervals (i.e. daily, weekly, monthly). These lenses are typically packaged such that multiple lenses are provided at the time of dispensing
   - Medically Necessary: Meet the requirements related to eye conditions as established by the Quality Assurance Committee. The eye conditions prevent the member from achieving a specified Contact lenses that provide superior visual and physical results to spectacles in individuals with the following eye conditions:
     - High Ametropia exceeding -10D or +10D in meridian spectacle Rx powers
     - Anisometropia of 3D in meridian spectacle Rx powers
     - Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses

ii If a contact lens allowance is proposed, state the proposed allowance for standard and premium contact lenses.

We propose [redacted].

l State how the Offeror proposes to administer the $200 contact lens benefit for other employee groups, and confirm that the eye exam, contact lens fitting, and contact lens material will be included.

Within our claim system, [redacted] as outlined above for Plan members.

m Indicate whether or not the Offeror currently has, and is proposing, a contracted Laser Vision Correction Network that provides both a covered benefit and a discount program. If so, please provide a listing of the proposed Laser Vision Correction Participating Providers located in New York State. In addition:

Confirmed. A list of Laser Vision Correction Participating Providers for the state of New York is in Section 5.

i Specify the minimum, maximum and average discount offered by Laser Vision Correction Participating Providers, expressed as a percentage.

Empire's laser vision correction discount is available through the nation's largest independently owned and surgeon-based LASIK network, U.S. Laser Network, which is owned and managed by LCA-Vision. Members receive a discount on LASIK, e-LASIK and PRK laser vision correction - at no additional cost to the Department.

The U.S. Laser Network provides access to more than 680 LASIK surgeons at over 1,000 locations across the country with 92 located in New York

LCA-Vision provides consistent discounts with all network providers. They define standard pricing, so members always pay less than the public. Members receive 15% off the standard price or 5% off any promotional price for treatments performed through the U.S. Laser Network. For even greater savings, your employees will receive $800 off at over 60 LasikPlus, TLC, and LVI locations nationwide, 10 of which are in New York.

These discounts apply to the global cost of the treatment, surgeon fee, facility fee, and all pre/post-operative care. Unlike some competitors, members are not required to get a referral from their optometrist or ophthalmologist prior to seeing a U.S. Laser Network doctor.

ii Describe how the Laser Vision Correction Participating Network and its availability will be communicated to Enrollees.

For information about the laser discount or to locate a nearby U.S. Laser Network provider, members can simply call 877-5LASER6 or visit the member portal on our website empireblue.com or via our Sydney Health mobile app.

n Describe the Offeror's proposed process to ensure that the Participating Providers and Laser Vision Correction Participating Providers meet the applicable state licensing requirements and are in compliance with all other federal and State laws, rules and regulations. Identify the resource, database, or other information that will be used by the Offeror to verify this information.

All doctors must meet the credentialing and quality standards set forth in the Professional Provider Manual to participate in Empire's network. All established criteria - all of which align with the industry standards set forth by the National Committee for Quality Assurance (NCQA).

Providers submit relevant demographic, educational, and professional data, which is verified for approval on the network. All providers are required to be re-credentialed at a minimum of every 36 months, or in accordance with state law.

The following information is verified for all doctors:

- Work history
- Licensure and certification
- Minimum professional liability insurance
- Criminal history
- Member complaints
- Liability and malpractice claims
- Education and training (Initial Credentialing only)
- Questionnaire that validates provider ability to practice
- Medicare and Medicaid Sanctions

Laser Vision Providers

EyeMed partners with LCA-Vision, an experienced leader in the laser vision correction industry. They have the expertise to ensure a quality LASIK product for members. They carefully select quality providers to participate in their network. Doctors are credentialed and re-credentialed every three years. They also feature an in-house call-center comprised entirely of LASIK specialists to answer your calls.

o Describe the Offeror's proposed approach for credentialing Participating Providers and Laser Vision Correction Participating Providers. Specify if the Offeror is proposing to utilize an external credentialing verification organization. Indicate when the credentialing verification process was last completed, the Offeror's process for confirming continued compliance with credentialing standards, and how often the Offeror will conduct a complete review.

Routine Care Network Providers

EyeMed's credentialing process is performed in complete compliance with all NCQA standards and applicable regulatory requirements. Providers submit relevant demographic, educational, and professional data which is verified by an NCQA-certified Credentialing Verification Organization for approval on our network. We verify work history; licensure and certification; minimum professional liability insurance; criminal history; member complaints; liability and malpractice claims; operating hours, and locations.

All providers are required to be re-credentialed at a minimum of every 36 months, or in accordance with state law. Credentialing and re-credentialing review includes State Board of Medical Examiners, State Board of Optometry, the Department of Professional Regulations, etc., as well as the National Practitioner Data Bank (NPDB) and Death Master File.

We also validate our entire provider network against the following on a monthly basis:

- Office of Inspector General (OIG/LEIE)
- Medicare/Medicaid Opt Out
- State Medical Exclusion
- Office of Personnel Management (OPM)
- Office of Foreign Assets Control (OFAC)
- Excluded Parties List System (GSA-EPLS/SAM)
- Social Security Death Master File (SSDMF)
- NPI Validation (NPPES)
- TIN Validation (IRS)
- Licensing Boards

Validation occurs only with Primary Sources. Primary Sources include all State and Federal exclusions lists and sanction sources.

Laser Vision Providers

The laser vision correction discount and funded benefit is available through the U.S. Laser Network, which is owned and administrated by LCA-Vision. This network of providers has been credentialed by the U.S. Laser Network using an NCQA-certified process. All laser providers are credentialed through a systematic, continuous, and verified review of credentials and approval by a credentialing committee consisting of similarly licensed providers.

When choosing to take advantage of our specialized LASIK benefit, members can rest assured the doctor they choose to visit is qualified. That is because we offer our LASIK discount through the U.S. Laser Network who credentials all of their surgeons through the NCQA-certified CVO (Credentialing Verification Organization). To participate in the network, providers must:

- Meet the standards of the Quality Assurance Program that includes peer reviews, patient surveys, and outcome evaluations
- Be re-credentialed every three years

Each and every one of the network's 680 surgeons go through a rigorous, multi-step credentialing process, which ensures our members receive excellent LASIK vision services.

LCA-Vision, which administrates the U.S. Laser Network, also requires that laser providers meet the standards of the Quality Assurance Program, which includes peer review, patient surveys, and outcome evaluations.

p Describe what steps will the Offeror take between credentialing periods to ensure that Participating Providers and Laser Vision Correction Participating Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Participating Provider Network and/or Laser Vision Correction Provider Network as soon as possible.

Empire is dedicated to providing a network of quality providers and services. Providers failing to meet standards enter the disciplinary process, which grants a probationary period to correct the issue when the issue does not involve imminent harm to any member, professional qualifications or licensure, insurance sufficiency, legal actions/sanctions or fraud. If the items found are not corrected to satisfaction, the provider will be removed from the network.

q Outline the steps that the Offeror will take to advise members when a Participating Provider/Laser Vision Correction Participating Provider has been removed from the associated network(s).

Should a provider be removed from our network, we will immediately remove the provider from the provider locator. We update our system each night. Therefore, the most current information is always displayed on the provider locator.

Provider turnover is consistently low with only 0.48% voluntary turnover last year. Therefore, we will only notify clients if the provider termination affects more than 2% of our book of business. In this case, they will send advance notification to the Department and will develop and implement a recruitment plan to fill the access gap as quickly as possible.

r Explain the Offeror's proposed contracting process. Describe the type of data analysis or access analysis that is/will be performed before extending participation into your network(s) to a new Provider. Provide a copy of the Offeror's proposed Participating Provider and Laser Vision Correction Participating Provider contracts, rate sheets (if applicable), and provider manual.

Our main focus in selecting providers is to make sure that members can use their benefits in all areas of the United States, Puerto Rico, and the U.S. Virgin Islands. In fact, across the country, we have outlined a minimum number of providers to include, based on the population in the area.

If a specific area does not offer adequate access, we will begin looking for providers within that location and work to recruit them to the network. Once identified, consideration of targeted providers is narrowed to the following criteria:

- Capability of dispensing materials
- Provider type: Independent or retail
- Geographic location
- Ability to accept minimum benefit requirements
- Lab network utilization capability

Providers who want to join the network must meet eligibility requirements, accept the terms and conditions of the professional provider agreement, and complete the credentialing process before they can start seeing patients.

The first step for a provider to join the network is completing the provider contract. Contracts with providers are evergreen, negating the need to re-contract with network providers at designated intervals.

The contract standards cover many items, including the following:

- Acceptance of all service and process guidelines within the professional provider manual
- Acceptance of professional fees
- Non-discrimination against patients
- Agreement to dispute resolution provisions
- Acceptance of malpractice insurance and indemnification requirements
- Fund recovery processes and network termination guidelines

Contracts with network providers are at a tax ID level. All participating providers practicing under the tax ID must complete the credentialing process and are held to the terms of the contract and provider manual, which ensures consistency and quality throughout the network.

Contracts with network providers are evergreen, which means they do not contain a specified length of time. Potential changes to the provider contractual relationship are considered proprietary and confidential. While details cannot be disclosed, any potential changes will be made in the best interest of providers and members and will not adversely affect the Department.

The need for contract updates is continually evaluated to ensure compliance with industry standards, and to support future business needs. We will provide as much advance notice as possible when there are changes that could potentially impact the network.

As requested, we have included a sample provider contract and provider manuals for both EyeMed and US Laser Network in Section 5.

Laser Vision Providers

The laser vision correction discount is available through the U.S. Laser Network, which is owned and administrated by LCA-Vision. LCA-Vision handles all recruiting, credentialing, and contracting for laser surgeons.

The main focus in selecting LASIK providers is to make sure that members can access a credentialed LASIK surgeon across the United States. If a specific area does not offer adequate access, we will begin looking for providers within that location and work to recruit them to the network. Once identified, consideration of targeted providers is narrowed to the following criteria:

- Ability to meet NCQA credentialing standards
- Provider type: Independent or retail
- Ability to accept offer set discounted rates

Those LASIK providers who want to join the network must meet NCQA credentialing requirements, accept the terms and conditions of the professional provider agreement before they can start seeing patients. The first step for a provider to join the network is completing the provider contract. Contracts with providers are evergreen, negating the need to re-contract with network providers at designated intervals.

The contract standards cover many items, including the following:

- Acceptance of all service and process guidelines within the contracted agreement
- Acceptance of professional fees
- Non-discrimination against patients
- Agreement to dispute resolution provisions
- Acceptance of malpractice insurance and indemnification requirements
- Network termination guidelines

Contracts with network providers are at a tax ID level. All participating LASIK providers practicing under the tax ID must complete the NCQA credentialing process and are held to the terms of the agreement, which ensures consistency and quality throughout the network. Contracts with network providers are evergreen, which means they do not contain a specified length of time. Potential changes to the provider contractual relationship are considered proprietary and confidential. While details cannot be disclosed, any potential changes will be made in the best interest of providers and members and will not adversely affect the Department. The need for contract updates is continually evaluated to ensure compliance with industry standards, and to support future business needs. We will provide as much advance notice as possible when there are changes that could potentially impact the network.

s Explain the legal and operational relationship between the Offeror and any optical labs that are used to supply materials provided by Participating Providers.

There is no legal or operational relationship between the Offeror (Empire) and the optical labs providing materials under the Plan.

Network providers are free to choose the lab location that best fits their needs from our entire network of 100 labs. This full-service network produces approximately 8.5 million eyewear orders annually. Our national network of labs is operated by the country's most respected optical lab organizations. With a national network of labs that offer a large variety of manufacturers and products, our lab network is purposely broader than most managed vision care organizations to provide for faster turnaround times, consistent delivery of materials, and the option to keep revenues local to you and your members.

t Describe the Offeror's proposed method(s) for communicating with Participating Providers to advise them of Vision Plan benefits and modifications. Include copies of newsletters or other correspondence, as applicable.

We are committed to keeping all providers and their staff well informed about the policies, procedures, and standards of care expected for serving the Department's members. Our participating providers are fully supported through several communication channels including:

inFocus

An online communication vehicle designed to give providers operational information to make working with us easy, as well as educational information that will improve their ability to deliver quality care to members. The site includes:

- Monthly updates on new benefits
- Best practices
- Access to the professional provider manual and forms
- News targeted to doctors and staff

Provider Onboarding

Upon completing credentialing, providers will receive an onboarding email, which will direct them through a self-guided training program. This program will educate providers on how to access needed information and processes, including what to expect as a provider, how to recognize members and claims filing training.

Professional Provider Manual and Training Tools

Also available through inFocus, the professional provider manual outlines the processes and procedures for participating in the network. A separate forms page gives providers the ability to download any documents they need to service members.

New Client Introduction

For new clients, like the Department, we give network providers an overview of benefits and any special processes required for serving applicable members. Due to the size and complexity of the Department's plan, this communication method will be used to advise providers on the details of your plan.

Toll-Free Provider Relations Line, Voice Response System, and Email

Providers have a dedicated toll-free line and email address for the Member Services Center should they have any urgent questions.

Please refer to Section 5 for sample provider communications.

u Describe how the Offeror will monitor Participating Provider and Laser Vision Correction Participating Providers compliance with Vision Plan benefits. Include the steps that the Offeror will take when notified by an Enrollee of a billing dispute with a Participating Provider/ Laser Vision Correction Participating Provider or dissatisfaction with services received.

Our Compliance and Audit Department leads monthly audits and claim-related process enhancements, involving internal reviews and the claims adjudication process. Any identified errors or inconsistencies are logged and reported for review. Because of the high percentage of auto-adjudicated claims ([redacted]%*), providers and members benefit from payment auto-calculation, as it minimizes the risk of miscalculation and member or provider over-payments or under-payments.

Listed below is an overview of the claims auditing and quality control processes:

System Check

The automated system compares the claim to the member's specific benefit to determine if it has already been utilized during the benefit period, which ensures all benefits were applied correctly.

Claims Processors

When the Claims department receives a paper claim, one of our Claims processors will verify it is complete and manually review it for accuracy.

Daily Audits

Every day, our Quality Assurance team randomly selects and audits a statistically significant sample of claims for proper handling and financial accuracy. If any claim fails this audit process, it is will be sent to a Claims processor for manual review to determine next steps.

Process Audits

The Compliance and Audit department leads monthly audits and claim-related process enhancements, involving internal reviews as well as the claims adjudication processes. Any identified errors or inconsistencies are logged and reported for review.

As member satisfaction is always our focus, if a member reports an inconsistency in how a claim is processed, our client service representatives have access to the detailed claim and can review the claim further to determine how the benefits were applied as well as have the claim investigated and adjusted as needed. In addition, members have access to an explanation of benefits, which details how benefits were applied alleviating questions of benefit application.

** EyeMed Book of Business, 2020*

2 Provider Network Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following three program service level standards:

a Network Access Urban Areas Guarantee: The Offeror's network cannot provide less than ninety-five percent of urban Enrollees in New York State with access to those Providers and Facilities outlined in Section 3.3(1)(a) of this RFP.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which less than ninety-five percent of urban Enrollees in New York State do not have Provider access that meets the Network Access-Urban Areas requirement. The forfeited amount (Standard Credit Amount) is $1,000, calculated quarterly. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's service level standard, and our proposed credit amount is [redacted], of your Standard Credit Amount. At least [redacted]% of urban enrollees in New York State will have provider access that meets the Network Access-Urban Areas requirement (1 in provider within 5 miles). Please refer to Section 10 for the completed Attachment 6.

b Network Access Suburban Areas Guarantee: The Offeror's network cannot provide less than ninety-five percent of suburban Enrollees in New York State with access to those Providers and Facilities outlined in Section 3.3(1)(a) of this RFP.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must, propose a single forfeiture amount for each quarter in which less than ninety-five percent of suburban Enrollees in New York State do not have Provider access that meets the Network Access-Suburban Areas requirement. The forfeited amount (Standard Credit Amount) is $1,000, calculated quarterly. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's service level standard, and our proposed credit amount is [redacted], of your Standard Credit Amount. At least [redacted]% of urban enrollees in New York State will have provider access that meets the Network Access-Urban Areas requirement (1 in provider within 5 miles). Please refer to Section 10 for the completed Attachment 6.

c Network Access Rural Areas Guarantee: The Offeror's network cannot provide less than ninety-five percent of rural Enrollees in New York State with access to those Providers and Facilities outlined in Section 3.3(1)(a) of this RFP.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must, propose a single forfeiture amount for each quarter in which less than ninety-five percent of rural Enrollees in New York State do not have Provider access that meets the Network Access-Rural Areas requirement. The forfeited amount (Standard Credit Amount) is $1,000, calculated quarterly. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's service level standard, and our proposed credit amount is [redacted], of your Standard Credit Amount. At least [redacted]% of urban enrollees in New York State will have provider access that meets the Network Access-Urban Areas requirement (1 in provider within 5 miles). Please refer to Section 10 for the completed Attachment 6.

3 Turnaround Time for Receiving Eyewear Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following program service level standard:

a The Vision Plan's service level standard requires that ninety-five percent of all orders placed with a Participating Provider for covered eyewear will be shipped to the Participating Provider within seven Calendar Days after the order is received by lab processing the eyewear. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Administrative Fee for failure to meet this standard.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must, propose a single forfeiture amount for each quarter in which less than ninety-fine percent of all orders from a Participating Provider for covered eyewear are not shipped to the Participating Provider within seven Calendar Days after the order is received by the lab processing the eyewear. The forfeited amount (Standard Credit Amount) is $1,000, calculated on a quarterly basis. However, an Offeror may propose a higher amount.

Confirmed. We have exceeded your expectations by increasing our amount at risk to [redacted]; to be calculated quarterly. Please refer to Section 10 for the completed Attachment 6.

5.5 Customer Service

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Customer Service specified in Section 3.4 of this RFP, including the following:

1 Describe the training that will be provided to CSRs before they go "live" on the phone with Members/Providers, including the orientation and training materials provided to employees to guide them in the administration of the Vision Plan.

We designed our training program to equip our Member Services representatives (MSRs) with the skills to answer members' questions quickly and accurately. Our MSRs undergo extensive stage-based training and a six-month probationary period, which ensures they are ready for calls before they go "live" on the phone. By using an issue-based training program, MSRs will only be able to answer calls at their skill level, leaving tenured MSRs for more complex inquires. All MSRs must consistently meet stringent call quality standards, with calls audited weekly.

Below is an overview of our issue-based training:

Member

- Call types: Eligibility status, ID cards, benefit information, provider locator, claim status, out-of-network reimbursements
- Training: HIPAA compliance, classroom instruction, hands on training, small group sessions, mentoring, call monitoring, three assessment tests, and three quality observations

Provider

- Call types: Eligibility status, claims status, other claims inquiries
- Training: Member experience, classroom instruction, two assessment tests, and three quality observations

Provider Relations

- Call types: Provider relations and complex inquiries
- Training: Member and provider experience, classroom instruction, and mentoring

Hours of Training

- Member: 88 hours of classroom learning
- Provider: 80 hours of classroom learning
- Provider relations: 16 hours of classroom learning

2 Describe the internal reviews that are performed to ensure quality service is being provided to Members/Providers.

Empire focuses on quality in all aspects of our business. From plan member care and material dispensing to behind-the-scenes benefit management, we consistently monitor quality levels and continuously seek out methods to improve service and care for clients and members. Our commitment to quality is demonstrated in services, materials, credentialing, and quality assurance through industry recognition and the use of outside experts, as described below.

Monitoring Satisfaction

Independent firms with extensive research experience conduct objective satisfaction surveys on EyeMed's behalf. We will be performing member satisfaction surveys as required for the Department's vision program. In addition, EyeMed tracks provider satisfaction and client satisfaction with all aspects of the program. Further, they use this data to develop future initiatives and improvements.

Credentialing Network Providers

To ensure that EyeMed's network includes only those providers who are committed to quality care and service, a NCQA-certified credentials verification organization is used to credential and re-credential providers. The CVOs use primary and secondary source verification for all aspects of the credentialing and recredentialing application.

Monitoring Quality of Care

EyeMed employs a Quality Assurance Program based on vision industry standards to monitor the ongoing performance of providers. The independent Quality Assurance Committee oversees the program and includes optometrists, ophthalmologists, and opticians who are not employed by EyeMed. This ensures fair and accurate evaluation.

In addition, EyeMed's Medical Director, Joe Wende, OD, is responsible for ensuring the network delivers quality vision care to members. For example, Dr. Wende oversees the credentialing process, member grievance and appeals procedures, and provider quality improvement processes.

Customer Care Center Experience

EyeMed's Member Services Center has earned the distinction as a "Certified Center of Excellence" from BenchmarkPortal 12 years in a row. Specific areas of strength include speed of answer, first call resolution, service level, low abandonment rate, and low associate turnover.

There are three key components to our Member Services quality control initiatives:

Daily Reporting on Key Performance Indicators

Our Member Services center has key performance indicators (KPIs) representing minimums, which must be met or exceeded to satisfy client and corporate expectations. In the call center, we measure:

- Average speed of answer
- Hold times
- Call abandonment rate
- Usage of our automated IVR system

A reporting manager monitors these statistics, along with call volume throughout the day and reports results at the end of each day. The Member Services center shares weekly performance with the associate vice president of Operations, who works with the call center manager and other organizational leaders to address any areas that could potentially fall below KPIs. This reporting structure allows call center management and supervisory staff to allocate resources to address spikes in activity throughout the day or week.

Dynamic Staffing Structure

Our goal is to resolve questions or issues during the first call. To do so, our automated system routes calls into Member Services representatives queues based on skill level. More experienced representatives handle sophisticated inquiries and issues while less tenured associates address basic questions such as benefit information and the location of providers. We also use a Resource team for escalation or research. With this structure, representatives can focus on answering other calls while Resource team associates delve into deeper member and provider issues.

Call Monitoring

Member Services Center supervisors review staff performance through silent monitoring at least five times each month. Recorded calls are maintained for 90 days, though some monitoring is done live.

The following criteria are used to evaluate performance:

- Greeting
- Tone
- Accuracy of information
- Member services skills

In addition, we track call statistics – including number of calls and average talk time – for individual representatives.

3 Specify the first call resolution rate for the proposed call center.

Your members' calls will be answered by the right person, on the first ring, which we back by a [redacted]% first call resolution rate.*

**Blue View Vision Book of Business, 2020*

4 Identify the call center location, average number of CSRs on telephones during business hours, and turnover rate for CSRs.

While most of our MSRs are currently working remotely, our Member Services centers locations are:

- 4000 Luxottica Place, Mason, Ohio 45040
- 1101 Pacific Avenue, Erlanger, Kentucky 41018

Staffing

We have nearly 350 Member Services Center representatives answering calls during business hours. Member Services representatives average three years of service.

Overview and Hours of Operation

We staff our award-winning service center Monday through Friday from 7:30 a.m. until 11 p.m., on Saturdays from 8 a.m. until 11 p.m., and on Sundays from 11 a.m. until 8 p.m. ET. We have extended hours on Sundays starting at 8 a.m. from October to April when members use their benefits most. With extended hours, we have built our service model around members' very busy lifestyles.

The Member Services representatives are available to help seven days a week, 362 days per year. We only close on Easter, Thanksgiving Day, and Christmas. However, even if your members have a question when we are not in office, our IVR system ensures they can access the help they need 24 hours a day, every day of the year.

Turnover Rate

In 2020, we experienced 19% turnover, which is far below the industry's turnover standard of 30% to 40% for call centers. Due to our commitment to our associates' development and our corporate culture driven by professional passion, diversity, and community activism, the primary reason for turnover is associates moving into new positions, including promotions.

Our successful retention rate is a direct result of our associate satisfaction initiatives, which include the following:

- Ongoing training opportunities
- Career development tools and support
- Tuition reimbursement program
- Internal advancement opportunities

5 Identify proposed staffing levels, including the ratio of management and supervisory staff to CSRs and the logic used to arrive at the proposed staffing levels.

We propose using the same designated staff of 350 Member Services representatives for the Department. All representatives are U.S. based and 100% dedicated to answering only vision plan questions. Our independent vendor EyeMed performs the member services functions.

Staffing levels are continuously evaluated to ensure the ratio of management and supervisory staff is adequate. This allows us to continue to meet and exceed the Department's service expectations. Our approach makes it easy to deliver faster and more accurate service as all representatives are empowered to address all inquiries and resolve them during the first call.

Our staffing model includes the following:

Management

- 1 Sr. Director of Operations
- 1 Director, Member Services
- 1 Director, Member Experience
- 1 Director, Program Management
- 1 Director, Technology
- 2 Sr. Managers, Member Services

Member Services Staff

- 5 Member Services managers
- 11 team member leads
- 20 supervisors
- 310 representatives

Support Staff

- 6 Training and quality specialists
- 1 Training documentation administrator
- 1 Quality administrator
- 1 Operations analyst
- 2 Technical administrators
- 3 Workforce Management analysts

6 Describe the information, resources and capabilities that will be available for the CSRs to address and resolve member inquiries. Include whether any Interactive Voice Response (IVR) system is proposed and if so, provide:

We will provide a custom toll-free number for the Department and work with you to create a custom greeting for your members and their dependents. Member Services representatives (MSRs) have online access to member benefit information. MSRs may access plan design, eligibility, and claims information from their terminals using customized software. Through our self-service site, MSRs can access the same information that members can access.

IVR

Our IVR system serves as an important tool for members. All member calls will be answered through our IVR. However, at any time, callers can speak to an MSR during business hours by pressing zero or saying, “customer service.”

On average, more than 40% of calls are resolved completely through the IVR system, negating the need to speak to a live representative. In addition, with nearly 24-hours of service availability, member inquiries are answered around the clock.

The IVR includes the following self-service functions for your members:

- High-tech speech recognition
- A personal assistant to help with navigation
- Benefit-level playback
- Provider locator
- Email or fax benefits request

Capabilities

We designed our systems to anticipate members’ needs and to continually exceed your service expectations. As part of our commitment to delivering excellent service, we consistently monitor all our systems and look for areas of improvement to serve our clients better. Our systems' functions are summarized below:

Pure Connect

Our all-inclusive call management system:

- Call routing intelligence – routes calls based on skill, queues calls and allows for eligibility verification and the provider locator function
- Call recording functionality – records 100% of calls for quality management
- Workforce management – allows scheduling based on historical call data

CURA

Member data and provider locator.

MetaStorm

Back-end call tracking tool that allows us to track issue resolution.

Scheduled Maintenance

We update the IVR nightly. The application is offline for approximately two hours daily, anytime between 1 a.m. and 7 a.m. ET, for scheduled maintenance.

a A sample of the IVR script and a description of customizable options, if any, the Offeror is proposing for the Vision Plan;

We will provide a custom toll-free number and work with you to create a custom greeting for members. Below is a sample IVR greeting:

"Thank you for calling Blue View Vision, the vision provider for the New York State Vision Plan. If you are trying to find a provider in your area, get benefit and eligibility information, or receive an identification card, it is all available online. …your call may be monitored or recorded for quality assurance. In a few words how can I help you?"

b A description of the management reports and information that will be available from the system including any key statistics the Offeror is proposing to report; and

The Department will receive quarterly reporting of our Performance Guarantees including the following Member Services KPIs:

- The Member Services toll-free telephone line must be operational and available to members and providers equal to or better than [redacted]% of the required up-time (between 8:00 a.m. and 8:00 p.m. ET, Monday through Friday; and between 9:00 a.m. and 4:00 p.m. ET on Saturday, except for legal holidays observed by the Department).
- No more than [redacted]% of incoming calls to the Member Services toll-free telephone line shall be blocked by a busy signal.
- No more than [redacted]% of callers to the Member Services toll-free telephone line will disconnect a call prior to the call being answered by an MSR.
- At least [redacted]% of incoming calls to the Member Services toll-free telephone line will be answered within 60 seconds.

c A description of the capabilities of the telephone system to track call types, reasons, and resolutions.

We train Member Services representatives (MSRs) to document calls that require action in summation, and if an inquiry requires follow up, the call is documented in our internal systems. Our client tracking system documents calls requiring further follow up.

Member inquiries are documented with the following methods:

Call Recording

100% of calls are recorded and held for 15 months. MSRs are trained to document each member record for every interaction.

Online Notes

Items documented within the member record are as follows:

- Date of call
- Call tracking ticket number (if follow-up is required)
- Communication to member
- Documentation sent to member (if applicable)
- Member Services representative's first initial and last name

For Calls Not Resolved

Member Services representatives use a workflow tracking system accessible by each functional area of our organization, to document the following items for calls not resolved by the call center:

- Follow-up actions taken
- Final resolution
- Ticket open and ticket closed dates

Member Services Center quality managers continuously monitor this system for ticket volume levels and turnaround time ensuring that issues are resolved in a reasonable timeframe for the Department's members.

Call Volume and Statistics

Supervisors closely monitor and review call center call volume and call statistics, including number of calls. We also track average talk times.

We observe all MSRs to ensure they meet service expectations. This includes silent monitoring by Member Services supervisors a minimum of six times per month with results reviewed with the representative within 24 hours. We continually focus on the quality of call responses. We evaluate MSRs on the following:

- Greeting
- Tone
- Accuracy of information
- Member services
- Issue assessment skills

7 Describe the Offeror's back-up systems for its proposed primary telephone system which would be used in the event the primary telephone system fails or is unavailable. Indicate the number of times the back-up system has been utilized over the past two years.

In the event we need to implement our disaster recovery plan, you can rest assured that the Customer Care Center will be ready and available to take your calls. To ensure a seamless continuation of service, we have set-up the following safeguards:

- Genesys call routing platform leverages multiple servers in multiple locations for failover, if needed, to quickly recover from any physical or technical outage
- Integrated Voice Response (IVR) platform also leverages multiple servers in multiple locations to quickly recover from any physical or technical outage
- EyeMed back-office systems are hosted out of a hardened data center leveraging carrier and power diversity

In the event of a commercial power outage, both EyeMed and Concentrix Call Center agent desktops are supported by Uninterrupted Power Supply (UPS) and diesel generators ensuring no impact to the caller.

In the past two years, EyeMed has not had the need to utilize their back up system.

8 Describe the information and capabilities the Offeror's proposed website will provide to Enrollees/Providers. Indicate whether the Offeror currently has customized websites for its clients and, if so, describe the process utilized by the Offeror to establish customized websites for its clients.

Our secure website empireblue.com provides the following communications and interactive capabilities for members and providers:

Members

- Provider locator
- Online exam scheduling for most locations
- Eligibility status for exams, frames, lenses, and contact lenses
- Claim status for in-network providers
- Plan look-up/benefits coverage
- Last date of service
- Future dates members are eligible for services again
- Out-of-network claim form
- Printable ID cards
- Printable EOB
- LASIK and PRK information
- Online vision wellness tool for the following resources:
  - Eye health materials: A series of one-page fact sheets focused on various components of eye care, including eye exams
  - Eye health videos: A series of short consumer focused animations, ranging from how the eye works to disease of the eye, and LASIK surgery
  - Eye health websites: External resources and links to websites such as the American Optometric Association

Providers

- View benefits plans
- Check eligibility
- Submit claims

Customized Microsite

Empire is including a custom microsite designed specifically for the Department's Vision Plan. r We have developed more than 100 sites for clients and will provide a check list of customizable items including photos, colors, and unique features of the program the Department would like highlighted for members.

The website offers on-demand service around the clock. The site is designed to make accessing benefit information easy and hassle-free. Members can receive service anytime, anywhere from any smartphone or smart device. With this, members can locate a provider, get directions from their current location, and even look up plan information before walking into a provider's office.

Sydney Mobile App

Sydney Health delivers personalized engagement and real-time access to health plan information including vision, hospital, as well as medical and Rx. Plan members will enjoy a simpler, more connected healthcare experience. Within the Sydney app, they can find answers to vision care questions, see vision benefits and claims information, view ID cards, find care and local providers, access telehealth resources, check costs, learn ways to help save money, and use the MyHealth Dashboard for personalized health and wellness information.

Alexa App

In addition to empireblue.com and the Sydney app, we offer the Department's members the option to use their Amazon smart speaker or the Alexa app for information regarding their vision plan, creating a personalized experience using real-time plan information. Members do not need to go online, use a mobile app, or call the Member Services center to get an answer. It is safe and secure with a 4-digit authentication code and voice biometrics.

Members can ask Alexa the following:

- Request a digital ID card
- Find a network eye doctor
- Check latest claims
- Healthcare notifications also called care alerts
- Ask to define common vision terminology

9 Summarize how the Offeror will comply with federal and State law to assist hearing-impaired Members and those who need translation services.

Services for Hearing Impaired Members

Our Member Services center meets all standards for the Americans with Disabilities Act. Services for hearing impaired members include:

- Interpretation through the use of the 711 National Relay Service
- Telecommunications device for the deaf (TDD)

Language Translation Services

Empire is compliant with all state and federal language assistance mandates including:

- The 2017 NBPP –FFM Issuer Letter
- The 2017 Nondiscrimination in Health Programs and Activities Rule (ACA Section 1557 Rule)
- The 2011 PPACA Rules Relating to Internal Claims and Appeals and External Review Processes
- 2011 PPACA Summary of Benefits and Coverage
- California Senate Bill 353/853, etc.

Our Member Services staff has the ability to translate in many languages. EyeMed contracts with CQ fluency to provide translation in 217 languages. We continuously monitor language requests, adding or deleting languages based on your needs. We also employ Spanish-speaking representatives. These agents represent 10% of the total call center staff.

10 Call Center Telephone Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following four program service level standards:

a Call Center Response Time Guarantee: Ninety percent of incoming calls to the Offeror's customer service toll-free telephone line must be answered by a CSR within sixty seconds.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which the number of phone calls answered within sixty seconds falls below ninety percent of all incoming calls. The forfeited amount (Standard Credit Amount) is $1,000 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's Standard Credit Amount by offering [redacted]. Please refer to Section 10 for the completed Attachment 6.

b Telephone Availability Guarantee: The Offeror's customer service toll-free telephone line must be operational and available to Members and Providers equal to or better than ninety-nine and five-tenths percent of the Offeror's required up-time (between 8:00 a.m. to 8:00 p.m. ET, Monday through Friday; and between 9:00 a.m. to 4:00 p.m. ET on Saturday, except for legal holidays observed by the State).

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which the Offeror's customer service toll-free telephone line is not operational and available to Members and Providers ninety-nine and five-tenths percent of the time.

The forfeited amount (Standard Credit Amount) is $1,000 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's Standard Credit Amount by offering [redacted]. Please refer to Section 10 for the completed Attachment 6.

c Telephone Abandonment Rate Guarantee: No more than three percent of callers to the Offeror's customer service toll-free telephone line will disconnect a call prior to the call being answered by a CSR.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than three percent of callers disconnect a call prior to the call being answered by a CSR. The forfeited amount (Standard Credit Amount) is $1,000 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's service level standard, and our proposed credit amount is [redacted]% of the Standard Credit Amount, or $[redacted]. No more than [redacted]% of callers will disconnect a call prior to the call being answered. Please refer to Section 10 for the completed Attachment 6.

d Telephone Blockage Rate Guarantee: No more than three percent of incoming calls to the Offeror's customer service toll-free telephone line shall be blocked by a busy signal.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than three percent of incoming calls to the Offeror's telephone line are blocked by a busy signal. The forfeited amount (Standard Credit Amount) is $1,000 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's service level standard, and our proposed credit amount is [redacted]% of the Standard Credit Amount, or $[redacted]. No more than [redacted]% of incoming calls to our telephone line will be blocked by a busy signal. Please refer to Section 10 for the completed Attachment 6.

11 Website Maintenance Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all Vision Plan benefit changes be accurately updated by the Offeror to the Vision Plan's customized website within thirty Calendar Days of notification by the Department.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each Calendar Day beyond thirty Calendar Days notification by the Department that all Vision Plan benefit changes are not accurately updated to the Vision Plan's customized website. The forfeited amount (Standard Credit Amount) is $100 a day for each Calendar Day in which this guarantee is not met. However, an Offeror may propose a higher amount.

Our proposed performance guarantee exceeds the Program's Standard Credit Amount by offering [redacted] per day. Please refer to Section 10 for the completed Attachment 6.

5.6 Reporting Services

1 The Offeror must submit examples of the financial, utilization and Enrollee satisfaction survey reports that have been listed without a specified format in the reporting requirements above, as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the NYS Vision Plan. Provide an overview of the Offeror's reporting capabilities and the value the Offeror believes it will bring to the Plan.

Please refer to Section 6 for sample reports available.

We offer a comprehensive standard cost and utilization reporting package for medical, pharmacy, dental and vision products. Our standard client reporting package is available online 24 hours a day. Standard vision reports are updated and available monthly at no additional cost and can be produced for any custom period. The following reports are available for the Department:

- Vision membership – Shows average membership counts by contract type for the current and prior report periods. Membership distribution by age range and gender is also displayed with average age by gender compared to benchmark.
- Vision monthly member utilization – Displays month-by-month counts of subscribers, members and claimants, as well as utilization and cost information for vision exams and materials for the current period.

- Vision utilization summary – Displays key vision utilization indicators for the current period and prior period including member counts, claimant counts, and member months. Utilization metrics are displayed as a percentage of claimants using these services.
- Vision network utilization – Summarizes in-network and out-of-network utilization and savings amounts for in-network retail versus independent providers for the current period. A separate table provides information on vision exams and materials for the top five network retailers and independent providers, along with the percentage of transactions that occurred during the weekend.

We also have an interactive vision summary dashboard. This dashboard highlights vision utilization and engagement trends for members with medical conditions, which can affect vision health.

2 The Offeror must include a copy of the data sharing agreement the Offeror proposes, if any, for Department staff to execute in order to obtain system access.

Our online standard client reporting package will provide the Department with access to a comprehensive library of reports, which can be sub-selected, merged, exported, and printed on demand. We can provide various reports by business unit, location, employee status, etc., to accommodate the Department's business needs.

A sample data sharing agreement is included as Section 6.

3 The Offeror must provide examples of Ad Hoc reporting that the Offeror has performed for other clients.

We have the ability to produce a variety of ad hoc reports. Ad hoc reporting is available on any field captured within the data warehouse. The majority of ad hoc reports are delivered electronically in encrypted Excel or PDF format.

An example of an ad hoc report performed for other clients is included as Section 6.

4 Management Reports and Claims File Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all Vision Plan management reports and claim files listed in Section 3.5 of this RFP, will be accurate and delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Administrative Fee.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each Calendar Day the Department has not received the Vision Plan management report and claims file by their respective due date. The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by its respective due date is $100 per Calendar Day per report. However, an Offeror may propose a higher amount.

We are offering the requested performance guarantee. Producing standard Utilization Reporting Package within [redacted] days of the end of the reporting period. Our proposed performance guarantee exceeds the Program's Standard Credit Amount by offering [redacted]% or $[redacted]. Please refer to Section 10 for the completed Attachment 6.

5.7 Enrollee and Provider Communication Support

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Member communications specified in Section 3.6 of this RFP, including the following:

1 An outline of the communications campaign the Offeror is proposing for the Vision Plan's communication support.

Empire is committed to working in conjunction with the Department to create communication materials that give members and providers all the information needed to understand the benefits for each individual covered group. We are dedicated to finding the most effective way to help the Department communicate benefit information to your employees.

Through pre- and post-enrollment materials, ongoing wellness initiatives and web content, our communication strategy promotes education, vision wellness and access to care. We are here to help you support all facets of enrollment and ongoing participation.

The following materials are available at no added cost for the Department:

Material	Description	Timing	Distribution
Open Enrollment Content Pack	Customizable pre-enrollment ads, articles, brochures, posters, reminders, and more to help the Department communicate with its members about the vision benefits (available in both English and Spanish).	These materials are available for the Department during the pre-enrollment phase.	All items can be downloaded to print, insert into the Department's newsletters, or sent via email.
Customized Website for Open Enrollment	An open enrollment website is available where eligible employees can get the big picture about Blue View Vision, get a personalized vision benefits analysis from LevEye - our personal enrollment concierge, learn about available providers and frame brand, and see how easy it will be to use their vision benefits.	The open enrollment site is available for the Department's members during the pre-enrollment phase.	All eligible employees will be directed to this site through open enrollment digital advertising designed specifically for the Department.

Material	Description	Timing	Distribution
Benefit Summary	The benefit summary provides an overview of the Department's benefits, vision health and wellness, open enrollment, and member support tools.	The benefit summary will be distributed during the pre-enrollment phase.	Benefit summaries will be delivered through your virtual benefit fair or packages assembled by the Department.
Welcome Packet	The welcome packet includes everything your members need to know to start using their benefits such as the benefit details and a customized listing of providers.	The welcome packet will be available following initial enrollment of the Department's plan.	Welcome packets will be distributed to each enrolled employee.
Member Material Content Packs	A full suite of content packs (including Welcome to Blue View Vision and Member How-To) that include downloadable member materials.	Material content packs will be available for the Department following initial enrollment.	Material content packs can be requested from your Account Team to distribute to the Department's members.
EyeSiteOnWellness.com	This site is a one-stop resource, which provides downloadable health and wellness articles, videos, and interactive resources - including a customizable wellness calendar.	Members will have ongoing access to this site.	Members can access the website anytime and content can be downloaded to print, insert into the Department's newsletters, or sent via email.
Email Blasts	We can create email blasts for the Department including educational wellness articles, and tips.	Email blasts are available on an ongoing basis.	We will send emails to members who opt-in through eyemed.com.
Text Alerts	We can create text alerts for the Department including wellness information, special offers, benefits, quick tips, and guides.	Text alerts can be released once per month.	We will send alerts to members who opt in by calling the number on the sticker on their ID card.

Material	Description	Timing	Distribution
Member Web/Sydney App	Our secure app, Sydney, and online portal at empireblue.com gives members access to benefit details, find a provider, get special offers, view claims, and more.	Access to our website is ongoing.	Members can create an account online and have access 24hrs a day.

2 A description of the experience and qualifications of the staff who will be assigned to attend health benefit fairs, conferences, and benefit design information sessions when so requested by the Department.

As Empire already administers the Empire Plan Hospital Program, we are well-qualified to continue supporting the Department with benefit fairs, conferences, and benefit design information sessions.

Angela Blessing, Account Executive has more than 13 years of experience supporting the Department and nearly 30 years in the health care industry. Anthony Savignano, Specialty Account Manager has more than 20 years of industry experience. He has in-depth knowledge of vision plan benefit design and administration and will, along with Angela, support the Department with benefit fairs, conferences, and benefit design information sessions.

As we want your members to understand their benefits and the power of the eye exam, we will offer complimentary support during enrollment through event representation and customized, educational materials. We can support health fairs annually with at least 500 eligible employees on-site.

5.8 Enrollment Management

1 The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to manage enrollment data as specified in Section 3.7 of this RFP, including the following descriptions:

a The Offeror's proposed testing plan to ensure that the initial enrollment load is accurately updated to the Offeror's system and that the Offeror's enrollment system interfaces correctly with the Offeror's claims system.

The Empire Electronic Enrollment Transaction (EET) will work with the Department to ensure enrollment files are accurately updated in our system. We will review the test files and provide feedback to the Department during feed development. We perform full production parallel testing to ensure data accuracy, comparing each member’s record against membership data to determine if it is an add, change, or term (terms by omission are identified in the case of full population files). We will send unresolved discrepancies to the Department. Once file feeds are signed off by both parties, the file feed settings will be changed to allow production files.

Making sure the initial enrollment is loaded and previous service dates are added to our claims system is one of the most important items we will address during implementation. We have provided dates for testing of eligibility files as well as receiving and loading prior service from the incumbent carrier. After testing, an error report will be created and discussed as needed to ensure that we are ready for go live on 1/1/2022. Knowing the incumbent carrier will be processing claims through 12/31/2021, we will schedule times to receive additional claims files to ensure all utilization of the vision benefit is captured.

Our claims system is fully integrated with all cross-functional departments, providing for checks and balances to ensure only eligible members receive verification for service and that correct reimbursements are sent to providers and members. It is designed to process claims from initial submission, either electronically or by mail, through payment to the provider or member and through billing of the plan.

The system has been modified over time to support detailed business needs. It enables network providers to submit claims electronically through a dedicated web portal. Providers must register and create a secure account using their unique provider ID assigned by EyeMed. All information is password-protected. It is key to note that 98% of in network claims are submitted electronically ensuring that claims are processed quickly and accurately.

b Quality controls that will be performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system.

In the production environment, there will be tolerances based on activity levels (percentage limit of adds, terms, errors, etc.), which if not met will require an Empire EET resource review the results and determine if the file can be run. This occurs the same day for change files and within 24 hours for full population files.

In addition, we schedule future expected file dates. If we do not receive a file when expected, the EET team will receive an alert and follow up with the Department. We will also accept and process a quarterly reconciliation file to ensure the enrollment in Empire's system is accurate and up to date. Any discrepancies between Empire's system and the reconciliation files will be reported back to the Department for review and guidance.

We have noted key milestones in our implementation plan which includes auditing plan set up. We conduct internal audits and system testing to ensure plans are set up accurately and claims payments are processing accurately. In addition to our internal audit, we can coordinate with the Department to schedule a virtual meeting so we can share our screen showing sample claims processed based on the plans set up in our system.

c How the Offeror's system will identify transactions that will not load into the Offeror's enrollment system including what exceptions will cause enrollment transactions to fail to load into the enrollment system, what steps will be taken to resolve the exceptions, and the proposed turnaround time for the exception records to be added to the enrollment file.

Empire currently processes an average of 2,000 eligibility transactions per day for the Hospital Program, most of which are processed systematically. Any membership transactions that do not meet quality standards or fall out based on other factors will be reviewed and updated manually by a team of associates dedicated specifically to the Plan. These associates will compare our eligibility records with New York Benefits Eligibility and Account System (NYBEAS) records to ensure accuracy. We load most manual transactions within one business day.

We can produce the following reports from eligibility data:

Activity Report

This report displays valid activity, which is defined by an '*' next to the action taken. The left side of the report displays the member record as reflected in the membership database. The right side of the report displays the member record as it was represented on the client's file.

Error Detail Report

This report displays activity that could not be processed. An '*' is placed next to the intended action to indicate activity that would have taken place if an error had not occurred. The left side of the report displays the member record as reflected in the membership database. The right side of the report displays the member record as it was represented on the client's file.

Error Summary Report

This report provides a description of the type of error that occurred along with a count of that error type.

Client List Report

This report is a list of the client data as submitted on the client's file. This report is available upon request.

Format Error Report

This report lists format errors, or errors where data is missing or corrupted on the client's file.

Termination Report

This report lists those members who are terminated because of an implicit termination also known as a 'cancel 27'). Note: Not all implicit terminations are the result of a cancellation of coverage. A 'cancel 27' can also be the result of the member moving from one type of coverage to another, for example Active to COBRA.

Bypass Report

This report lists those members slated for termination because of an implicit termination (also known as a 'cancel 27'). Note: Not all implicit terminations are the result of a cancellation of coverage. A 'cancel 27' can also be the result of the member moving from one type of coverage to another, for example Active to COBRA. The system will not automatically cancel members if the group is set up with a Bypass and the members listed on the report need to be confirmed and cancelled manually.

Control Report

This report lists a summary of activity and errors at a group level in addition to a total for all groups.

Prior to implementation, we will meet with the Department to discuss file mapping and enrollment file testing to ensure the cleanest file possible.

Claims System

Our goal is to identify and correct any errors that may keep an eligible employee from loading into the system during implementation testing. However, to ensure data integrity and overall quality, EyeMed reviews load results before applying the data into the system. This ensures if there is a significant discrepancy, the file will not be applied to avoid potentially causing disruption in eligible members' service. After every file load the system generates a suite of post processing reports including a summary, exceptions, terminations, and group detail. Some common file errors include a missing termination date or date of birth that has been transposed. If there are minimal errors on a report, the data team will review and make corrections. For members that may be left off a file or do not load, we do have the ability to manually enter them into the system and they will be immediately eligible. For manual edits, we will request the change be shown on the next electronic file.

d The Offeror's system capabilities for retrieving and maintaining enrollment information within forty-eight hours of its release by the Department as well as:

Empire will process enrollment change files the same day as they are received. The dedicated Enrollment and Billing (E&B) team will review any fallout and manually load the eligibility record. We will process full population (reconciliation) files within 24 hours. When we receive a file it immediately triggers the compare process, and if passes tolerance checks, will trigger the database update process. We only process transactions that we identify as different data from what we have on the system. Confirmations will be sent when a file is received by the Empire EET system.

i How the Offeror's system will maintain a history of enrollment transactions and how long enrollment history will be kept online. Indicate whether or not there will be a limit as to the quantity of historic transactions that can be kept online.

We maintain enrollment file transaction history for a maximum of six months. We maintain online transactions indefinitely.

Claims

We are able to automate the file process and will set up the day of the week and time with the Department. The Department will automatically receive confirmation the file has been loaded along with the reports mentioned above. Per HIPPA retention guidelines, claims data is digitally archived and accessible for a period of up to 10 years. There are no limitations on the amount of data we can retain.

ii How the Offeror's system will handle retroactive changes and corrections to enrollment data.

We will process retroactive changes and other enrollment data corrections in accordance with the Department's guidelines. We generate a weekly report of claims needing review due to a retroactive change. The Recovery team performs the recovery process.

Claims

Our system accepts retroactive eligibility adjustments regardless of the timeframe. Typically, any retroactive adjustments are limited to 90 days. As members are only able to receive services if their information is in the system, there is little opportunity for errant claims to be processed.

e Whether or not the Offeror's enrollment and claims processing system has any special requirements to accommodate employee identification numbers; including an explanation on how dependents will be linked to the Enrollee in the enrollment and claims processing systems.

Dependents are linked to the enrollee in our enrollment and claims processing system by the employee ID number and the Department-supplied Health Care Identification (HCID) number. We capture individual member Social Security numbers (SSNs) at enrollment. There are no special requirements to accommodate these three identification numbers.

Claims

Our system can accommodate unique identification numbers provided by the Department or can automatically generate them. The use of unique member ID numbers in place of using SSNs is encouraged. Empire can accept any 9-digit numeric identifier from the employer to tie subscribers to their dependents. However, they do ask that the last four digits of Social Security numbers continue to be submitted in the appropriate field on the enrollment file, as this is an additional way for members to identify themselves at the point-of-sale and when calling the Member Services Center. Members are able to obtain services using only their name and date of birth.

f The Offeror's ability to meet the administrative requirements for national Medical Support Orders and dependents covered by a QMCSO, including storing this information in the Offeror's system so that information about the dependent is only released to the individual named in the QMCSO.

Confirmed. EyeMed's system allows for the addition of a privacy address that will notify where to send ID cards and EOBs specifically for that covered dependent.

Support of dependent access requirements include separate online accounts and HIPAA authorization forms for release of information. For instance, dependents 18 years and older must have their own online account, and their information is not visible to the subscriber. We even issue reimbursement checks specifically to dependents 18 and older for out-of-network claims.

Our Customer Care Center will not provide any HIPAA related dependent information to a subscriber if the dependent is 18 years of age or older without a HIPAA authorization form on file. For dependents under age 18, we follow a verification process and only provide requested HIPAA related information to the subscriber or verified parent(s) on the plan.

g How the Offeror's enrollment system data transfer and procedure for handling data are HIPAA compliant.

To ensure HIPAA compliance, Empire uses only the minimum required data. We will communicate using HCIDs, unless specifically approved. The file feeds will be set up with unique and secure login and password information; only designated Department resources and the Empire EDI team will know the password.

We have adopted a number of policies and procedures to ensure the sensitive information received is protected at all times, both at rest and in motion. Only associates with a need to know are provided access to systems that house PHI, and password controls ensure only those associates can access their systems. All policies, procedures, and systems comply with HIPAA and applicable state privacy laws. These actions include:

- Modified existing computer system to be compliant with national code sets to transmit, receive and process HIPAA compliant EDI files
- Implemented software for HIPAA EDI compliance

- Contracted with a clearinghouse to provide transaction brokering services between EyeMed and payers and providers for the 270/271 and 837/835 transactions
- Distributed a Notice of Privacy Practices (NPP) to all insured and fixed fee subscribers and made the NPP available to view on its website
- Completed mandatory company-wide training regarding HIPAA and refresh HIPAA rules through annual training
- Increased member website security, including password protection for member benefits information
- Tailored claims system security to restrict access to member data
- Aligned written information security program with ISO 27001 to meet all applicable legal and regulatory requirements including HIPAA, PCI, and state privacy laws

h The Offeror's backup system, process or policy that will be used in the event that enrollment information is not immediately available.

In the event enrollment information is unavailable due to an outage, there is an established IT Disaster Recovery Plan that covers all critical aspects of the business. The plan is reviewed annually and is not currently tested offsite.

This plan covers both major and minor events. It also provides for full redundancy of operating systems (hardware and connection lines) between our primary data center in Suwannee, Georgia and our alternate data center in Alpharetta, Georgia. This means we can recover service to our clients, members, and providers quickly and efficiently with minimal interruption.

In the event of a major disaster, the primary objectives of the plan are to:

- Maintain continuance of all business operations that are critical to customer service, IT support services and cash flow
- Provide critical processing capabilities as soon as possible
- Restore the data center or provide all services within Recovery Point Objective (RPO) and Recovery Time Objective (RTO) requirement

i How the Offeror will ensure that the provider portal is updated timely and accurately when accessed by Participating Providers to verify Enrollee eligibility status.

Electronic and manual updates to eligibility are reflected immediately within the system. The eligibility and claims system are integrated meaning providers verifying eligibility for a member have access to the current and accurate eligibility. In fact, a member who may be missing from the system can be entered by an account manager and the provider will be able to verify their eligibility within minutes.

The systems do not have data exchanges or other synchronization that have to occur between eligibility and claims. Therefore, providers can immediately verify eligibility and administer services for members.

2 Enrollment Management Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that one hundred percent of all Vision Plan enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within forty-eight hours of release by the Department.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each forty-eight hour period or portion thereof in which one hundred percent of the enrollment records that meet the quality standards for loading are not loaded in the Offeror's enrollment system after such enrollment records have been released by the Department. The forfeited amount (Standard Credit Amount) is $100 for each forty-eight hour period or portion thereof in which this guarantee is not met. However, an Offeror may propose a higher amount.

[redacted], we are offering the following performance guarantee:

[redacted]% of electronic eligibility files that meet the quality standards for loading will be loaded in the Offeror's enrollment system within [redacted] business days after of receipt of clean data delivered via SFTP. Our proposed performance guarantee exceeds the Program's Standard Credit Amount by offering [redacted] for each [redacted] period. Please refer to Section 10 for the completed Attachment 6.

5.9 Claims Processing

1 The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in processing claims specified in Section 3.8 of this RFP, including the following:

a Provide a flow chart and step-by-step description of the Offeror's proposed methodology for processing Participating Provider, Laser Vision Correction Participating Provider and Enrollee-submitted claims for the Vision Plan.

In-network claims are always submitted by our providers, so it is simple and convenient for Plan members to use their benefits. We have included the requested flow chart as Section 8 and provided step-by-step descriptions below:

Provider Online Claims

1 Verify Eligibility and Submit Claim

Providers are required to verify eligibility before providing services. When eligibility is verified, either electronically or by calling our Customer Care Center, providers can submit the claim for processing.

2 Claim Passes through Claims System

After acceptance, the complete claim will run through an automated claims system where it is matched up against the member's benefit. The claims system ensures all benefit levels were applied correctly according to the plan and verifies the correct reimbursement amount.

3 Reimbursement to Provider

Finally, the claim will process through the payments system and payment is dispersed to the provider.

Provider Hard Copy Claims Submission

1 Complete and Mail Claim

After eligibility is verified, the provider can complete the claim form and mail it for processing.

2 Entering of Data and Passing through Claim

Once received, the claim will be manually entered into our system and will run through an automated claims system where it is matched up against the member's benefit. The claims system ensures all benefit levels were applied correctly according to the plan and verifies the correct reimbursement amount.

3 Reimbursement to Provider

Finally, the claim will process through the billing system and payment is dispersed to the provider.

Member Out-of-Network Claims Submission

Most of our members choose to visit an in-network provider, but if a member wants to see an out-of-network provider, they can easily submit the claim for reimbursement:

1 Request an Out-of-Network Claim Form

Members can be quickly and easily downloaded an out-of-network claim form online at eyemed.com. Or, members also have the option to call the Customer Care Center and request an out-of-network claim form to be mailed, emailed or faxed to them.

2 Receive Services and Submit Claim Form

Next, the member will receive services, request an itemized paid receipt, and submit claim form.

3 Entering of Data and Passing through Claims

Once received, the claim will be manually entered into our system and will run through an automated claims system where it is matched up against the member's benefit. The claims system ensures all benefit levels were applied correctly according to the plan and verifies the correct reimbursement amount.

4 Reimbursement Check mailed to Subscriber

Once complete, a reimbursement check will be mailed directly to the subscriber

Laser Vision Claims Submission

In-network laser vision claims are always submitted by our providers, so it is simple and convenient for Plan members to use their benefits.

b Describe the capabilities of the Offeror's claim processing system addressing each of the following Vision Plan components:

EyeMed’s platform is built on industry-leading software solutions including Facets, Oracle, and SAP. The system is fully integrated with all cross-functional departments, providing for checks and balances to ensure only eligible members receive verification for service and that correct reimbursements are sent to providers and members (where applicable). It is designed to process claims from initial submission, either electronically or by mail, through payment to the provider or member (where applicable) and through billing of the plan.

i Eligibility verification;

The system supports real-time eligibility verification and benefits calculation at the point of service, resulting in streamlined services for providers and members. In network, providers verify the member's eligibility using their name and date of birth. The member's next eligible date of service and benefit is also displayed, ensuring that the member receives the appropriate services and materials.

ii Prior authorization for Medical Exception Program benefits;

We request further discussion of the desire of the Department. If a vision care provider's findings would trigger this extra benefit, it could be performed systemically. We could also duplicate the current procedures which appear to require completion of a form attesting medical necessity from the member. Once the form has been submitted, it will be recorded into the system allowing the member additional exams going forward should their condition qualify.

iii Variations in covered Vision Plan benefits for various employer groups;

A foundational element to the claims system is the plan design set up – this detail ensures that all claims are processed correctly against the contracted benefits. Each individual employer group will be set up in the system as a subgroup of the Department plan. Plan set up will create the benefits within the system for each group during implementation. Internal audits and testing will be done to ensure the system is applying and administering the benefits as specified within the RFP.

iv Duplicate claims;

Our providers verify eligibility before a member can receive services. Claims are submitted through a systematic adjudication process which automatically identifies and rejects duplicate claims.

v Accurate claims pricing; and

The fully integrated claims system compares the charges by the provider to the specific plan benefits configured in the system. Currently, almost [redacted]% of all claims are automatically adjudicated.

vi Edits, controls, and safeguards to ensure claims are processed according to benefit design.

More than 96% of claims are submitted electronically and [redacted]% of all claims are auto adjudicated. Since the invoicing processes are fully integrated with the membership and claims processing system, several quality checks are incorporated to identify variances and ensure accuracy as follows:

- A membership assessment is performed when data is loaded to ensure the numbers are correct
- To verify that all members are billed correctly, each new plan is compared against the membership loaded
- Membership results above specified limits are manually verified to ensure accuracy

c Describe the Offeror's claims processing system platform including any backup system utilized.

EyeMed has developed a custom extension of the Facets application that fully deals with record evaluation and integrity of the data prior to committing to the system. The claims system is fully integrated with other functional areas of our business including the Customer Care Center, membership services, billing, reporting, and provider relations. This provides checks and balances to ensure that only eligible members receive services and providers are reimbursed correctly.

The main computer systems are housed in a secure data center facility in Suwanee, Georgia, which has robust physical security & disaster recovery capabilities. Data backups are performed daily and with a full system backup performed monthly. All backup tapes are stored securely off-site. Additionally, the system maintains a "journal" of all transactions on a 24-hour basis to facilitate data recovery procedures. Access to our systems is defined at the user level, which allows us to limit access to data, including read/write capabilities, based on an associate's role.

We are always researching and developing new ways to enhance our systems. When we find something to incorporate, we do so in-house and have associates devoted to the process.

d Describe the Offeror's disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure, including the process to service Enrollees who try to receive Vision Plan services when the claim payment system is down or not available.

There is an established IT Disaster Recovery Plan that covers all critical aspects of the business. The plan is reviewed annually and is not currently tested offsite. This plan covers both major and minor events. It also provides for full redundancy of operating systems (hardware and connection lines) between our primary data center in Suwannee, Georgia and our alternate data center in Alpharetta, Georgia. This means we can recover service to our clients, members, and providers quickly and efficiently with minimal interruption.

In the event of a major disaster, the primary objectives of the plan are to:

- Maintain continuance of all business operations that are critical to customer service, IT support services and cash flow
- Provide critical processing capabilities as soon as possible
- Restore the data center or provide all services within Recovery Point Objective (RPO) and Recovery Time Objective (RTO) requirements

e Describe how any changes to the benefit design would be monitored, verified and tested for the Vision Plan, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Vision Plan.

Our administrator manages over 22,000 individual clients, many with unique benefits. The sophisticated claims system silos each individual client's benefits to ensure they are administered as designed. Changes to other clients would have no impact on the administration of the Plan's benefits.

f Describe what steps the Offeror will take to ensure that Participating Providers and Laser Vision Correction Participating Providers comply with the HIPAA requirement for use of National Provider Identifiers for all electronic claims submissions.

All in-network provider claims include the National Provider Identifier. Claims data will include identification data specific to the provider that treated each member including:

- NPI
- Provider Last Name
- Provider First Name
- Professional Designation
- Provider Address Information

g Describe how the Offeror's adjudication system will feed the reporting and billing systems.

Our system is fully integrated with each functional area to process data from initial submission of eligibility to claims payment and billing. The claims system is fully integrated with other functional areas, including: Customer Care Center, membership services, billing, reporting. and provider relations. This provides for checks and balances to ensure only eligible members receive verification for service and the correct reimbursements are sent to providers and members.

A foundational element to the claims system is the plan design – this detail ensures that all claims are processed correctly against the contracted benefits. The system also supports real-time eligibility verification and benefits calculation at the point of service, resulting in streamlined services for our providers and members.

All reporting is pulled directly from this system to ensure accurate and transparent reporting and billing for our clients. We have provided sample data elements in Section 10.

5.10 Occupational Vision Program

1 The Offeror must provide a narrative describing its proposed Occupational Vision Program based on the specifications in Section 3.9 of this RFP, including the following:

a Indicate whether the Offeror has experience administering an Occupational Vision Program for an Employer. If so, describe the Offeror's experience administering an Occupational Vision Program and state what percentage of Enrollees receive Occupational Vision eyewear for a similar client, using the same criteria that the Offeror proposes for the Vision Plan.

Confirmed. Our vision administrator, EyeMed, has the experience and expertise to administer your Occupational Vision Program. Currently, 14 clients have a similar safety/occupational vision benefit with 30% of their enrollees receiving a safety/occupational vision benefit.

Members with Occupational Vision Program coverage are eligible for certified frames and lenses that meet ANSI (American National Standards Institute) standards for safety.

b Specifically state the Offeror's proposed eligibility criteria for the Occupational Vision Program. Based on the proposed criteria, indicate whether there are additional procedures outside of the regular, comprehensive eye examination that Participating Providers will be required to perform. If so, describe the additional procedures.

A separate membership file-feed will be maintained for those eligible to receive the Occupational Vision program. Providers will verify eligibility and the member's benefits displayed will include ANSI certified frames and lenses. Only prescription eyewear will be dispensed through the occupational program. There are no additional procedures that providers are required to perform outside a comprehensive examination.

The claims system is fully integrated with all cross-functional departments, providing for checks and balances to ensure only eligible members receive verification for service and that correct reimbursements are sent to providers and members. The system supports a large portfolio of vision benefit plan designs.

c Indicate whether the Offeror's lens fabricator has experience with or the ability to fabricate lenses for insertion into respirators, as specified in *NYS Police Respirator Insert Dispenser Instructions* (Attachment 34). If so, describe that experience or ability.

Confirmed. All LensCrafters locations will have the ability to fabricate the respirator lenses as outlined in Attachment 34 of the RFP. Lenses will be fabricated either at a LensCrafters in-store lab or at a central lab location. In cooperation with the Department, the lab will:

- Have the Department send a sample of frame or insert
- Lab to test frame/insert for approval to be processed
- Once approved, lab personnel will provide instructions and training on how to process the frame or insert.

d Describe how the Offeror will communicate the Occupational Vision Program to Enrollees and Participating Providers.

We will work with the Department on custom communications that can be shared with members who are eligible for the Occupational Vision Program. In addition, custom member communications will be posted to the Department's vision plan website.

Providers are sent a New Client Introduction with an overview of benefits and any special processing required. With the member's name and birthdate, providers can verify eligibility via an automated IVR or an online claim and membership system. The member's next eligible date of service and benefit is also displayed, ensuring that the member receives the appropriate services and materials.

e Describe how the Offeror will monitor Participating Provider compliance with the established Occupational eligibility criteria to ensure eye wear that does not meet the criteria will not be charged to the Vision Plan or dispensed to the Enrollee. Detail how the Offeror will prove compliance with the established criteria and refund any claims that were inappropriately charged to the Vision Plan.

Providers have two simple methods available to confirm the member has benefits available:

- Automated IVR
- Online claim and membership system

The member's next eligible date of service and benefit is displayed, ensuring the member receives the appropriate services and materials. If a member's eligibility is unable to be verified, the provider can call the Member Services Center for additional support.

More than [redacted]% of all claims are adjudicated automatically with 98% of in-network provider claims submitted electronically.* The fully integrated system compares the charges by the provider. Senior processors review any claims falling outside a threshold. EyeMed also randomly audits [redacted]% of manually processed claims daily to ensure accuracy. Less than [redacted]% of claims require adjustment and more than [redacted]% of claims are auto-adjudicated.* The system performs many checks and balances to ensure claims are paid at the appropriate benefit levels for eligible services only; therefore, adjustments are rarely required. The claims adjustment percentage is based on claims receiving a non-system adjustment. Non-system adjustments are flagged in the system so they can be pulled for reporting purposes.

Network providers that support the Occupational Vison Plan offer a selection of safety frames and use only ANSI certified labs to fabricate materials. Using these controls ensures the eyewear your employees receive through the Occupational Program meet or exceed ANSI standards. During implementation, the safety programs will be designed based on each group's standards as detailed within the RFP.

The occupational program will endure the same claim auditing procedures as our dresswear program. As part of its Quality Assurance program, EyeMed conducts several hundred provider financial audits a month, which verifies accurate billing amounts and application of benefits. To ensure compliance, they audit providers' clinical records. All network providers must adhere to the Quality Assurance program as outlined in the Professional Provider Manual.

In the rare occurrence where a billing adjustment for a self-insured plan is needed due to claim adjustment, an adjustment summary form will be included with the claims invoice. The summary will identify any post-billing adjustments and reflect the revised total amount due from the client.

** EyeMed Book of Business, 2020*

5.11 Medical Exception Program

1 The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in its Medical Exception Program as specified in Section 3.10 of this RFP, including the following:

a The Offeror's experience administering a Medical Exception Program.

We have been administering additional benefits for those with specific medical conditions for more than 10 years. Our network providers record over 250 ICD-10 codes related to eight high-risk conditions when they submit the electronic claim. While our system automatically identifies conditions reported by our vision care providers, using this data would significantly increase the number of members qualifying for the medical exception program. In 2020, nearly 6.5% of all exam claims included an ICD-10 code.

As outlined in the RFP, the medical exception program requires provider documentation. Therefore, we are proposing the Department's members utilize a Medical Exception Form where their physician will attest to the member being diagnosed with a medical condition or prescription that qualifies them for an annual eye exam.

Please refer to Section 9 for a sample medical exception form based on a similar program we currently administer for the State of Michigan. The Department's form will include a barcode utilized by our claim department to quickly identify the Medical Exception Program within the system.

b A listing of medical conditions that the Offeror is proposing to use to qualify an Enrollee or dependent to receive services under this program.

Our medical director has reviewed the conditions referenced in Section 3.10 of the RFP. Therefore, we are proposing the following conditions to be eligible for a medical exception:

- Diabetes
- Cataracts
- Keratoconus
- Eye surgery within two years of last Rx
- Prescription medications that may impact vision

We believe the list to be very comprehensive to ensure high risk members are receiving the vision care needed. While children under 19 may be recommended, per the benefit eligibility outlined, they are already eligible for an exam every 12 months.

c The Offeror's proposed authorization process for the Medical Exception Program, including a sample of any Medical Exception Program authorization forms that the Offeror is proposing to use under the program, timeframes for authorization and eyewear benefit criteria.

The Medical Exception form will be available to members on the Vision Plan's custom microsite. Members may also call Member Services to request. A sample is included in Section 9. The process for requesting Medical Exception is as follows:

- Member will submit completed form to EyeMed.
- EyeMed will review form for accuracy and required attestation from the provider. To qualify for additional eyewear, documentation of the change in prescription will be required from the vision provider.

- Should required information be missing, the member will be contacted by our Member Services team who will educate member on completing the form and advise to resubmit once complete.
- Once deemed compliant with outlined requirements, the qualifying member's exam eligibility and or eyewear benefit will be updated within the system with 10 days.

d How the Offeror will communicate the Medical Exception Program and monitor Participating Provider compliance.

Details of the program will be outlined to members with a custom communication piece developed specifically for the Department during implementation. This will be accompanied by the form required outlining conditions for which a member will need to submit attestation by their physician detailing their diagnosed condition or medication qualifying them for the additional exam.

Providers will have no additional responsibilities in this program as they will receive authorization for the additional exam simply by verifying the member's eligibility via IVR, online claim and membership system, or by calling the Customer Care Center. They will be provided with the member's next eligible date of service and benefit, ensuring that the member receives the appropriate services and materials.

More than [redacted]% of all claims are adjudicated automatically with 98% of in-network provider claims submitted electronically.* The fully integrated system compares the charges by the provider. Senior processors review any claims falling outside a threshold.

As part of its Quality Assurance program, EyeMed conducts several hundred provider financial audits a month to verify accurate billing amount and application of benefits. Providers' clinical records are also audited to ensure compliance. All network providers must adhere to the Quality Assurance program as outlined in the Professional Provider Manual.

5.12 Upgrade Program

1 The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in its Upgrade Program as specified in Section 3.11 of this RFP. In this narrative, the Offeror must:

a Explain the Offeror's experience in administering an upgrade program, including what direction the Offeror gives to Participating Providers regarding Upgrade selling and how this benefit is communicated to Enrollees.

Empire administers similar programs for a majority of our clients. We understand how the options a member selects may greatly alter their out of pocket expense. We believe providing members with the detailed information of out of pocket options and the cost for each, aids them in the decision-making process when they purchase their glasses.

As retail charges for these options vary greatly between providers, we provide low out-of-pocket cost for members by providing fixed pricing on the most popular lens options and 20% off for all other add-ons and services including glasses cases, lens cleaners and even non- prescription sunglasses. With this approach, our members save 71% versus retail cost at all provider locations*

Providers simply enter the member's selections into our claim system and their benefit's applicable allowances, fixed pricing and discounts are automatically applied.

Balance billing and up charging of services to gain greater reimbursement are not permitted and are examples of provider billing abuse, which is subject to disciplinary action. EyeMed continuously analyzes claims data to identify any upcoding of services or materials. Any identified instances of billing abuse result in recoupment of overcharges and reimbursement of member out-of-pocket expense, as appropriate. Providers found to have up charged services or materials are subject to disciplinary action up to and including termination from the network.

**EyeMed member average savings*

b Propose a minimum discount of retail pricing for upgrade selections that are not a covered benefit for any employee group covered under the Vision Plan. Propose a methodology for charging Enrollees for these options under the Upgrade Program, including examples of the pricing methodology for frames with a retail cost of $200 or more, premium progressive lenses and premium anti-reflective lens coating.

With the exception of pediatric vision plans and safety eyewear plans, EyeMed does not restrict members' choices to a limiting frame tower or frame selection. In order to ensure high member and provider satisfaction, all frames at all provider locations are available to members through their frame allowance.

Our frame model is built around the freedom of choice for all types of members. Benefits should be easy to understand and empower members to make fashionable or economical based decisions in choosing the eyewear that best fits their needs and lifestyles.

Our proposed benefit offers fixed pricing on lens options negotiated with our in-network providers at no additional cost to the Department for these upgrades. Progressive lenses are categorized into five tiers. For groups with benefits that include fully covered progressive lenses, we propose using the Standard Tier and Tier 1 which represent more than 60 brands that would be included at no-cost to the member. Enrollees will receive fixed pricing on Tiers 2 and 3 in addition to a 20% discount on all other progressives not listed. Enrollees who select anti-reflective coating will also receive a fixed surcharge based on tier. Below are the requested examples:

Upgrade Program Option	Member Cost
$200 retail frame	$200 - $130 frame allowance = $70 less 20% discount on frame overage Member cost: $56
Progressive Lenses	Standard and Tier 1 (over 60 options): $0 copay Tier 2 (over 30 options): $95 copay Tier 3: (over 60 options): $110 All others: 20% discount off retail
Anti-Reflective Coating	Standard: (24 options) $45 Tier 1: (12 options) $57 Tier 2: (20 options) $68 Tier 3: $85 copay All others: 20% off retail

For complete details including premium progressive and anti-reflective classifications, please refer to Section 5.

c Confirm that the Enrollee surcharge for Upgrade Program selections that are a covered benefit for one or more employee groups covered under the Vision Plan will be equal to the Vision Plan fees set forth in the *Participating Provider/Laser Vision Correction Surgery Fee Schedule and Administrative Fee* Form (Attachment 16). [Note: Do not specify the actual amount of the Participating Provider Fee Schedule when responding to this question. The amount of the Participating Provider Fee Schedule should be included in the Financial Proposal only.]

Confirmed.

5.13 Transition and Termination of Contract

1 The Offeror must provide a narrative describing in detail how a transition to a successor entity will ensure uninterrupted benefits to Members, as specified in Section 3.12 of this RFP.

Confirmed. While we do not like to see clients leave, we understand it does happen. We commit to continuing the administration of the program as we have committed to in the RFP and to aid the Department in the transition process, including transmitting electronic files to the new carrier so previous claims activity can be captured. Should you choose to leave Blue View Vision, we know the experience you have during implementation may directly impact our opportunity to earn your business back.

If the contract is terminated, there's a claims run-out period where any claims submitted with service dates within the contract period, but received after the termination date, are billable to the Department for up to [redacted] months for provider claims, [redacted] months for a provider Medicare claim and [redacted] months for member claims.

Should you choose to leave Blue View Vision, we know the experience you have during implementation may directly impact our opportunity to earn your business back.

2 Transition and Termination Guarantee: In this part of its Technical Proposal the Offeror must state its agreement and guarantee all Transition Plan requirements outlined in Section 3.12 of this RFP will be completed in the required times frames to the satisfaction of the Department.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each day or part thereof that the Transition Plan requirements are not met. The forfeited amount (Standard Credit Amount) is $300 for each Calendar Day this guarantee is not met. However, an Offeror may propose higher amounts.

Our proposed performance guarantee exceeds the Program's Standard Credit Amount by offering [redacted] per day. Please refer to Section 10 for the completed Attachment 6.

Section 2

Executive Summary

Empire BlueCross

An Anthem Company

Empire BlueCross

An Anthem Company

A vision plan that lets you see the whole picture

Working to improve the health of all New Yorkers

We understand taking care of your Vision Plan members is important to you. It's important to us, too. That's why we offer trusted and caring solutions to guide your enrollees and covered dependents (members) to the best eye care possible. It's one way we can achieve our shared mission, together.

Empire Blue View Vision Select will bring you **comprehensive vision assets** backed by our depth of expertise. We will deliver a **market-leading vision plan** for your members and a "**Blue point of view**" on vision products, along with extensive experience and documented success. In conjunction with our vision plan administrator, EyeMed, we offer a **best-in-class administrative model** through our partner's **industry-leading member tools and support**.

Our Blue View Vision plan provides cost-effective and inclusive benefits, from a broad range of eye care providers and locations. The plan is designed to be user-friendly and aims to provide savings beyond basic coverage.

We have thoroughly reviewed and fully understand the requirements contained within the Request for Proposal (RFP). Empire Blue View Vision is committed to administering a vision care program that meets or exceeds your objectives, including:

01

Access to a network with more than 4,200 provider locations in New York.

The network is comprised of approximately 75% independent providers and 25% retail chain providers, including: LensCrafters, Target Optical, America's Best, Sterling Optical, and Pearle Vision. Nearly [redacted]% of your members will have access to a participating provider due to our broad network.

02

A vision care partner providing accurate and transparent administrative services.

We believe in simplifying vision plan implementation for both the Department as well as your members. To support this endeavor, a Welcome Kit is mailed to each enrolled member's home, containing two (2) identification cards, a detailed summary of benefits, and a list of eight (8) network providers closest to their home address. This makes it easier for members to use their vision benefits and reduces in-bound calls and questions.

We believe in a seamless and simplified vision plan experience. Our team will partner with you to develop a custom website and create informative member communications, ensuring each bargaining unit and group understands how their vision plan works.

03

Support from our integrated mobile application, Sydney Health℠.

Sydney Health delivers personalized engagement and real-time access to health plan information. Members will enjoy a simpler, more connected healthcare experience. Within the Sydney app, they can find answers to vision care questions, see vision benefits and claims information, view ID cards, find care and local providers, access telehealth resources, check costs, learn ways to help save money, and use the MyHealth Dashboard for personalized health and wellness information.

04

Collaboration with the Plan's other carriers — for example, The Medical Exception Program.

We welcome this type of collaboration to better tie the preventive nature of the Program to your overall health-related cost containment goals. We will support your existing wellness and disease management initiatives by reporting on over 250 ICD 10 diagnosis codes and CPT II reporting codes for eight (8) high-risk conditions.

Our integrated systems allow us to supply claims utilization reports to other carriers, as well as Flexible Spending Account feeds to third-party administrators, as requested. We can work with you to identify any reporting needs (e.g. required data elements, frequency of transmission) and will provide appropriate solutions for all types of plans.

05

A State of New York dedicated toll-free number will be provided — answered by live representatives — 7 days a week, 362 days per year.

We are closed on Easter, Thanksgiving, and Christmas. But even if your members have a question when we're not in the office, our Interactive Voice Response (IVR) system, self-service website, and convenient Sydney Health app ensure help is available 24 hours a day, every day of the year. We aim to address every call with the right care at the right time, providing each person with the information they need. Our first call resolution rate is [redacted]% because of this effort.

06

Experience administering benefits for collectively bargained clients.

We understand the importance of administering the benefit design in a manner consistent with your collectively bargained benefit structure. We've developed both systematic and administrative flexibility to align with your union-negotiated benefit designs.

Our experience with large, complex clients shines through in our response.

Empire serves more than seven million members and insures over 100,000 employer groups. We administer multiple states' vision benefits, each with their own unique customizations and nuances. These states include [redacted], [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted].

The nine groups and differing plan designs outlined in the RFP requires a system that is vision-centric and detail-oriented to seamlessly administer benefits. Empire has administered The Empire Plan Hospital Program since 1957 and understands the intricacies of not only this Program, but also of your Vision Plan.

Our vision care partner, EyeMed, administers vision plans for more than 22,000 clients and 62 million members, including more state governments than any other vision benefits provider in the country. More than 25 state governments rely on the expertise, experience, and administrative excellence that EyeMed offers, including [redacted], [redacted], [redacted] and [redacted].

EyeMed supports*

62M
members

22,000+
clients

[redacted]vernments

*EyeMed internal data.

Empire serves*

7M+
members

100,000+
employer groups

*Empire internal data, 2020.

Completing your mission

We're ready to show you how we can deliver best-in-class vision benefits for healthier outcomes. We are uniquely positioned as the leading partner to achieve these results based on our existing relationship with the Empire Plan as the Hospital Program administrator, our unique capabilities and provider collaborations, unmatched technology and data, and a member-centric view known as the Whole Health Connection.

It's our goal to help ensure your Plan members have peace of mind, knowing they have the comprehensive care and support to keep them in good eye health for many years to come.

Section 3

Account Team

Empire BlueCross

An Anthem Company

Biographical Sketch Forms (Attachment 14)

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Alan Murray

Job Title: President and CEO

Relationship to Project: As President and CEO, Alan is accountable for Empire's New York operations including sales, product, marketing, network and service. He has overall responsibility for the operations and administrative management of the State of New York account, working closely with the Account Team and Operations leaders.

Alan is available to the Department and has the ability to engage leaders at the highest level of our organization to support the delivery of program services. He is an experienced leader with an understanding of the unique needs and requirements of the Department. Alan and his leadership team will support the Account Team to ensure we provide the Department with programs and services that achieve your financial and administrative expectations. He is committed to the success of the Vision Plan and providing the Department with the exclusive service you deserve as our largest client.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
The Open University Milton Keynes, UK	BS with Honors	2005	Open
Warsash Maritime College Southampton, UK	NVQ4	2002	Merchant Vessel Operations
Warsash Maritime College Southampton, UK	Higher National Diploma	2002	Nautical Science
Warsash Maritime College Southampton, UK	NVQ3	1999	Merchant Vessel Operations

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
Sep 2018 – Present	Anthem, Inc.	President and CEO Empire BlueCross BlueShield
Aug 2017 – 2018	Executive Consultant	Executive Consultant
Aug 2013 – Aug 2017	CareConnect Insurance Co.	President and CEO
Apr 2012 – Jul 2013	Northwell Health	VP, Managed Care
Nov 2007-Apr 2012	United Healthcare	VP, NY Market Lead
Nov 2002-Nov 2007	Anthem, Inc.	RVP, New York Provider Network Development
Sep 1996-Feb 2002	Shell International Shipping and Trading Co.	Second Officer, British Merchant Navy

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Alan is an experienced President with a demonstrated history of working in the insurance industry. He is skilled in Physician Relations, Healthcare Management, Medicare Part D, Medicare, and Quality Improvement. He is a strong business development professional with a Bachelor of Science with Honors from The Open University, Milton Keynes, United Kingdom.

Alan has an in-depth knowledge of the industry and the local market which greatly benefits our consumers, customers, and provider partners in New York.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: John Thorp

Job Title: Staff VP Vision Services

Relationship to Project: John has overall accountability for the Vision business at Empire BlueCross (NY), as well as, in the other 13 States Anthem, Inc. operates the Blue Cross and/or Blue Shield licenses. He is responsible for all product/benefit design, operations, provider network, cost of care controls and financials for the vision business. He manages all vision partners/vendors we utilize to help administer the vision business in our markets. He works closely with the Sales and Account Management teams in all markets to ensure the vision business operates seamlessly and is appropriately integrated with the medical products & services.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Denison University	BA Economics	1994	Economics
Xavier University	MBA	2000	Finance

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2014 – Present	Anthem, Inc.	Staff VP Vision Services
2011 – 2014	Anthem, Inc.	Dir I Product Development
2010 – 2011	Anthem, Inc.	Product Management Dir Sr.
2006 – 2010	Anthem, Inc.	Product Management Dir.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

John Thorp is the president of Anthem's Vision business. He is responsible for leading the organization towards meeting its operating gain and membership goals with its Vision insurance products and services representing approximately 7.3 million members. Since joining Anthem in 2006, he has served in a number of key roles, including Product Director and Senior Product Director for the company's Vision business.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Jason O'Malley

Job Title: Regional Vice President, Sales

Relationship to Project: Jason has overall accountability for the management of the State of New York account. As such, Jason is responsible for the leadership and direction of all account management activities associated with the Vision Plan along with working collaboratively with the Empire BlueCross team to provide oversight and support to ensure we meet the Department's expectations. Jason has the authority to command the resources necessary, and access to senior level management within the organization, to ensure flawless execution of the Vision Plan.

As the current Regional Vice President over the Empire Plan Hospital Program, the Department will have an accountable, experienced team leader with in-depth knowledge of the State's benefit programs and strong relationships with key government and labor contacts. Jason is committed to maintaining our strong partnership and ensuring that Empire continues to serve as a trusted and effective partner, providing the Department with the expertise and dedicated resources required to administer the Vision Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
State University at Albany School of Business	MBA	1995	Business

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2019 – present	Empire BlueCross	RVP, Sales
2008 – 2019	Empire BlueCross	Director, NYS Account
2005 – 2008	Empire BlueCross	Account Executive, NYS Account
1997 – 2005	Empire BlueCross	Account Manager
1995 – 1997	Empire BlueCross	Implementation Analyst
1993 – 1995	Empire BlueCross	Claims Adjuster

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Reporting directly to the President and CEO, Jason leads the Upstate Sales and Account Management team for Empire BlueCross. He is responsible for overseeing the growth and profitability of the Upstate market, ensuring successful long-term relationships with client and brokers, as well as setting direction on product development, advertising and community relations.

Jason has been with the company since 1993 with more than 20 years of account management experience at Empire, as well as prior experience in operational and analytical roles within our account implementation and claims areas.

As the current Regional Vice President over the Hospital Program, Jason works with the account team to develop recommendations on ways to improve Plan administration, benefit design, and various approaches to control cost.

Jason earned his master's degree in business administration from the State University at Albany School of Business. He is also a licensed life and health insurance agent in New York.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Angela Blessing

Job Title: Account Executive

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Relationship to Project:

Angela will be responsible for all aspects of account management including overseeing the day-to-day management of the Vision Plan, monitoring account performance, and strategic planning. She will serve as the single point of contact for the Department. Angela will have direct access to senior management across multi-functional clinical, operational, and financial areas.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Southern New Hampshire University	AA	2017	General Studies Business Concentration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2008 – Present	Empire BlueCross	Account Executive
2007 – 2009	Empire BlueCross	Provider Network Business Analyst
2004 – 2007	Empire BlueCross	Manager, Provider Data
2000 – 2004	Empire BlueCross	Manager, Provider Service

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Angela has over 30 years of experience in healthcare, working at the forefront to address the challenges of an ever-evolving industry. During her tenure at Empire, she has advanced to positions of increasing responsibility, with specialized experience in areas relating to Provider Contracting, Claims, Customer Service, and Account Management.

Angela has been the Account Executive since 2008 for the Empire Plan Hospital Program, Student Employee Health Plan, and the Excelsior Plan. She routinely collaborates with the Department and the Governor's Office of Employee Relations and provides recommendations on ways to improve Plan administration, benefit design, and various approaches to control cost. She also provides recommendations and/or insight on developments in the healthcare industry, legislative and regulatory requirements, and their financial and/or procedural impact to the Program.

As the current Account Executive, the Department will have an accountable, experienced team leader with in-depth knowledge of the State's benefit designs, strong familiarity with key government and labor contacts, and a proven track record to build upon our longstanding relationship. With her in-depth knowledge and experience, combined with her direct access to leaders across multi-functional operational, clinical, and finance areas, Angela will ensure the same efficient and exceptional administration of the Vision Plan as experienced on the Hospital Program. She is well known by the Department, the Governor's Office of Employee Relations, and key union contacts. These long-standing collaborative relationships, prior operational and provider contracting experience, and longevity serving the State of New York uniquely qualifies Angela to oversee administration of the Vision Plan.

Angela holds a Life, Accident, and Health license in New York.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Nicholas Generali

Job Title: Account Manager

Relationship to Project: As part of the dedicated account team, Nicholas supports the Account Executive with all activities involved in the management of the Empire Plan Hospital Program. For the Vision Plan, Nicholas will continue in this role and will also support Vision Plan Account Manager when needed with day-to-day management of the account, monitoring account performance and long-term strategic planning. He will also attend enrollment meetings, interacting with enrolled and prospective members as needed.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Siena College	Bachelor of Science	2011	History

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
Jan 2013 – Current	Empire BlueCross	Account Manager & Account Representative
Jan 2012 – Dec 2012	AAA	Member Service Representative

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Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Nicholas has been with Empire for eight years, beginning his career in the Large Group Sales department. In 2015, he advanced to account management and was responsible for supporting a book of business with a focus on school consortiums, educational trusts, and municipalities. This has given Nicholas experience in the complex and unique requirements of municipal clients, including union negotiations.

Nicholas holds a Life, Accident, and Health license in New York.

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Anthony Savignano

Title: Specialty Retention Consultant

Relationship to Project: As the Vision Plan Account Manager, Anthony will be accountable for ensuring all aspects

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Bridgewater State University	Bachelors	1998	Political Science

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2017 – Present	Empire BlueCross	Specialty Retention Consultant
2006 – 2017	MetLife	Account Manager

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Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Anthony has over 20 years of industry experience working in the large group insurance market. He is responsible for all aspects of client service including implementation, escalated service resolution, and strategic planning. Anthony has any in-depth knowledge of vision benefit design and administration and meets with his clients to proactively discuss performance, utilization data, and other key items.

Anthony holds a Life and Health Insurance license on New York and Connecticut.

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Brenda McCumber

Job Title: Account Service Manager

Relationship to Project: Brenda is involved in many aspects of the day-to-day operation of the State of New York account with primary responsibility for all benefit changes, membership inquires, and issues involving claims processes to ensure the account is being administered correctly. In addition, Brenda is a direct point of contact for the Department of Civil Service and the Department of Employee Benefits for urgent member situations and benefit questions.

As the current Account Service Manager for the Hospital Program for the past seven years, the Department will have an accountable and experienced team member who strives to ensure all inquiries are handled thoroughly, accurately, and timely. She is constantly looking for ways to enhance the member's overall experience through internal process improvements and plan coordination. Brenda also has a close working relationship with external business partners to ensure plan administration and benefit changes are coded timely and accurately.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Hudson Valley Community College	Associates Degree	2003	Physical Education

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"**

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2015 – Present	Empire BlueCross	Account Service Manager
2010 – 2015	Empire BlueCross	Operations Expert
2003 – 2010	Empire BlueCross	Mentor/Customer Service Rep

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Brenda has over 22 years of customer service experience, including 18 years at Empire BlueCross. During Brenda's tenure at Empire, she has developed a strong working knowledge of benefits, membership and claims processing. She has worked with several "white glove" accounts and has been in her current role on the Account Team for seven years. She has experience handling escalated inquiries and requests.

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Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Janna Liberty

Job Title: Audit and Reporting Liaison

Relationship to Project: As the audit and reporting liaison, Janna tracks and monitors all aspects of audits in process and ensures the Department or the Office of the State Comptroller receives the required reporting in a timely manner. She provides the agencies with all supporting documentation and coordinates all meetings and site visits, including coordinating responses for audits.

She frequently works with the Office of the State Comptroller and the Department of Civil Service Audit and Resource Management Team. In addition, she assists the Department of Civil Service Office of Financial Administration as it relates to client reporting and updates to outbound claim activity files to all three agencies.

Janna has supported the account team for the past four years, meeting all deliverables with the goal of exceeding the Department's expectations. She has the experience and knowledge of the State account, along with a proven record of accomplishment, to ensure we continue to provide excellent service to the Department.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University at Albany	Bachelors	2002	Communications

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
September 2017-Present	Empire BlueCross	Business Analyst II

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

Jun 2017 – Sep 2017	Beacon Health Options	Customer Service Rep III
Jan 2017 – May 2017	Conduent (Contractor)	QA Specialist
Aug 2013 – Jan 2017	MAXIMUS Inc.	Privacy/Compliance Analyst
Sep 2011 – Aug 2013	Empire BlueCross	Sr. Grievance and Appeals Analyst
Feb 2017 - Sep 2011	Empire BlueCross	Utilization Management Rep III
Dec 2005 - Feb 2007	Empire BlueCross	Operations Expert
Aug 2003 – Dec 2005	Empire BlueCross	Provider Service Rep

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Janna has over 17 years of health insurance experience, with 13 years at Empire. She has been on the NYS Account team acting as a client reporting analyst and audit liaison for over three years. She has developed a strong rapport with auditors at the NYS Office of the State Comptroller and NYS Department of Civil Service Audit and Resource Management Team by coordinating all aspects of their audits including, but not limited to, providing timely and thorough responses, providing requested materials, and facilitating audit site visits and conference calls with relevant internal stakeholders.

She has supported the technical and operational functions of the NYS account for three years including updating client reporting, managing all inbound and outbound files to NYS and our business partners and coordinating all IT support and ticketing associated with this maintenance.

Janna has five years of experience in quality assurance and conducting system, site, operational and documentation audits. She also successfully completed the ISO 9001:2008 Certified Lead Auditor Training.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Christopher Jacques

Job Title: Product Management Director

Relationship to Project:

Christopher supports large group product and sales efforts for our Vision Plans in the states of New York, Maine, New Hampshire, Connecticut, Virginia & Georgia. Specific to this Project, he will work closely with the Account Management teams to ensure the Vision Plan is implemented accurately and on time.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University Of Southern Maine	BA	1990	History
Husson University	MS	1998	Business

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
Oct 2017 – Present	Anthem, Inc,	Product Management Director
Jan 2015 – Oct 2017	Anthem, Inc.	Sales and Retention Executive
Mar 2011 – Jan 2015	Anthem, Inc.	Sales Account Executive
Sep 2005 – Mar 2011	Allen Insurance & Financial	Employee Benefits Executive

PROFESSIONAL EXPERIENCE

Christopher is the Product Management Director for Vision Services for the east coast and reports to the President of Anthem's Vision business, John Thorp. He is responsible for contributing towards meeting the organizations operating gain and membership goals in his assigned territory. Christopher is also the Product Director for Anthem's Small Group and Individual Business in all 14 Anthem/Empire States.

Since joining Anthem in 1995, he has served in a variety Sales roles in both the small

and large group markets in the State of Maine. Christopher was also an employee benefits broker for 5 ½ years selling and servicing individual business clients in the State of Maine.

Christopher earned his Bachelor of Arts degree in History from The University of Southern Maine, and his Master of Science degree in Business from Husson University.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Travis Weir

Job Title: Staff VP Specialty Underwriting

Relationship to Project: Travis has underwriting responsibility for the Vision, Dental, Life, Disability and Supplemental Health business. He and his team will be responsible for the evaluation and pricing of various risk factors and plan designs to ensure financial stability and soundness of the Vision Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Mankato State University	BA	1999	Economics & & Mathematics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
2020 – Present	Anthem, Inc.	Staff VP Specialty UW
2016 – 2019	Anthem, Inc.	Staff VP Dental UW & Analytics
2014 – 2016	Anthem, Inc.	Director of Dental Analytics
2009 – 2013	Anthem, Inc.	Director of Dental Actuarial

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Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

With over 20 years of experience and holding leadership positions in Actuarial, Analytics and Underwriting, Travis has deep knowledge and a 360 view of pricing, underwriting, and risk management/evaluation. He reports directly to the VP of Anthem Underwriting, and is responsible for managing a billion dollar block of annual revenue and over 17 million members. Travis has experience in Commercial, Medicaid, Medicare and ACA and has oversight responsibility for all segments from Individual to National Accounts.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: James Wright

Job Title: Vice President Strategic Alliances – EyeMed

Relationship to Project: As the EyeMed senior leader of the Anthem relationship, Jim leads the joint collaborative effort with Empire BC to provide the New York State Vision Plan Services RFP response. He will also be involved in in the ongoing administration of the Vision Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Ohio Northern University	BS Ph	1983	Pharmacy
Cleveland Marshall College of Law	JD	1991	Law

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
Jan 1999 – Present	EyeMed Vision Care	VP Strategic Alliances
Jan 1992 – Dec 1998	Continental Managed Pharmacy Services	Senior VP/President
Jan 1985 – Dec 1991	Revco DS Inc.,	Director/VP Third Party Svcs

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"**

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Jim has over 36 years of managed care experience in pharmacy and vision care, with the past 22 years in vision care. He has held leadership roles in almost every area of the managed care business, including finance, legal, operations, systems, sales, marketing, and account management. From 2006 to 2008 when he was Vice President of Account Management for EyeMed, he was very involved with the New York State Vision Plan that was administered by his team.

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Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Joe Wende, OD

Job Title: Senior Director, Medical Services-EyeMed

Relationship to Project: As the leader of the EyeMed provider relations and quality assurance, I am responsible for overseeing key provider and medical components of the Vision Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
State University of NY College of Optometry	OD	1982	Optometry
Pennsylvania State University University Park, PA	BS	1978	General Arts & Sciences

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From – To	Employer	Title
Apr 2016 – Present	EyeMed Vision Care	Senior Director Medical Services
Apr 2013 – April 2016	Carl Zeiss Vision	Vice President Managed Care
Dec 2011 – Apr 2013	Independent	Eye Care Consultant
Mar 1996 – Dec 2011	Davis Vision	Sr. VP Professional Affairs & Quality Mgt

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Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

With over 30 years in the vision industry, I support provider relations, quality improvement and utilization management functions and staff for EyeMed. My years of experience, including time as a practicing optometrist, uniquely qualifies me to oversee key components of provider network.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Dawn Richards

Job Title: Director, National Accounts and State Government Sales - EyeMed

Relationship to Project: As the assigned EyeMed sales executive, I reviewed the RFP, assisted in defining unique aspects of administration and collaborated with Empire to provide responses. As a State government subject matter expert, I will be part of the project team through implementation to ensure the commitments contained within our response are implemented seamlessly.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Butler University- Indianapolis, IN	BS	1989	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
Dec 2008 – Present	EyeMed Vision Care	Director- National Account Sales
Feb 1996 – Dec 2008	UHC Vision/ Spectera	Senior Account Executive
Jan 1994 – Feb 1996	Vision Service Plan	Account Executive

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

With more than 25 years of vision benefit experience, I am responsible for new business development with large complex clients. In addition to national clients, I also work on all State bids from the proposal development stage through implementation. Since 2016, I have worked either directly or in conjunction with a strategic partner to successfully add 11 State governments representing nearly one million members to the EyeMed platform.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

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Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Leslie Nathan

Job Title: Sr. National Account Manager- Strategic Accounts- EyeMed

Relationship to Project: Leslie represented EyeMed, Empire's vision care partner, reviewing RFP requirement and providing responses. Her involvement will continue through implementation and throughout the day-to-day administration of the Plan. Leslie will be a critical liaison between Empire and EyeMed to ensure reporting, files, customer service, PGs, and other operations and commitments meet or exceed expectations.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Miami University, Oxford, OH	Bachelors	2001	Education, Mathematics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
May 2017 – Present	Luxottica/EyeMed	Sr. Account Manager
Dec 2009 – Apr 2017	Assessment Technologies Institute	Client Executive
Aug 2008 – Dec 2009	Pacific Pulmonary Services	Patient Care Coord.
Aug 2001 – Jun 2008	Chicago Public Schools	Educator

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

With over 13 years' experience in sales and account management, Leslie will serve as a dedicated, day-to-day contact for Empire. At EyeMed, Leslie has provided over four years' operational, sales, and retention consultation and support to Empire's vision business covering State, Commercial, Medicare, and Medicaid lines of business.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"

Prepare this form for each key staff individual, including subcontractor-provided key staff, if any, of the Offeror's proposed Account Team (RFP Section 5.2). Where individuals are not named, please include qualifications that will be sought to fill the positions. If additional space is needed you may add additional sheets.

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

Individual's Name: Matthew MacDonald

Job Title: Senior Vice President, Operations- EyeMed

Relationship to Project: Matthew oversees all operational departments within EyeMed including operations, claims and customer service. He has been involved in reviewing the RFP requirements and will continue to be involved throughout the contract term to ensure your Vision Plan performs as detailed throughout our response.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Columbia Business School, NY	MBA	2006	Finance
Northwestern University, IL	BS	2001	Social Policies & Economics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
Nov 2013 – Present	EyeMed Vision Care	Senior VP Operations
Feb 2012 – Dec 2013	Accretive Health	Senior Director, Population Health
Sep 2006 – Feb 2012	Accenture	Senior Manager

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Biographical Sketch Form - RFP entitled: "New York State Vision Plan Services"**

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Matthew has more than 11 years' experience in operations including developing, implementing, and leading strategic operational improvements. In my eight years at EyeMed, we have doubled in membership. In his current role, he has responsibility for operational functions including claims, customer service, and membership. In 2017 he led the organization through a system migration which was implemented ahead of schedule and without impact to our constituents.

Organizational Chart

Empire BlueCross

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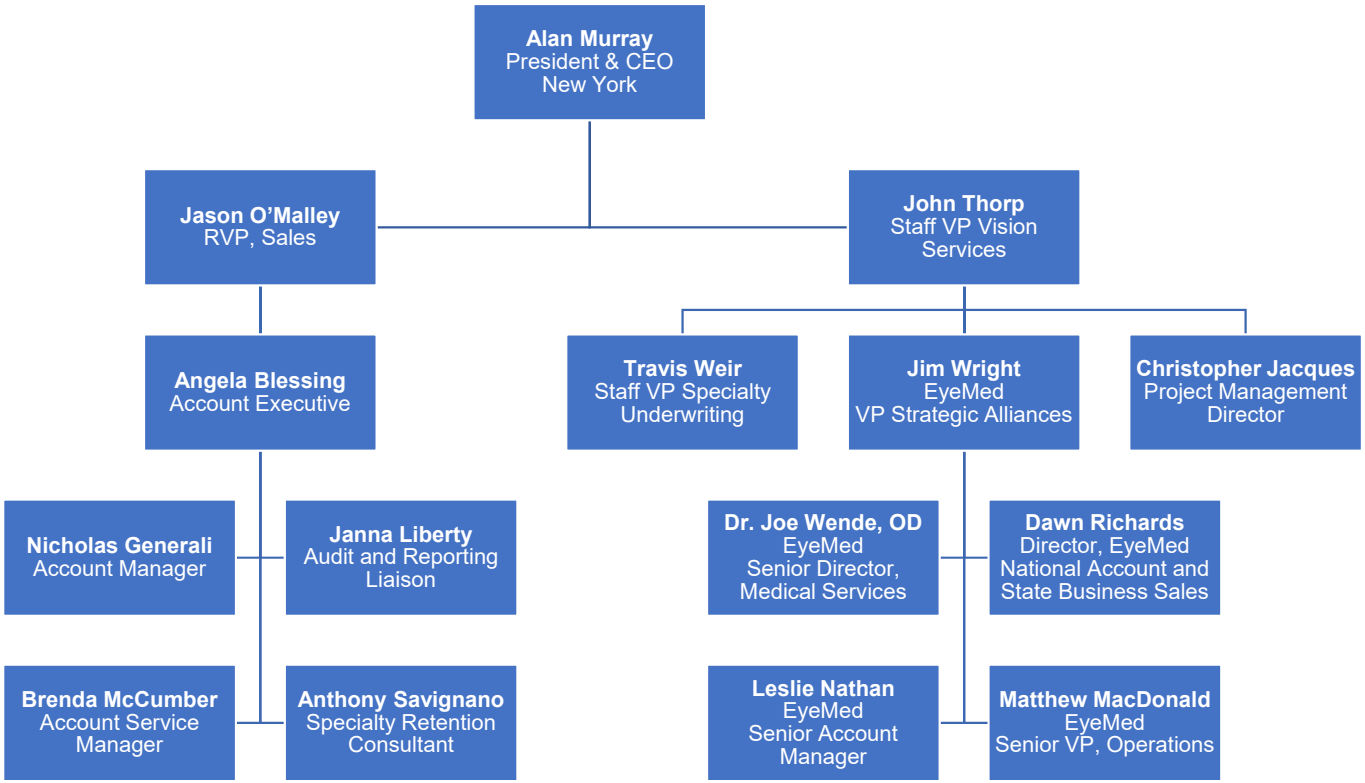
New York State Vision Plan

Proposed Account Management Team



Staffing Plan

Empire BlueCross

An Anthem Company

Staffing Plan

Empire's relationship with the Department is our top priority and one we never take for granted. Our focus has always been, and will continue to be, to consistently serve you and your Plan members and provide the highest level of service every day. Accordingly, we will provide the Department with a cross-functional sales, operational and clinical team that reports up to Alan Murray, President and CEO and John Thorp, Staff Vice President Vision Services. Alan and John's leadership teams are committed to the success of the program and providing the Department with the exceptional service you deserve as our largest client. This team will be available on a daily basis to deliver a superior account management experience for the duration of our business relationship.

Account Team – Empire BlueCross

Alan Murray, President and CEO

- Responsible for the overall operations and administrative management of the client contracts in New York, including the New York State Vision Plan contract

John Thorp, Staff VP Vision Services

- Responsible for overall accountability for the Vision business in New York as well as the other 13 states we have licenses to operate
- Responsibilities include all product/benefit design, operations, provider network, cost of care controls, and financials

Jason O'Malley, Regional Vice President, Sales

- Responsible for leadership and direction of all account management activities
- Responsible for and has the authority to command the appropriate resources necessary to deliver program services
- Oversight responsibility for all aspects of account management

Angela Blessing, Account Executive

- Responsible for ensuring all program expectations are being met or exceeded
- Responsible for proactively identifying corporate initiatives that require discussion with the Department
- Coordinates and leads discussions on benefit, industry and network trends
- Formulates strategies to improve plan administration, control or reduce plan costs and ensure member satisfaction
- Facilitates meetings with the Department, other staff on behalf of the Council on Employee Health Insurance and union representatives to communicate industry and network trends, potential program enhancements, operational performance updates, legislative and regulatory requirements that will impact the plan or could potentially impact the plan, and actual or anticipated events impacting plan costs and delivery of services

Nicholas Generali, Account Manager

- Supports Account Executive with all activities involved in the daily management of the plan
- Attends enrollment meetings and interacts with enrolled and prospective members

Anthony Savignano, Specialty Retention Consultant

- Supports Account Executive with all activities involved in the daily management of the plan
- Attends enrollment meetings and interacts with enrolled and prospective members

Brenda McCumber, Account Service Manager

- Resolves all escalated service and claim issues
- Collaborates with internal and external business partners to ensure plan administration and benefit changes are coded timely and correctly

Janna Liberty, Audit and Reporting Liaison

- Tracks and monitors all aspects of audits in process and ensures the required reporting is provided to the Department or the Office of the State Comptroller in a timely manner
- Compiles audit supporting documentation requested by the Department or the Office of the State Comptroller
- Services as the primary reporting contact and ensures monthly, quarterly and annual reports are accurate and timely

Christopher Jacques, Project Management Director

- Responsible for ensuring all aspects of the Plan are implemented accurately and timely

Travis Weir, Staff VP Specialty Underwriting

- Responsible for oversight of all aspects of underwriting including but not limited to premium and administrative fee development and all required financial reporting

Extended Account Team – EyeMed

Jim Wright, Vice President Strategic Alliances

- Senior leader dedicated to Blue View Vision
- Identifies and coordinates team responsibilities to meet the Department's objectives

Dr. Joe Wende, OD, Senior Director, Medical Services

- Responsible for managing provider network including credentialing, contracting, and recruiting
- Provides clinical direction and ongoing support for the Occupational Vision Program, the Medical Exception Program, and the Upgrade Program
- Supervises all quality improvements to the Quality Assurance program
- Supervises ongoing provider education initiatives and process improvements

Dawn Richards, Director, National Account and State Business Sales

- Reviewed RFP and provided direction based on objectives
- Identified unique requirements and escalated to internal departments
- Collaborated with Empire Vision to develop proposal response
- Involvement
- Will continue through implementation

Leslie Nathan, Senior National Account Manager, Strategic Accounts

- Serves as primary point of contact for the Empire Account Team
- Partners with Empire throughout implementation to fulfill the Department's specific needs including communications, plan design set up, reporting and eligibility
- Ensures reporting, file, customer services, performance guarantees and other operational commitments meet or exceed the Department expectations

Matthew MacDonald, Senior Vice President, Operations

- Responsible for overseeing all operational departments including operations and customer service

Section 4

Implementation Plan

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Implementation Guide

Empire BlueCross

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Empire BlueCross BlueShield
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Blue View Vision Network
IMPLEMENTATION GUIDE

Contents

1 Introduction

Thank you for choosing Blue View Vision! This guide provides information on how Blue View Vision plans are administered for Vision Clients.

1.1 Definitions & Acronyms

The following are terms and acronyms that will be used in this guide.

Term/Acronym	Expansion
BCBSA	Blue Cross Blue Shield Association
Claimant	The member or provider that submits a claim to Empire
DOS	Date of Service
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
SFTP	Secure File Transfer Protocol
HIPPAA	Health Insurance Portability and Accountability Act
SOB	Summary of Benefits
NASCO	An Empire System in which vision claims may be process
PHI	Personal Health Information
TPA	Third Party Administrator
Tier 1 Member Service Calls	Member inquiries regarding general plan information, such as benefits, eligibility or assisting members with finding In-Network providers.
Vision Client (Client)	The TPA that has entered into an agreement with Empire for their Vision plan
WGS	An Empire System in which vision claims may be processed

1.2 Vision Network / Provider Finder

Members will have access to the Blue View Vision Insight Network. Members can find an In-Network provider via the website www.EmpireBlue.com. Instructions are provided in the documents below.

Empire Blue Cross Blue Shield:

NY Empire BCBS Find a Provider_Visi

Empire Blue Cross:

NY Empire BC Find a Provider_Vision.pd

Note: When searching as a guest, be sure to select the Blue View Vision Insight plan/network.

1.3 Roles and Responsibilities

This provides an overview of the responsibilities for Empire and the Vision Client. More information will be provided on these topics throughout this guide.

Activity	Vision Client	Empire
Client Implementation		
Product / Account / Group Setup	x	x
Enrollment & Eligibility		
Enrollment	x	x
Eligibility (for claims processing)	x	
Eligibility (for provider look up)		x
ID Card issuance	x	x

Activity	Vision Client	Empire
Periodic membership feed to Empire (standard file layout)	x	
Claims		
Collection and pricing of claims		x
Claims adjudication		x
Payment of provider-payable claims		x
Payment of member-payable claims		x
EOB generation		x
Provider-initiated adjustments		x
Member or benefit-initiated adjustments		x
Customer Service		
Provider calls regarding claims pricing		x
Provider calls regarding eligibility and benefits		x
Member calls regarding eligibility and benefits	x	x

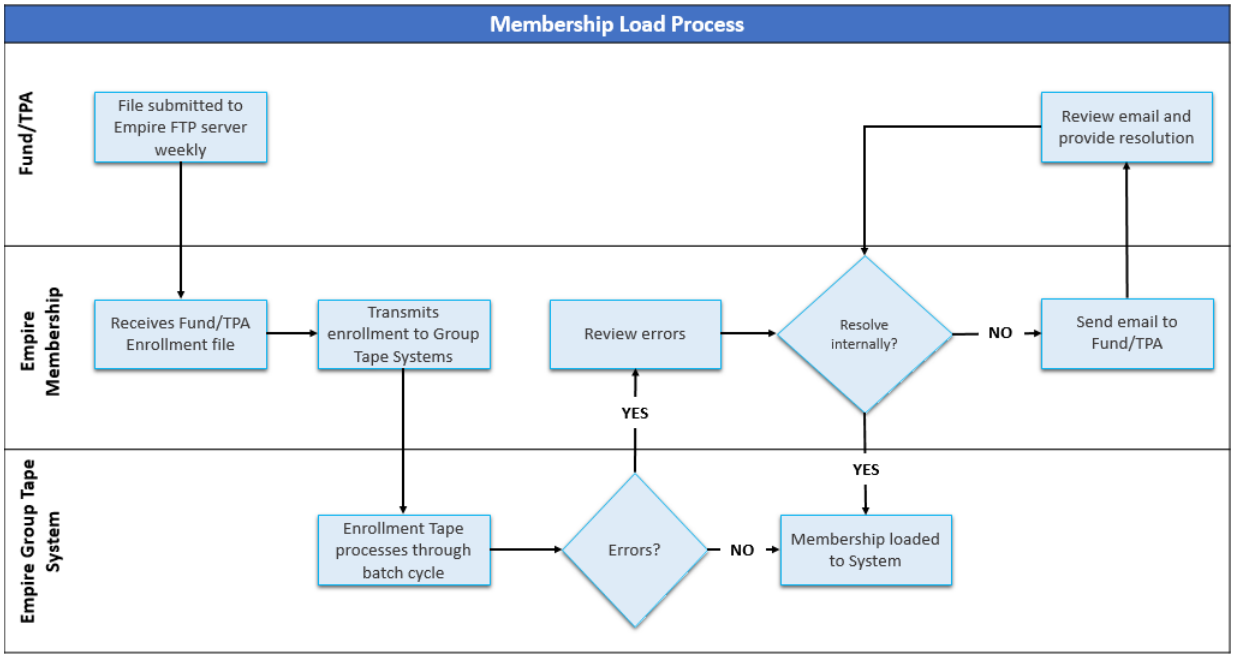
2 Membership

2.1 Eligibility File

The Vision Client collect and consolidate eligibility and enrollment information and send to Empire.

- Eligibility file will be submitted to Empire weekly.
- Eligibility file submitted to Empire shall be in the HIPPAA 834 format.

The below chart provides an overview of the membership load process.



2.2 Group Structures and Plan Designs

Group structures and plan designs will be generated and provided by Empire.

Group Structure Values	Description
Case Number	Case number is the parent identification number assigned to a specific Client
Group Number	Group numbers are sub-levels of plans/groups within a case number
Effective Date	The date coverage starts under the Empire vision plan
Contract Code(s)	A 4 character alpha/numeric value unique to each vision plan
Plan Code	A 7 digit numerical value used internally to identify types of plans

2.3 ID Cards

Vision Clients are able to create their own customized ID cards. ID Card Implementation Guides that outline detailed requirements for ID cards are available upon request. Below are some important requirements for customized ID cards:

- ID cards must be approved by Implementation.
- ID cards must include Empire Blue Cross Blue Shield logo for plans issued in New York.
- ID cards must include the member's name and member ID.
- ID card must have a unique ID number for identification within Empire systems
    - ID number can be assigned by Empire or by the Client. If Client wants to assign, ID number must comply with the following requirements:

WGS System ID card number requirements	• Can be alpha/numeric value • 9 characters (or bytes) • 4th character (or byte) may **NOT** consist of the letter **A**, **B** or **M** (for example, 123**A**45678)
NASCO System ID card number requirements	• Can be alpha/numeric value • 12 characters (or bytes) • First 3 characters consist of the group prefix • 7th character may **NOT** consist of the letter **A**, **B** or **M** (for example ABC123**A**45678)

2.3.1 Member Services Contact on ID Cards

The contact for Member Services on the ID cards will depend on whether the Vision Client will take Member Service calls. See the section 4.1 Member Services for more information.

3 Claims

3.1 Claims Adjudication and Payment

Under this program, members will submit claims directly to Empire to be adjudicated and paid. Below is more information on how claims are adjudicated.

In-Network. When a member receives vision care In-Network, claims are adjudicated at the time of service by the In-Network provider's office. In-Network providers will submit a claim to Empire for reimbursement.

Out-of-Network. When a member receives vision care Out-of-Network, the member is responsible to pay all charges at the time of service. The member will then submit a claim and will be reimbursed according to their Vision plan.

Empire will bill the Vision Client for all claims paid. See the section Admin Fees and Claims Paid for more information.

3.2 Claims Returns

Claims must meet certain criteria to be processed and paid. The following are common situations in which claims may be returned to the claimant for more information:

- The claim does not clearly identify the member or include the member's ID from their ID card.
- The claim does not clearly identify the provider from which vision care was received. For example:
    - The member did not include an invoice that clearly identifies the provider or facility.
    - The provider did not include their NPI and/or license number with their claim.

The following are common situations in which claims may be denied:

- The claim submitted is for services received prior to the member's effective date.
- The claim is for services or supplies that exceed plan frequency limits.
- The claim was submitted more than 12 months after the service was received.

3.3 Explanation of Benefits

Empire will generate EOBs for all vision claims according to state laws in which the plan has been issued.

3.4 Contract Service Levels

The following service levels are representative of Blue View Vision's standard performance guarantees, which are measured using aggregated data based upon Empire's book of vision business.

Functions	Measure
Claim Timeliness	98% processed within 30 calendar days
Claims Financial Accuracy	99% processed accurately
Claims Processing Accuracy	99% processed accurately

3.5 Coordination of Benefits Adjudication

Empire does not coordinate benefits for vision plans. Empire vision plans are considered primary in all cases.

3.6 Claims Paid Upon Termination of Vision Client

If a Vision Client terminates their agreement with Empire, Empire will continue to pay claims for services members received prior to the effective date of the termination. Claims submitted for services received after the effective date of termination will be denied and returned to the claimant.

4 General Operations Information

4.1 Member Services

4.1.1 Vision Client to Accept Member Calls

The Vision Client may choose to manage Member Service calls. This includes member inquiries regarding:

- Member benefits
- Member eligibility
- Assisting members with finding an In-Network provider

Empire will provide the Vision Client access to a portal that will house member and vision plan information to assist the Vision Client in taking member calls. If further assistance is needed, the Vision Client or the member can contact Blue View Vision Member Services at (877) 635-6403.

For this option, the Vision Client will provide the Member Services contact information that will show on the ID cards.

4.1.2 Blue View Vision to Accept Member Calls

If the Vision Client does not want to manage Member Service calls, Blue View Vision is available to take member calls at the number noted in the section above.

4.2 Grievance and Appeals

Empire will process member and provider appeals according to their standard processes.

4.3 Client Questions and Correspondences

- Emails between Empire and the Vision Client will be acknowledged within 1-3 business days.
- Escalated items to Empire management will be acknowledged within 24 hours.
- Empire will acknowledge Client correspondence via email or phone call.
- Secure email transmissions will be used by Empire and the Client when transmitting member PHI or claims pricing information.

4.4 Member Access to ID Cards

The Vision Client should encourage members to present their new ID card to providers. Members can easily access ID cards via the member portal at www.EmpireBlue.com or through the Sydney mobile app.

4.5 Admin Fees and Claims Billing

- Admin fees are billed to the Vision Client on a monthly basis.
- An invoice for claims paid will be provided to the Vision Client weekly and will contain the following information:
    - Summary of the amount due
    - An Excel spreadsheet with detailed information, including:
        - Member name, gender and relationship to subscriber
        - Claim paid date
        - Service incurred date
        - Reimbursement amount
        - HCID#s

5 Technical Components

5.1 System Requirements

Vision Client must have the capability to:

- Receive files via SFTP with or without PGP encryption, or access and retrieve secure SFTP hosting servers (other secure methods available for discussion)
- Standard file delivery method is push/pull.
- Recognize multiple sender/receiver EDI – IDs

5.2 File Transmission

- The Vision Client will build a process to recognize multiple trading partner EDI IDs

5.3 System Enhancements / Upgrades

Empire is subject to system enhancements and/or upgrades due to BCBSA mandates, state or federal regulatory mandates, policy changes, HIPAA updates, claim system enhancements or process improvements.

- Vision Clients may be required to update their coding and/or processes to accommodate these changes.
- Enhancements or upgrades to systems will include end-to-end testing between Empire and the Client.
- Empire will notify the Client of any changes that may impact operations between Empire and the Client:
    - Minimum of 90 days advance notice for any technical changes
    - Minimum of 30 days advance notice for any non-technical changes

Section 5

Participating Provider Network Management

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Participating Provider Network Access Summary (Attachment 17)

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ATTACHMENT 17 (Amended 7/6/21)

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Participating Provider Network Access Summary - RFP ENTITLED: "New York State Vision Plan Services"

New York State Vision Plan

State Column (1)	Location Column (2)	# of NYS Vision Plan Enrollees With Access Column (3)	# of NYS Vision Plan Enrollees Without Access Column (4)	Total Vision Plan Enrollees Column (5)	% With Access Column (6)
NYS	Urban				
	Suburban				
	Rural				
	Total NYS				
Out-Of-State	Urban				
	Suburban				
	Rural				
	Total Out-of-State				
	Total				

A. Enter the number of NYS Vision Plan enrollees who meet the minimum access requirements from your GeoAccess Accessibility Summaries (column 3)

B. Enter the number of NYS Vision Plan enrollees who do not meet the minimum access requirements from your GeoAccess Accessibility Summaries. (column 4)

C. Column (5) equals Column (3) plus Column (4).

D. Column (6) equals Column (3) divided by Column (5).

E. The average NYS access % in column (6) must equal, at a minimum, 80% in order to meet the Network Access Prerequisite required to submit a proposal.

Current Participating Provider Network File (Attachment 18)

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Participating Provider Quest Analytics Report (Attachment 19) – All Employees

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ATTACHMENT 19

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror's Participating Provider Quest Analytics Report- RFP entitled: "New York State Vision Plan Services"**

Attachment 19 will consist of the Offeror's Geo Access analysis utilizing Quest Analytics software.

Offeror's GeoAccess analysis should include every ZIP Code that is in the demographic file; even ZIP Codes with no access should be included. Use Estimated Driving Distance from the employee's home ZIP code for calculating distance. The most current version of Quest Analytics software should be used to create these reports. The Offeror's report must note which version of the software was used to create their report.

Blue View Vision℠

Network Analysis

EyeMed Vision Care

Blue View Vision Select Network

Created for...

State of New York

July 20, 2021

Contents

Report Contents

All Employees

Employee Map

July 20, 2021

All Providers

Blue View Vision Select Network

July 20, 2021

All Providers

Access Detail By Zip Code Classification

Employees With and Without Access									
Zip Code Class	Employee #	Provider Standard	With Access #	With Access %	Without Access #	Without Access %	Average Distance 1	Average Distance 2	Average Distance 3
Rural	51,722	R 1 in 30 miles	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Suburban	25,521	S 1 in 15 miles							
Urban	26,480	U 1 in 5 miles							
Grand Totals	**51,722**	**R 1 in 30 miles**	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	25,521	**S 1 in 15 miles**							
	26,480	**U 1 in 5 miles**							

Access Analysis
xDynamic By Zip Code - EMS ALL

Employee / Provider Groups
All Employees

Access Summary By City

Employees With and Without Access	
Employee Group	**103,723 employees** [redacted] employees with access [redacted] employees without access
Provider Group	([redacted] total access points)

Key Geographic Areas

City	Employee	With Access[1]		Without Access[1]		Counts[2]	Average Distance		
	#	#	%	#	%	#	1	2	3
With Access	[redacted]								
Without Access	[redacted]								

July 20, 2021

Access Analysis
xDynamic By Zip Code - EMS ALL

Employee Group
All Employees

Provider Group
EyeMed Select Providers

Areas With Access
Top 21 Cities in the market, sorted by the number of employees with access

Areas Without Access
Bottom 21 Cities in the market, sorted by the number of employees without access

[1] The Access Standard is defined as (All Employees) employees accessing in:
Urban areas...

Too many lines to display

Participating Provider Quest Analytics Report (Attachment 19) – In-State Employees

Empire BlueCross

An Anthem Company

ATTACHMENT 19

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror's Participating Provider Quest Analytics Report- RFP entitled: "New York State Vision Plan Services"**

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Blue View Vision℠

Network Analysis

EyeMed Vision Care

Blue View Vision Select Network

Created for...

State of New York

July 20, 2021

Contents

Report Contents

All Employees

Employee Map

July 20, 2021

All Providers

Blue View Vision Select Network

July 20, 2021

All Providers

Access Detail By Zip Code Classification

Employees With and Without Access									
Zip Code Class	Employee #	Provider Standard	With Access #	With Access %	Without Access #	Without Access %	Average Distance 1	Average Distance 2	Average Distance 3
Rural	50,821	R 1 in 30 miles							
Suburban	24,863	S 1 in 15 miles							
Urban	25,382	U 1 in 5 miles							
Grand Totals	**50,821**	**R 1 in 30 miles**							
	24,863	**S 1 in 15 miles**							
	25,382	**U 1 in 5 miles**							

Access Analysis
xDynamic By Zip Code - EMS ALL

Employee / Provider Groups
All Employees

Access Summary By City

Employees With and Without Access	
Employee Group	**101,066 employees** [redacted]) employees with access [redacted] employees without access
Provider Group	([redacted] total access points)

Key Geographic Areas

City	Employee	With Access[1]		Without Access[1]		Counts[2]	Average Distance		
	#	#	%	#	%	#	1	2	3
With Access	[redacted]								
Without Access	[redacted]								

July 20, 2021

Access Analysis
xDynamic By Zip Code - EMS ALL

Employee Group
All Employees

Provider Group
EyeMed Select Providers

Areas With Access
Top 21 Cities in the market, sorted by the number of employees with access

Areas Without Access
Bottom 21 Cities in the market, sorted by the number of employees without access

[1] The Access Standard is defined as (All Employees) employees accessing in:
Urban areas...

Too many lines to display

Participating Provider Quest Analytics Report (Attachment 19) – Out-of-State Employees

Empire BlueCross

An Anthem Company

ATTACHMENT 19

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Offeror's Participating Provider Quest Analytics Report- RFP entitled: "New York State Vision Plan Services"**

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Offeror's GeoAccess analysis should include every ZIP Code that is in the demographic file; even ZIP Codes with no access should be included. Use Estimated Driving Distance from the employee's home ZIP code for calculating distance. The most current version of Quest Analytics software should be used to create these reports. The Offeror's report must note which version of the software was used to create their report.

Blue View Vision℠

Network Analysis

EyeMed Vision Care

Blue View Vision Select Network

Created for...

State of New York

July 20, 2021

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All Employees

Employee Map

July 20, 2021

All Providers

Blue View Vision Select Network

July 20, 2021

All Providers

Access Detail By Zip Code Classification

Employees With and Without Access									
Zip Code Class	Employee #	Provider Standard	With Access #	With Access %	Without Access #	Without Access %	Average Distance 1	Average Distance 2	Average Distance 3
Rural	901	R 1 in 30 miles							
Suburban	658	S 1 in 15 miles							
Urban	1,098	U 1 in 5 miles							
Grand Totals	**901**	**R 1 in 30 miles**							
	658	**S 1 in 15 miles**							
	1,098	**U 1 in 5 miles**							

Access Analysis
xDynamic By Zip Code - EMS ALL

Employee / Provider Groups
All Employees

Access Summary By City

Employees With and Without Access	
Employee Group	**2,657 employees** [redacted]%) employees with access [redacted]%) employees without access
Provider Group	([redacted] total access points)

Key Geographic Areas

	City	Employee #	With Access[1] #	With Access[1] %	Without Access[1] #	Without Access[1] %	Counts[2] #	Average Distance 1	Average Distance 2	Average Distance 3
With Access	Jersey City, NJ	115	[redacted]							
	Fort Lee, NJ	37								
	Teaneck, NJ	37								
	Milford, PA	35								
	Newark, NJ	29								
	Stamford, CT	29								
	Bergenfield, NJ	26								
	Edison, NJ	25								
	Paramus, NJ	24								
	East Brunswick, NJ	21								
	Danbury, CT	20								
	Westwood, NJ	20								
	Bayonne, NJ	19								
	Clifton, NJ	18								
	Union, NJ	18								
	Irvington, NJ	17								
	Old Bridge, NJ	16								
	Englewood, NJ	15								
	Hackensack, NJ	15								
	Hoboken, NJ	15								
	New Milford, NJ	15								
Without Access	The Villages, FL	6	[redacted]							
	Arnett, OK	1								
	De Queen, AR	1								
	Great Mills, MD	1								
	Idabel, OK	1								
	Madison, NH	1								

July 20, 2021

Access Analysis
xDynamic By Zip Code - EMS ALL

Employee Group
All Employees

Provider Group
EyeMed Select Providers

Areas With Access
Top 21 Cities in the market, sorted by the number of employees with access

Areas Without Access
Bottom 21 Cities in the market, sorted by the number of employees without access

[1] The Access Standard is defined as (All Employees) employees accessing in:
Urban areas...

Too many lines to display

Access Detail By Zip Code

Employees Without Access							
City	Zip Code	Employee #	Without Access[1] #	Without Access[1] %	Average Distance 1	Average Distance 2	Average Distance 3
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Grand Totals		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

July 20, 2021

Access Analysis

xDynamic By Zip Code - EMS ALL

Employee / Provider Groups

All Employees

EyeMed Select Providers

xDynamic By Zip Code - EMS ALL

[1] The Access Standard is defined as (All Employees) employees accessing in:

Urban areas...

1 (EyeMed Select Providers) provider in 5 miles

Suburban areas...

1 (EyeMed Select Providers) provider in 15 miles

Rural areas...

1 (EyeMed Select Providers) provider in 30 miles

Standard and Premium Lens Option Classifications

Empire BlueCross

An Anthem Company

Progressive and anti-reflective tier classifications 2021

POWERED BY eyeMed

Progressive classification*

STANDARD PROGRESSIVES

- Adaptar®
- Adaptar® Short
- Essilor Computer™
- Essilor Interview®
- Freedom™ Fit
- Freedom™ 5
- Freedom ID™
- Hoya GP Wide BKS
- HoyaLux Tact
- Kirkland Signature Office Lens
- MVC Standard Progressive
- Natural®
- Navigator®
- Navigator Short®
- Ovation™
- SEIKO AF2
- SEIKO AF2 Mini
- SEIKO Diamond Clear Mini
- Shamir Genesis HD
- Shoreview®
- Shoreview Mini®
- SolaMax®
- Super No Line®
- Synchrony® Access
- Synchrony® Easy M
- Synchrony® Easy View
- Unique SoftWear®
- VIP®
- ZEISS Business
- ZEISS Progressive Light D

PREMIUM PROGRESSIVES

Tier 1

- Adage™
- Adaptar® Digital
- Adaptar® Digital Short
- Amplitude BKS
- Amplitude Mini BKS
- AO Easy
- Concise™
- Everyday Progressive
- Gradal® Top
- Illumina
- Image®
- Image® Wrap
- Instinctive® HD
- Kirkland Signature HD Lens
- MVP
- Natural® Digital
- Navigator FBS
- Navigator Short FBS
- Oakley® True Digital™
- Ovation™ Digital
- Novel®
- Novella®
- Precise®
- Precise® Short
- Premium Progressive
- Proceed II
- Proceed III
- Shamir FirstPAL™
- Short Fit Progressive
- SmallFit™
- SmallFit™ Digital
- Synchrony®
- Synchrony® Easy S
- Tact BKS
- Xplorer™
- ZEISS Progressive Light H

Progressive and anti-reflective tier classifications 2021

POWERED BY EyeMed

Tier 2

- DST Custom Plus
- Element™
- GT2™
- GT2™ Short
- HD WorkSpace™
- Hoya Amplitude HD3
- Hoya Amplitude HD3 Mini
- Hoya Sumit cd BKS
- Hoya Sumit ECP BKS
- Ideal™
- Ideal Short™
- IOT Everyday
- KODAK Precise® PB
- KODAK Precise® PB Short
- Nikon Presio I Digital
- Oakley® OTD™ Advance
- SEIKO PC Wide Computer
- Signet Armorlite DirecTek™
- Signet Armorlite DirecTek™ Short
- Succeed
- Succeed WS
- Synchrony® Access HD
- Synchrony® Easy Adapt
- Synchrony® Easy View HD
- Synchrony® Easy View M HD
- Synchrony® Easy View S HD
- Synchrony® Easy Wear
- TruClear®
- Varilux Comfort 2®
- Varilux Comfort 2® Short
- Varilux Comfort® DRx
- Varilux Comfort® DRx Short
- Workday Progressive
- Workspace
- ZEISS Choice
- ZEISS Digital Wrap
- ZEISS Progressive Light V
- ZEISS SmartLife Digital

Tier 3

- AO Easy HD
- Autograph II Attitude™ Wrap
- Autograph II Office
- Compact Ultra™ HD
- Concise® Digital
- Costa C-Scape Fashion
- Costa C-Scape Sport
- Definity™
- Definity Short™
- DST Custom Plus HD
- DST Custom Plus HD Sun Wrap
- Hoya Array Fixed
- Hoya Array VL
- Hoya iD Screen
- Hoya iD Space
- Hoya iD Zoom
- Ideal™ Advanced
- Ideal™ Advanced Wrap
- IOT Ultimate
- IOT Universal
- IsSential
- KODAK Unique™
- KODAK Unique DRO™
- Nikon Digilife
- Oakley® OTD™ Advance Plus
- Precise® Digital
- Precise® Digital Short
- Ray-Ban® Tuned III
- Ray-Ban® Varilux Comfort Max
- Shamir Autograph III Attitude® Fashion
- Shamir Autograph III Attitude® Fashion Short
- Shamir Autograph III Attitude® Sport
- Shamir Computer™
- Shamir Golf™ Progressive
- Shamir InTouch™
- Shamir Spectrum+™
- Shamir WorkSpace™
- Supercede II
- Synchrony® Easy Wear HD
- Synchrony® PAL Starter HDS
- Synchrony® Performance HD
- Synchrony® Ultra HD
- Synchrony® Work & Go HD
- Synchrony® Work & Office HD
- Synchrony® Work & Read HD
- TruClear® SD
- Varilux Comfort Max
- Varilux Comfort Max Fit
- Varilux Comfort® W2+
- Varilux Comfort® W2+ Fit
- Varilux® Ellipse
- Varilux® Panamic
- Varilux® Physio®
- Varilux® Physio® DRx
- Varilux® Physio® DRx Short
- Varilux® Physio® Short
- Varilux® Stylistic Wrap
- ZEISS EnergizeMe
- ZEISS Offilens
- ZEISS Progressive SmartLife Pure L
- ZEISS Progressive SmartLife Pure M
- ZEISS Progressive SmartLife Pure S

Tier 4

Other premium progressives

Progressive and anti-reflective tier classifications 2021

POWERED BY eyeMed

Anti-reflective classification*

STANDARD ANTI-REFLECTIVE COATINGS

- Anti-Reflective AR
- Backside AR
- Blue Shield AR
- Clean Shield AR
- CleAR
- Crizal Kids UV™
- Custom CleAR
- Custom CleAR Sun
- HMC® Plus
- Hoya Premium Coating
- ProClean
- Ray-Ban® AR w/ UV
- Ray-Ban® Sun AR
- Ray-Ban® Sun AR w/ Mirror
- Reflection Free
- RF Endura
- SharpView+™
- Standard AR
- Standard Backside AR
- Synchrony® HMC
- SYNERGY Crystal AR
- SYNERGY Crystal UV AR
- Trion AR
- ZEISS Super ET

PREMIUM ANTI-REFLECTIVE COATINGS

Tier 1

- BluCrystal
- Crizal Easy UV™
- Crizal® Prevencia® Kids
- Hi Vision
- Hoya Premium w/ ViewProtect
- Kirkland Premium AR
- KODAK CleAR
- RF Endura EZ
- VISO®
- Xperio Sun UV™
- Xperio Sun UV™ w/ Mirrors
- ZEISS Dura Vision Chrome

Tier 2

- Clean Shield Elite AR
- Clean Shield Elite Sun AR
- Crizal Alize UV™
- Crizal SunShield™ UV
- Custom CleAR Plus
- Custom CleAR Plus Sun
- EasyCare™ Premium AR
- ECC AR
- EZ Premium CleAR
- Hi Vision w/ ViewProtect
- KODAK Clean N CleAR™ AR UV
- KODAK Clean'N'CleAR™
- KODAK Total Blue® AR
- Oakley® Stealth AR
- Premium AR
- Ray-Ban® Premium AR
- Synchrony® HMC+
- VISO XC®
- Vivid AR
- ZEISS DuraVision Silver

Tier 3

Other premium anti-reflective coatings

We reserve the right to make changes to the products on each tier and the member out-of-pocket amounts.

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

January 1, 2021

Summary of Contact Lenses Covered by the Plan (Attachment 33)

Empire BlueCross

An Anthem Company

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Summary of Contact Lenses Covered by the Plan - RFP entitled: "New York State Vision Plan Services"**

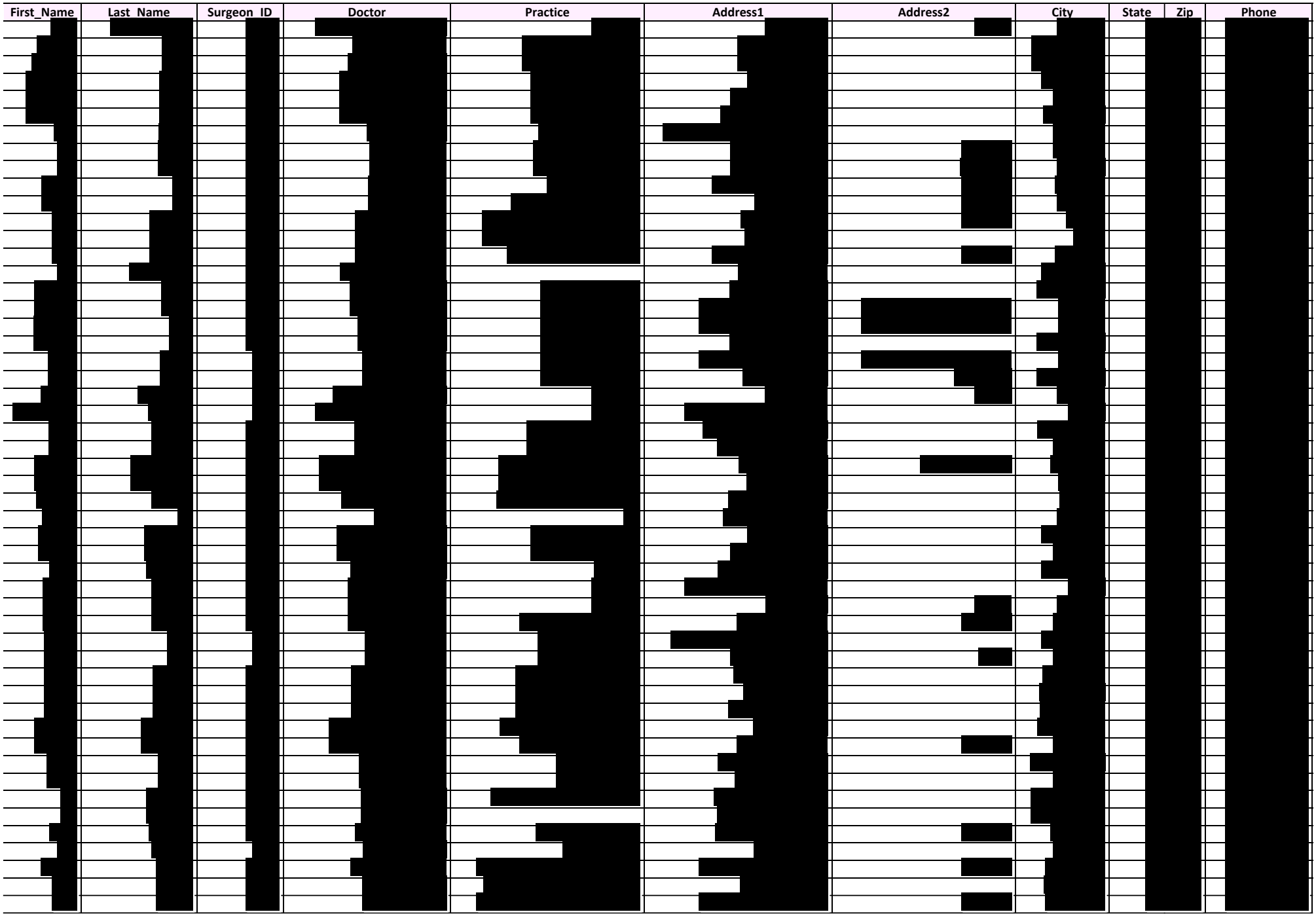
Offeror Name: Empire Blue View Vision

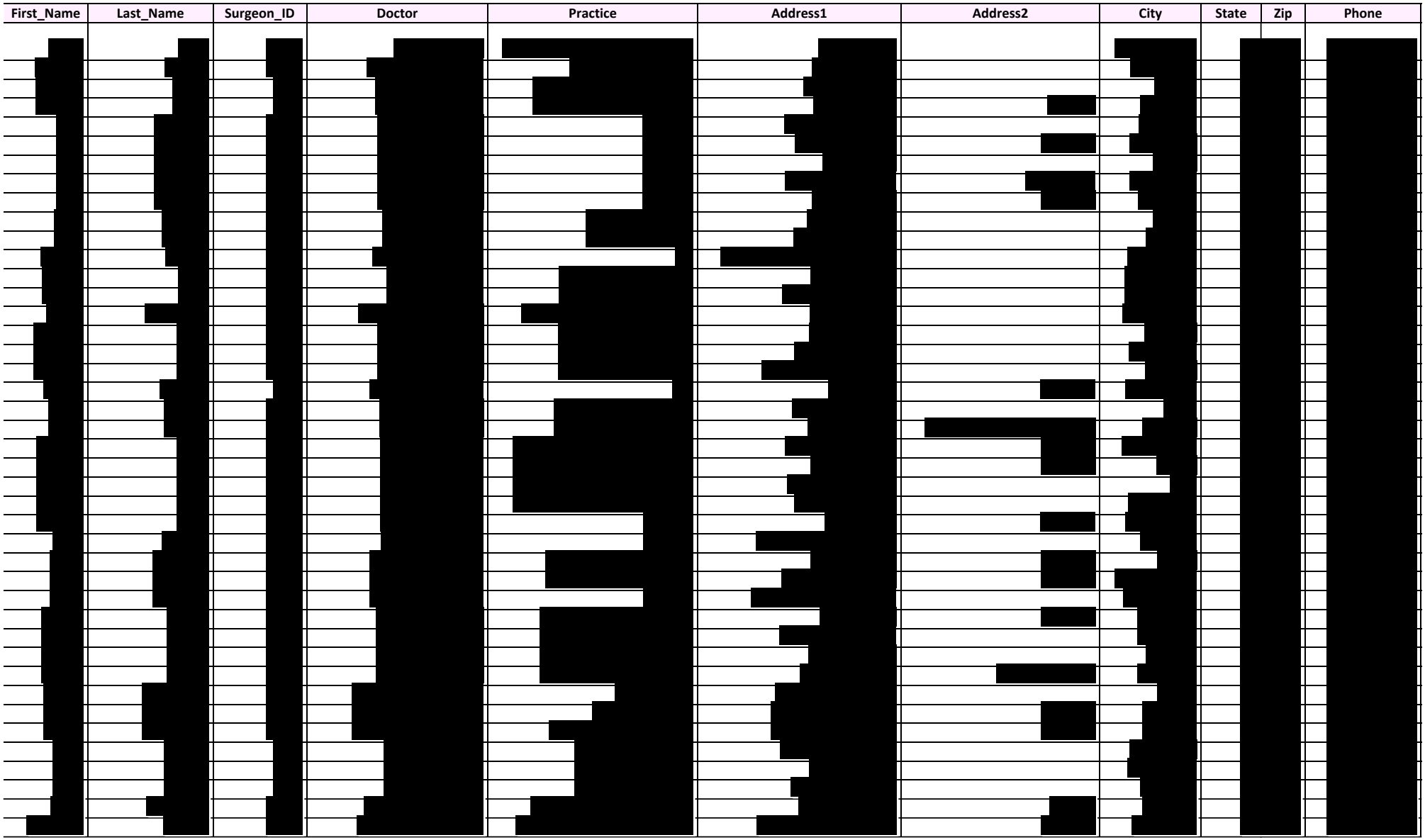
Contact Lens Description	# of Lenses Provided to Enrollees	Copayment for PEF, M/C & unrepresented ($25 or $45)
Soft, Daily Wear lenses:		
Our program provides members a contact lens allowance in lieu of a limited selection.		
Meeting requirements as stated in 3.3 Participating Provider Network Management.		
Planned Replacement:		
Disposable:		

Laser Vision Correction Participating Providers

Empire BlueCross

An Anthem Company


First_Name
Last_Name
Surgeon_ID
Doctor
Practice
Address1
Address2
City
State
Zip
Phone


First_Name
Last_Name
Surgeon_ID
Doctor
Practice
Address1
Address2
City
State
Zip
Phone

Sample Provider Contract

Empire BlueCross

An Anthem Company

You're almost there

Execute your contract so credentialing can start

Deadline: Respond to the EyeMed contract within 30 days or your request will be cancelled

Test **7-15-2019**
999999999
123 Main St
SomeCity, NV 12345

Dear Test,

On the following pages you will find the EyeMed contract. As you look over the contract, pay close attention to Appendix 2, which shows you the location(s) and networks you'll be participating on.

Remember, if you have any questions, you can contact us at 888.581.3648 or send an email to provider@eyemed.com .

Sincerely,

[redacted]
John W. Lahr, OD, FAAO
Vice President, Provider Relations/Medical Director
EyeMed Vision Care

Eye Care Professional Agreement

This ***agreement*** is between and among EyeMed Vision Care, LLC ("***EyeMed Vision Care***"), EyeMed Vision Care IPA, LLC, ("***IPA***")[1], EyeMed Vision Care HMO of Texas Inc. [2]("***HMO***"), and First American Administrators, Inc. ("***FAA***")[3] (collectively, "***EyeMed,***" "***our,***" or "***we***"), Optical Procurement Services LLC ("***Supplier***") and the legal entity (or individual if there is no legal entity) identified on the signature line below ("***you***" or "***your***") on behalf of ***you*** and ***your*** employed and contracted ***providers*** that wish to provide ***covered services*** to ***members*** ("***affiliated eye care professionals***"). Throughout this ***agreement***, ***you*** and ***affiliated eye care professionals*** collectively shall be referred to as "***Eye Care Professional***." This ***agreement*** consists of this contract, appendices, and the ***provider manual*** (collectively, the ***"agreement"***).

If ***EyeMed*** or an affiliate has an existing agreement with ***you*** concerning the same subject matter as this ***agreement***, this ***agreement*** shall supersede and replace that agreement as of the ***effective date***.

Defined terms are bold and italicized throughout this ***agreement***. Definitions are provided above and in Appendix 3.

* * * * * * * * * * * * * * * * * * * *

I. EYE CARE PROFESSIONAL'S RESPONSIBILITIES.

1.1 **Licensed and Credentialed**. ***Eye Care Professional*** shall:

1.1.1 Be fully licensed to provide ***covered services*** within the scope of ***Eye Care Professional's*** respective license (if required by applicable law);

1.1.2 Maintain such license (if required by applicable law) during the term of this ***agreement***;

1.1.3 Be fully credentialed as provided below; and

1.1.4 Not be debarred, excluded, suspended or otherwise determined to be ineligible to participate in any Federal health care programs (collectively, "***ineligible***"), or convicted of a criminal offense that could result in such party becoming ***ineligible***

In addition, ***you*** must have 20 or fewer locations under common ownership or control.

[1] For New York HMO ***clients***.
[2] For certain Texas HMO ***clients***.
[3] Provides claims administration services.

1.2 **Insurance**. ***Eye Care Professional*** shall maintain insurance coverage in the amounts, limits and coverage specified in the ***provider manual***. The provisions of this section shall survive termination of this ***agreement***.

1.3 **Credentialing Policy**. ***Eye Care Professional*** shall comply with ***EyeMed's*** credentialing and re-credentialing policies and procedures. ***Eye Care Professional*** must be credentialed and receive a ***credentialing letter*** before providing ***covered services***. The ***credentialing letter*** shall be incorporated by reference and made part of Appendix 1 to this ***agreement***. Provided however, opticians that are ***affiliated eye care professionals*** are not credentialed by ***EyeMed***, and are therefore, not subject to ***EyeMed's*** credentialing and re-credentialing policies and procedures.

1.4 **Confirm Member Eligibility**. ***Eye Care Professional*** shall follow ***EyeMed's*** verification procedures in order to confirm that a patient or prospective patient is a ***member*** and that the services to be provided are ***covered services*** prior to providing any services to ***member***.

1.5 **Services**. Consistent with the scope of ***Eye Care Professional's*** respective license and practice, ***Eye Care Professional*** shall:

1.5.1 Provide all visually and medically appropriate ***covered services*** under the ***member's benefit plan*** that ***Eye Care Professional*** routinely provides in compliance with this ***agreement***, in the best interest of the ***member,*** and ***consistent*** with applicable professional standards;

1.5.2 Maintain in good working condition all necessary diagnostic equipment to perform the ***covered services***; and

1.5.3 Manage, coordinate, and monitor all such care.

1.6 **Submit Claims**.

1.6.1 ***You*** shall submit ***clean claims*** to ***EyeMed*** promptly, and in no event no later than 180 days after the date of service. If ***clean claims*** are submitted later than 180 days after the date of service, such ***claims*** may be denied, at ***FAA's*** sole discretion, and ***Eye Care Professional*** may not bill or seek payment from ***members,*** third parties, or ***EyeMed*** for these ***covered services***.

1.6.2 ***You*** agree to submit all ***claims*** electronically, if requested by ***FAA***. In the event ***you*** are unable to submit ***your*** claims electronically, ***you*** agree that ***FAA*** may deny or otherwise reduce your reimbursement by an administrative charge as described in the ***provider manual***. Any such denial or charge shall not be billed to or otherwise collected from the ***member***.

1.6.3 ***You*** shall ensure that ***you*** can receive electronic remittance advice and payment, consistent with and to the extent permitted by applicable law. ***You*** agree to receive remittance advice and payment electronically, if requested by ***FAA***. In the event ***you*** are unable to receive electronic remittance advice and payment electronically, ***you*** agree that ***FAA*** may deny or otherwise reduce your reimbursement by an administrative charge as described in the ***provider manual***. Any such denial or charge shall not be billed to or otherwise collected from the member.

1.6.4 If ***you*** disagree with ***FAA***'s payment determination, ***Eye Care Professional*** may submit an appeal as described in section 1.20 of this ***agreement***.

1.6.5 In the event that ***EyeMed*** or a ***client*** requests additional information for data integration, care management, disease management, or other legally permitted purposes, ***you*** shall provide such data as part of the claims submission process or other reporting process. This may include any data necessary to characterize the context and purpose of a ***member*** visit, including by way of example, appropriate ICD diagnosis codes, which may be used for disease management programs.

1.7 **Communication with EyeMed**. ***Eye Care Professional*** shall not provide ***us*** with any misleading or false information, including by way of example, claims, services, and status of licensure. All ***claims*** shall identify the ***provider*** that actually provides the ***covered services***.

1.8 **Communicate Electronically**. ***Eye Care Professional*** shall provide ***EyeMed*** with a valid, working email address so that ***we*** may communicate with ***Eye Care Professional*** electronically. ***Eye Care Professional*** consents to the receipt by email of communications, including but not limited to updates to the ***provider manual*** and amendments to this ***agreement***. ***Eye Care Professional*** will promptly notify ***EyeMed*** of any changes in ***Eye Care Professional's*** email address. In any such communications both parties will comply with applicable law, including laws regarding member data, protected health information, and other confidential information, as well as the form and format of any such communications.

1.9 **Notify EyeMed**. ***Eye Care Professional*** shall notify ***EyeMed*** of subsequent changes in status of any information relating to ***Eye Care Professional's*** professional credentials, including loss of licensure and such other events as described in this ***agreement***.

1.10 **Treatment Records**. ***Eye Care Professional*** shall prepare and maintain for each ***member*** a treatment record that meets or exceeds industry standards, complies with applicable law, and complies with any requirements described in the ***provider manual***. The provisions of this section shall survive termination of this ***agreement***.

1.11 **Open Communication.** Consistent with the scope of ***Eye Care Professional's*** license, at all times ***Eye Care Professional*** shall:

1.11.1 Have open and honest discussions with ***members*** regarding their clinical needs, regardless of their ***benefit plan***.

1.11.2 Discuss all possible treatment options, including the possible risks of treatment and alternative treatments. ***Eye Care Professional*** agrees that nothing contained in this ***agreement*** is intended to or shall affect these open communications and ***Eye Care Professional's*** discussions with a ***member*** regarding what clinical treatment and services are in ***member's*** best interests and are necessary or appropriate for the member's diagnosis and care.

1.11.3 Be solely responsible for delivering ***covered services***.

Nothing in this ***agreement*** shall be construed to restrict the doctor-patient relationship, as applicable, or to interfere with ***Eye Care Professional's*** responsibility to exercise professional judgment in treating ***members***.

Eye Care Professionals may not engage in activities that will cause EyeMed to lose existing or potential members, including but not limited to: whether directly or through ***members*** or other third parties: (i) advise, encourage, or induce ***client(s)*** who currently contract with ***EyeMed*** to cancel, modify, or not renew their contract with ***us*** or (ii) impede

or otherwise interfere with negotiations that ***we*** are conducting with ***client(s)*** or prospective ***client(s)*** for the provision of ***benefit plans***.

1.12 **Non-Discrimination**. ***Eye Care Professional*** shall treat all ***members*** with respect and dignity and shall make ***Eye Care Professional's*** services available to members on the same basis as those services are provided to all other patients. ***Eye Care Professional*** shall not discriminate against ***members***, including without limitation, discrimination as to the availability of appointment days or times, because of age, race, sex, sexual orientation, religion, color, creed, ancestry, disability, genetic predisposition, height or weight, veteran's status, gender identity or expression, source of payment, or affiliation with ***us***, or any other characteristics protected by applicable law.

1.13 **Copy Records**. ***Eye Care Professional*** shall comply with applicable law and the ***provider manual*** when ***Eye Care Professional*** receives a request for disclosure or copies of a ***member's*** treatment records. The provisions of this section shall survive termination of this ***agreement***.

1.14 **Comply with Rules, Policies and Procedures**. ***Eye Care Professional*** shall comply with ***EyeMed's*** requirements, including by way of example, requirements for quality assurance, medical management for primary eye care or similar programs, claims submission, and quality improvement. These requirements, as well as others, are described in the ***provider manual***.

1.15 **Out of Office Coverage**. In the event that ***Eye Care Professional*** is out of the office for several consecutive days, ***Eye Care Professional*** shall comply with ***EyeMed's*** policies and procedures described in the ***provider manual*** regarding back-up coverage.

1.16 **Comply with Client Contracts.** At times ***clients*** may require that ***Eye Care Professional*** comply with certain operational or other non-reimbursement related requirements set forth in the ***client's*** contract with ***EyeMed***. Therefore, these requirements are expressly made part of this ***agreement*** and ***Eye Care Professional*** shall comply with all such requirements. ***EyeMed*** will notify ***Eye Care Professional*** of these requirements through the ***provider manual*** or through other communications.

1.17 **Comply with Laws**. ***Eye Care Professional*** shall comply with all applicable laws and regulations and any such requirements set forth in Appendices 5 (state regulatory and/or Medicaid requirements) and 6 (Medicare Advantage requirements).

1.18 **Cooperate with EyeMed**. ***Eye Care Professional*** shall cooperate with ***EyeMed's*** requests to provide information that ***we*** reasonably need. ***EyeMed*** may need this information to perform ***our*** obligations under this ***agreement,*** under our contracts with ***clients***, or as required by regulatory or accreditation agencies.

1.19 **Cooperate with Audit**. ***EyeMed*** shall have access to ***Eye Care Professional's*** records regarding the provision of services to ***members***, including but not limited to medical eye, vision, and ***claim*** records. ***Eye Care Professional*** consents to such access. ***EyeMed*** conducts audits by clinical records/claim review and/or onsite office inspection. In the event that ***EyeMed*** determines a discrepancy (including overpayments) resulting from an audit or other investigation, ***Eye Care Professional*** agrees that ***we*** may use statistical sampling and extrapolation as a means for ***us*** to determine the amount owed by ***you*** as a result of any audit determination, unless the process is prohibited by law. The provision of this section shall survive termination of this ***agreement***.

1.20 **Appeals/Grievances/Complaints**. If ***Eye Care Professional*** disagrees with ***our*** decision, ***Eye Care Professional*** may file an appeal, grievance, or complaint (as the

case may be and collectively referred to as a "***grievance***"). These rights and the process for filing a ***grievance*** will be described in the ***provider manual***. Before taking any legal action, ***Eye Care Professional*** must file a ***grievance*** (if required under the ***provider manual***). The provisions of this section shall survive termination of this ***agreement***.

1.21 **Member Confidentiality**. ***Eye Care Professional*** shall maintain and protect confidential ***member*** information in accordance with applicable law and this ***agreement.*** The provisions of this section shall survive termination of this ***agreement***.

1.22 **EyeMed Confidentiality**. ***EyeMed*** may share certain business sensitive, proprietary, and/or confidential information with ***Eye Care Professional***. ***Eye Care Professional*** shall use such information only for furtherance of carrying out ***Eye Care Professional's*** obligations under this ***agreement*** and at all times ***Eye Care Professional*** shall protect this information and not disclose such information to any third parties unless authorized in writing by ***EyeMed*** or as required by applicable law. ***Eye Care Professional's*** obligation to protect this information extends to the terms and conditions of this ***agreement***, and in particular, the compensation provisions, which are proprietary and confidential to ***EyeMed.*** The provisions of this section shall survive termination of this ***agreement***.

1.23 **Criteria and Network Selection**. Eye Care Professional shall comply with EyeMed's contracting and network requirements. ***EyeMed*** shall invite ***Eye Care Professional*** to one or more ***network(s)***. ***Eye Care Professional*** may elect not to participate in a ***network(s)*** and may also request participation in a particular ***network(s);*** however, ***Eye Care Professional*** understands that ***Eye Care Professional*** has no right to select the ***network*** or ***networks*** that ***Eye Care Professional*** will participate in.

1.24 **State Third Party Contracting Laws**.

1.24.1 To the extent, if any, required by applicable law, the terms of this Section 1.24 shall apply to this ***agreement***.

1.24.2 ***You*** have entered into this ***agreement*** with ***us*** for the provision of ***covered services*** by ***Eye Care Professionals*** including network rental arrangements. In addition to all other rights under this ***agreement***, ***EyeMed*** may sell, lease, rent, assign or grant access to ***Eye Care Professional's*** services and the fees established in this ***agreement*** to ***clients***, including any of the following:

1.24.2.1 a payer or third party administrator or other entity responsible for administering claims on behalf of the payer;

1.24.2.2 a preferred provider organization or preferred provider network, including a physician-hospital organization; or

1.24.2.3 an entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator.

1.24.3 A ***client*** that is granted access to ***Eye Care Professional's*** services under this ***agreement*** shall comply with all applicable terms of this ***agreement***.

1.24.4 A list of third parties accessing ***Eye Care Professional's*** services under this agreement is set forth in the ***provider manual***.

1.25 **Sales and Use Tax**. ***Supplier*** shall be responsible for procuring lenses for ***Eye Care Professionals*** ordering lenses through ***EyeMed's*** online claims system. ***Supplier*** is

responsible for the sale of lenses to ***Eye Care Professional*** and payment to the lab on ***Eye Care Professional's*** behalf. ***Supplier*** shall perform the collection and remittance of applicable sales and use tax as set forth herein. ***Supplier*** must calculate and pay any applicable local and state sales tax or other taxes with respect to the direct purchase of any product and/or service offering. ***Eye Care Professional s***hall, as required under applicable state or local law, pay to ***Supplier***, all applicable state and local sales and use taxes arising from the provision of covered services offerings or from ***Eye Care Professional's*** use of or consumption of the materials acquired during the provision of covered services. Before claiming available exemptions from state and local sales and use taxes, as allowed by applicable state or local law, ***Eye Care Professional*** shall provide ***Supplier*** with complete and valid state or local sales or use tax exemption certificates, including, but not limited to Uniform Sales & Use Tax Certificate.

II. AFFILIATED EYE CARE PROFESSIONALS.

2.1 **Applicability**. This ***agreement*** applies to ***you*** and to all ***affiliated eye care professionals***. Termination of this ***agreement*** automatically terminates participation with ***EyeMed*** of all ***affiliated eye care professionals***.

2.2 **Notice.** ***You*** will ensure that new ***providers*** that ***you*** employ or contract with will submit ***EyeMed's*** required credentialing information as soon as reasonably possible and in no event more than 30 days after the employment or contract begins. ***Providers*** shall not provide ***covered services*** to members until ***providers*** are credentialed and become an ***affiliated eye care professional***.

2.3 **Oversight**. ***You*** represent and warrant that ***you*** have authority to bind ***provider(s) you*** employ or contract with to the terms and conditions of this ***agreement***. ***You*** shall ensure that ***affiliated eye care professional(s)*** are specifically advised of and agree in writing to the same terms and conditions that apply to ***you*** under this agreement and will comply in all respects with this ***agreement***. In the event that an ***affiliated eye care professional*** fails to comply with any terms or conditions of this ***agreement***, ***you*** shall immediately notify ***us*** and ***you*** shall be liable for and shall defend and indemnify ***us*** in accordance with Article VII for such failure by the ***affiliated eye care professional***. The provisions of this section shall survive termination of this ***agreement***.

2.4 **Affiliated Eye Care Professional Leaving**. ***You*** shall notify ***EyeMed*** within 10 business days after ***you*** become aware that an ***affiliated eye care professional*** will no longer be employed or contracted with you as an ***affiliated eye care professional***.

III. OUR RESPONSIBILITIES.

3.1 **Processing of Claims**. ***FAA*** will promptly process ***claims*** that are submitted by ***you*** as provided in section 4.1 below. ***FAA*** shall comply with all applicable laws in processing ***claims***. While ***FAA*** endeavors to promptly process ***claims***, ***you*** understand that except for ***HMO clients***, ***we*** contract with ***clients*** that are ultimately responsible for paying ***clean claims***. In the unlikely event that a ***client*** fails its reimbursement obligations, ***we*** shall not be liable to pay for such ***covered services*** and unless prohibited by applicable law and upon notice by ***EyeMed***, ***Eye Care Professional*** may bill third parties or the ***member*** for such ***covered services***.

3.2 **Verify Eligibility.** ***EyeMed*** shall make available a mechanism for ***Eye Care Professional*** to confirm a ***member's*** eligibility as of the date of the verification. ***Eye Care Professional*** understands that notwithstanding such confirmation, at times, individuals may not be eligible as of the date of service for a variety of reasons, including a ***client's*** retrospective adjustments to eligibility files. Therefore, unless prohibited by

applicable law, verification of eligibility is not a guarantee of payment. If a ***member*** loses eligibility after verification, ***Eye Care Professional*** agrees that ***client*** and ***EyeMed*** shall have no financial responsibility and ***Eye Care Professional*** may seek payment directly from the individual who is determined to have not been an eligible ***member*** on the date of service.

3.3 **Provider Manual**. ***EyeMed*** shall establish and maintain a ***provider manual*** that sets forth ***our*** policies and procedures (and other requirements) that ***Eye Care Professional*** must follow, including by way of example: credentialing and re-credentialing; ***claim*** submissions; grievance/complaint and appeals; and information on ***covered services***. The ***provider manual*** may be changed from time to time by ***EyeMed*** with at least 30 days advance notice to ***Eye Care Professional***. ***EyeMed*** shall provide ***Eye Care Professional*** with online access to the ***provider manual*** and ***Eye Care Professional*** must be able to access and review the ***provider manual*** and any changes on a secure computer terminal.

3.4 **Audit Records**. ***EyeMed*** may periodically, whether during the term of this ***agreement*** or anytime thereafter, audit ***Eye Care Professional's*** records to confirm compliance with this ***agreement***. The provisions of this section shall survive termination of this ***agreement***.

3.5 **Confidentiality**. ***You*** may share certain business sensitive, proprietary, and/or confidential information with ***EyeMed***. ***We*** shall use such information only for furtherance of carrying out our obligations under this ***agreement***, contracts with ***clients***, and for other legally permissible purposes. The provisions of this section shall survive termination of this agreement.

3.6 **Comply with Laws**. ***EyeMed*** will comply with applicable laws and regulations.

IV. COMPENSATION.

4.1 **Payment**. ***FAA*** shall pay ***you*** pursuant to Appendix 4, which may be amended by ***us***, in ***our*** sole discretion, upon at least 30 days prior notice, in writing or by email to ***you***, unless a longer period of time is required by law. In the event that a ***client*** or prospective ***client*** requires that ***FAA*** reimburse ***you*** at a non-standard payment rate for ***covered services***, ***EyeMed*** shall notify ***you*** in writing or by email of such non-standard payment rate at least 30 days prior to the effective date of such non-standard payment rate. ***You***, in ***your*** sole discretion, may notify ***EyeMed*** by email within 30 days of delivery by ***EyeMed*** of the notice of non-standard payment rate that ***Eye Care Professional*** and all of ***Eye Care Professional's*** locations covered by this ***agreement*** will not provide services or materials to such ***members*** associated with the non-standard payment rate. Such notice shall be effective on receipt by ***EyeMed***. If ***you*** do not so notify ***EyeMed, you*** shall be deemed to have accepted the non-standard payment rates for ***you*** and ***affiliated eye care professionals***. If ***you*** do so notify ***EyeMed***, ***Eye Care Professional*** shall notify any applicable ***members*** that ***Eye Care Professional*** does not participate with ***EyeMed*** for purposes of the ***member's benefit plan***.

4.2 **Payment in Full**. ***You*** agree to accept as payment in full for ***covered services***, the fees set forth in Appendix 4, as may be amended or as otherwise provided in Section 4.1, plus any applicable ***member expense*** to be collected from the ***member***, on behalf of ***Eye Care Professional***. All payments by ***FAA*** shall be paid directly to ***you*** and not to ***affiliated eye care professionals***. To the extent permitted by applicable law, ***you*** shall receive such payment electronically. ***You*** shall ensure that ***affiliated eye care professionals*** look solely to ***you*** for any payments for ***covered services*** and shall indemnify and hold ***clients***, ***members***, and ***us*** harmless from any claims made by ***affiliated eye care professionals*** for payments made to ***you***.

4.3 **Waiver of Member Expenses**. ***Eye Care Professional*** will collect, and not waive, any applicable ***member expense*** from the ***member***.

4.4 **Non-Covered Services**. ***You*** will not charge a ***member*** higher fees than ***you*** regularly charge private pay patients (i.e., non-***members***) for any professional services, materials, or other goods that are not ***covered services***. ***Eye Care Professional*** will comply with any requirements set forth in the ***provider manual*** regarding non-***covered services***.

4.5 **Overpayment**. ***You*** agree to promptly refund to ***EyeMed*** any erroneous payments regarding billing or coding errors, ineligible ***members***, non-***covered services***, and other incorrect payments, either after discovery by ***Eye Care Professional*** or after written notice from ***EyeMed***. ***You*** will promptly notify ***us*** if ***you*** learn of an overpayment. If ***FAA*** believes that a ***claim*** has not been paid correctly ***we*** may seek correction or adjustment of the payment. In the event of an overpayment, ***we*** will correct these errors by adjusting future claim payment and/or billing ***you*** for the amount owed to ***us***. ***Eye Care Professional*** will cooperate with ***us*** and promptly return any overpayments. ***We*** will not seek a refund or offset any payments if prohibited by applicable law. In the event that ***client*** or ***we*** determine, in ***our*** sole discretion, that there was an overpayment, we may either request a refund or withhold future payments. Any requests for refunds or payment withholds will comply with applicable laws.

4.6 **Negative Balance.** If a negative balance occurs, ***FAA*** has the right to offset future compensation owed to ***you*** with the amount owed to ***supplier***, except if prohibited by applicable law. ***We*** will automatically, when possible, apply the negative balance to other outstanding payables on ***your*** account. If ***supplier*** submits an invoice ***you*** will promptly pay such negative balance. A negative balance is not an overpayment as provided in Section 4.5.

4.7 **Do Not Bill Member**. ***Eye Care Professional*** shall not charge a ***member*** for the services ***Eye Care Professional*** provides, if those services are ***covered services*** under the ***member's benefit plan***, except for the applicable ***member expense*** (if any). If the services ***Eye Care Professional*** provides are denied or otherwise not paid due to ***your*** failure to file a timely ***claim***, to submit a ***clean claim***, to respond to ***our*** request for information, or based on ***our*** reimbursement policies and methodologies, ***Eye Care Professional*** shall not charge the ***member***. If the services ***Eye Care Professional*** provides are not ***covered services***, ***you*** may, of course, bill ***members*** directly, subject to any requirements described in this ***agreement***.

4.8 **Hold Harmless.** For members of ***HMO clients***, ***Eye Care Professionals*** agrees that in no event, including insolvency or non-payment by ***HMO client*** or ***us,*** will ***Eye Care Professional*** charge, collect a deposit, or seek compensation from a ***member*** for any amounts other than for applicable ***member expenses***, or services not covered under the ***benefit plan***; and further agrees that this provision is for the benefit of the ***member***, supersedes any oral or written agreement with the ***member***, shall survive the termination of this ***agreement***, and that no change to this provision is effective until fifteen (15) days after the relevant Commissioner of Insurance or other government agency has been notified of the proposed change if such notice is required by applicable law.

4.9 **Coordination of Benefits**. ***Eye Care Professional*** shall cooperate with ***EyeMed*** with respect to coordination of benefits as described in the ***provider manual***.

4.10 **Payment for Performance**. To the extent that ***FAA*** implements or facilitates a payment for performance or other supplemental payment program, such program and any corresponding payments shall be set forth in an Appendix to this ***agreement***.

V. EFFECTIVE AND TERMINATION DATE; TERMINATION OF AGREEMENT.

5.1 **Effective Date**. This ***agreement*** shall be effective as of the date described in Appendix 9.

5.2 **Termination**. This ***agreement*** may be terminated as described in Appendix 9.

VI. NO CLASS ACTIONS. ***Eye Care Professional*** and ***Supplie***r and ***we*** each agree that, no matter in what capacity, neither ***Eye Care Professional*** nor ***we*** will (1) file (or join, participate or intervene in) a class-based lawsuit, or court case (including any collective action) that relates in any way to this ***agreement*** or (2) file (or join, participate or intervene in) a class-based arbitration (including any collective arbitration claim) with regard to any claims relating in any way to this ***agreement*** to the extent permitted by applicable law. Both ***Eye Care Professional*** and ***Supplier*** and ***we*** recognize that each side's contractual obligations run exclusively to the other. Claims of two or more persons may not be joined or consolidated in the same lawsuit or arbitration.

VII. INDEMNIFICATION. ***Eye Care Professional*** shall indemnify, defend and hold ***EyeMed*** and Luxottica U.S. Holdings Corp., ***Supplier***, and each of their respective officers, agents, parents, employees, representatives, affiliates, ***clients***, successors and assigns harmless from any and all third party claims, demands, causes of actions, suits, losses, obligations, judgments, costs of settlement, liabilities, damages and expenses (including reasonable attorney's fees and costs) for injuries, illnesses or death to persons or for loss of or damage to property, arising, in whole or in part, from any act, omission, negligence, or fault of ***you***, your officers, agents, independent contractors, employees, or ***affiliated eye care professionals*** (collectively, "Indemnitor"), or arising, in whole or in part, out of or in connection with the Indemnitor's services performed or Indemnitor's products furnished related to this ***agreement*** (including claims against ***us*** and Luxottica U.S. Holdings Corp. based on apparent or ostensible agency or vicarious liability).

VIII. MISCELLANEOUS

8.1 **Amendment**. Except as otherwise provided in this agreement, ***EyeMed*** may amend this ***agreement*** on at least 30 days' prior written or electronic notice by sending ***you*** a copy of the amendment. ***Your*** signature is not required to make the amendment effective.

8.2 **Assignment**. ***EyeMed*** and ***you*** agree that this ***agreement*** may not be assigned to any other person, except that ***Supplier*** and ***we*** may assign this agreement to any affiliates, successors or assigns.

8.3 **Headings**. The subject heading of the Articles and sections of this ***agreement*** are included for purposes of convenience only and shall not affect the construction or interpretation of any of the provisions of this ***agreement***.

8.4 **Entire Agreement**. This ***agreement*** constitutes the entire agreement between the parties in regard to its subject matter.

8.5 **Governing Law**. This ***agreement*** shall be governed by and construed in accordance with the laws of the State of Ohio.

8.6 **Notices**. Any notice or other communication required or permitted under this Agreement shall be in writing and shall be deemed to have been duly given and made (i) when delivered if personally delivered to the party for whom it is intended; (ii) upon receipt if delivered by telecopier with receipt confirmed; (iii) one business day after being sent to the recipient by reputable overnight courier service (charges prepaid); (iv) three business days after being mailed to the recipient by certified or registered mail, return-receipt

requested and postage prepaid; and addressed (a) to ***Supplier*** and ***EyeMed*** at the address set forth below and (b) to ***Eye Care Professional*** at the address that we have on file; or (iv) one business day after sent by email to the email address that each party has on file for the other party.

Notice to EyeMed, FAA, and Supplier: 4000 Luxottica Place, Mason OH 45040, Attention: Provider Relations. The fax number and email address are provided in the ***Provider Manual.***

8.7 **Relationship.** ***Eye Care Professional*** shall act at all times solely as an independent contractor with respect to the services described in this ***agreement***. It is specifically understood that ***Eye Care Professional's*** relationship with ***EyeMed*** and the relationship of ***EyeMed*** to ***Eye Care Professional*** shall be that of an independent contractor only. Nothing herein shall be construed to create a relationship of employer and employee between ***Eye Care Professional*** and ***EyeMed*** or between ***affiliated eye care professional*** and ***us.***

8.8 **Names and Logo**. ***Eye Care Professional*** shall have the right to use ***EyeMed's*** name solely to make public reference to ***Eye Care Professional's*** participation status and shall not otherwise use ***EyeMed's*** name, symbol, trademark or service mark without ***our*** prior written approval. Additional information regarding usage guidelines is provided in the ***provider manual***. ***We*** shall have the right to use ***Eye Care Professional's*** name in ***our*** provider directory and for any other reasonable purposes in connection with administering ***benefit plans*** or performing services pursuant to ***our contracts*** with ***clients***.

8.9 **Waiver**. The waiver by either party of any breach of this ***agreement*** shall not be construed as a continuing waiver or a waiver of any other breach of this ***agreement***.

8.10 **Severability**. In the event that any clause, term, or condition of this ***agreement*** (which includes the appendices and ***provider manual***) shall be held invalid or contrary to law, this ***agreement*** (including the appendices and ***provider manual***) shall remain in full force and effect as to all other clauses, terms, and conditions.

8.11 **No Third Party Beneficiaries.** Except as expressly provided in this agreement, no third parties shall have any rights because of or under this ***agreement,*** except that ***EyeMed*** may enforce this ***agreement*** as it relates to ***affiliated eye care professionals***.

8.12 **Electronic Signatures**. The ***parties*** acknowledge and agree that a ***party's*** electronic signature shall be deemed an original signature for purposes of execution of this agreement.

8.13 **Counterparts**. This ***agreement*** may be executed in any number of counterparts, each of which when so executed shall be deemed to be an original and all of which when taken together shall constitute one and the same instrument. One or more counterparts of this ***agreement*** may be delivered via facsimile or other electronic means with the intention that they shall have the same effect as an original executed counterpart thereof.

8.14 **Business Associate.** ***Eye Care Professional*** shall comply with the attached Business Associate Appendix, which shall automatically be amended to meet and comply with any changes in law or regulation.

8.15 **Appendices**. The following additional documents bind ***you*** and ***us*** and may be changed at any time by us in our discretion.

Appendix 1 "Participating Eye Care Professionals"	This Appendix identifies the ***participating Eye Care Professionals*** that will provide ***covered services*** under this ***agreement***
Appendix 2 "Practice Locations"	This Appendix identifies the locations where ***covered services*** will be provided under this ***agreement***
Appendix 3 "Definitions"	This Appendix provides a list of definitions used throughout this ***agreement***
Appendix 4 "Reimbursement"	This Appendix describes the reimbursement requirements.
Appendix 5 "State Regulatory Requirements"	This Appendix describes any additional or different requirements that apply to this ***agreement*** due to state laws and regulations
Appendix 6 "Medicare Regulatory Requirements"	This Appendix describes the Medicare requirements for ***you*** and ***us*** as it relates to Medicare Advantage ***members***.
Appendix 7 "Client Requirements"	This Appendix describes specific ***client*** requirements.
Appendix 8 "Business Associate Agreement"	This Appendix describes ***EyeMed*** and its applicable affiliates and ***your*** responsibilities to protect member information.
Appendix 9 "Effective and Termination Date; Termination of Agreement"	This Appendix describes the effective and termination dates of this ***agreement***.

EXECUTION PAGE FOLLOWS

Appendix 1

EYE CARE PROFESSIONALS

Appendix 2

EYE CARE PROFESSIONALS' PRACTICE LOCATIONS

Business Name: NVTest

Services: Exams, Contacts, Materials

Address: 123 Main St

City: SomeCity ST: NV Zip: 12345

Phone: 9999999999 Fax: _____

Email: ritest@testing.com

Business Name: _____

Services:

Address: _____

City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Business Name: _____

Services:

Address: _____

City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Business Name: _____

Services:

Address: _____

City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Business Name: _____

Services:

Address: _____

City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Appendix 2

EYE CARE PROFESSIONALS' PRACTICE LOCATIONS

Business Name:_____ Services:

Address:_____

City:_____ ST:____ Zip:_____

Phone:_____ Fax:_____

Email: _____

Business Name:_____ Services:

Address:_____

City:_____ ST:____ Zip:_____

Phone:_____ Fax:_____

Email:_____

Business Name:_____ Services:

Address:_____

City:_____ ST:____ Zip:_____

Phone:_____ Fax:_____

Email:_____

Business Name:_____ Services:

Address:_____

City:_____ ST:____ Zip:_____

Phone:_____ Fax:_____

Email:_____

Business Name:_____ Services:

Address:_____

City:_____ ST:____ Zip:_____

Phone:_____ Fax:_____

Email:_____

APPENDIX 3

DEFINITIONS

"Affiliated eye care professional" means a ***participating provider*** who is (i) either employed by ***Eye Care Professional*** or who is an independent contractor providing services to you, but who is not in a leasing or subleasing relationship with Eye Care Professional and (ii) has been credentialed by EyeMed.

"Agreement" has the meaning set forth in the introductory paragraph to the contract.

""Benefit Plan" means the vision care plan, group health plan, insurance plan, or other benefit plan underwritten by an insurance carrier or sponsored or administered by employer or plan Sponsor, or other purchaser of vision coverage that contracts directly or indirectly with EyeMed and/or FAA to administer the ***benefit plan***.

"Claim" means a request for payment by ***Eye Care Professional*** for providing services to members as permitted under the ***benefit plan***.

"Clean claim" means, unless otherwise required by law or regulation, a ***claim*** which (i) is submitted within the timeframes set forth in the ***agreement***; (b) contains all elements for ***EyeMed*** to process the claim; (c) is submitted in accordance with the formatting and submission requirements which ***EyeMed*** may establish from time to time; and (iv) is medically necessary, to the extent that a ***client*** or ***we*** make such determinations.

"Client" means any third party who has directly or indirectly contracted with ***EyeMed*** and/or ***FAA*** to arrange for the provision of ***covered services*** and includes, by way of example, insurance carriers, health maintenance organizations, Medicare Advantage Organizations, Medicaid managed care organizations, ERISA employee health plans, health and welfare plans, and other purchasers of vision care services.

"Covered service(s)" means vision and/or medical examinations and vision materials (as the case may be) that are: (i) within ***Eye Care Professional's*** license and scope of practice; (ii) routinely provided by ***Eye Care Professional***; (iii) covered under a ***member's benefit plan***; (iv) provided in accordance with the terms of this ***agreement***.

"Credentialing Letter" means the letter issued by ***EyeMed*** identifying a specific ***provider*** or ***providers*** that have been credentialed by ***us***, the date the ***provider(s)*** will become ***affiliated eye care professionals***, and such other information as deemed appropriate by ***EyeMed***.

"Effective date" means the date the agreement is first effective as described in section 5.1.

"Eye Care Professional" means the legal entity that has entered into the ***agreement*** with ***EyeMed*** or if there is no legal entity, the ***provider*** that has entered into this ***agreement***.

"Member" means a person who, at the time that services are rendered, is eligible to receive ***covered services*** under the terms of the applicable ***benefit plan***.

"*Member expenses"* means any amounts that are the member's responsibility to pay ***you*** in accordance with the member's benefit plan, including copayments, coinsurance, and deductibles.

"Network" means one of the ***provider*** panels administered and designated by ***EyeMed*** for **participating providers** to deliver ***covered services.***

"Participating provider" means a ***provider*** that has entered into a contract with ***EyeMed*** to provide ***covered services*** to ***members***.

"Party" means ***you*** or ***us.***

"Parties" means ***you*** and ***us.***

"Provider" means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician

"Provider manual" means the EyeMed Vision Care Professional Manual, as amended from time to time by ***EyeMed***.

"Supplier" means ***Optical Procurement Services LLC***.

"We" or ***"Us"*** means ***EyeMed Vision Care, LLC*** and its affiliates that provide services under this ***agreement***.

"You" and ***"Your"*** means the party that has entered into this ***agreement*** with ***us***.

APPENDIX 4

REIMBURSEMENT

"Proprietary and Confidential"

APPENDIX 5

STATE REGULATORY REQUIREMENTS

APPENDIX 6

MEDICARE REGULATORY REQUIREMENTS

This Medicare Addendum to the ***agreement*** is intended to add to and consolidate contract language that is required by the Centers for Medicare and Medicaid Services ("CMS") for participation in the Medicare Advantage program.

CMS requires that specific terms and conditions be incorporated into the ***agreement*** and that all providers comply with the Medicare laws, regulation, and CMS instructions, including but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Public Law 108-73) (MMA).

In the event that another provision in the ***agreement*** is in conflict with this Medicare Addendum, this Medicare Addendum shall govern.

1. For purposes of this Medicare Addendum, the following terms shall have the following meanings:

   Centers for Medicare & Medicaid Services ("CMS") means the agency within the Department of Health and Human Services that administers the Medicare program.

   Medicare Advantage ("MA") is an alternative program to traditional Medicare under which private Medicare Advantage Organizations provide health care benefits that eligible Medicare beneficiaries would otherwise receiver directly from the Medicare program.

   MA Payers means the entities that contract with CMS to provide or offer a MA program and that also contracts with ***EyeMed*** to provide the vision benefit under such MA program.

   Medicare Enrollee means an individual eligible for a Medicare who has enrolled in or elected coverage through a Medicare Advantage Organization.

   All other capitalized terms in this Medicare Addendum shall have the same meaning as set forth in the ***agreement***.

2. For purposes of this Medicare Addendum, the following terms and conditions shall apply:

   Confidentiality of Records. For any medical records or other information ***you*** maintain with respect to members, ***you*** must establish procedures to: (i) safeguard the privacy and confidentiality of any information that identifies a member; (ii) release information from, or copies of, records only to authorized individuals; (iii) ensure that unauthorized individuals cannot gain access to or alter member records; (iv) release original medical records only in accordance with state and federal laws, court orders, or subpoenas; (v) maintain the records and information in an accurate and timely manner; (vi) ensure timely access by members to the records and information that pertain to them; (vii) abide by all state and federal laws regarding confidentiality and disclosure for mental health records, medical records, other health information and member information; and (viii) assure accuracy of member medical, health and enrollment information and records.

   Comply with Rule, Policies and Procedures. ***You*** shall be bound by all Policies and Procedures, as they relate to this ***agreement***, adopted by MA Payers from time to time and set forth in the MA Payer provider manual.

Comply with Laws. ***You*** acknowledge that ***EyeMed*** receives federal funds from MA Payers and that as a subcontractor of ***EyeMed***, the payments to ***you*** under this ***agreement*** are, in whole or in part, from federal funds. ***You*** shall follow and adhere to all applicable laws in carrying out the terms and conditions of ***your*** respective duties and obligations under this ***agreement***, including, but not limited to, Medicare laws, regulations, reporting requirements and CMS instructions, which shall be monitored by ***EyeMed*** and MA Payers on an ongoing basis. Further, the terms and conditions of this ***agreement*** shall be construed in compliance with any applicable state law not pre-empted by federal law, and in the event of any conflict between a term or condition of the ***agreement*** and such non-pre-empted state law, such non-pre-empted state law shall prevail.

Compliance with Contract. ***You*** agree that all services or other activities performed by a related entity, contractor, subcontractor or downstream entity pursuant to a written agreement are consistent and comply with MA Payers' contractual obligations, including but not limited to the provisions in this Medicare Addendum. ***You*** may only perform services under this contract in accordance with the contract's terms and ***you*** are subject to termination from ***your*** MA activities if CMS, a MA Payer or ***EyeMed*** determines performance under this ***agreement*** has not been satisfactory. MA Payers retain the right to approve, suspend or terminate any arrangement whereby ***EyeMed*** has been delegated selection of individual providers, contractors or subcontractors.

Access to Records. ***You*** shall maintain for at least ten (10) years after the date of delivery of services, and readily make available to MA Payer and governmental agencies with regulatory authority, copies of medical and all related administrative records of members that receive services, as required by MA Payer in accordance with this ***agreement*** or pursuant to applicable Laws. Notwithstanding any other provision to the contrary, ***you*** hereby agree to the following: ***EyeMed***, MA Payers, the Department of Health and Human Services ("DHHS"), CMS, the Comptroller General or other government agencies, or their designee may evaluate, through audit, inspection or other means: (i) the quality, appropriateness, and timeliness of services furnished to members; (ii) ***your*** facilities ; and (iii) the risk arrangement between ***you*** and ***EyeMed*** if any. ***You*** further agree that ***EyeMed,*** MA Payers, DHHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of ***yours*** (or its assignee) that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under CMS Contract, or as the Secretary may deem necessary to enforce the CMS contract. ***You*** agree to make available ***your*** premises, physical facilities and equipment, records relating to Members, and any additional relevant information that CMS may require and agree to cooperate, assist and provide information as requested. ***You*** further agree that ***EyeMed***, MA Payers, DHHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the final date of the contract period of CMS Contract or completion of any audit, whichever is later.

Reporting Requirements. ***You*** agree to assist ***EyeMed*** and MA Payers with their CMS reporting requirements found in 42 C.F.R. §§ 422.310 and 422.516. These requirements include, but are not limited to, reporting of risk adjustment data, data necessary to characterize the context and purpose of each covered service, patterns of utilization of covered services, the availability, accessibility, and acceptability of covered services, developments in the health status of members, and any other matters that CMS may require.

Dual Eligible Enrollees. ***You*** agree that cost sharing for dual eligible Enrollees is limited to the Medicaid (including Medi-Cal) cost sharing limits; and that for those dual-eligible Enrollees ***you*** will accept the MA Payer payment, as payment-in-full or will separately bill the appropriate state source for any amounts above the Medicaid (or Medi-Cal) cost sharing.

Benefit Continuation. In the event of MA Payer's insolvency or other cessation of operations or termination of the MA Payer's contract with CMS, ***you*** shall continue to provide services to a

member through the later of the period for which premium has been paid to MA Payer on behalf of the member, or, in the case of members who are hospitalized as of such period or date, until the member's discharge. Services for a member confined in an inpatient facility on the date of insolvency or other cessation of operations shall continue until the member's continued confinement in an inpatient facility is no longer medically necessary.

Delegation and Oversight. ***You*** acknowledge that (1) MA Payers and ***EyeMed*** oversee and MA Payers are accountable to CMS for any functions and responsibilities described in the MA regulations, and (2) ***you*** agree to perform ***your*** activities or functions related to MA members in a manner that adheres to the MA regulations.

Hold Harmless. ***You*** agree to hold Medicare Enrollees harmless for fees that are the legal obligation of MA Payers or ***EyeMed***, notwithstanding the insolvency of MA Payer or ***EyeMed,*** breach of contract, or provider billing.

Prompt Payment. ***EyeMed*** shall remit payment for ***covered services*** within forty-five (45) days of receipt of a clean claim.

Interest Assessment. In the event ***EyeMed*** fail to make a timely payment of amounts due under the agreement, ***EyeMed*** shall be obligated to pay ***you*** interest beginning on the forty-sixth (46^{th}) day after receipt of a clean claim, at a rate equal to the Medicare interest rate effective on the date of service.

APPENDIX 7

CLIENT REQUIREMENTS

APPENDIX 8

BUSINESS ASSOCIATE AGREEMENT

For purposes of this Addendum, "you" are the "Covered Entity" and "EyeMed" and its applicable affiliates identified in the Agreement" are the "Business Associate."

I. DEFINITIONS

A. In General. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103 and 164.501.

B. Specific Definitions

1. "Applicable Law" shall mean any of the following items, including any amendments to any such item as such may become effective:

a. the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

b. the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Privacy Rule");

c. the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 162 (the "Transaction Rule");

d. the federal regulations regarding security and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Security Rule"); and

e. the Health Information Technology for Economic and Clinical Health Act of ("HITECH") and any of its implementing regulations.

2. "ePHI" means electronic protected health information within the meaning of 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

3. "HIPAA Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.

4. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

5. "Service Agreement" shall mean EyeMed Professional Services Agreement or other agreement for the provision of services by Business Associate that is between Covered Entity and Business Associate.

6. "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR § 164.402, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

II. RIGHTS AND OBLIGATIONS OF BUSINESS ASSOCIATE

A. General Obligations

1. Compliance with Privacy Rule.

a. Business Associate shall not use or further disclose PHI other than as permitted or required by HIPAA, the Privacy Rule, and this Agreement.

b. Business Associate shall use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.

c. Business Associate shall report to Covered Entity any use or disclosure of PHI, known to Business Associate, that is not permitted by this Agreement.

2. Compliance with Security Rule.

a. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI.

b. Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

3. Compliance with HITECH.

a. Business Associate shall comply with the breach notification requirements provided in Section II.A.4 of the Agreement below.

b. Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by HITECH § 13405(d) and the Privacy Rule. ***This paragraph shall be effective on and after September 23, 2013*.**

c. Business Associate shall comply with those portions of the Privacy Rule made applicable to Business Associate by HITECH.

d. Business Associate shall comply with those portions of the Security Rule made applicable to Business Associate by HITECH.

4. Breach Notification.

a. **Notice to Covered Entity**. Business Associate shall notify Covered Entity without unreasonable delay and within thirty (30) calendar days of Business Associate's discovery of a HIPAA Breach of Unsecured PHI. The notice to Covered Entity shall include the identity of each Individual whose Unsecured PHI was involved in the HIPAA Breach, a brief description of the HIPAA Breach and any mitigation efforts. To the extent that Business Associate does not know the identities of all affected Individuals when it is required to notify Covered Entity, Business Associate shall provide such additional information as soon as administratively practicable after such information becomes available. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate

(including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of Business Associate).

b. **Notice to Individuals**. Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of Covered Entity, without unreasonable delay but no later than sixty (60) calendar days following the date the HIPAA Breach of Unsecured PHI is discovered or such later date as is authorized under 45 CFR § 164.412 to each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, used, or disclosed as a result of the HIPAA Breach. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of Business Associate).

The content, form, and delivery of such written notice shall comply in all respects with 45 CFR § 164.404(c)-(d).

Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to any Individual, Business Associate shall first provide a draft of the notice to Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

c. **Notice to Media.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of Covered Entity, to the media to the extent required under 45 CFR § 164.406. Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

d. **Notice to Secretary.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of Covered Entity, to the Secretary to the extent required under 45 CFR § 164.408. Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to Covered Entity. Covered Entity shall have five business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

If the HIPAA Breach of Unsecured PHI involves less than five hundred (500) individuals, Business Associate will maintain a log or other documentation of the HIPAA Breach of Unsecured PHI which contains such information as would be required to be included if the log were maintained by Covered Entity pursuant to 45 CFR § 164.408, and provide such log to Covered Entity within five (5) business days of Covered Entity's written request.

5. **Subcontractors and Agents.** Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees in writing to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI.

6. **Access to Books and Records by Secretary.** Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with HIPAA. Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Business Associate's compliance with HIPAA.

7. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (a) a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement, or (b) a Security Incident.

B. Obligations Relating to Individual Rights

1. **Restrictions on Disclosures.** Upon request by an Individual, Covered Entity shall determine whether an Individual shall be granted a restriction on disclosure of the PHI pursuant to 45 CFR § 164.522. Covered Entity will not agree to any such restriction, if such restriction would affect Business Associate's use or disclosure of PHI, without the prior consent of Business Associate, *provided, however,* that Business Associate's consent is not required for requests that must be granted under HITECH § 13405(a). Covered Entity will communicate any grant of a request, made consistent with the foregoing, to Business Associate. Business Associate will restrict its disclosures of the Individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request for restrictions, Business Associate shall forward such request to Covered Entity within five (5) business days.

2. **Access to PHI.** Upon request by an Individual, Covered Entity shall determine whether an Individual is entitled to access his or her PHI pursuant to 45 CFR § 164.524. If Covered Entity determines that an Individual is entitled to such access, and that such PHI is under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to access his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.

3. **Amendment of PHI.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to amend his or her PHI pursuant to 45 CFR § 164.526. If Covered Entity determines that an Individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to amend his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.

4. **Accounting of Disclosures.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to an accounting pursuant to 45 CFR § 164.528. If Covered Entity determines that an Individual is entitled to an accounting, Covered Entity will communicate the decision to Business Associate. Business Associate will provide information to Covered Entity that will enable Covered Entity to meet its accounting obligations. If Business Associate receives an individual's request for an accounting, Business Associate shall forward such

request to Covered Entity within five (5) business days.

C. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement or by Applicable Law, Business Associate may:

1. Use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, as specified in the Service Agreement between the Parties and in this Agreement, *provided that* such use or disclosure (i) is consistent with Covered Entity's Notice of Privacy Practices and (ii) would not violate HIPAA or the Privacy Rule if done by Covered Entity;

2. Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;

3. Disclose PHI for the proper management and administration of Business Associate, *provided that* (i) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached or (ii) the disclosures are Required By Law; and

4. Use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

III. RIGHTS AND OBLIGATIONS OF COVERED ENTITY

A. Privacy Practices and Restrictions

1. Upon request, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520. If Covered Entity subsequently revises the notice, Covered Entity shall provide a copy of the revised notice to Business Associate.

2. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

B. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

IV. TERM AND TERMINATION

A. **Term.** The term of this Agreement shall begin on the effective date of the Services Agreement, and shall end upon the termination of the Services Agreement or upon termination for cause as set forth in the following Section IV.B, whichever is earlier.

B. **Termination for Cause.** Upon any Party's knowledge of a material breach of this Agreement by another Party, the nonbreaching Party shall have the following rights:

1. If the breach is curable, the nonbreaching party may provide an opportunity for the other Party to cure the breach or end the violation. Alternatively, or if the other Party fails to cure the breach or end the violation, the nonbreaching Party may terminate this Agreement and the Services Agreement.

2. If the breach is not curable, the nonbreaching Party may immediately terminate this Agreement and the Services Agreement.

3. If termination is not feasible, the nonbreaching Party may report the problem to the Secretary.

C. Effect of Termination.

1. Except as provided in the following paragraph, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and all PHI that is in the possession or control of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

2. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

V. MISCELLANEOUS

A. Electronic Health Records. The Parties agree that Business Associate shall not maintain any "electronic health record" or "personal health record," as those terms are defined in HITECH, for or on behalf of Covered Entity. As such, Business Associate has no obligation to document disclosures that are exempt from the accounting requirement under 45 CFR § 164.528(1)(i)-(ix), and Covered Entity agrees not to include Business Associate on any list Covered Entity produces pursuant to HITECH § 13405(c)(3).

B. Regulatory References. A reference in this Agreement to a section in any Applicable Law means the section in effect or as amended, and for which compliance is required.

C. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of Applicable Law. Upon the effective date of any amendment to the Privacy Standards or the Security Rule or the effective date of any other final regulations with respect to PHI, this Business Associate Addendum will automatically be amended so that the obligations they impose on the Parties shall remain in compliance with such regulations.

D. Survival. The respective rights and obligations of Business Associate under Section IV.C. of this Agreement shall survive the term and termination of this Agreement.

E. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with Applicable Law.

F. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person, other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

G. **Assignment**. No assignment of rights or obligations under this Agreement shall be made by either Party without the prior written consent of the other Party; provided however, that Business Associate may assign this Agreement to an affiliate.

H. **Effect on Agreement.** Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the underlying Services Agreement shall remain in force and effect.

APPENDIX 9

Standard

EFFECTIVE AND TERMINATION DATE; TERMINATION OF AGREEMENT

5.1 **Effective Date.** This ***agreement*** shall become effective after it has been executed by ***you*** and after (a) ***you*** have completed the credentialing process; (b) ***EyeMed*** determines that ***you*** are eligible to contract with ***us*** based on the completion of the credentialing process and any professional criteria for contracting with ***us***, and (c) ***we*** sign this ***agreement*** and invite ***you*** to a ***network*** or ***networks*** as provided in section 1.23 above. ***We*** will notify ***you*** of the ***effective date*** of this ***agreement*** and the date that ***you*** (and ***affiliated eye care professionals***, as applicable) may begin providing ***covered services***. This ***agreement*** shall become effective with respect to an ***affiliated eye care professional*** after (a) such ***affiliated*** e***ye care professional*** has completed the credentialing process, (b) ***we*** determine that such ***affiliated eye care professional*** is eligible based on the professional criteria for participating with ***us***, and (c) ***we*** provide notice to ***you*** of the date that such ***affiliated eye care professional*** may begin providing ***covered services***.
We may terminate this ***agreement***, as provided below, to any ***one*** or more ***affiliated eye care professionals*** or to all ***affiliated eye care professionals*** and ***you*** covered under this ***agreement.***

5.2 **Termination Date.** We may terminate this ***agreement***, as provided below, to any ***one*** or more ***affiliated eye care professionals*** or to all ***affiliated eye care professionals*** and ***you*** covered under this ***agreement***. This agreement may be terminated as follows:

5.2.1 By mutual agreement of the parties.

5.2.2 By either ***party*** upon 60 days prior written notice to the other ***party*** for any reason or no reason.

5.2.3 By either ***party*** in the event of a material breach of this ***agreement*** by ***EyeMed*** or ***Eye Care Professional***, as the case may be, upon 30 days prior written notice to the other party if the breaching party does not cure the breach within this 30 day period.

5.2.4 By ***us***, immediately upon written notice to ***you***, due to ***Eye Care Professional's*** loss or suspension of license.

5.2.5 By ***you*** upon 30 days prior written notice to ***us*** if such notice is given within 30 days after ***your*** receipt of an amendment made to this ***agreement*** as described in section 8.1; provided however, ***you*** may not terminate this ***agreement*** under this section 5.2.5 for amendments that are the result of changes in law.

5.2.6 By ***us*** in accordance with our credentialing plan.

5.2.7 By ***us***, immediately, if ***Eye Care Professional*** files for bankruptcy.

5.2.8 By ***us***, immediately, if ***Eye Care Professional*** no longer meets EyeMed's contracting requirements.

5.2.9 By ***us***, immediately for the submission of false claims.

5.2.10 By ***us***, immediately, upon notice of any legal or governmental action against ***Eye Care Professional***.

5.2.11 By ***us***, immediately, if ***Eye Care Professional*** fails to comply with ***our*** insurance requirements.

IN WITNESS WHEREOF, the undersigned have executed this Agreement by initialing each page of this agreement, unless signed by electronic copy, and the signature block below.

EyeMed Vision Care, LLC

Name:_____

Title:_____

Date/Time: _____

IP Address:_____

Eye Care Professional

Signature:_____

Name:_____

Title:_____

Date/Time: _____

Legal Name:_____

Tax ID #:_____

IP Address: _____

First American Administrators, Inc.

Name:_____

Title:_____

Date/Time: _____

IP Address:_____

Optical Procurement Services, LLC

Name:_____

Title:_____

Date/Time: _____

IP Address:_____

EyeMed Vision Care IPA, Inc.

Name:_____

Title:_____

Date/Time: _____

IP Address:_____

EyeMed Vision Care HMO of Texas Inc.

Name:_____

Title:_____

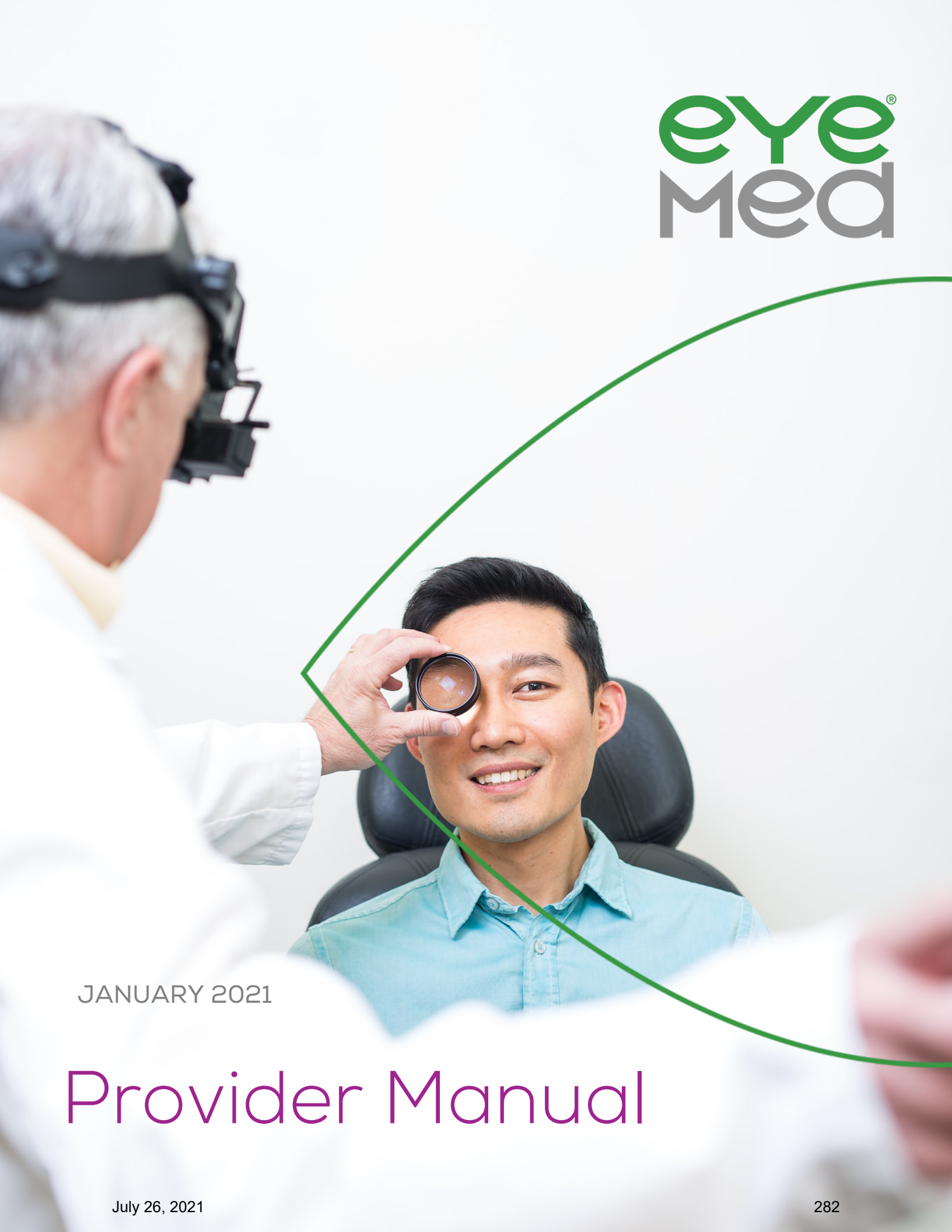
Date/Time: _____

IP Address:_____

Provider Manual – EyeMed

Empire BlueCross

An Anthem Company



JANUARY 2021

Provider Manual

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INTRODUCTION

This version of the EyeMed Vision Care® Professional Provider Manual supersedes any prior manual you have received from EyeMed. EyeMed reserves the right to revise these policies and procedures at our sole discretion and at any time. All applicable laws and regulations supersede the provisions of this manual. This Provider Manual is confidential and should not be shared with third parties.

Effective Date (all states except as noted below): January 1, 2021

Effective Date – Tennessee and Washington: 60 days after the above-indicated date

REQUIREMENTS

You're expected to provide certain levels of service and follow rules for interacting with members.

Participation requirements and responsibilities

Minimum participation requirements

- **TPA and DEA certification/licensing.** You need to have either a TPA certificate or DEA license, except in Puerto Rico.
    - You can use diagnostic pharmaceutical agents (DPAs) as long as the member's age, condition type and severity and other contributing factors justify it.
    - Use therapeutic pharmaceutical agents (TPAs) as appropriate when a member has a condition that requires them, but get the member's consent. You can also refer them to another health care professional as stated in their medical care plan. As with DPAs, document member refusals or referrals.
- **Good standing.** To be eligible for participation on our networks, you have to be in good standing with EssilorLuxottica and all relevant subsidiaries. This includes being current with all financial obligations and complying with all contractual commitments and policies.
- **Professional liability insurance.** Contracted eye care professionals and all affiliated eye care professionals must maintain professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate.
    - In states that have limitations on liability, state law applies.
    - An umbrella policy can meet these requirements.
- **Commercial liability insurance**. You must maintain commercial liability insurance in the amount of $1,000,000 per occurrence and $2,000,000 in aggregate.

Your responsibilities

- **Full-service locations.** All participating provider locations must offer both exams and materials.
- **Open to new patients.** All locations must accept new patients.
- **Member eligibility and access.** You can't turn away members and must represent yourself as an in-network provider to them. You can't submit claims for out-of-network services on behalf of members if you participate in their network(s).
- **Claims.** Submit all required claims information.
- **Disparagement.** Do not share your concerns/issues about EyeMed publicly. Instead, follow the provider complaints and appeals processes.

- **Information verification.** When EyeMed asks you to report or verify information through our provider website, inFocus, you must report the information timely, accurately and completely. You may be asked to supply signed confirmation.

Network participation

- **Additional networks.** You may be contracted for specific networks only. You can request participation on other EyeMed networks by completing our online Network Request form.
- **New location requests.** Network policies are at the sole discretion of EyeMed. We'll review requests to add new locations under your Tax ID, even those operated by providers who already participate on the network.
- **Information updates.** You must keep your information up-to-date by using our online form, available at eyemedinfocus.com.
- **Leaving the network.** If you want to opt out of one or more of our networks, complete our online Network Request form.

Credentialing and recredentialing

Before providers can legally deliver service to members, they must complete credentialing, which verifies that the provider meets our participation requirements. You'll complete recredentialing every 3 years so we can verify the validity of your provider status.

These credentialing and recredentialing requirements apply to all doctors who will provide care to EyeMed members.

Credentialing and recredentialing overview and requirements

- **Credentialing and recredentialing vendors.** We use the following companies during credentialing and recredentialing:
    - The Council for Affordable Quality Healthcare (CAQH)
        - 888.599.1771
        - 866.293.0414
        - https://proview.caqh.org/Login
        - caqh.udphelp@acgs.com
    - OneHealthPort (Washington only)
        - 855.252.4314 option 1
        - https://www.onehealthport.com/
        - https://onehealthport.formstack.com/forms/contact_us
    - Gemini Diversified Services, a CVO
    - You must ensure your CAQH profile is up to date, as we rely on that information to confirm requirements. You'll verify your information and provide proof of your license, liability insurance and professional certifications to CAQH.

- **Credentialing and recredentialing requirements.** You must meet the below requirements to participate on our network. We'll confirm you meet the criteria during credentialing and re-verify during recredentialing. Documentation is required for some items as indicated.

Criteria	Documentation Required	Required for OD	Required for MD/DO
Submission of a complete, signed and dated state-specific application for participation in network	✓	✓	✓
Satisfactory work history for prior 5 years with explanation of any gaps of 6 months or more, unless state law requires otherwise Recredentialing: 3 years work history only		✓	✓
Signed and dated attestation of completeness, accuracy and release of information	✓	✓	✓
Valid, unencumbered license in state(s) of practice	✓	✓	✓
Minimum professional liability insurance for all states in which provider practices, as indicated below, or state statutory cap, state regulations or as required by our contractual agreement with plan ▶ Optometrist or ophthalmologist – $1 million per occurrence and $3 million aggregate *Requirement can be met with separate umbrella policy.* Puerto Rico requirements align with those in the territory.	✓	✓	✓
No exclusion from Medicare/Medicaid in the last 5 years		✓	✓
Not opted out of Medicare/Medicaid		✓	✓
No conviction of a criminal offense that reasonably calls into question a provider's ability to practice		✓	✓
No more than a combined total of 3 liability and/or malpractice claims resulting in settlements within the last 5 years		✓	✓
No reported sanctions on the provider's license within the last 5 years, excluding advertising violations, soliciting patients door to door, establishing temporary offices and/or delay in reporting continuing education credits*		✓	✓
Operation of all equipment (in clean and working condition) used in the course of patient care and management		✓	✓
No history of EyeMed chart/site evaluation failures in the past 5 years*		✓	✓
No more than 3 adverse events within the past 3 years*		✓	✓
Practice open to new members		✓	✓
Graduation from an accredited school or college of optometry (optometrists) or an accepted professional medical or osteopathic school and completion of an accredited residency program in ophthalmology (ophthalmologist)	✓	✓	✓
No history of insurance fraud*		✓	✓
List of other states where provider is or has been licensed, registered or certified	✓	✓	✓
Operation of a practice with normal business hours and after-hours coverage	✓	✓	✓
No office location subleased from or affiliated with a corporate-owned retail optical chain not accepted in our network (subject to state regulations)		✓	✓
A valid TPA Certification and/or DEA Certification as indicated by state regulations	✓	✓	
A valid DEA Certification or CDS Certification as indicated by state regulations	✓		✓
Demonstrated board certification (if applicable)	✓		✓

Abbreviations: OD = optometrist, MD/DO = ophthalmologist. Credentialing does not apply to opticians.

Starting the credentialing and recredentialing process

- **Credentialing after contracting.** After completing contracting, we will begin the credentialing process.
- **Credentialing of providers new to your practice.** Use our online form to begin credentialing for new providers in your practice and/or to associate fill-in providers to your practice.
- **Recredentialing notification.** You'll receive a letter and the online claims system will notify you when it's time to begin recredentialing.
- **Verification and documentation.** You will provide all verification and documentation to our credentialing vendors. They may contact you directly to request additional information if needed. Some items require verification from the primary source (for instance, from the school you graduated from).

Credentialing and recredentialing status and timing

- **Credentialing and recredentialing status.** You'll receive email updates as you move through the process and upon completion. You can also check the status of credentialing or recredentialing on our communications portal, inFocus.
- **Credentialing timing.** Initial credentialing takes up to 45 days.
    - **Recredentialing timing.** If your profile is not complete, preventing completion of recredentialing within 90 days, you will be removed from the network.
        - If you do not provide missing information, you may have to reapply to the network as a new provider.
- **Completing credentialing and recredentialing.** After receiving conformation from our vendors that you meet our requirements, our credentialing committee reviews all providers. In most states, you cannot serve EyeMed members UNTIL you are fully credentialed and approved. You'll be notified by email when you can begin seeing members.

In-network reimbursements during credentialing

- **States allowing in-network reimbursement during credentialing.** State laws in Louisiana (HB 775), Missouri (HB 1682), Virginia (HB 822), Washington (HB 1552) and West Virginia (Code § 33-45-2(11)) permit doctors to request to be reimbursed at in-network rates while still in the credentialing process.
- **Contract requirements.** You or your employer must have a contract in place with EyeMed to receive in-network reimbursements during credentialing.
- **Request for in-network reimbursement during credentialing.** You must submit a request prior to submitting any claims to EyeMed.
    - Your request must include a copy of the following:
        - Your complete, active and current CAQH profile with your CAQH ID#, recently updated Attestation Questionnaire with no history of adverse events (within the last 5 years) and recently updated Information Release form

        - Valid Professional Liability Insurance policy meeting our minimum requirements
        - Valid state license(s)
        - DEA or TPA certifications
        - Proof of Medicare participation
    - Submit your request in writing to credentialing@eyemed.com.
- **Submitting claims before completed credentialing.** If your request is approved, you must submit claims using our hard copy claims process.

Your rights during credentialing and recredentialing

- **Right to review information.** You can request to review any information submitted with the application at any time. You can also request a copy of the information received from the CVO.
- **Right to correct erroneous information.** If the information we receive from the CVO differs from what's on the application, we'll contact you. You'll have 15 business days from the date of receipt to respond. This lets you correct any inaccurate information from the CVO submitted by third parties through the primary source verification process.
- **Right to be informed of your application status.** You can request to be informed of the status of your application at any stage of the process. The CVO will respond by phone, fax or email.

Fill-in doctors

- **Fill-in doctors.** You must arrange for back-up if you'll be out of the office for 7 consecutive days or more. The fill-in doctor must file claims under his or her own National Provider Identifier (NPI).
    - The doctor must be credentialed with EyeMed, except in Missouri.
    - Use our online form to associate the doctor with your location so claims can be filed.
- **Non-credentialed fill-in doctors (Missouri only).** If you wish to have a non-credentialed doctor fill in for you, you must submit a request prior to submitting any claims to EyeMed.
    - Your request must include a copy of the following:
        - Your complete, active and current CAQH profile with your CAQH ID#, recently updated Attestation Questionnaire with no history of adverse events (within the last 5 years) and recently updated Information Release form
        - Valid Professional Liability Insurance policy meeting our minimum requirements
        - Valid state license(s)
        - DEA or TPA certifications
        - Proof of Medicare participation
    - Submit your request in writing to credentialing@eyemed.com.
    - If your request is approved, the fill-in doctor must submit claims using our hard copy claims process.

Location requirements

Network providers must have a physical location and make sure all offices have the required instruments listed below on-site and in working order. All locations must also meet hygiene and safety measures.

Required instruments

- Phoropter or trial lenses
- Visual acuity testing distance and near charts and/or projector
- Retinoscope, autorefractor or wavefront analyzer
- Keratometer/ophthalmometer/ topographer
- Ophthalmoscope: direct and binocular indirect with condensing lens
- Tonometer
- Biomicroscope
- Lensometer
- Color vision testing system
- Stereopsis testing
- Diagnostic pharmaceutical agents within expiration dates

Office cleanliness requirements

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

Safety and security

- **Environmental safety.** You're required to operate a safe and secure environment. At a minimum, this includes having:
  - Adequate lighting in public area
  - Safe and secure flooring and fixtures

    - Hand-held fire extinguishers up to local and state fire codes with current inspection tags
    - A complete first-aid kit that includes at a minimum:
        - Adhesive bandages
        - Adhesive tape
        - Ammonia inhalants
        - Antibiotic ointment
        - Antihistamine
        - Antiseptic towelettes
        - Eye wash solution
        - First-aid/burn cream
        - Latex gloves
        - Pain reliever
        - Scissors
        - Sterile eye pads
        - Sterile gauze pads
    - Medical waste container(s)
    - Any other safety equipment recommended by state or local emergency preparedness ordinances
- **Prescription pad security.** Keep prescription pads secure at all times.

Americans with Disabilities Act

- You are expected to meet federal and state accessibility standards as defined in the Americans with Disabilities Act of 1990.

Other location requirements

- **Seating.** Provide adequate seating for patients in your reception area and provide an area that offers privacy and confidentiality for discussion of vision care or health information.
- **Licenses and certifications.** Post your license and certifications in plain sight or make them otherwise available to members per state law.
- **Business hours.** Display and maintain reasonable business hours. If the doctor's hours are different from the dispensary's, post both sets of hours.

Access to care/emergencies

Appointment and wait time standards

- **Appointment wait standards.** You must offer non-urgent appointments with EyeMed members within 2 weeks of a request.
- **California requirements.** In California, the following requirements apply:
    - Urgent care appointments (no prior authorization required) must occur within 48 hours or 2 days.
    - Urgent care appointment (prior authorization required) must be made within 96 hours or 4 days.
    - Non-urgent doctor appointments must be scheduled within 15 business days (note that we require appointments within 14 business days).
    - During normal business hours, the wait time for a patient to speak by telephone with a knowledgeable and competent staff person can't exceed 10 minutes.

- Have (or arrange for) telephone triage or screening services on a 24/7 basis through which patients can get help to determine the urgency of their condition. Patients should receive return calls from this line within a reasonable timeframe, not to exceed 30 minutes.

After-hours access

- **24-hour phone access.** All offices must have (or arrange for) telephone triage or screening services on a 24/7 basis through which patients can get help to determine the urgency of their condition. Patients should receive return calls from this line within a reasonable timeframe, not to exceed 30 minutes.

Urgent and emergency care

- **Urgent care services.** You must perform urgent-care services the same day as requested.
- **Emergency care.** Your location must have referral instructions on hand to give members who have an emergency eye care need outside your scope of practice during your office hours and after hours. In addition, offer after-hours support—via mobile phone, pager or an answering system—to members seeking emergency eye care.
- **Definition of eye care emergency.** We define an eye care emergency as a physical condition involving 1 or both eyes which, if untreated or if treatment is delayed, may reasonably be expected to result in irreversible vision impairment.
- **Examples of eye care emergencies.** Eye care emergencies include the below. Lost or broken eyeglasses or contact lenses, regardless of the strength of the prescription, do not constitute eye care emergencies.
  - Severe eye pain
  - Any penetrating injury to the eye
  - Chemical contact with the eye (particularly alkaline substances)
  - Sudden total loss of vision in one or both eyes
  - Sudden loss of vision to a degree that prohibits mobility
- **Emergency eyewear.** If a member has an eye care emergency requiring eyewear, follow our emergency lab process.

Interacting with members

You must follow the below requirements when interacting with EyeMed members.

Marketing guidelines

- **Direct marketing.** You can't market directly to clients and their members as it relates to your participation in the network. We don't permit direct contact with members or clients who have not previously received care or purchased eyewear from you.
- **Representation**. You can't represent yourself as an extension of EyeMed to clients and or members in person or in writing (e.g., letters, promotional materials).
- **Sharing of information.** You can't share EyeMed information (e.g., group lists, member lists, group benefits, member benefits) with clients and members outside of individual doctor-patient relationships.
    - You can't use the list of groups near you on inFocus to promote your practice with clients and members.
- **Inducement.** You can't induce members to seek care from you through gifts, rewards or free items unless legally permitted. Consult your legal counsel for guidance on federal and state anti-kickback regulations.
- **Logo usage.** You can use EyeMed's logo in your marketing and in-office signage according to the terms of the logo usage agreement, which you must complete before using the logo. You can't use client logos, including logos of private-label resellers.

Pricing and communicating costs

- **Price sheets.** You can't charge members more than you would charge patients who do not have vision care benefits, and you can only use 1 price sheet.
- **Cost transparency.** You must make members aware of their costs when you're providing services that are not covered under their plan.
- **Non-covered services notification.** For all members, a verbal notification is sufficient when their vision benefits don't cover a service or item.
    - If the member is part of a Medicare plan, do not issue an Advanced Beneficiary Notice (ABN), as these do not apply to Medicare Advantage plans or protect you from liability.
    - In Louisiana, per Senate Bill 271, you must supply a written notification to the member in advance when vision benefits do not cover a service or item.

Documentation and record-keeping requirements

- **Record retention**. You must secure and retain member records (both clinical and financial) either electronically or in hard copy for the below timeframes:
    - Adults: 10 years from the date of the last visit or the date of the completion of any audit by the Centers for Medicare and Medicaid (CMS), unless superseded by state law.
    - Minors: 28 years from the date of birth.

    - Deceased patients: 6 years from the date of death.
- **Notation of coverage discussion.** Note in the patient file that you had a conversation about what services are and are not covered by the member's vision benefits.
- **Refusal of pharmaceuticals or services.** Document when a member refuses any DPAs, TPAs or services you recommend.

Referrals

- Referrals are not required for routine vision care services provided under our plans.

Member confidentiality and privacy laws

- **State and federal laws.** You must follow all applicable state and federal laws and regulations restricting unauthorized access, use, destruction and the release of member information that includes Protected Health Information (PHI) (which includes but is not limited to data from our online claims system), Personally Identifying Information (PII) and credit card data.

Cultural competency and language assistance

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

Cultural competency

- **Cultural respect and service orientation.** Respect and provide services in a manner that meets member cultural preferences and needs.
- **Cultural competency training.** You must complete cultural competency training annually to help all staff members understand how to deliver care across cultures.
    - EyeMed includes cultural competency in the training module that all providers must complete by December 31 of each year. See our Annual Training Requirements section for more details.

Interpretation and translation requirements

- **Reporting of languages spoken.** Report all languages spoken in your office, including American Sign Language, so we can include this

information on our provider directory. You can provide this information in the Manage My Profile section of the online claims process.

- **Translation and interpretation of materials.** Provide oral interpretation, American Sign Language interpretation and/or written translation of your practice materials and service delivery upon member request.
- **Member preferred languages.** Note the patient's preferred languages in your patient documentation so your staff knows to communicate and provide oral and written information in their preferred language.
    - Use an interpreter, when necessary, to ensure patients understand all options and are able to make informed decisions.
    - Provide language assistance to members with limited English proficiency.
    - Call us at 888.581.3648 during normal business hours (7:30 a.m. to 11 p.m. ET Monday through Saturday and 11 a.m. to 8 p.m. ET on Sunday) to access free interpreter services.
    - Members can use their family members as interpreters, but you still need to make them aware interpreter services are available to them. If they do opt for a family member or friend, this shouldn't compromise the effectiveness of the service or violate a member's confidentiality.
    - Customize, print and make available copies of section 1557 of the Affordable Care Act's Notice of Nondiscrimination and Statement of Nondiscrimination in the most common languages your practice encounters. Translated versions are available online at https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.
- **California language assistance requirements.** If you have a location in California, you must:
    - Prominently post a notice of language assistance in each of your locations.
    - Provide members with access to free highly skilled, qualified interpreters through our interpreter service.
    - Let members know that grievance forms and language procedures are available by calling at 888.581.3648. California members can contact the California Department of Managed Health Care's Help Center at 888.HMO.2219 or TDD 877.688.9891.

Medicare and Medicaid participation

EyeMed requires network providers to be eligible to participate in federal healthcare programs, including Medicare and Medicaid. Providers found on the Preclusion List will be removed from our networks.

Medicare exclusion

- **Medicare opt-outs and exclusions.** Providers who do not remain enrolled in Medicare will be immediately removed from all EyeMed networks. Providers excluded from participation in programs that receive federal funding cannot participate in EyeMed networks.

State Medicaid Agency enrollment

- **Medicaid enrollment.** If you participate in a Medicaid Managed Care plan served by an EyeMed network, you must be enrolled in the State Medicaid Agency. Your ID number will be key to participate in this program, and we have to monitor the accuracy of it on a regular basis.

State laws

- **Arizona Charge Transparency Law.** According to state law, any optometrists or ophthalmologists practicing in Arizona must meet the following requirements regarding disclosure of information to members:
  - If a member asks for a list of direct pay prices (prices you would charge patients who have no vision benefits) for the 25 most commonly provided services you need to provide the list. If your practice is owned by an optometrist or ophthalmologist and you have fewer than 3 licensed doctors, you're exempt from this requirement.
  - When members choose to pay you directly for a service rather than have you submit claims on their behalf, you must have them sign a waiver stating they understand their rights as a member of the plan.
- **Rhode Island.** To comply with Rhode Island Office of the Health Insurance Commissioner (OHIC) regulation 230-RICR-20-30-9, section 9.9, providers in the state of Rhode Island cannot hold the member liable for any provider charges for covered benefits, except co-payments, deductibles or coinsurance. Specifically, providers are prohibited from billing, charging, collecting a deposit from, or seeking compensation, remuneration or reimbursement from a beneficiary for covered services. This includes but isn't limited to facility or administrative fees or if the provider has not been paid for services.

Mobile providers

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

Definition of Mobile Providers. We define a Mobile Provider as a third party who performs eye exams and/or dispenses materials at a location(s) other than a contracted brick-and-mortar location(s). Mobile Providers include, but are not limited to:

- Vision vans
- Temporary eye clinics
- Those who serve patients at nursing homes or other care facilities.

Mobile Provider categories. EyeMed has categorized Mobile Providers as:

- Category 1: Those who increase access to care to otherwise underserved populations. EyeMed generally accepts Mobile Providers who fall in this category.
- Category 2: Those who provide a service of convenience to members who already have adequate access to care. EyeMed only accepts providers in this category under certain circumstances.

Application process

- **Mobile Provider Application.** All Mobile Providers who want to participate in an EyeMed network must go through a Mobile Provider application and approval process.
    - Download a copy of the Mobile Provider Application from eyemedinfocus.com and email it to us at provider@eyemed.com.
    - Once a completed initial Mobile Provider Application package is received, it takes a minimum of 30-60 days to complete the process.
    - We will deny claims submitted for mobile providers that have not been pre-approved through this process.
- **Recertification.** Mobile Providers must recertify compliance with EyeMed's requirements every 2 years.
- **Doctor credentialing.** If approved, doctors performing exams will also need to be credentialed.

Requirements

- **Brick and mortar location.** You're required to have a brick-and-mortar location that provides comprehensive eye exams in addition to mobile services to ensure that members have access to continuity of care, or document alternate arrangements to provide timely appropriate sequential care through participating network providers without additional cost to the member or to EyeMed.
- **Follow-up information.** Leave clear, legible contact information, exam findings, follow-up notes and recommendations with the patient after every patient encounter.
- **Continuity of care.** Provide/ensure appropriate medical eye care follow-up and/or ensure continuity of care with other medical providers, as indicated.

- **Equipment.** Have and maintain the required equipment at both the physical office location and mobile setting. We may request proof of equipment.
- **Requirement to report changes.** Report any material changes to information submitted in your original Mobile Provider Application within 30 days and provide written program and protocol revision descriptions as appropriate. Any finding of falsification of this information or failure to report material changes is grounds for immediate termination.

Telemedicine

Telemedicine may be helpful to provide access to care to under-served populations, specifically members who live in geographies without reasonable access to conventional eye care practices. EyeMed will contract with telemedicine providers only when specific requirements are met.

Application process

- **Telemedicine Provider Application.** All providers who want to offer telemedicine as an EyeMed network provider must complete the telemedicine application and approval process.
    - Download a copy of the Telemedicine Provider Application and email it to us at provider@eyemed.com.
    - Once a completed initial Telemedicine Provider Application package is received, it takes a minimum of 30-60 days to complete the process.
    - We will deny claims submitted for telemedicine providers who have not been pre-approved through this process.
- **Doctor credentialing.** If approved, doctors performing exams will also need to be credentialed.

Requirements

- **Brick and mortar location.** You must have a fully licensed and accredited brick-and-mortar location where patient data is collected (the Originating Site). A credentialed provider who is a licensed optometrist or ophthalmologist must be available for in-person care at the Originating Site at least 1 day per week.
- **Prior patient relationship.** Before performing any telemedicine service, the provider performing the service must establish a doctor-patient relationship via one of the following means:
    - A prior in-person examination

    - An examination using synchronous telemedicine incorporating both audio and visual connections between the provider and member[1]
    - Consultation with or referral from another EyeMed participating provider who has established or will establish a doctor-patient relationship with the patient, and who intends to manage the patient's care. If the provider is rarely or never personally at or near the Originating Site, he or she may establish a relationship with 1 or more participating providers near the Originating Site who are willing to manage the patient's in-person care needs. The selection of such a provider will remain the choice of the member.
- **Quality of care.** Telemedicine providers will be held to the same standards of appropriate care as, and the level of care must be equal to, providers offering in-person service.
- **Licensing and credentialing.** The doctor providing the care must comply with state law regarding the need for licensure or registration in the state where the Originating (patient) Site is located as well as the Distant (provider) Site.
- **Informed consent.** Prior to initiation of the telemedicine examination service, the provider must inform the member that the service will be conducted without the optometrist or ophthalmologist being physically present (in-person) and must consent to receiving care via telemedicine.
- **Privacy and security.** You need to have privacy and security measures in place that meet healthcare industry standards.
- **Audio and video systems.** Telemedicine providers must use interactive audio and video telecommunications systems that permit real-time interaction between the patient at the originating site and the provider at the distant site.

Network terminations

Voluntary terminations

- **Voluntary termination process.** You can request to be removed from the network, which we call a voluntary termination, with 60 days advance notice by completing our online Termination of Tax ID or Location form.

Involuntary terminations

- **Definition of involuntary terminations.** Involuntary terminations occur when we terminate your participation.
- **Reasons for involuntary termination.** EyeMed can involuntarily terminate you for reasons listed in your provider contract or for the following additional reasons:
    - Commission of fraud, waste or abuse

[1] https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf

    - Providing false or misleading information upon initial or subsequent application, credentialing or recredentialing and/or contracting
    - A pattern or practice of unprofessional or inappropriate conduct toward members or clients
    - When termination is deemed necessary to protect against the risk of imminent danger to the health or welfare of our members
- **Involuntary termination process.** In the event of an involuntary termination, you'll receive a written notice specifying the date of termination from the network, any applicable appeal rights and process.

Responsibilities upon termination

- **Removal from locator.** Once you're no longer participating on the network, we'll remove your location(s) from our automated locator services effective the day of termination.
- **Claims payment.** We'll process all claims submitted before the termination date and within claim-filing limits per the plan design.
- **Member notification.** You must notify your patients who have EyeMed benefits that you are leaving the network and, if applicable, explain how they can locate a new in-network provider if desired. You're required to inform our members you're no longer a participating provider before seeing them.
- **Referrals and follow-up care.** Provide referral instructions for follow-up care or clinical record requests when necessary.
- **Outstanding balances.** You're responsible for paying any outstanding balances owed for lab materials orders or withholds.

PAYMENTS

Chargebacks and lens payments when using the lab network

Lens options chargebacks and reimbursements

- **Chargebacks**. You'll be responsible for lab/lens chargebacks according to our Lens and Options Chargeback Schedule.
- **Progressive lenses and options.** Your payments for progressive lenses and lens options are detailed in the Standard Lens Options Schedule.
- **In-office finishing dispensing fee.** When using single vision in-office finishing, you'll receive an additional $7 dispensing fee for single vision lenses.

Payments for medically necessary contact lenses

Standard reimbursements

- **Reimbursement for medically necessary contact lenses.** Standard reimbursements for medically necessary contacts lenses are based on the qualifying condition as noted below.

Qualifying criteria	Provider reimbursement
Anisometropia	95% of retail up to $700
High ametropia	95% of retail up to $700
Keratoconus – Mild/Moderate	95% of retail up to $1,200
Keratoconus – Advanced/Ectasia	95% of retail up to $2,500
Vision improvement	95% of retail up to $2,500
Pediatric aniridia*	95% of retail up to $3,730
Pediatric aphakia*	95% of retail up to $5,800
Pediatric pathological myopia*	95% of retail up to $700

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

- **Annual fee review.** We review the fee schedule for medically necessary contact lenses at least once a year.
    - You can submit cases for fee review to our Quality Assurance department at eyemedqa@eyemed.com. Include supporting statements, invoices and clinical documentation for consideration at annual fee review.

Medically necessary contact lenses - EyeMed Individual and Family Plans

- **Member allowances.** Some members of EyeMed Individual and Family Plans have a maximum allowance of $210 for medically necessary contact lenses.
    - Members will pay you 100% of retail amount above the allowance.
    - Members in some states, and those whose plan effective dates are prior to 2020, may have standard allowances and reimbursements as described above.
    - Review each member's benefits carefully to ensure you apply the Individual and Family Plans benefit correctly.

Client-specific medically necessary contact lens benefits

- Always refer to the Client-specific Plan section for rules that pertain to specific clients.

Payments for special services

- **Retinal imaging.** Some plans include a benefit or discount for retinal imaging. When they do, members pay either:
    - $39 (or your standard office charge if it's less) on a retinal imaging screening
    - A $0, $10, $20 or $30 copay (you'll be reimbursed up to $39 after the copay)
- **Diabetic eye care plans.** You'll be reimbursed according to the diabetic eye care plan fee schedule.
- **Pediatric Vision Benefits.** You'll receive a flat payment for frames. See the Pediatric Vision Benefits fee schedule.
- **Safety Eyewear Program.** Details about the program, including reimbursements, can be found in the Safety Eyewear Program section.
- **Low Vision benefits.** We'll reimburse 100% of retail up to the member's allowance amount, which varies by plan. You can't balance-bill the member for amounts over the allowance, unless the benefit indicates that you can.
- **Visual Display Terminal (VDT) benefits.** You'll receive your contracted eye exam reimbursement for the additional refraction services required for VDT benefits.

- **Medicaid plans.** Your reimbursements for Medicaid Plans will be based upon the EyeMed Medicaid fee schedule for a specific state. When we enter a market, qualified participating providers will receive a contract amendment that includes the EyeMed Medicaid fee schedule for the state.

Client-specific payments

Always refer to the Client-specific Plan section for rules that pertain to specific clients.

CLAIMS

Members with medical and vision benefits

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

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

- **Patients lacking a specific complaint related to a medical condition.** If the **patient does not have a specific complaint related to a medical condition**, it is most appropriate to bill the vision plan (EyeMed) for the visit.
    - If during a visit where the patient presented without a medical-related complaint you discover the patient has a medical condition and your prescribed treatment plan would require medical eye care, inform the patient of their condition and their need for the diagnostic testing and/or treatment anticipated, then schedule the patient for a follow-up medical eye care visit.
    - Follow-up medical eye care should be billed to the patient's medical plan.
- **Patients requesting vision plan exam based on presenting problem.** If the **patient asks for the exam to be billed to the vision plan based on a presenting problem**, explain to the patient the needed care and coverage/billing options under their medical plan, possible out-of-pocket payments or possible referral options.
- **Patients with no reported medical conditions.** When the **patient reports no medical conditions**, the coverage of services rendered by an eye care professional depends on the purpose of the examination or service and not the ultimate diagnosis of the patient's condition.

    - When a patient goes to his/her physician for an eye examination with no specific complaint related to a medical condition, the expenses for the examination are likely not covered under the patient's medical benefit, even though a pathological condition was discovered as a result of the eye examination.
    - Under these circumstances, the eye examination should be billed to the vision plan if the patient presented without a specific complaint related to a medical condition.
    - If you recommend that the eye care service(s) provided be billed to the patient's medical plan, it must be fully disclosed to the patient as to the reason for the recommendation to bill the medical plan and the possible deductible and/or copay out-of-pocket expenses.
- **Refusal to provide services under the vision plan.** Should an EyeMed member insist that a vision plan claim be submitted and the presenting problem, in your professional judgment, would indicate the need for another service and/or procedure, you may elect to refuse to provide the comprehensive eye examination under the vision plan.
    - Clearly document the reasons for any refusal of care in the patient's clinical record and contact us at 888.581.3648 to inform us of the refusal of care and the reason.
- **Disclosure form.** Following your explanation of the entity to be billed, the patient should acknowledge this explanation by signing a Disclosure Form that states:
    - The medical reason (diagnosis) a claim is being filed with the medical benefit.
    - The potential cost (out-of-pocket expense), which would include the deductible and/or copay. It's understood you may not be able to definitively determine the amount; therefore, listing your usual and customary charges for the service(s) would be an acceptable disclosure.
- **Eye exams covered by medical plan.** If you deem the eye exam would be covered by the medical plan:
    - If you're a participating provider for the patient's medical plan, inform the patient of your participating status.
    - If you are not a participating provider, inform the patient that your practice's usual and customary fees will be charged, and disclose those proposed fees.
- **Referrals to medical providers.** If the patient elects to be referred to a participating medical provider, make every effort to refer appropriately and provide the subsequent professional with all relevant information concerning your findings that will lead to the best possible outcome for the patient.

Coordination of benefits

Our plans do not allow for coordination of benefits except for the groups included on our exception list.

Coordination of benefits policies

- **Primary payer.** We're considered the primary payer.
- **Dilation and refraction.** We don't reimburse separately for any services included in a comprehensive eye exam (including dilation and refraction) unless the contract with the client specifically permits it.
  - Claims for refraction only will be denied unless they are for members of groups that have specific contract provisions for coordination of benefits.
  - You cannot submit dilation only claims.

Coordination of benefits process

- **Submitting COB claims.** File COB claims in hard copy using a CMS 1500 form. You must attach a copy of the primary plan's denial.
  - Refer to the Special Claims Processes section for more information.
  - If you do not follow this process, your claim will be denied and you may be responsible for returning money to the member.

Submitting claims

Claims submission

- **Claims submission process.** You will use the online claims system to file claims, except when the benefits need special processing. Or, you can submit claims electronically using 837 inbound format through outside clearinghouses.
  - If you decide to use electronic data interface (EDI), you'll be reimbursed according to the fees listed under the Claims Submitted Outside the Online Claims System section of your fee schedule.
  - To begin the process of setting up EDI, contact us at 888.581.3648.
- **Fraud warnings.** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement is guilty of insurance fraud. Your state's fraud warning applies to any claims you submit.

Timely filing

- **Standard timely filing.** All claims must be submitted within 180 calendar days of the date of service except as noted below. If you do not file the claim in this time period, it will be denied, and you will not be able to collect money from the member.
- **Medicare claims.** For Medicare members, you have 12 months to file the claim.
- **Medicaid claims.** Medicaid timely filing requirements vary. Refer to your state's Medicaid Provider Manual for details.
- **Client-specific exceptions.**
    - Anthem claims must be filed within 12 months of the date of service.

Claims codes

- **Eye exam codes.** We use CPT codes 92004 and 92014 for eye exams because they describe specific definitions of what a comprehensive eye exam should include.
- **Refraction code.** We consider the refraction (CPT 92015) part of a comprehensive eye exam.
    - The only time we'll reimburse you for refraction by itself is when we're contracted to coordinate benefits for the group, or when the plan includes VDT benefits.
    - The Coordination of Benefits section has a list of groups refraction only claims apply to.
- **ICD-10 code reporting.** We require you to submit all applicable ICD-10 diagnosis codes when filing a claim.
    - The online claims system lets you note primary and high-risk diagnoses, including abnormal pupil, age-related macular degeneration, cataract, diabetes, diabetic retinopathy, glaucoma, hypercholesterolemia and hypertension.
- **Annual supply contact lens benefits.** If a group has a benefit that covers an annual supply of contact lens materials, use code S050026 on the claim.

Hard copy claims

- **Hard copy claim submission.** Some circumstances may require hard copy claims. Any plans, services or materials requiring a CMS 1500 hard copy submission are not eligible for lab ordering.
    - If you send us a hard copy claim for materials that should have been submitted to a lab though our online claims system, we'll reimburse you according to the Claims Submitted Outside of Our Claims System fee schedule on your network schedules. You'll be responsible for all lab and eyewear fabrication costs, and you can't bill the member for the balance.

- **Preferred claims codes.** Use our Preferred Claims Codes to ensure proper processing. We might also deny codes not on this list based on the member's plan and benefits.
- **Faxing claims.** Fax hard copy claims to 866.293.7373.
- **Mailing claims.** Mail hard copy claims to:

  EyeMed/FAA
  PO Box 8504
  Mason, OH 45040-7111

Special claims processes

- **Notification of special processes.** We will notify you if the claims process for any of our services changes, or if new groups or products require unique processes.
- **VDT and primary/medical eye care benefits.** You can submit claims for VDT benefits and some primary/medical eye care benefits through our online claims system.
- **Refraction only claims (only for groups that permit coordination of benefits).** File refraction only claims in hard copy following the below process:
  - Collect only the medical carrier's eye exam copay from the member, if applicable. Don't collect any exam copays that would apply under our plan.
  - After you're paid by the medical carrier, submit a CMS 1500 form with only the refraction code (leave the exam off) and attach a copy of the EOB from the primary payer showing that an exam was rendered. We'll reimburse you your retail charge for the refraction up to the maximum exam reimbursement, and the member will be ineligible for eye exam benefits until the next benefit cycle.
- **Medically necessary contact lens claims.** The materials and fit and follow-up services for medically necessary contact lens benefits must be submitted on 1 claim. File the claim in hard copy following the process below:
  1. Complete our Medically Necessary Contact Lens claims form. If you practice in California, you have a state-specific form.
     - Enter a single contact lens fitting code to indicate the qualifying condition.
     - Include a material contact code on the same claim and same date of service.
     - Include the applicable vision and high-risk diagnosis codes.
     - When filling out the claim, use these codes to indicate the qualifying condition:

Qualifying criteria	Medically necessary contact lens codes
Anisometropia	92310AN

Qualifying criteria	Medically necessary contact lens codes
High ametropia	92310HA
Keratoconus	92072
Vision improvement	92310VI
Pediatric aniridia*	92310AI
Pediatric aphakia*	92311AP and 92312AP
Pediatric corneal and post-traumatic disorder (filed as vision improvement)*	92310VI
Pediatric pathological myopia*	92310PM

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

    - If you put more than 1 diagnosis on the claim, we'll reimburse based on the lowest paying condition.

2. Fax the completed form to 866.293.7373 or mail to:
   EyeMed Vision Care/FAA
   P.O. Box 8504
   Cincinnati, OH 45040

- **Safety Eyewear Program powered by EyeMed.** Refer to the Safety Eyewear Program section for instructions on filing claims for this program.
- **Post-cataract eyewear benefits.** File claims for post-cataract eyewear through the online claims system, unless they have unique processes as outlined in our Client-specific Plan section.
- **Medicaid medically necessary claims.** When filing claims for Medicaid exams and eyewear that require medical necessity, you can use the online claims system but will need to provide additional information. (Note that contact lenses follow a different process.)
    - Always include a medical necessity reason code.
    - Indicate the appropriate diagnosis code for a qualifying condition as defined in your state's Medicaid provider manual.
    - Filing online:
        - Use the Routine tab in the online claims system for medically necessary lens options on the member's first pair of glasses.
            - Select the appropriate diagnosis code and reason code on the Usual and Customary screen.
            - For replacement eyewear, use the ST code.
        - Use the Medically Necessary tab in the online claims system for additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.

    - Filing in hard copy:

        - When filing paper claims, use the RP reason code modifier only.
        - Include the modifier "RP" along with the V-code for lens options.
- **Medical/Surgical eye care claims.** You can submit medical/surgical eye care claims online or using 837 inbound.
    - Choose the Medical tab to access medical/surgical services.
    - For services that do not require pre-authorization, we'll match the procedure and diagnosis codes for relevance.
    - When also providing routine vision care services, you'll use the online claims system like you normally do, but you should file routine vision claims separately from medical/surgical eye care services.
        - Do not file medical eye care and routine vision services on the same claim.
    - Refer to the Utilization Management section for details on obtaining pre-authorization for services.
- **Low vision claims.** We don't accept low vision claims online, and you can't use our lab network.
    - Low vision claims require pre-approval.
        - To obtain pre-approval, fax the Low Vision Request form (available for download from inFocus) with the invoice or catalog sheet to 866.552.9115, or email it to medexceptions@eyemed.com.
        - If we approve the form, you'll receive an approval letter and authorization.
        - If we don't approve the form, you'll receive an explanation as to why.
    - Once you receive approval for low vision benefits, you can submit the low vision benefit claim.
        - Faxing a completed CMS 1500 claim form to 866.293.7373.
        - Sign the form and be sure to include the following information:
            - Authorization number.
            - Stamped or handwritten line indicating "Low Vision Exam or Aids."
            - Copy of the low vision approval letter.
    - Anthem Blue View Vision requires a slightly different process for submitting low vision claims. Please refer to the Anthem section for more details.

Voiding and correcting claims

You can correct or void routine eye exam, contact lens or medical/surgical eye care claims by submitting a CMS 1500 form to us.

Corrected or voided claim process

- **Faxing corrected or voided claims.** Fax a corrected CMS 1500 form to us at 866.293.7373 with "CORRECTED CLAIM" written on the top.
- **Mailing voided or corrected claims**. You can mail corrected CMS 1500 forms to:

  EyeMed Vision Care/FAA
  PO Box 8504
  Mason, OH 45040
- **Voiding or correcting claims with lab orders.** You can't correct or void claims for eyewear if the lab has already started the order. If you used the lab network and need to cancel the materials portion of a claim, you must void the entire claim.
  - First, call the lab to cancel the order. The lab will confirm if a cancellation is required and process the cancellation if needed. If the lab determines the order doesn't need to be canceled, no further action is needed.
  - Allow 24 hours for the cancellation to flow through our system. If you don't see the member eligibility reopen after 2 business days, please contact the lab to escalate the issue.
  - Once the eligibility is reset to "Yes," proceed by refiling the claim and submitting the correct order.
- **Member eyewear returns.** If a member returns eyewear, the member may be eligible for a free remake depending on the reason for the return.
  - When members return their glasses, we need to know why.
    - **Returns for poor quality or non-adapt -** Refer to our remake policy to replace the glasses.
    - **Change in frame style or "no questions asked" return policy -** Call us at 888.581.3648 if the member is taking advantage of your practice's "no questions asked" satisfaction guarantee or simply wants to change the frame. We can reinstate the member's benefits at your request, but you'll be charged for the lab work based on the Lens and Options Chargeback Schedule.
  - **Medicaid medically necessary replacements -** Some Medicaid members are eligible for medically necessary eyewear replacements. Refer to your program's Medicaid provider manual for more information.

- **Returns, exchanges and voids under the Safety Eyewear Program powered by EyeMed.** Returns, exchanges and voids are not processed as part of the Safety Eyewear Program, with the exception of voids in the case a member cancels his or her order before the order is in the manufacturing process. In this case, follow our normal void process.

Claim payments and withholds

Payments and withholds

- **Claims payments.** A wholly owned subsidiary of EyeMed, First American Administrators, Inc. (FAA), processes all claims.
- **Withholds.** If we overpay you as part of a claim correction or complaint resolution, we'll withhold funds overage from a future payment.
    - Clients may request withholds if they find errors during audits. We'll notify you if this happens.

Claims payment process

- **Payment turnaround time.** You'll be paid within 30 business days of submitting a clean claim. We'll adjust the claims process timing as required by state law.
    - For lab orders, the turnaround time begins when the lab lets us know the order has shipped.
    - Exam portions of claims are not paid until the materials are shipped from the lab.
- **Payment frequency.** Claims are paid electronically by FAA at least once per week.
- **Payment methods.** We pay claims by electronic funds transfer (EFT) or check.
    - Use our online form to sign up for or change any of your direct deposit details, like account number.
    - You can have checks mailed to you, but you could be charged a 5% administrative fee for this service, per section 1.6 of your provider contract, except where prohibited by state law.
- **Payer names.** Electronic payments may appear on your statement under different names, but they will always have the EyeMed name in the memo field. The below names may appear on check payments for claims:
    - Aetna Life
    - Administered by: First American Administrators, Inc.
    - Anthem Insurance Companies, Inc.
    - APC PASSE, LLC d/b/a Summit Community Care
    - Blue Cross Blue Shield Arizona
    - Blue Cross Blue Shield North Carolina
    - Combined Insurance Company of America

    - Combined Life Insurance Company of New York
    - EyeMed Insurance Company
    - EyeMed MVC IPA
    - EyeMed Vision Care HMO of Texas, Inc.
    - Eyexam
    - First American Administrators, Inc.
    - Fidelity Security Life Insurance Company
    - Fidelity Security Life of New York
    - Heritage Vision Plans Inc.
    - Humana
    - Optical Procurement Services LLC
- **Remittance advices.** Remittance advices summarize your payments and will also show any withholds applied because of incorrect or voided claims. These are available for download from our online claims system.

Claim denials

- **Denial notification.** If a claim is denied for missing information, we'll send you a letter within 30 days explaining why we denied it, and request that you correct and resubmit it.
    - You'll be paid only when you resubmit the claim within the appropriate timeframe, and it's accepted.
    - You can collect payment from members for denied claims with member liability ***only*** if we determine they weren't eligible for benefits at the time of service.
- **Lab charges on denied claims.** If you used the lab network and the materials portion of your claim is denied, you'll be billed for the cost of the materials and any associated lab charges.

SERVICES AND MATERIALS

Eye exam services

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

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

Refraction and dilation

- **Refraction as part of eye exam.** Refraction is a component of the covered services available to eligible members and must be performed in conjunction with a comprehensive examination.
    - Refraction will not be reimbursed separately unless coordination of benefits (COB) is permitted per the client contract.
    - If a client contracts with us to perform coordination of benefits, you can submit a claim for the refraction only, along with a copy of an EOB or claims denial. Please refer to Coordination of Benefits for the list of participating groups.
    - If the plan includes benefits for Visual Display Terminal (VDT) eyewear, the member will have an additional eye exam benefit to cover the separate refraction.
- **Dilation.** The routine eye exam benefit includes dilation when professionally indicated and performed within 30 days of the initial eye exam.
    - Retinal imaging doesn't replace dilation.
    - You must dilate all members who have diabetes.
    - If the member refuses to be dilated, document the refusal in their patient file.

Eye exam requirements

- **Eye exam components.** You must provide the services below as part of an eye exam:

Case history

- Chief complaint
- Ocular disease history (including prescriptive and non-prescriptive medications)
- Family history: general and ocular
- Occupational/lifestyle: use of vision; glasses or contact lenses
- General medical history (including medications)
- Allergies, including medication allergies

General patient observation

- Neurological: orientation (time/place/person)
- Psychiatric: mood and effect (depression/anxiety/agitation)

Clinical and diagnostic testing and evaluation

- Examination of orbits
- Test visual acuity
- Gross visual field testing by confrontation or other means
- Ocular motility
- Binocular testing
- Slit lamp examination of irises, cornea(s), lenses, anterior chambers, conjunctivae and sclera
- Examination of pupils
- Measurement of intraocular pressure
- Ophthalmoscopic examination with pupillary dilation, as indicated, of the following:
  - Optic disc(s) and posterior segment
  - Macula
  - Retinal periphery
  - Retinal vessels
  - Vitreous
  - Other examinations (must specify)

Note: Pupillary dilation is required for members with diabetes.

Refraction

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

Color vision testing*

Stereopsis testing*

Case presentation

- Assessment
- Management plan
- Professional reports* (i.e., driver's license, health physical)
- Visual acuities and tonometry findings
- Photographs and findings, if applicable.
- Diagnosis (ICD) codes

  ICD-10 diagnosis codes should include diagnosis from the patient's history, the patient's reported medications and/or your clinical findings. List the primary diagnosis first followed by all secondary diagnosis codes determined in the exam (especially those including diabetes, diabetic retinopathy, hypertension and glaucoma).

*As indicated

Note: In some cases, exam may be completed with other instrumentation because of member limitations.

- **Eyeglass prescriptions.** You must follow FTC guidelines related to the release of eyeglass prescriptions.

Second opinions

- **Second opinion process.** Members may be entitled to a second opinion on their eye exam results.
    - If a member wants a 2nd opinion, ask them to complete a written request for a 2nd opinion and submit it directly to EyeMed Quality Assurance at eyemedqa@eyemed.com.
    - We will then reach out to you to request records for the initial visit and to hear your point of view.

Referrals

- **Referrals to in-network providers.** If a referral is required, refer the member to his or her health plan for assistance finding an in-network provider to provide the referred services.
- **Pennsylvania out-of-network referrals.** In Pennsylvania, if you refer the patient to an out-of-network provider, you must inform the member in writing that the provider is out-of-network, that there may be increased financial responsibility and that in-network options exist.
    - Pennsylvania providers who do not comply with out-of-network referral requirements could be subject to PA Department of Insurance (DOI) penalties up to $500,000 per calendar year:
        - $5,000 civil monetary penalty per violation
        - $10,000 penalty per each willful violation

Contact lens fit and follow-up and materials

Contact lens fit and follow-up definition

- **Definition of contact lens fit and follow-up.** Contact lens fit and follow-up means the evaluation, testing and observation that include precise measurements, analysis and recommendations of the specific contact lens to fit the curvature of the patients eye. It also includes the subsequent care necessary to ensure that the prescribed contact lenses provide appropriate visual correction, subjective comfort and support eye health. Contact lens fit and follow-up is provided subsequent and in addition to a Comprehensive Eye Examination.

- **Contact lens fit and follow-up benefits.** EyeMed's contact lens fit and follow-up benefits include training and a complete lens evaluation and up to 2 follow-up visits (in addition to the standard eye exam).

Components of contact lens fitting/evaluation

- **Initial diagnostic evaluations.** When treating contact lens patients, perform compatibility tests, diagnostic evaluations and diagnostic lens analyses to determine if contact lenses are right for a member, or if their contact lens prescription has changed.
- **Timing of fit and follow-up services.** Except for package plans, the contact lens fitting should be initiated during the same visit as the exam and completed within 45 days of the initial fitting.
- **Contact lens evaluation requirements.** Your contact lens evaluation must follow the below requirements depending on whether the patient has worn contact lenses in the past.
    - A "new contact lens wearer" is a new patient at your practice, or a patient who hasn't worn contact lenses in the past 12 months.
    - An "existing contact lens wearer" is a patient who has worn contact lenses within the last 12 months and is an established patient at your practice.

	New Wearer	Existing Wearer
	Required Test (✓)	
Contact lens-related history	✓	✓
Keratometry and/or corneal topography	✓	✓
Anterior segment analysis with dyes	As Indicated	As Indicated
Biomicroscopy of eye and adnexa	✓	✓
Biomicroscopy with lens • Fluorescein pattern (rigid lenses) orb. • Movement and/or centration (soft lenses)	✓	As Indicated
Over-refraction	As Indicated	As Indicated
Visual acuity with diagnostic lenses	✓	As Indicated
Determination of contact lens specifications determined to obtain the final prescription	As Indicated	As Indicated
Member instructions and consultations	✓	✓
Proper documentation with assessment and plan	✓	✓

Standard vs. premium contact lens fittings

- **Standard contact lenses.** A standard contact lens is defined as a clear, soft, spherical, daily wear contact lenses for single vision prescriptions. Standard contact lenses do not include extended or overnight wear lenses, which are intended to be worn during periods of sleep.

- **Premium contact lenses.** Premium contact lenses are toric, multifocal, monovision, post-surgical, gas permeable contact lenses and other non-standard contact lenses. Premium contact lenses include extended and overnight wear lenses, which are intended to be worn during periods of sleep. The below situations also qualify as premium contact lens fittings:
    - Contact fittings started as a toric fit with multiple visits due to astigmatism, in which you ultimately prescribe spherical lenses
    - Toric soft lens fittings
    - Fitting of spherical lens(es) used in a monovision application
    - Prescribing or dispensing an extended-wear lens to a member who intends to wear the contact lens as extended wear.

Follow-up care, training and education

- **Follow-up visits.** Our benefit covers up to 2 follow-up visits.
    - If the member requires more than 2 follow-up visits (excluding insertion and removal training), you may charge them for the extra visits.
    - Medically necessary contact lens benefits cover unlimited follow-up visits.
- **Training and education.** You can't charge members additional fees for training and education, which should include written instructions on how to handle, clean, maintain and wear their contact lenses.

Contact lens materials dispensing requirements

- **Valid contact lens prescription.** Before dispensing contact lenses, make sure the member's prescription hasn't expired and still meets the member's eye health and vision needs before dispensing contact lenses.
- **FTC Fairness to Contact Lens Consumers Act.** You must follow the FTC Fairness to Contact Lens Consumers Act (15 U.S.C. §§ 7601-7610).

Frames

Frame inventory and dispensing requirements

- **Minimum frame inventory.** Each participating location must maintain/display at least 100 prescription frames priced $130 or less, from any manufacturer.
- **Frame availability.** Members can apply their benefits to any frame available in your dispensary, with the exception of programs such as Medicaid that limit the selection available.
- **ANSI standards.** Dispense only frames that meet ANSI Z80.5 Spectacle Frame Standard.
- **Pediatric Vision Benefits inventory requirements.** To receive fully covered corrective eyewear, members of Pediatric Vision Benefits must choose from a frame selection that you make available to the member.

- You'll need a minimum of 35 frames in your dispensary that meet the following criteria for Pediatric Vision Benefits members to choose from:
  - A total wholesale acquisition cost of at least $19
  - 20% to 40% (or at least 5 units) each of girl, boy and unisex styles
  - Eye size assortment as follows:

Eye size	Minimum # of units
Less than 46	6
46 to 47	6
48 to 49	2
50 to 51	1
52 and higher	1

- **Safety eyewear requirements through the Safety Eyewear Program.** Safety eyewear dispensed under the Safety Eyewear Program must meet ANSI Z87.1 safety standards.

Frame restrictions

- **Designer frames that prohibit discounts.** Many high-end brands have restrictions on which frames can be discounted.
  - Most of the time, these restrictions apply only to discounts (not funded plans like our benefits).
  - Ultimately, it's up to you to be aware of restrictions on the frames you carry.
- **Sports goggles.** Frames designed for use as protective eyewear in sports (often called sports goggles) are not part of our standard benefit. Members receive a 20% discount off the purchase of sports goggles as part of their discount on additional services.
- **Reading glasses.** Prescription spectacles for reading, where the lenses are fabricated by a network laboratory, are covered under the EyeMed benefit. Over-the-counter readers are **not** covered.

Frame dispensing

- **Frame to come.** When you use our lab network and select a Frame to Come job type, you'll supply your own frame.
- **Eyeglass cases and postage.** The EyeMed reimbursement includes the eyeglass case and any postage.

Plano lenses and frame-only transactions

Restrictions on plano sunglasses

- **Exclusion of plano sunglasses from frame allowance.** EyeMed's frame allowance can be used only for frames *without* lenses. See our Limitations and Exclusions.
    - Members can't use our lens benefit for plano sunglasses unless the member's plan explicitly includes such benefits. Please check the Member Details in the online claims system for details. You can also refer to our Client-specific Plan section.
- **Frames purchased without prescription lenses.** If the member doesn't purchase prescription lenses at the same time they purchase a frame (including sunglass frames), you must remove the plano lenses from the frame before selling them.
- **Audits on frame-only transactions.** In the event of an audit, you will need to attest that the frame was sold to the member without lenses.

Discounts on sunglasses

- **Discounts on sunglasses.** Plano sunglasses are not eligible for complete pair discounts.
    - Members receive a 20% discount on plano sunglasses, which are considered non-covered items.
    - The Discounts section provides more information.

Lenses

Lens requirements

- **Standard lenses.** We consider standard lenses to be uncoated, CR-39 plastic single vision, bifocals (ST 25 and 28) and trifocals (7x28). Any other lens types are considered premium lenses.
- **ANSI standards.** If you use a non-network lab or in-office finishing to produce eyewear, lenses must meet current ANSI standards.
- **Safety Eyewear Program lens requirements.** When dispensing safety eyewear, lenses will need to meet different standards. Refer to the Safety Eyewear Program section for details.

Lens sourcing

- **Lens ordering through network labs.** Unless your contract allows otherwise, you're required to use our contracted labs (or, when applicable,

you may provide single vision in-office finishing) to produce eyewear for members.
- **Product catalogs.** Our product catalogs define the lenses and treatments available through our lab network. See the Lab section for details.

Progressive lenses

- **Standard vs. premium progressives.** We classify progressives as standard or premium according to this list.

Anti-reflective treatments

- **Standard vs. premium anti-reflectives (A/R).** We classify anti-reflective treatments as standard or premium according to this list.

Lens options

- **UV coating included in premium products.** Because UV protection is already included in premium products (such as polycarbonate and high-index lenses), members don't pay a separate $15 charge for UV coating.
- **Lens options included in lens packages.** If you sell lenses as packages that bundle multiple add-ons with the lens, make sure you're charging the member for each of the individual lens add-ons (unless the add-on is inherent to the lens material).
    - When the lens add-on material automatically includes some other lens add-on — like scratch-coating inherent in polycarbonate or UV and scratch-resistant coating in a photochromic lens — the member only has to pay for the main add-on.
- **Lens options for Medicaid programs.** We cover only specific medically necessary lens options for Medicaid members. Refer to the provider manual for your state for details.
- **Digital single vision lens with boost power for digital eyestrain.** New digital single vision lens designs provide at least a 0.25 power boost or greater to single vision Rx to help address digital eyestrain. These lenses are covered under a member's funded lens benefit even if there is no vision correction in the lenses.
- **Materials with blue light filtering achieved with a tint.** Lens materials that offer better balances of clarity and blue light filtering are classified under our benefits as a tint.
    - If you don't use the lab network, check the tint box if you dispense lenses that achieve blue light filtering via a tint.
    - All other blue light filtering materials will follow the base materials reimbursement and member out-of-pocket cost.
- **Lens rechecks.** If a member asks for a lens recheck, verify the lenses and, if necessary, the refraction, within the first 45 days of receiving new eyewear based on that prescription, at no additional charge to the member.

Documentation of approved lens designs

- **Audits and consequences.** Failure to provide proper documentation that you dispensed an approved blue light or digital single vision lens design could result in recoupment and/or notification of non-compliance during an audit.

Eyewear warranties and return policies

Manufacturer warranties

- **Defective lenses and frames.** Honor manufacturer and lab warranties pertaining to defective lenses and frames.
- **Warranties for lenses purchased through network labs.** Contracted labs will also honor all manufacturer warranties. Contact the lab that manufactured the materials for further information.

Return policies

- **Return policies for lenses purchased from network labs.** Specific return policies apply to eyewear manufactured through the lab network. Refer to the Lab section for details.
- **Practice return policies.** If you have a specific return policy in place at your practice, you must share it with members when you dispense the eyewear.

Protection plans

- **Eyewear protection plans.** Our benefits don't cover product warranties or protection plans available for additional cost to the member, but you're welcome to offer members the option to purchase an extended protection plan through your office.

Discounts

- **Requirement to honor discounts.** You're required to provide point-of-sale discounts to members who are entitled to them unless your state law dictates otherwise. Available discounts by network are provided in the attached.
- **Exam only plan discounts on materials.** Members with exam only plans also receive point-of-sale discounts on any materials they purchase from your practice.
    - You can order these materials from the lab of your choice or order them through the EyeMed lab network.

- **State laws pertaining to discounts.** Some states may prohibit eye care plans from requiring providers to accept these discounts on non-covered services.
    - If you practice in any of these states, you can opt out of these discounts by logging into the Online Claims System and checking the appropriate box on the Location Details page under Manage My Profile.
    - The provider portal, inFocus, provides step-by-step instructions.
- **Ohio and Pennsylvania – requirements for notification.** The following 2 states have specific notification requirements in the event your location does not offer all discounts.
    - **Ohio**. If you opt out of discounts, you must post the following language in your location for members:
        - "IMPORTANT: this vision care provider does not accept the fee schedule set by your insurer for vision care services and vision care materials that are not covered benefits under your plan and instead charges his or her normal fee for those services and materials. This vision care provider will provide you with an estimated cost for each non-covered service or material upon your request."
    - **Pennsylvania**. If you opt out of discounts, you must notify members in writing that they are receiving non-covered services at non-discounted rates because you do not participate in EyeMed's discount program.
        - The Department of Insurance (DOI) may impose penalties of $5,000 civil monetary per violation and $10,000 per each willful violation up to $500,000 per calendar year.
- **Client-specific discounts.** Always refer to the Client-specific Plan section to ensure members receive discounts they are entitled to.

Medically necessary contact lenses

Overview of medically necessary contact lenses

- **Definition of medically necessary contact lenses.** Many plans include benefits for contact lenses when the member's vision correction needs meet specific requirements that make the use of contact lenses a medical necessity.

Covered benefits

- **Medically necessary contact lens benefits.** The benefit covers materials, fitting and unlimited follow-up visits.
- **Benefit frequency and annual supply limits.** Members who qualify can use the benefit once a benefit year based on member's eligibility and can't

exceed annual supply limits defined by contact lens manufacturer replacement guidelines.

- **Member out-of-pocket.** You may not bill members for any difference between your retail fees and the plan's reimbursement unless the plan benefits specifically say the member is responsible for payment above the allowance.

Qualifying conditions

- **Minimum qualifications for eligibility.** A member's vision and spectacle prescription must meet the below criteria to qualify for medically necessary contact lens benefits. Members can't use this benefit for conditions not listed, even if you determine that contact lenses are necessary to correct other vision issues.
  - **Anisometropia** of 3D in meridian powers.
  - **High Ametropia** exceeding –10D or +10D in meridian powers.
  - **Keratoconus** when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses. For the purposes of our benefit, there are 2 types of keratoconus as defined in our ectasia scale.
    - **Emerging/Mild:** Contact lenses in this tier are anticipated to include, however not be limited to, soft toric, rigid gas permeable, scleral, semi-scleral and hybrid designs/materials. The below severity scale applies:
      - Multiple spectacle remakes
      - Unstable topography
      - Light sensitivity/glare issues
      - Signs including Fleischer ring, Vogt's striae and scissor reflex with retinoscopy
      - No scarring
      - Topography (steep K <53D)
      - Corneal thickness >475 microns
    - **Moderate/Severe**: Patients who begin in the emerging or mild categories and are not successful with contact lens materials and keratoconus designs may be elevated into this moderate/severe tier. Contact lenses in this tier are anticipated to include however not be limited to scleral, semi-scleral and hybrid designs/materials. Patients who qualify as moderate/severe will have all of the emerging/mild symptoms, plus:
      - Mild to no scarring or some scarring
      - Topography (steep K of 53D or higher)
      - Corneal thickness up to 475 microns
      - Refraction not measurable
  - **Vision improvement other than keratoconus** for members whose vision can be improved by 2 lines or more on a standard visual acuity

chart with contact lenses when compared to the best correction attainable with standard spectacle lenses.

Documentation requirements

- **Establishing qualification for benefit.** You're responsible for determining if members meet the qualifying criteria based on your exam and evaluation.
- **Spectacle prescription.** The documented spectacle prescription must support the qualifying condition submitted.
- **CPT codes.** When filling out the claim, you will indicate the member's qualifying condition.
    - CPT procedural codes for contact lens fitting are limited to keratoconus (92072). CPT has not designated codes for anisometropia, high ametropia and vision improvement, so you should use the below codes to indicate the qualifying condition:

Qualifying criteria	Medically necessary contact lens codes*
Anisometropia	92310AN
High ametropia	92310HA
Keratoconus	92072
Vision improvement	92310VI
Pediatric aniridia**	92310AI
Pediatric aphakia**	92311AP and 92312AP
Pediatric corneal and post-traumatic disorder (filed as vision improvement)**	92310VI
Pediatric pathological myopia**	92310PM

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

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

- **Diagnosis codes.** Include the applicable refractive and high-risk diagnosis codes on all medically necessary contact lens claims.
    - For keratoconus or anisometropia, submit the applicable diagnosis codes listed in ICD-10.
    - If you put more than 1 diagnosis on the claim, we'll reimburse based on the lowest-paying condition.
- **Supporting documentation.** We may also ask you for additional supporting documentation.
- **Audits and clinical records reviews.** We'll periodically review clinical records to make sure you're correctly applying the medically necessary contact lens benefit. We'll be checking whether the documented prescription supports the qualifying condition submitted on the original claim.

- If the clinical record doesn't support the reported condition, we can recoup any overpayment by withholding payment on future claim(s) where law permits.
- We can consider any inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. We might also have to report it to regulatory and law enforcement agencies as appropriate.

Materials requirements

- **Minimum industry standard.** Dispense contact lenses that have been manufactured to meet the most current industry standards.
- **Filling existing prescriptions.** When filling an existing contact lens prescription, make sure the prescription is current and meets the member's vision needs prior to supplying contact lens materials.

Client-specific medically necessary contact lens benefits

- **Non-elective contact lenses through Blue View Vision.** Blue View Vision uses the term non-elective contact lenses instead of medically necessary.
- **Clients with unique benefits.** The following have different medical necessity requirements, which are documented in the Client-specific Plan Requirements section.
  - Tufts Health Plan members
  - Humana Vision members
  - Members of Pediatric Vision Benefits plans in California
- **Medicaid.** Refer to your state's Medicaid Provider Manual for details.

Diabetic Eye Care plans

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

Diabetic Eye Care benefits

- **Covered diagnostic services.** Members who qualify will be eligible to receive benefits for the below follow-up diagnostic services:
  - Fundus Photography – bilateral
  - Extended ophthalmoscopy – unilateral
  - Gonioscopy – bilateral
  - Scanning laser – bilateral
- **Covered procedure codes.** The below procedure codes are covered by Diabetic Eye Care plans.

92020	92134

92201	99212
92202	99213
92250	99214
99211	99215

- **Overlap with medical benefits.** Members might have coverage for the same follow-up services through both a Diabetic Eye Care plan and their medical plan. Members are ultimately responsible for deciding which plan to bill and will pay any applicable copayments, allowances and/or deductibles.

Qualifying diagnoses

- **Qualifying ICD-10 codes.** For the member to qualify for our Diabetic Eye Care plan, a diagnosis within the following range must be present and reported on the claim: E08.XX – E13.XX.
- **Humana Inc. qualifying conditions.** Please see client-specific plan information for the list of additional conditions that qualify for Diabetic Eye Care services for Humana, Inc., employees.

Safety Eyewear Program powered by EyeMed

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

Reimbursements

- **Dispensing fee for safety eyewear.** You will receive a $25 dispensing fee for each pair of complete safety glasses.
- **Lens options under the Safety Eyewear Program.** You'll receive your standard payments for lens options as listed in the Standard Lens Options Schedule, except for polycarbonate.
    - There is no additional reimbursement for dispensing polycarbonate lenses in safety eyewear.
    - Lens and Options Chargebacks will apply for all safety eyewear orders placed through the lab network.

Safety Eyewear Program benefits

- **Eye exams.** The Safety Eyewear Program is typically a materials-only benefit, so an eye exam is usually not covered.
    - If the plan includes a covered eye exam, you'll be reimbursed your standard contracted eye exam rate for the network.

    - In most cases, members will be eligible for a comprehensive eye exam under other sources, such as medical coverage or routine vision benefits. Double-check exam eligibility under any available plan for that member. If the member is still eligible for eye exam coverage through a different plan, and you accept that plan, you can bill the eye exam to the other plan.
- **Frames.** Members will typically have a frame allowance to apply toward the retail price of safety eyewear frames. If a member buys a frame that exceeds the allowance, apply a 20% discount to the overage, and collect the remainder from the member. Refer to the Member Benefit Display for details or variations.
- **Lenses.** Members will have copays for lenses. Refer to the Member Benefits Display in the online claims system for the member's specific copay amounts.
- **Lens options and add-ons.** Lens add-ons are available for safety eyewear.
    - If the patient chooses an option that's covered under their plan, charge the plan copay amount, otherwise follow the standard Lens Options Schedule for member payment.
    - Polycarbonate is typically a covered benefit for safety eyewear.
- **Additional pair discount.** Members receive 20% off additional complete pairs of safety eyewear. This can't be submitted through the system. Simply apply the discount at the point of sale as you do for other EyeMed discounts.
- **Limitations and exclusions.** The following are excluded and are not covered under the Safety Eyewear Benefit:
    - Plano safety glasses
    - Contact lenses
    - Everyday eyewear instead of safety certified frames and lenses
    - Any frame, lens or lens option that does not meet current ANSI Z87.1 safety standards
    - Materials obtained by other means than those approved as part of the program

Eligibility

- **Subscriber-only.** Only the employee who is enrolled in the Safety Eyewear Program is eligible. Dependents are not eligible.

Safety eyewear requirements

- **ANSI standards.** All prescribed materials must meet current American National Standards Institute (ANSI) Z87.1 standards for safety.
- **Valid prescription.** The patient's prescription must be valid (<2 years old). If a member received an eye exam elsewhere, they will present their prescription. Based on your professional judgment, you can require a new exam prior to dispensing the safety eyewear.

- **Employer-specific requirements.** Employers may have specific guidelines regarding allowable safety materials for their employees based on work conditions or specific job functions. See the notes in the Service Restriction section on the Member Details page in the online claims system for plan specific information.

Safety Eyewear Program when using EyeMed's lab network

- **Safety-authorized labs.** Only certain labs in the EyeMed lab network can fulfill safety eyewear jobs. Refer to our Safety Lab Listing to see which labs currently support the Safety Eyewear Program.
    - You will need to register for at least 1 of these labs before placing your first Safety Eyewear Program claim. Instructions are provided in our lab registration job aid.
- **Frame selection.** Members will choose from a selection of ANSI-certified safety frames available from the participating network of labs.
    - The full list of available frames is provided in the Safety Frame Catalog.
    - If you would like to purchase any of the program frames for your dispensary, contact Hilco OnGuard at 800.955.6544.
- **Frame kits.** Sample frame kits may be provided to your location, depending on the expected volume of members in your practice.
    - The kit includes a sampling of available frames. Refer to the Safety Frame Catalog for the full list of available frames, materials and colors.
    - Frames in the kit are for display only and should not be sent to the lab with the member's order.
- **Sample try-on safety frames.** If you do not have an in-office frame kit, you can order sample safety eyewear frames directly from Hilco.
    - After the member selects a frame from the digital catalog, contact Hilco at orders@hilco-usa.com or by phone at 800.955.6544 ext 3291. Provide the frame SKU.
    - Hilco will ship you the frame via UPS within 48 hours.
    - Once you receive the frame, have the member return to your office so you can take measurements.
    - Return the frame to Hilco in the same box using the pre-paid label included with the shipment.
    - File the claim online, and choose "Frame at Lab." Do not send the sample frame to the lab.
- **Lens products.** The current Safety Product Catalogs, which include all of the ANSI-certified safety eyewear lens products available through EyeMed's lab network, can be downloaded from our communications portal, inFocus.

- **Frame at lab.** All safety frames will be supplied by the labs. You'll select the frame during the integrated claims submission and lab ordering process.
- **Submitting safety eyewear claims when using the lab network.** Follow these steps to file claims and order safety eyewear:
    - Be sure to select the member record associated with the plan that includes the word "SAFETY" in the name.
    - Submit lab orders to the safety-certified lab you selected through our online claims system.
    - Choose "Frame at Lab." Do not send frames to the lab, as safety-certified labs carry all safety frames.
- **Complimentary side shields.** All safety frames come with side shields (built-in or removable) at no additional charge. For replacement side-shields, call Hilco OnGuard at 800.955.6544.
- **Remakes on safety eyewear.** You can request a first-time remake from the network lab at no charge within 6 months of the date of delivery for the reasons stated in the Lab section.
    - Process the remake or redo as a lens-only order.
    - Work with the lab for remake procedures to find out if you need to return the frame with the remake.
    - Eyewear can be remade in the case of damage or quality issues with the frame at no cost as part of the manufacturer's product warranty.
    - If a member wants to change a frame only, he or she is responsible for the cost to change the frame, and you'll handle it as a private pay transaction.
- **Emergency safety eyewear claims when using the lab network.** Use a CMS 1500 claim form with the applicable service codes to submit an Emergency Service claim. The member must qualify for emergency eyewear according to our standard Emergency Service lab policy.
    - Indicate the word "SAFETY" at the top of the form and include a valid diagnosis code based on their prescription, so we pay you correctly.
    - Fax the completed form to 866.293.7373.
- **Returns, exchanges and voids of safety eyewear.** Returns, exchanges and voids are not processed as part of the Safety Eyewear Program.
    - The only exception is when the member cancels his or her order before the order is in the manufacturing process.
    - In this case, follow our normal void process. Refer to the Lab section for details.
- **In-office finishing and uncut lens ordering.** You cannot use in-office finishing or uncut lenses to fulfill a safety order.
- **Safety eyewear for other members.** You cannot order safety eyewear through our lab network for members who are using their routine vision

plan. Please refer to our Client-specific Plan section for details on these groups.

Safety Eyewear Program when NOT using EyeMed's lab network

- **Frame selection.** You must offer a frame selection of at least 8 ANSI-approved frames that meet the following criteria:
  - Unisex or at least 4 men's frames and 4 women's frames
  - Varied material types
  - Varied eye sizes
  - Manufactured at a safety-certified lab
  - Displaying ANSI-required markings
- Submitting claims for safety eyewear when using the lab of your choice. Follow these steps to file claims:
  - Be sure to select the member record associated with the plan that includes the word "SAFETY" in the name.
  - File the claim through the online claims system or submit the claim using 837 inbound format.
- **Complimentary side shields and case.** Provide complimentary side-shields and a frame case with every safety eyewear purchase.
- **Frames from Hilco OnGuard.** Hilco OnGuard offers qualifying safety eyewear frames for offices looking for a selection of frames to offer. Call them at 800.955.6544 for more information.

Clients covering safety eyewear through a routine vision benefit

- **Client-specific information.** A few existing groups allow members to use their routine benefits on safety eyewear. You won't use the lab network for these groups. Refer to the Client-specific Plans section for details.
  - American Greetings
  - National IAM Benefits Trust
  - Northern Michigan University
  - Quad Graphics
  - Railroad Employees National Vision Plan
  - Vibracoustic

Pediatric Vision Benefits

Pediatric Vision Benefits overview

- **Frame selection.** To meet Affordable Care Act (ACA) requirements and ensure consistency of eyewear products, Pediatric Vision Benefits members select from a specific selection of frames. See the details of our inventory requirements.

- Members will have **no out-of-pocket cost** if they choose from the inventory selection.
- If they decide they want a frame outside the selection, they'll have to pay your regular retail price, and the transaction **will not be covered**.

- **Contact lens benefits.** Pediatric Vision Benefits members receive a 6-month, 3-month or annual supply of contact lenses, depending on the modality as detailed below, at no cost.

Replacement frequency	Amount dispensed
Monthly	6 month supply
2-week	6 month supply
Daily disposable	3 month supply
Conventional	Annual supply (one pair)

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

Multiple-pair benefits (California, Kansas, Kentucky and New York only)

- **Medically necessary additional pairs of eyewear.** Some health plans cover a medically necessary second pair of eyewear for Pediatric Vision Benefits members in California, Kansas, Kentucky and New York.
  - **California:** Members can qualify for medically necessary contact lenses when certain conditions are present.
  - **Kansas:** Members receive additional pairs of covered eyewear based on the doctor's recommendation. There are no special criteria or processes.
  - **Kentucky:** Qualifying members in Kentucky receive 1 additional pair of prescription spectacle lenses of the appropriate power to provide the best possible visual acuity. The frame can be the current frame, if usable, or a new frame that meets the benefit guideline.

    - **New York:** The benefit covers prescription spectacle lenses or contact lenses. The member is not restricted to 2 pairs only and can receive new glasses or contact lenses for each prescription change.
- **Qualifying conditions for additional pairs of eyewear (Kentucky and New York).** Members qualify for the additional pair of eyewear only when they experience vision change/loss must be due to 1 of the following conditions:
    - Diabetes
    - Keratoconus
        - Significant Rx Change/Progressive myopia/astigmatism
        - .75D sphere
        - 1.00D cylinder
        - For NY only: any significant Rx change/progressive myopia
    - Cataracts
    - Post-cataract surgery
    - Prescription medication
    - Other medical conditions that after review could reasonably cause a change in refractive status
    - You'll need to provide documentation of the vision change/loss each time a new prescription is needed sooner than the standard 12-month interval.
- **Qualifying conditions for additional contact lenses (California).** Members of Pediatric Vision Benefits plans in California can qualify for medically necessary contact lenses if they have the following conditions:
    - Pediatric aniridia
    - Pediatric aphakia

Low vision benefits

Some plans include a low vision benefit for members who have severe eye health and visual problems not correctable with conventional techniques.

How to become a low vision provider

- **Low Vision Provider Notification form.** To be added to our list of providers who provide low vision services to members, complete and submit a Low Vision Provider Notification form.

Covered services and materials

- **Low vision correction.** The following low-vision aids are covered:
    - **Spectacle-mounted magnifiers.** A magnifying lens mounted in spectacles (called a microscope) or on a special headband, which allows use of both hands to complete close-up tasks such as reading.

- **Hand-held or spectacle-mounted telescopes.** Miniature telescopes used for seeing longer distances such as across the room to watch television, or that can be modified for near tasks such as reading.
- **Hand-held and stand magnifiers.** Tools that help with short-term reading, such as price tags, labels and instrument dials. These magnifiers can be equipped with lights.
- **Video magnification.** Tabletop (closed-circuit television) or head-mounted systems that enlarge reading material on a video display. Some systems can be used for distance applications. Image brightness, size, contrast and foreground/background color and illumination can be customized.
- **Other low vision aids.** We consider low vision aids other than the above on a case-by-case basis. To request other low vision aids, email the Low Vision Service/Materials Approval Request form to medexceptions@eyemed.com or fax it to 866.552.9115.

- **Low vision supplemental testing.** Low vision supplemental testing consists of a diagnostic evaluation beyond a comprehensive eye exam.
  - Preliminary tests may include assessments such as color vision and contrast sensitivity and include a history of difficulties related to:
    - Reading
    - Activities in the kitchen
    - Glare problems
    - Travel vision
    - Workplace
    - Viewing television
    - School requirements
    - Hobbies and interests
  - When conducting low vision supplemental testing, take measurements of the member's visual acuity using low-vision test charts with a larger range of letters or numbers to more accurately specify a starting point for determining impairment level.
  - You can also evaluate visual fields or perform a specialized refraction, and you may prescribe various treatment options, including low vision aids, as well as inform the member of other resources for vision and lifestyle changes.

Qualifying conditions

- **Criteria for eligibility.** To qualify for low vision, the member must meet 1 of these criteria:
  - Best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription.
  - A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point.
  - The widest diameter subtends an angle less than 20 degrees in the better eye.

Utilization Management (Medical/Surgical Eye Care)

Utilization Management (UM) overview

- **Definition of UM.** Utilization management (UM) is the evaluation and determination of medical necessity, appropriateness and efficiency of health care services, procedures or a course of treatment based on clinical criteria or protocols.
- **Facility authorizations.** We'll work with the health plan to secure any required facility authorizations for the services.
- **Bonuses and incentives.** EyeMed does not provide bonuses or other financial incentives to the UM associates, clinical peer reviewers or consultants for making determinations, the volume of determinations made or encouraging utilization that could be considered inappropriate, resulting either in an increase or decrease in the level of care or total utilization. There are no bonuses or incentives based on the performance of any UM functions.
- **Reduction of required services.** EyeMed does not arbitrarily deny or reduce the amount, duration or scope of a required service solely on a diagnosis, type of illness or condition of a member.

Utilization Management (UM) process

- **UM process.** You'll need to follow our utilization management (UM) process to receive prior authorization for procedures and injections as defined by the health plan.
    - You'll request prior authorization through the UM form available on our online claims system.
    - You'll be notified of approval or denial for standard, non-urgent requests within 14 calendar days.
    - If the service also requires a facility authorization, we'll obtain that for you.
- **UM team contact.** Our UM team is available at 866.652.0038 between 8:00 am and 8:00 pm ET Monday through Friday.
- **Expedited requests.** You can request expedited decisions, which are rendered within 72 business hours, by indicating that it's an expedited request on the UM form. Expedited prior authorization is available only if the standard UM decision turnaround time:
    - Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function.
    - Would, in the opinion of a physician with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

- **Emergency services.** Emergency services do not require prior authorization.
    - Notify us by completing the UM request form on the next business day following the emergency care or by calling 866.652.0038.
    - Attach to the form any medical records related to the emergency care.
- **Claims submission for precertified services.** Once the procedure is precertified, you can file the claim online through the claims system or via 837 EDI format.
    - You can submit multiple dates of service and multiple service lines on the same claim, but only 1 provider should be listed on each claim.
    - Do not file medical eye care and routine vision services on the same claim.
    - When you or your patient are not satisfied with a denied UM decision, you can request an appeal by [appeal process TBD].
- **Co-management.** Co-management is allowed as long as the surgeon who performs the surgery uses co-management modifiers.
    - The appropriate modifiers must be on the claims submitted by both the surgeon and optometrist.
    - Co-management guidelines are the same as CMS.

Client-specific utilization management/pre-certification

Always refer to the Client-specific Plan section to see what other processes may apply.

Limitations and exclusions

Plan limits and exclusions include:

- Orthoptic or vision training, low vision aids and any associated supplemental testing, unless specifically covered by the plan.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures (except for plans that include Medical/Surgical Eye Care benefits).
- An eye or vision exam, or any corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under a plan. Some clients may offer the Safety Eyewear Program Powered by EyeMed in addition to their routine vision plan.
- Services provided as a result of any workers' compensation law or similar legislation or required by any governmental agency or program, whether federal, state or subdivisions.

- Plano lenses and plano sunglasses (except for 20% discount) unless specifically covered by the plan; see the Client-Specific Guidelines section for more details.
- 2 pairs of glasses instead of bifocals (does not apply to D or C plan members).
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days of such an order.
- Lost or broken lenses, frames, glasses or contact lenses, until the benefit resets.
- Not all materials are available at all provider locations.
- Members can’t combine benefits with any discount, promotional offer or other group benefits plans.
- Allowances are one-time use benefits unless otherwise noted.
- Members can’t use remaining balances for additional pairs unless the plan provides a declining balance benefit.

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

COMPLIANCE AND QUALITY ASSURANCE

Definitions of appeals and complaints

- **Definition of post-service claim appeal/dispute**. A request for review by the managed care organization of post-service payment-related claim matters.
- **Definition of clinical appeal.** An appeal is a review by a managed care organization of an adverse benefit determination.
- **Definition of complaint or grievance.** A complaint or grievance means an expression of dissatisfaction about any matter pertaining to administrative issues and nonpayment related matters.
    - You may access this process by filing a written complaint.
    - Providers are not penalized for filing complaints.
    - Any supporting documentation should accompany the complaint.

Provider post-service claim appeals process

- **Inquiries and correspondence.** The following are NOT considered claim appeals. If you have questions concerning these, call 888.581.3648 for assistance.
    - Claim Inquiry – A question about a claim that does not include a request to change a claim payment.
    - Claims Correspondence – When you receive a request for further information to finalize a claim. Examples include medical records, itemized bills and primary plan explanations of payment (EOPs).
- **Claims appeals.** A claim must be submitted prior to following this process.
    - If your claim has been finalized but you disagree with the amount you were paid or you disagree with the denial of your claim, you may request a post-service claim appeal.

    - If you are not satisfied with the payment of your submitted claim, you are entitled to a review (appeal) of the claim determination. To obtain a review, submit your request in writing to:

      Provider Appeals Coordinator
      EyeMed Vision Care
      4000 Luxottica Place
      Mason, OH 45040
      Fax: 513.492.3259
      eyemedqa@eyemed.com

- **Appeals timing.** For commercial plans, your request for an appeal must be submitted within 180 days of the date of your Remittance Advice.
- **Timely filing requests.** EyeMed will consider reimbursement of a claim which has been denied due to failure to meet timely filing deadlines only if you can provide proof of submission within the timely filing limits, or you can show good cause.

Assisting a member with an appeal

Members can access their specific appeals processes by referring to their Explanations of Benefits (EOBs) or by logging into the member section of eyemed.com.

Medicaid appeals

Refer to your state's Medicaid provider manual for specific appeals processes related to Medicaid claims.

Utilization Management appeals

Medical/surgical eye care procedures that require prior authorization have different appeal processes that may vary by state or health plan. Refer to the Utilization Management section for more information.

California disputes and appeals

- **Post-service claim disputes.** Use the Post-Service Claim Dispute process when you disagree with the amount you were paid versus what you feel you should have received. Issues may include:
    - Contractual payment issues
    - Disagreements over reduced claims or zero-paid claims not related to medical necessity

- Other plan denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Claim data issues

- **Provider dispute form.** Provider dispute requests may be submitted utilizing the Provider Dispute form.
  - Send the form to:

    EyeMed Vision Care
    Attn: Quality Assurance Dept.
    4000 Luxottica Place
    Cincinnati, OH 45040
    Fax: 513.492.3259
    Email: eyemedqa@eyemed.com
  - Submit 1 form for each post-service claim, though you can include disputes over substantially similar claims in bundled batches as long as sufficient individual claims identification is provided.
  - If the provider dispute does not include the required submission elements, we will return it to you with a written statement requesting the information necessary to resolve the dispute.
  - You must submit an amended dispute, including the required information, within 30 business days of the date of receipt of the returned dispute.
- **Dispute resolution timing.** You must submit disputes within 365 calendar days of the initial claim determination.
  - If the dispute is received outside the above receipt timeframe, it will be dismissed, and we will send you a dismissal letter.
- **Discrimination and retaliation.** We will not discriminate or retaliate against any provider for filing a dispute.
- **Review by California Department of Insurance.** You may seek review by the California Department of Insurance of a claim that an insurer has contested or denied by contacting the California Department of Insurance Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, or call the Consumer Hotline:
  - 800.927.HELP (4357)
  - Out-of-State Callers: 213.897.8921
  - TDD: 800.482.4TDD (4833)
  - Internet: www.insurance.ca.gov

- **Dispute resolution.** You have a right to enter into the dispute resolution process described in Section 10123.13 of Article 1. General Provisions – California Insurance Code.
    - You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the California Department of Insurance.

Colorado appeals

In Colorado, the following process applies:

- **Timing.** We'll resolve provider disputes/reconsideration requests in writing within 45 calendar days of receipt of all necessary information.
    - You and EyeMed may mutually agree in writing to extend the timeframes beyond the 45 calendar days from receipt of all necessary information timeframe established by regulation.
- **In-person and conference options.** You'll have the opportunity to designate a provider representative in the dispute resolution process, and you or your representative can present the rationale for the dispute resolution request in person. We'll also offer the opportunity to utilize alternative methods such as teleconference or videoconference to present the rationale for the dispute resolution request. We may require appropriate confidentiality agreements from the representative(s) as a condition to participating in the dispute resolution process.
- **Written notification of determination.** In the event the determination is not in your favor, the written notification shall include the principal reasons for the determination and the below details:
    - The names and titles of the parties evaluating the dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the dispute resolution request
    - A statement of the reviewers' understanding of the reason for the provider's dispute
    - The reviewers' decision in clear terms and the rationale for the decision
    - A reference to the evidence or documentation used as the basis for the decision.

Delaware appeals

In addition to the above, the following applies in Delaware:

- **Right to appeal**. You have the right to seek review of our decision regarding the amount of your reimbursement.
- **Claim arbitration**. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review this decision or any right of review based on your contract with us.
    - You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: DOIarbitration@state.de.us.
    - All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final.

Provider audits

Audit overview

- **Reasons for audits.** EyeMed is required to demonstrate that members receive quality eye care. Audits and associated reporting let us provide data that demonstrates consistent eye care that meets specific standards.
- **HEDIS audits.** We help collect Healthcare Effectiveness Data and Information Set (HEDIS) data through HEDIS audits.
- **Disciplinary actions.** Audits could result in disciplinary actions as justified by the findings.
- **Audit selection.** Our Quality Assurance team selects participating providers and/or locations for facility, clinical, financial and/or process audits.
- **Scoring process.** Professional reviewers score each clinical record to determine an average.
- **Medicaid audits.** Refer to the Provider Manual for your state's Medicaid program for audit processes related to Medicaid programs.

Types of audits and scoring

Evaluation type	What we're looking for	Scoring
Facility	• Areas of physical access, instrumentation and overall facility condition • 2 sections: Required equipment and facility environment	Required equipment: • 100% required to pass Facility section: • 100 – Excellent • 99 to 80 – Satisfactory • Less than 80 – Progressive Disciplinary Action
Clinical records	• Assessment of member records • Financial evaluation	• 100 to 90 – Good to Excellent • 89 to 80 – Satisfactory • 79 to 0 – Fail: Progressive Disciplinary Action
Financial	• Financial document evaluation reviews claims against payment and member records • Financial claim evaluation reviews a provider and/or location's claim history to reveal billing patterns	• 100 – Excellent • 99 to 80 – Satisfactory • 79 to 0 – Fail: Progressive Disciplinary Action
Process	• Review of clinical and business practices for a specific reason, such as adherence to clinical coverage criteria or application of a benefit and compliance with lab ordering, In-Office Finishing and emergency service policies	• 80% required to pass
HEDIS	• Collection of HEDIS data to assess and compare quality of care	NA

Audit process

- **Record availability.** You must make members' clinical, financial and administrative records available to us or other authorities that are reviewing quality of care at no charge to us or the member.
- **Audit documentation submission.** You will be asked to submit all audit documentation through a secure online form available at https://audit.eyemedonline.com in the timeline indicated on the audit request.
- **Consequences for non-response.** If you don't respond to our requests for information within the specified time, we will take action to recoup the reimbursements on those audited claims.

- **Forwarding address upon leaving network.** If you leave your practice or our network, provide us with a forwarding address so members can get copies of their clinical and administrative records if needed.

Audit disciplinary action

Noncompliance level	Reasons
Level 1 noncompliance	• Non-response to QA request or notice • Billing and/or claim filing errors • Lower than expected quality of service and/or materials, standards of optometric care and/or professional behavior • Failure to follow our quality, contractual or administrative protocols • Violating the terms of our Provider Agreement
Level 2 noncompliance	• Continued Level I noncompliance • Provider/member conflict: if your practice requires Provider Appeal, Peer Review or QA intervention
Level 3 noncompliance	• Continued noncompliance with our rules and standards that includes a "notice of involuntary termination" review from the Peer Review

- **Timing to respond to equipment failures.** If you fail an equipment evaluation, you'll have 10 business days to correct any issues or face disciplinary action. We'll remove you from the network if you don't respond or correct equipment issues within 30 days.
- **Member refunds.** If we determine the member is due a refund, and you don't reimburse the member or reinstate their benefit, we may reimburse them on your behalf and deduct the amount from future payments to your account, where permitted by law.
- **Corrective action plans.** You may be subject to re-evaluation or a corrective action plan if you fail or score less than "excellent" on audits. Facility audit failures are subject to accelerated disciplinary action, and the corrective action plan must be completed within 30 days.
- **Overpayment collections.** If we find any overpayments during a financial record audit, we'll collect the overage from future claim payments as allowed by law.
- **Fraud, waste and abuse violation disciplinary actions.** For suspected fraud, waste or abuse, additional actions, including involuntary termination, may be taken.

Fraud, Waste & Abuse prevention

Fraud, waste and abuse prevention overview

EyeMed follows Centers for Medicare and Medicaid Services (CMS) requirements and other industry standards related to preventing fraud, waste and abuse (FWA). Our FWA prevention goals are:

- To effectively pursue the prevention, investigation and prosecution of healthcare fraud, waste or abuse.
- To recover overpayments on behalf of our clients.
- To comply with state and federal regulations and clients' requirements for preventing fraud.

Exclusion screening and documentation

- **Exclusion from receiving federal funds.** You must make sure any individual or entity you intend to hire, sub-contract or add into your practice ownership is not excluded from receiving federal funds. If they appear the below exclusion lists, they will not be able to provide services to EyeMed members.
    - The Office of Inspector General's List of Excluded Individuals and Entities or LEIE at https://exclusions.oig.hhs.gov/.
    - System for Award Management or SAM at https://www.sam.gov/, see "search records."
- **Monthly monitoring.** You should check websites monthly for the exclusion status of any current or prospective team members.

Consequences of identified fraud, waste or abuse

We conduct audits and other measures to monitor and correct potential fraud, waste and abuse. Identified fraud, waste or abuse may result in *some or all* of following:

- Provider education and warning
- Monitoring of the provider's submitted claims activity and/or implementation of a Corrective Action Plan
- Comprehensive provider audit and/or quality review of the provider's claim activity
- Withholding of the provider's claim payments or demand for restitution for recovery of overpayments
- Termination of the provider from the network
- Reporting of suspected fraudulent activity to comply with state and federal regulations and/or clients' requirements

Annual training requirements

Our clients who are contracted with the Centers for Medicare and Medicaid Services (CMS) require providers to complete at hire and annually by December 31 compliance training related to fraud, waste and abuse (FWA) awareness. We must report compliance with these requirements to clients.

Your requirements

- **Who must take training.** The requirement applies to:
  - Everyone working within your location.
  - Anyone who has at least a 5% ownership in your business.
  - Anyone to whom you subcontract work.
- **Training topics.** Training should cover the following topics:
  - Fraud, waste and abuse prevention
  - Compliance Program Effectiveness (federal)
  - HIPAA (federal and state privacy)
  - Information Security (federal OCR & state)
  - Cultural competency
- **Additional topics.** Additional topics could be added in compliance with CMS requirements or state law.
- **Consequences for non-compliance.** You could be subject to disciplinary action and will be out of compliance with CMS or state regulatory agencies if you don't complete this process.

Annual training process

- **Annual training period.** We'll notify you when the annual tracking period is open.
- **Training sources.** You can download training from our communications portal or use another source that meets CMS requirements.
- **Training attestation.** Once the training has been completed by everyone in your practice, you must attest that you meet the requirement by logging in to our communications portal at eyemedinfocus.com and going to My EyeMed > Annual Training.

Returning to the network after involuntary termination

Waiting period and approval

- **One year waiting period.** If you're involuntarily terminated from the network and wish to reapply, you can do so after 1 year subject to approval by our Quality Assurance department and a probationary period.

Application process

- **Application for returning to network.** You can request to reapply to the network after termination in writing. Your request must acknowledge the reason for your termination and provide evidence of how you've addressed the issue that caused your removal from the network. You must also be in good financial standing with EyeMed and all affiliated entities.
- **Approval process.** Our Peer Review Subcommittee reviews reapplication requests from providers who were previously involuntarily terminated.
- **Next steps if approved.** If approved, you will:
  - Need to reapply to the network.
  - Be subject to network and credentialing rules and requirements at the time of reapplication.
  - Be under probation for 12 months following reinstatement.
- **Next steps if denied.** If your request to reapply is denied, we'll let you know why and explain the requirements to successfully re-enter the network. You may reapply again after 1 year.

Probationary period

- **Probationary period conditions.** If approved to re-join the network, you'll be admitted for a 12-month probationary period, during which:
  - You agree to additional audits at your expense to monitor compliance with all EyeMed participation criteria and your corrective action plan.
  - You must utilize the EyeMed lab network unless prohibited by state law.
  - You must attest annually that all staff members have completed a minimum of 10 hours of continuing education related to proper coding, billing and/or fraud, waste and abuse prevention.
- **Consequences for non-compliance during probationary period.** If you don't comply with all rules and standards during this period, EyeMed can immediately terminate you from the network.
- **Readmittance after probationary period.** If you do comply with all rules and standards during this period, EyeMed will readmit you to the network in the same manner as all providers.

- **Circumstances prohibiting re-entry.** Some situations prohibit re-entry, including evidence of physical or potential harm to a member or alleged fraud.

LAB PROCESSES AND OPERATIONS

Lab network

Lab network requirements

- **Contractual obligation to use network labs.** Unless your contract states otherwise, you must use our network labs or single vision In-Office Finishing program (if applicable) for all EyeMed member eyewear.
    - If your state allows you to use the lab of your choice and you wish to modify your arrangement, contact us at 888.581.3648 to receive a form to update your agreement with us.
- **Good financial standing.** You must stay in good financial standing with the network labs, even related to non-EyeMed orders.
    - If you don't stay in good financial standing with labs, your claim may be paid according to the fees listed under the heading Claims Submitted Outside of Our Online Claim System on the back of your fee schedules.
- **Online lab ordering.** You must submit all lab orders through our online claims system.
    - Labs do not accept CMS 1500 forms or 837 inbound.
    - If you submit a hard copy claim for eyewear that should have been ordered through the lab network, you will be reimbursed according to the fees listed under Claims Submitted Outside of Our Online Claims System on the fee schedules you received as part of your contract.

Our lab network

- **Lab network composition.** EyeMed's lab network includes labs across the country, including Essilor labs, Walman labs and Luxottica Lab Services (LLS).
    - Eyewear for Medicaid and Safety Eyewear Program members are available only at certain labs.
    - You can choose to fulfill orders at any of the labs on EyeMed's lab network.
    - The current list of network labs is available on our communications portal, inFocus.

Lab order process

- **Placing lab orders.** Submit lab orders through our online claims system at the same time you file the claim.

- **Lab responsibilities.** The lab will make lenses based on the member's prescription and options indicated on the claim, insert the lens into the frame you provided and ship the completed pair back to your office.
- **Lab order turnaround time.** The lab will ship the product back to you within 7 business days from the time it receives the frame.
    - If you do not receive your product within 7 business days, contact the lab directly.

Lab network exclusions

- You will not use the lab network for the below situations:
    - Standalone discount programs, materials only discount plans and discounts on additional purchases after use of the funded benefit (although you can order eyewear materials for members with discounted materials through our lab network if you choose)
    - Low vision materials
    - Pediatric Vision Benefits **pre-deductible plans** (all other plans use the lab network)
    - Pediatric Vision Benefits medically necessary multiple pairs
    - Any other benefit that requires the submission of a CMS 1500 form
    - Any plans or groups specifically excluded
    - Emergency services/situations

Product catalog requirements

Product catalog overview

- **Definition of product catalogs.** When using the lab network for eyewear orders, you're required to order lenses listed in the Essilor or Luxottica Lab Services product catalogs for EyeMed when members use their funded benefits, except for certain situations that require the use of a hard copy CMS 1500 form.
    - Product catalogs include all products available for order through the lab network.
    - Some product lines (e.g., Oakley and Ray-Ban) have their own catalogs.
    - You can access full product catalogs on our communications portal, inFocus.
    - Refer to the Safety Eyewear Program section for specific safety lens product information.
    - Medicaid programs will have unique catalogs that include the lenses and options available to those members.

- **Using the product catalog online.** When filing the claim online, you'll select the lenses and lens options you wish to order in the lab order section. Drop-downs for each lens, treatment and option will include the products available for the lab you choose at the beginning of the lab order process.
- **Updates and reviews.** We update catalogs periodically to ensure access to the latest technologies.
    - We update product catalogs periodically to reflect changes in technology and new products.
    - We'll notify network providers when new catalogs are available.
- **Lab charges.** You can find more information on lab charges for specific lenses, lens options and finishing services in the Lens and Options Chargeback Schedule.

Sales and use tax

You're required to follow your state laws regarding sales tax on eyewear purchases.

Sales and use tax resale certificate

- **Certificate submission.** If you're in a state or region that charges sales tax on eyewear, complete and return your state's sales tax resale certificate to provider@eyemed.com, or via fax at 513.492.4999.
    - These certificates allow a seller that buys products at resale to often avoid paying sales tax when purchasing the items.
    - If you don't return the form, and you're in a taxable region, you'll be charged sales tax on your lab orders.
    - The seller on the form should be indicated as: OPTICAL PROCUREMENT SERVICES LLC, 4000 LUXOTTICA PLACE, MASON, OH 45040.
- **Re-certification.** Your state may require re-certification periodically. Be prepared to provide an updated form when requested.
- **Reimbursement for taxes collected in error.** EyeMed will not refund taxes collected in error if you did not supply a sales and use tax form, or if the sales and use tax form on file expires.

Emergency eyewear orders

Definition of emergency eyewear orders

- **Qualifying reasons for emergency eyewear orders.** An emergency occurs when, in your professional judgment, there's a critical patient visual need that cannot be addressed through normal contract lab services. Examples include:

    - A member's safety and/or well-being is at risk without the immediate delivery of prescription eyewear.
    - The member is unable to function at work or school and doesn't have an alternate pair of glasses or contact lenses.
    - Lenses or lens options not in our product catalog that you deem necessary based on your professional judgment. When filing an emergency service claim, you'll need to explain your professional justification.
    - The member suffers a loss, theft or breakage of prescription eyewear, has no alternate pair and can't wear contact lenses.
- **Ineligible reasons for emergencies.** Requests for faster turnaround time for convenience (such as to accommodate trips, vacations or other events), a desire for faster service, or when the member has another serviceable pair of glasses or contact lenses, aren't considered emergencies.

Emergency lab order process

- **Labs for emergency orders.** You may use the lab of your choice, including a non-contracted lab, for emergency eyewear orders. It will be treated as a private pay lab transaction.
- **Emergency eyewear claims.** Submit a CMS 1500 form in hard copy to receive payment according to the amounts listed under the Claims Submitted Outside of Our Online Claims System section on your fee schedules.
- **Balance billing.** Don't balance bill the member for any difference in reimbursement from the schedule if you order a lens that's not in one of our catalogs.

Lab order refunds, returns and remakes

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

No-charge remakes

- **One-time free remake.** You can request a no-charge remake from a network lab 1 time per job within 6 months of the date of delivery
- **Reasons for no-charge remake.** The following reasons qualify for a no-charge remake:
    - Power changes (excludes power changes resulting in plano lenses).
    - Axis changes.
    - Base curve changes.
    - Segment height/segment style changes due to non-adaptation (i.e., FT28 to Executive).

    - Lens style change (except when going from a lower to higher technology like from a bifocal to a progressive)
    - Transcription errors (not including transcription errors involving tints, photochromics, frames or coatings).
    - Material change (i.e., glass to plastic, plastic to poly, plastic to high index plastic or glass, etc.)
    - Lab errors.
    - Progressive lenses under warranty.
- **Ineligible reasons for free remake.** You can't receive a free lens remake for the following:
    - Frame change remakes without a change in lens prescription
    - Subsequent remakes after the first 1 (excludes lab errors)
    - Patients' upgrade requests
    - Lost materials
    - Materials broken or damaged by the member or provider
    - Errors made during lab order process
    - Any lenses with upgrades
    - Changes requested after 6 months of delivery
- **Lab errors.** Remakes for lab errors are processed free of charge.
- **Changes to lesser technology.** If a member wants to change to a lesser technology from a more advanced lens type (for instance, from a progressive lens to a bifocal), work with the lab to determine applicable charges. Members are expected to pay any charges above and beyond the original order.
- **Manufacturer warranties.** Labs will honor any manufacturer warranties. Any financial issues resulting from the manufacturer's product warranty should be handled between you and the lab.

Remake process

- **Process for free remakes.** Return the lenses to the same lab (within 6 months of the original delivery date) along with the original invoice/shipping slip, an explanation of why you're returning the lens and any supporting documentation.

Changes to frames only

- **Frame change process.** Members are responsible for the cost to change a frame.
    - Handle it as a private pay transaction.
    - Fax the request to the lab and ship the new frame to the lab with the existing pair of glasses.

Progressive lens non-adapts

- **First-time progressive lens non-adapt.** When a member can't adapt to progressive lenses while they're under warranty, the lab will remake the

lenses 1 time at no charge in the same design and material (or lesser-priced design and material).
- **Additional progressive lens non-adapts.** If the member still can't adapt to the second (remade) glasses with progressive lenses, request another remake to switch the member back to lined bifocals, but you'll have to pay full invoice cost for this additional remake. If this happens, follow the same remake/return process outlined above.

Subsequent remake requests

- **Requests for additional remakes.** Additional requests must be handled as a private pay transaction between you and the lab.

Single Vision In-Office Finishing program

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

Participation requirements

- **Program requirements.** To participate in IOF, you must:
  - Order all lenses from Nassau Vision Group using our Lens Ordering link (iof.mylensorder.com) unless prohibited by state law (e.g., Utah, "free to choose" states, etc.).
  - Have IOF capabilities.
  - Produce eyewear that meets ANSI standards.
  - Complete eyewear within 7 business days.
- **Exclusions to IOF.** You can't use IOF for the following plan types (as of March 1, 2021):
  - Safety Eyewear
  - Medicaid (may vary by state)
  - Declining balance plans
  - Package benefits
  - Deductible plans
- **Program registration.** You must register for IOF on the online claims system.
  - Click on the In-Office Finishing link to agree to the terms above.
  - Detailed instructions are available on the communications portal, inFocus.

Claims and audits

- **Claims submission.** After you register for IOF, you will have the option to choose IOF when processing the claim. All other aspects of claims filing are the same.

- **Claims count and order auditing.** If allowed by law, your IOF claim count will be compared with your orders through our Lens Ordering link (iof.mylensorder.com).
    - If we notice a discrepancy between the two, we will provide you with notice of the non-compliance.
    - If you do not explain or correct the discrepancy, we may remove your access to the IOF program.

Lens only program

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

Lens only program requirements

- **Participation requirements.** You must have a tracer calibrated within manufacturer tolerances and according to manufacturer-suggested schedule, with the ability to download and transmit trace data in the Vision Council standard format.
- **Jobs ineligible for lens only.** Some frames or lens edging may necessitate sending the frame to the lab. If a submitted lens only order cannot be filled for a specific frame or lens, the lab may notify you if identified prior to starting the lens order. Examples of exclusions include:
    - Three-piece/drilled rimless
    - Wrap frames (those with a base curve higher than 6)
    - In-line/double-groove frames
    - U-bevel frames (zyl frames with deep groove)
    - Mini/shallow-bevel frame (too small for standard bevel)
- **Records requests.** We may request tracer and calibration records during our Quality Assurance process.

Lens only ordering process

- **Lens only orders through the online claims system.** Submit lens only lab orders through our online claims system by checking the "Lens Only w/ Trace" button. Upload a trace file in either text (.txt) or .xml format using the Vision Council standard format.
- **Archived trace files.** You can send a lens only job using a reference to an archived trace file.
    - Put a prior order or invoice number in the reference field in the online system.
    - If the lab needs an updated trace file, send it separately from the original order.

Order changes and remakes

- **Changes after the order has been started.** Changes to Lens Only orders, once submitted to lab, may result in a private pay transaction if the order has been started.
- **Remakes.** Our standard remake policy applies to lens only orders, with the following exceptions:
    - Lens fitting issues due to tracer calibration that exceed manufacturer tolerances or are outside the suggested calibration schedule.
    - Damage or breakage during lens fitting.
    - Fitting issues related to the trace data supplied for lens only jobs, unless caused by lab error.

Uncut lens program

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

Uncut lens program requirements

- **Participation requirements.** You must have an edger and the ability to edge and mount frames within manufacturer tolerances.
- **Jobs ineligible for uncut lenses.** You can't use uncut lens ordering for:
    - Tint
    - Mirror
    - Lab-applied UV
    - Glass
    - Balanced lenses
    - Slab off
    - Certain complex frames that require specific mounting or bevels

Uncut lens ordering process

- **Uncut lens ordering through the online claims system.** Submit uncut lens lab orders through our online claims system.
    - When you submit an uncut job, choose "uncut" as the job type from the available job type list.
    - Choose a frame type for every uncut order to ensure the member benefit is applied correctly.

Remakes

- **Remake policy and exceptions.** Our standard remake policy applies to uncut lens orders, with the following exceptions:
    - Damage or breakage during edging and/or mounting of the lens.

- If you’re unable to complete the edging or mounting of the frame, causing you to send a frame to the lab to complete the job.

CLIENT-SPECIFIC REQUIREMENTS

Medicaid

If you're part of a Medicaid program we administer, additional requirements pertain to your care of Medicaid members. You will be notified in advance of the program's start with specific requirements.

Provider Manuals for Medicaid programs are available on EyeMed's provider communications website, inFocus.

AT&T

- Members of AT&T's management plans have coinsurance. Please refer to our communications portal, inFocus, for a detailed explanation of coinsurance and a calculator to help you estimate the member's out-of-pocket cost when using coinsurance.
- **Safety eyewear.** AT&T lets members use their routine vision plan for safety eyewear.
    - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
    - Don't use the contracted lab network for safety eyewear under this plan

Blue View Vision (Anthem)

One of our largest private-label resellers is Anthem, which markets routine vision plans under the names Blue View Vision, UniView Vision and other names.

- **Member eligibility and claims submission.** You'll follow the same process to look up members and file claims that you do with EyeMed members.
- **Post-cataract lens exceptions.** Some Blue View Vision groups have additional coverage for eyewear after members have surgery for cataracts.
    - When this applies, members are loaded in to 2 plans — their routine vision care benefit and their post-cataract plan.

    - The post-cataract plan will be clearly identified in the plan name (e.g., Anthem POST-CAT).
- **Provider verification.** Each year Blue View Vision requires certain providers to verify their practice information on file with EyeMed. Failure to do so can result in termination from the Anthem network or removal from the in-network provider locator.
- **Anthem/Blue View Vision low vision benefits.** EyeMed forwards all documentation for low vision benefits to Anthem's Optometric Director for review.
    - The Anthem Optometric Director approves or denies the pre-authorization and determines the benefits available based on Anthem's benefit designs.
    - Benefit information is not housed in our claims system and may vary by member.

CareMore

- **Procedures and injections requiring pre-certification.** You're required to obtain pre-authorization for the below 6 surgical procedures and injections.
    - Intravitreal injections: J0178, J0585, J0586, J0588, J2778, J3396, J3490, J7313, J7316, J2503
    - Blepharoplasty and ptosis repair: 15822, 15823, 67900-67914
    - Botulinum toxin (Botox): J0585, J0586, J0588:
    - Cataract surgery: 66982 & 66984
    - Glaucoma Surgery: 65850 & 65855
    - Unlisted procedures 66999, 67299, 67399, 67999, 68399, 68899, 92499
    - Clinical guidelines for each are available on our provider portal at eyemedinfocus.com.
- **Facility authorizations.** If you need a facility authorization for services other than those processed through EyeMed, you'll need to obtain it directly from CareMore. Contact CareMore's Utilization Management department at 888.291.1358 (Option 3, Option 3, Option 2).

Cemex (through Aetna Vision)

- **Safety eyewear.** Cemex allows members use their routine vision plan for safety eyewear.
    - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
    - Don't use the contracted lab network for safety eyewear under this plan.

Chicago Regional Council of Carpenters Welfare Fund

- **Safety eyewear.** Carpenters Welfare Fund lets members use their routine vision plan for safety eyewear.
    - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
    - Don't use the contracted lab network for safety eyewear under this plan.

Concorde ROTC Program

If you participate in providing ROTC/US Service Academy Optometric Screenings through Concorde Inc., you must follow the processes outlined in the program's Procedure Manual.

Fallon Community Health Plan (FCHP)

- **Reimbursements for primary eye care plans.** FCHP's primary eye care plans follow this fee schedule.
- **Plan names.** In 2020, 2 Fallon member groups changed their names:
    - Plan ID 9847971 is Fallon Medicare Plus.
    - Plan ID 9847997 is Fallon Medicare Plus PRIMARY.
- **Refraction reimbursements – Mass Health and Navicare.** Members receive a separate reimbursement of $12.51 for refraction services performed during a comprehensive eye exam for members of Mass Health Routine (Group ID 9823253) and Navicare Routine (9823246) ONLY.
    - File the refraction claim on our online claims system. Select "Refraction" as a service provided when filing the exam claim.
        - If you need to file a hard copy claim, use CPT code 92015.

        - File the refraction claim at the same time as the eye exam claim.
- **Medical eye care services by ophthalmologists.** FCHP requires ophthalmologists to file claims for medical eye care services directly with them. Optometrists submit primary eye care claims to us using our standard claims submission process.
    - If an ophthalmologist provides the medical eye care services, submit the claim to Fallon instead of to us.
    - The primary diagnosis code must be a medical diagnosis for the claim to be filed as primary eye care. Any claims with routine vision diagnosis codes will be processed as a comprehensive eye exam through us.
- **NaviCare Navigator.** FCHP offers 2 NaviCare programs: NaviCare HMO SNP, a Medicare Advantage Special Needs Plan, and NaviCare SCO, a Senior Care Options program.
    - Members of these programs have access to a single point of contact, called a Navigator, to organize services and care. The Navigator can authorize services not normally covered under the benefit plan, including increased benefit allowances, coverage of non-covered items or eligibility extensions.
    - When members use the service, the Navigator will contact you and explain the additional benefits. We'll reimburse you for the indicated services at no additional charge to the member.
    - If the member is still eligible in our system, submit the claim online for all services. Your expected payment in the claims system will not include the additional services; we'll adjust your actual claim payment accordingly.
    - If the member is no longer eligible for any services according to our system (preventing you from filing an online claim), please submit the claim to us in hard copy using a CMS 1500 form.

HealthNow New York

- **Pediatric Vision Benefits additional pairs.** Members of HealthNow's Pediatric Vision Benefits plans can receive new glasses or contact lenses for ***any prescription change*** (with no limit on the number of pairs).
- **Coordination of care.** You must forward all pertinent information relating to the health care of a member to any of the member's providers for inclusion in the member's medical record, and to notify such providers of any significant change in the member's medical condition.

Humana

Humana medically necessary contact lenses

- **Reimbursements for medically necessary contact lenses.** Contact lens fitting fee and materials are reimbursed on an invoice cost basis. The reimbursement covers the initial fitting and materials only.
- **Medically necessary contact lens benefits.** Humana Vision covers, in lieu of eyewear or elective contacts, initial fitting and medically necessary contact lens materials. This applies to all Humana Vision members, whether part of Humana Vision Insight or Humana Vision VCP.
- **Member out-of-pocket.** There's no copayment for the initial fitting and materials. You cannot charge the patient the difference between your retail charge for contact lens services and the amount Humana Vision reimburses for the initial fitting and materials.
- **Discounts on additional pairs of lenses.** The medically necessary contact lens benefit covers the first pair of lenses. Members may purchase additional or companion lenses at your usual and customary fee less a 20% discount, as applicable by state.
- **Minimum qualifications for eligibility.** Humana Vision members must meet the following criteria to be eligible for medically necessary contact lenses:
  - **Monocular aphakia or binocular aphakia** where the doctor certifies that contact lenses are medically necessary for safety and rehabilitation to a productive life
  - **Anisometropia** of greater than 3.00 diopters and asthenopia or diplopia, with spectacles
  - **High ametropia** of either +10D or -10D in any meridian
  - **Keratoconus** supported by medical record documentation consistent with a 2-line improvement of visual acuity with contact lenses as the treatment of choice
  - When **visual acuity cannot be corrected to 20/70** in the better eye except through the use of contact lenses (example: nystagmus and/or other ocular diseases or conditions that meet this criteria)
- **Exclusions**. Humana Vision's medically necessary contact lens benefits do not cover the following:
  - Patients with a history of corneal or elective refractive surgery (ie. LASIK, PRK, RK)
  - Plano lenses to change eye color cosmetically
  - Artistically painted lenses
  - Additional office visits associated with contact lens pathology
  - Contact lens modification, polishing or cleaning
  - Therapeutic or bandage lenses

- **Eligibility.** For the patient to be eligible for Medically Necessary Contact Lenses, they must be currently eligible for both exam and full contact lens benefits.
- **Pre-authorization.** You must obtain pre-authorization from Humana for these services.
    - Refer to the Submitting Claims section for the full process.
    - If a claim is filed without the **approved** Humana Authorization Notification, standard **or** premium fit will be paid at the provider's contracted rate and the provider MAY NOT balance bill the member.
- **Follow-up visits and diagnostic tests.** Submit claims for follow-up visits and diagnostic tests (e.g., corneal topography) to the patient's medical insurance.
- **Claims and prior authorization.** You must obtain prior authorization for Humana members to qualify for medically necessary contact lenses. Follow the process below:
        1. Complete a Humana Medically Necessary Contact Lens Prior Authorization Form.
        2. Submit the form with a copy of the patient's Humana Vision ID card, a copy of the patient's complete medical records and the contact lens manufacturer's wholesale invoice or cost estimate to Humana Vision Utilization Management Department via fax to **866.685.2759**.
        3. The Humana Vision Utilization Management Department will return the Authorization Notification form, indicating approval and reimbursement amounts and authorization number or denial to provider.
        4. Order and dispense materials after receiving the returned Authorization Notification form.
    - After you receive approval and provide service to the member, submit the CMS-1500 form and a copy of the authorization approval:
        - via fax to: **866.293.7373**
        - via mail to:
          Humana Specialty Benefits
          PO Box 8504
          Mason, OH 45040
    - Use the below codes to indicate the qualifying condition:*

Service	Procedure or HCPC Code	Modifier	Expected Diagnosis
Medically Necessary Contact Lens Fitting (General)	92310	22	
Anisometropia	92310	22	H52.31

Service	Procedure or HCPC Code	Modifier	Expected Diagnosis
Ametropia	92310	22	H52.0x, H52.1x
Keratoconus	92072		H18.601—H18.629
Contact lens fitting for aphakia, one eye (monocular)	92311		H27.00—H27.03
Contact lens fitting for aphakia, both eyes (binocular)	92312		H27.00—H27.03
Contact lens fitting, corneoscleral lens	92313		H52.31, H52.0x, H52.1x, H18.601-H18.629, H27.00-H27.03
Medically Necessary Contact Lens Materials (General)	V2599	P2	
—Contact Lens, GP, Spherical, Per Lens	V2510	P2	
—Contact Lens, GP, Toric, Per Lens	V2511	P2	
—Contact Lens, GP, Bifocal, Per Lens	V2512	P2	
—Contact Lens, GP, Extended Wear, Per Lens	V2513	P2	
—Contact Lens, Hydrophilic, Spherical, Per Lens	V2520	P2	
—Contact Lens, Hydrophilic, Toric, Per Lens	V2521	P2	
—Contact Lens, Hydrophilic, Bifocal, Per Lens	V2522	P2	
—Contact Lens, Hydrophilic, Extended Wear, Per Lens	V2523	P2	
—Contact Lens, GP, Scleral, Per Lens	V2531	P2	
—Contact Lens, Other Type	V2599	P2	

**Submit 1 fit and up to 2 material codes (1 per eye) per claim with 1 date of service.*

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

Diabetic Eye Care Program for hypertensive patients – Humana Inc.

- **Eligible members.** Additional benefits for hypertensive members apply **only to Humana, Inc. employees**, not to other Humana members.
- **Reimbursement.** Refer to the Diabetic Eye Care section of the provider manual for information about your reimbursements for these services.
- **Qualifying conditions.** Employees of Humana, Inc. enrolled in the company's vision plan (group ID 1011145) are eligible for Diabetic Eye Care benefits if they are diagnosed with hypertensive retinopathy, essential (primary) hypertension, abnormal blood pressure reading with or

without hypertension diagnosis, a non-specific low blood pressure reading or a hypertensive emergency (see below for corresponding ICD-10 codes).
    - H3503.XX
    - I10
    - R03.X
    - I161
- **Covered procedures.** Anyone with hypertension and/or diabetes (based on our standard Diabetic Eye Care diagnoses requirements) is eligible for the below additional services with no copay in addition to their standard routine vision benefits. Qualifying members can receive each service one time during the plan year.

Procedure Code	Service
92002 / 92012	Intermediate Exam
92020*	Bilateral Gonioscopy
92134*	GDX / OCT for retina
92250	Fundus photography (with interpretation and report)
92201 * / 92202*	Extended Ophthalmoscopy
99212	Focused-Straight Forward (Established) - Level 2
99213	Expanded-Low Complexity - Level 3
99214	Detailed-Moderate Complexity - Level 4
99215	High Complexity -Level 5

*Covered for patients with diabetic diagnoses only

- **Claims submission.** You'll file claims for these members through the online claims system. Simply click the "Medical" tab on the Member Details screen to begin. Make sure to include the correct diagnosis code during the claims submission process.

TRICARE through Humana Military

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

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

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

You'll use Humana Military's provider self-service to look up eligibility and file electronic claims.

Wisconsin Physicians Service (WPS), Humana Military's claims processing partner, pays claims for TRICARE services.

Dual-eligible members

- **Medicare and Medicaid dual-eligible members.** Regulatory Requirements for Joint CMS/State sponsored Medicare-Medicaid Financial Alignment Demonstration or its successor ("Demonstration"). The Demonstration will provide for managed care plan coordination of both the Medicare and Medicaid benefits for those Medicare Advantage Members who are dually eligible for both and who enroll in a health benefits plan offered by Plan pursuant to the Demonstration ("Demonstration Members"). In addition to any other Medicare Advantage requirements, you agree that:
  a) Services will be provided in a culturally competent manner to all Demonstration Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
  b) Your locations shall be accessible and able to accommodate the needs of Demonstration Members with disabilities per the Americans with Disabilities Act (ADA).
  c) Demonstration Members shall have zero cost share responsibility and Demonstration Members will not be held liable for same.
  d) You agree to accept as payment in full for Covered Services rendered to Demonstration Members, the lesser of billed charges or EyeMed's rates set forth in your contract with EyeMed.

Humana Select and Humana Medicare plans in Virginia

- **Virginia Medicaid Web Portal.** DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations and electronic copies of remittance advices.
  - Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov.
  - If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 866.352.0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays.

- The MediCall audio response system provides similar information and can be accessed by calling 800.884.9730 or 800.772.9996. Both options are available at no cost to the provider.
- Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

- **Copies of manuals.** DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.
  - The Internet is the most efficient means to receive and review current provider information.
  - If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 804.780.0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.
- **"HELPLINE."** The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern time, except on holidays. The "HELPLINE" numbers are:
  - 804.786.6273 Richmond area and out-of-state long distance
  - 800.552.8627 All other areas (in-state, toll-free long distance)
  - The "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Johnson & Johnson

- **Paid-in-full annual supply of contact lenses.** Johnson & Johnson member receive a paid-in-full annual supply, as defined by the manufacturer's guidelines, of contact lenses manufactured/marketed by Johnson & Johnson (ACUVUE).
  - Reimbursement is 100% up to MSRP. Refer to the member's benefit for details.
  - MSRP 2020
  - Contact lens code modifier list

Lahey Health (MA)

- **Referrals to Lahey Health facilities.** You must refer Lahey members who require referrals for additional treatment (for conditions such as glaucoma and cataracts) back to their hospital for additional medical care as needed.

Los Angeles Airport Peace Officers Association (LAAPOA)

- **Covered plano sunglasses.** Members of the Los Angeles Airport Peace Officers Association (LAAPOA) plan have a benefit that covers 1 pair of sunglasses each plan year, including plano sunglasses.
  - Members of **group ID 9680497** have a separate plan that covers non-tinted eyewear.
  - The LAAPOA sun plan has no copay for lenses and a $100 frame allowance.
  - This is the only exception to our normal policy, which excludes non-prescription glasses from benefits.

Northern Michigan University

- **Safety eyewear.** Northern Michigan University lets members use their routine vision plan for safety eyewear.
  - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
  - Don't use the contracted lab network for safety eyewear under this plan.

Priority Health

- **Routine benefits based on member diagnosis.** Priority Health determines whether services are covered by routine vision or medical benefits based on the member's diagnosis. If the member's primary diagnosis is 1 of the codes listed below, file the claim with us. Any other codes are considered medical, and you should file the claims directly with Priority Health.
  - Hyperopia H52.01 – H52.03
  - Myopia H52.10 – H52.13
  - Astigmatism, unspecified H52.201 – H52.209
  - Regular astigmatism H52.221 – H52.229
  - Irregular astigmatism H52.211 – H52.219
  - Anisometropia H52.31
  - Aniseikonia H52.32
  - Presbyopia H52.4
  - Transient refractive change H52.6
  - Unspecified disorder of refraction and accommodation H52.7
  - Emmetropia

Quad/Graphics

- **Safety eyewear.** Quad/Graphics allows members use their routine vision plan for safety eyewear.
    - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
    - Don't use the contracted lab network for safety eyewear under this plan.

Railroad Employees National Vision Plan

- **Safety eyewear.** Railroad Employees National Vision Plan allows members use their routine vision plan for safety eyewear.
    - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
    - Don't use the contracted lab network for safety eyewear under this plan.
- **Post-cataract contact lenses.** Railroad Employees National Vision plan members may have a benefit for contact lenses after cataract surgery.
    - The benefit covers 1 paid-in-full contact lens per eye following surgery and is available once per each surgery the member has.
    - Submit a CMS 1500 form.
        - Write "Railroad Employees Post-Cat Plan" on the top of the form.
        - Put the date of the surgery on the claim form.

SCAN Health Plan

- **CPT codes for diabetic retinopathy.** To allow for specific reporting of diabetic retinopathy, use these disease diagnosis codes for SCAN members:
    - CPT II 3072F for low risk for retinopathy (no evidence of retinopathy in the prior year)
    - CPT codes 92004, 92014, 92012 and 92002 or CPT II code 3072F for NO diabetic retinopathy

Sentara Health Plans (VA and NC)

- **Safety eyewear.** Sentara allows members use their routine vision plan for safety eyewear.
  - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
  - Don't use the contracted lab network for safety eyewear under this plan; file the claim using a CMS 1500 form.

State of Delaware

Vision therapy benefits

- **Covered services.** The State of Delaware vision plan includes benefits for vision therapy evaluation and therapy sessions as detailed in the following:

Vision care service	Patient payment
Exam evaluation* – 1 every 12 months	$0
Therapy sessions** – Up to 10 every 12 months	25% of RETAIL
Exam evaluation* – 1 every 12 months	$0

*CPT Code 92060: Sensorimotor examination with multiple measurements of ocular derivation, with interpretation and report.

**CPT Code 92065: Orthoptic and/or pleoptic training, with continual medical direction and evaluation.

- **Qualifying conditions.** To qualify for vision therapy benefits, the member must meet 1 or more of the following conditions:
  - *Accommodative disorders*
    - Paresis of accommodation H52.54 – H525.29
    - Complete internal opthalmoplegia H525.11 – H525.19
    - Spasm of accommodation H52.531 – H52.539
  - *Amblyopia*
    - Strabismus amblyopia H53.031 – H53.039
    - Refractive amblyopia H53.021 – H53.029
  - Non-strabismic binocular disorders
    - Binocular vision disorder, unspecified H53.30
    - Suppression of binocular vision H53.34
    - Simultaneous visual perception without fusion H53.33
    - Fusion with defective stereopsis H53.32
    - Intermittent heterophoria, unspecified H50.30
    - Heterophoria, unspecified H50.40
    - Esophoria H50.51
    - Exophoria H50.52
    - Vertical hyperphoria H50.53
    - Cyclophoria H50.54
    - Alternating hyperphoria H50.55

- Spasm of conjugate gaze H51.0
- Convergence insufficiency or palsy H51.11
- Convergence excess or spams H51.12
- Anomalies of divergence H51.8

- *Strabismus*
  - Monocular esotropia with other noncomitances H50.041 – H50.042
  - Alternating esotropia H50.05
  - Alternating esotropia with a pattern H50.06
  - Alternating esotropia with v pattern H50.07
  - Exotropia, unspecified H50.10
  - Monocular exotropia H50.111 – H50.112
  - Monocular exotropia w/ other noncomitances H50.141 – H50.142
  - Alternating exotropia H50.15
  - Alternating exotropia w/ other noncomitances H50.18
  - Intermittent esotropia monocular H50.31 – H50.332
  - Intermittent esotropia alternating H50.32
  - Intermittent exotropia alternating H50.34
  - Hypertropia H50.21 – H50.22
  - Hypotropia H50.21 – H50.22
  - Cyclotropia H50.411 – H50.412
  - Monofixation syndrome H50.42
  - Accommodative component in esotropia H50.43

Tufts Health Plan

- **Therapeutic and post-cataract reimbursements.** You'll be paid according to the Tufts Therapeutic benefits fee schedule for any claims for Therapeutic services, or materials after cataract surgery.
- **Primary eye care reimbursements.** Primary eye care plans follow the below fee schedules:
  - Massachusetts

Tufts Health Plan primary eye care exceptions

- **Routine vision and primary eye care by provider type.** The primary diagnosis codes submitted on the claim will determine whether the exam is paid under the member's routine vision care or primary eye care plan. Follow the guidelines below to ensure your claim is paid appropriately and quickly.

Provider type	Primary diagnosis code*	Secondary diagnosis code*	Type of benefits	Claim filing process
Optometrist	Routine	Routine or Medical	Routine	Online Claims System
	Medical	Routine or Medical	Medical Eye Care	CMS 1500 Form
Ophthalmologist	Routine	Routine or Medical	Routine	Online Claims System
	Medical	Routine or Medical	Medical	Tufts medical claim process

*In most cases, if the member has a pre-existing high-risk medical condition, the primary diagnosis code will be for routine eye care. The medical condition would then

be submitted as a secondary diagnosis code. If the member comes to you for treatment of complications or symptoms of a medical condition, or such symptoms prevent you from obtaining a quality refraction, the medical condition would be considered the primary diagnosis and the eye exam would be covered by the member's medical eye care benefits.

- **Diagnosis code classifications by age.** Use the below as a guide for determining whether a condition is considered medical or routine under Tufts:

ICD-10 Diagnosis Codes	Primary Diagnosis	Age 18 or under	Over age 19
H53.0001 – H53.029	Amblyopia	Medical	Routine
H50.000 – H50.008	Esotropia	Medical	Routine
H50.10 – H50.18	Exotropia	Medical	Routine

- **Medical diagnosis codes.** If any of the below diagnoses are listed as the primary diagnosis, the claim will be paid as medical.

ICD-10 Diagnosis Codes	Diagnosis
H26.0001 – H26.9	Cataract
E11.9 – E10.8, E08.15 – E13.39, E08.311	Diabetes
H40.0001 – H40.9	Glaucoma
H35.031 – H35.039, H01.001 – H01.009, H43.811 – H53.819	Other

  - If you put a medical diagnosis code in the primary diagnosis field of the claim, we'll deny the claim.

Medicare Preferred member therapeutic lens/post-cataract exception

- **Post-cataract eyewear.** Tufts Health Plan **Medicare Preferred** members are covered for one pair of standard eyeglasses or contact lenses if their prescription changes after cataract surgery.
  - After cataract surgery, the plan covers only corrective lenses or frames without a lens implant (tints, anti-reflective coating, UV lenses or oversized lenses), and only when a treating physician deems it medically necessary.
  - No prior authorization is required.
- **Eyewear in the event of prescription change.** These members are also covered for 1 pair of standard eyeglasses every year (includes standard frames and single-vision, bifocal or trifocal lenses) or contact lenses per prescription change for keratoconus, anisometropia (more than 3.0 diopters) or high myopia (more than 7.0 diopters). No prior authorization is required.
- **Filing claims for Tufts post-cataract eyewear.** File claims for this benefit online.

Commercial member therapeutic/post-cataract lens benefits

- **Qualifying conditions.** Tufts Health Plan commercial member therapeutic/post-cataract lens is available for patients who have lost the natural lens of the eye, experienced vision loss or experienced a vision change. The member must be under the care of a physician for one of the qualifying conditions listed below.
    - Aphakia
    - Post-cataract surgery
    - Additional conditions:
    - Keratoconus
    - Anisometropia (more than 3.0 diopters)
    - High myopia (more than 7.0 diopters)
    - Persistent epithelial defects
    - Post-corneal-transplant perforations
    - Aniridia
- **Covered benefits.** Members receive additional lens benefits if they meet a defined criterion that qualifies the eyewear as "therapeutic."
- **First-time therapeutic/post-cataract lens benefits.** The first time a Tufts Health Plan commercial member uses the therapeutic/post-cataract lens benefit, there's no pre-authorization required. Complete and fax a CMS 1500 claim form to 866.293.7373.
- **Additional therapeutic/post-cataract lens benefits in a calendar year.** If a member wishes to use the therapeutic/post-cataract lens benefit for a second time in a calendar year, obtain prior authorization from Tufts Health Plan, unless the member is requesting the lens post-cataract surgery.
    - To request pre-authorization, fax a letter of medical necessity to the Tufts Health Plan Pre-certification Department at 617.972.9409.
    - If you receive approval for the benefit, complete a CMS 1500 claim form for the service and fax it with a copy of the pre-authorization letter from Tufts Health Plan to 866.293.7373.

Vision therapy for Commercial members

- **Vision therapy benefits.** Tufts Health Plan Commercial members are eligible for vision therapy benefits up to a maximum of 30 visits per lifetime.
- **Claims submission.** For Tufts Health Plan, the vision therapy CPT code is 92065 and you can only submit 1 claim per visit. Fax the completed CMS 1500 claim form to 866.293.7373.

Universal Forest Products (through Aetna Vision)

- **Safety eyewear.** Universal Forest Products allows members use their routine vision plan for safety eyewear.
  - When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear.
  - Don’t use the contracted lab network for safety eyewear under this plan.

Xerox

- **Additional eyewear for children.** Kids under age 13 can receive a second pair of covered lenses during the benefit year if they experience a diopter change of + or - .50 or more.

Provider Manual – US Laser Network

Empire BlueCross

An Anthem Company

PROVIDER MANUAL

PROVIDER RELATIONS DEPARTMENT
PHONE: 855-450-3937
FAX: (513) 792-5623
E-MAIL: managedcare@lca.com

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I. INTRODUCTION

I. INTRODUCTION

Welcome to the U.S. LASIK Network. We look forward to your participation as a provider of laser vision services. This Provider Manual contains information to assist you to complete requirements to be a participating network provider. The Provider Relations Department at LCA-Vision's corporate headquarters will be available to assist you at any time. We value each of the selected providers in this quality network. Our goal is simply to direct patients to our network providers while keeping the processes simple and easy to manage.

Company Background

LCA-Vision, is a leading provider of fixed-site laser vision correction services. Our U.S. Laser Network and its participating vision centers provide the staff, facilities, equipment and support services for performing laser vision correction that employ FDA-approved laser technologies to help correct nearsightedness, farsightedness and astigmatism. Our vision centers are supported by credentialed ophthalmologists and optometrists, as well as other healthcare professionals. The ophthalmologists perform the laser vision correction procedures in our vision centers, and the ophthalmologists or optometrists conduct the pre-procedure evaluations and post-procedure follow-ups appointments.

LCA-Vision currently operates the Lasik*Plus, TLC Laser Eye Centers and The Lasik Vision Institute* free-standing laser vision correction centers, generally located in large metropolitan markets throughout the United States. LCA-Vision centers have performed over 6 million laser vision correction procedures in our vision centers in the United States and Canada since 1991.

LCA-Vision and the centers they operate provide customized procedures in all of our markets using state-of-the-art technology, including VISX Star 4, Wavelight Wavefront Optimized, and Contoura technology. To perform a customized treatment, we use digital technology to identify and measure imperfections in an individual's eyes to precisely diagnose and treat the front surface using all laser LASIK technology. The lasers also track and monitor the movements of the eye to provides greater precision and accuracy during the treatment.

LCA-Vision has also developed a LASIK Network, a nationwide network of over 400 laser vision providers with approximately 680 offices throughout the U.S. This network offers extensive geographic coverage for members we serve in the U.S. As a participating provider in this panel, our surgeons make laser vision correction more available and affordable to millions of potential new patients. In return, our provider's gain access to millions of covered lives under management through LCA's affiliation with many of the leading health and vision insurers in the industry.

The laser vision correction benefit allows members of these plans to receive special pricing from LCA's provider panel of LASIK surgeons, including LCA-Vision's own Lasik*Plus* centers. Approximately, 96% of all members have at least one provider within a 50-mile radius of their home.

All practitioners in the network are credentialed by an outside CVO (Credentialing Verification Organization) that meets NCQA (National Committee on Quality Assurance) standards.

II. PROCESS OVERVIEW

II. PROCESS OVERVIEW

This section discusses the patient process flow, the network provider's role, and the role of LCA-Vision in the process and management of the LASIK Network.

The goal of LCA-Vision is to simplify the process and paperwork required by the providers. These steps are outlined in Section II, Process Overview, Provider Role.

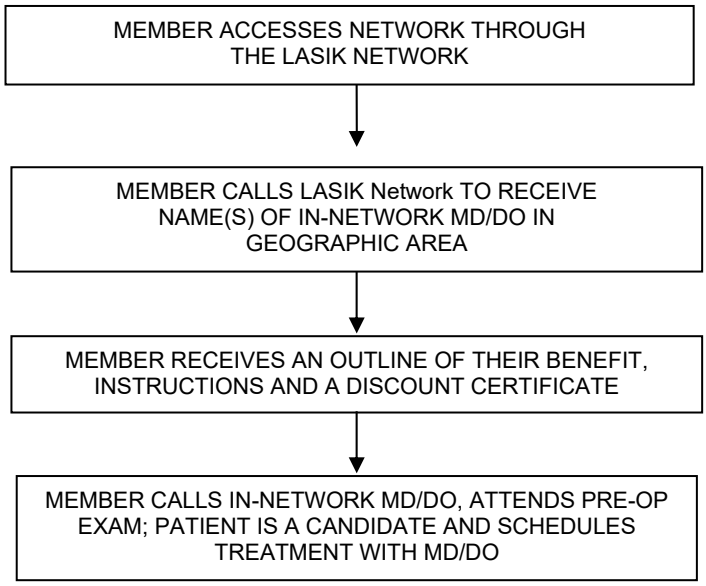
II. PROCESS OVERVIEW

1. Patient learns about the laser vision correction benefit in their member materials via hard copy or on-line.

2. Patient calls LCA's Call Center. The patient receives direction to a network MD/DO. Patient information is entered into the LCA database.

3. Patient has an initial screen with the MD/DO. Candidacy is confirmed and a treatment date is scheduled.

MEMBER FLOW MODEL



PROVIDER ROLE
PATIENTS ACCESSING NETWORK

Our goal in this network is to simplify the process and paperwork for the provider.

Complete these steps for each patient

1. ***SCHEDULE TIMELY APPOINTMENTS FOR PATIENTS***
    - Patients should be scheduled **within 2 weeks** from their phone call for the initial eye exam
    - Patients should be scheduled **within 6 weeks** for treatment following initial eye exam.

2. ***DEDUCT THE APPROPRIATE DISCOUNT***

    Provider's staff will be responsible for deducting the appropriate member discount, as outlined below.
    - Discount is 15% off of provider's Standard charge for LASIK or 5% off of any promotional price, whichever results in the lesser price for the member.

ROLE OF LCA-VISION

1. ***PROVIDER RELATIONS DEPARTMENT*** Provides assistance as needed to the network provider and his/her own staff.

2. ***PATIENT TOLL-FREE CALL CENTER***
   LCA-Vision will provide a toll-free number for patients to receive direction to a LASIK Network provider and assist the patient.

3. ***MEMBER INSTRUCTIONS AND DISCOUNT CERTIFICATE***
   LCA-Vision will e-mail members instructions to utilize their discount as well as a discount certificate. This certificate is intended to help your staff recognize the vision plan and is not required for the member to receive the discount.

4. ***CREDENTIALING***
   LCA-Vision will initially credential as well as recredential all providers in the network every three years.

5. ***QUALITY ASSURANCE PROGRAM***
   LCA-Vision manages the Quality Assurance program for the network.

6. ***SATISFACTION SURVEY***
   Each patient will receive a survey to be completed and sent to LCA one month after the treatment date. Provider will receive his/her own results on a quarterly basis or as needed.

III. TRAINING REQUIREMENTS

III. TRAINING REQUIREMENTS

This section outlines the training requirements for personnel. Any new staff that requires training as outlined in this section needs to forward the certificates to LCA-Vision prior to patient treatment. The minimum requirements for Lasers and Facilities are also outlined in this section. Attach the required certificate(s) to the Staff Training Documentation form in Section III, Training Requirements.

III. TRAINING REQUIREMENTS

MINIMUM REQUIREMENTS FOR PERSONNEL

LCA-Vision, through its Quality Assurance Program, ensures that all network providers offer Covered Services to patients with personnel who satisfy the minimum requirements established under the terms of the policies set forth.

Personnel Minimum Requirements

POLICY STATEMENT: Equipment that requires specific training (more than mere in servicing) shall be operated only by individuals trained and certified to do so.

METHOD:

1. Individuals operating an approved laser shall be able to present documentation of certification by the manufacturer that they have successfully completed an authorized laser training course.

   In the event no certificates were awarded at the time of training and the employee has been operating the laser successfully prior to this policy, documentation in the form of a letter signed by a staff physician or Medical Director who has worked with the employee for more than 10 cases is acceptable. The letter shall state the employee's experience and working knowledge of the laser and its operation. LCA and/or its Credentialing Verification Organization reserve the right to verify this documentation.

2. Microkeratomes shall be assembled, maintained, and operated only by individuals who can present documentation of certification by the manufacturer of the microkeratome that they have successfully completed an authorized training course.

U.S. LASER NETWORK

STAFF TRAINING DOCUMENTATION FORM

This form must be completed before new staff members provide laser vision correction patient care.

Initially, the provider was required to send all staff personnel credentials on the Provider Information form. Any personnel hired after the date of that initial form must submit the information requested below and attach their laser and/or microkeratome training course certificates to this form.

New Employee Name:_____

Date of Hire:_____

Employed by Physician☐ Employed by Facility☐

Physician's Name:_____

Physician Practice Name:_____

Address:_____

City, State, Zip:_____

Work Phone:_____ Fax #:_____ E-Mail:_____

Laser Facility::_____

Address:_____

City, State, Zip:_____

Work Phone:_____ Fax #:_____ E-Mail:_____

Form completed by:_____ Date:_____

LCA-Vision, Inc., 7840 Montgomery Road, Cincinnati, OH 45236
Fax #513/792-5623 E-MAIL ADDRESS: managedcare@lca.com

MINIMUM REQUIREMENTS FOR LASERS AND FACILITIES

LCA-Vision, through its Quality Assurance Program, ensures that all network providers offer covered services to patients only on qualified lasers and qualified microkeratomes.

Laser Minimum Requirements

The following lasers meet the criteria.

- VISX
- AUTONOMOUS (ALCON)
- NIDEK
- LADARVISION (ALCON
- APEX PLUS (ALCON)
- BAUSCH & LOMB
- LASERSIGHT
- WAVELIGHT

Microkeratome Minimum Requirements

The following microkeratomes meet the criteria.

- CHIRON, (ACS)
- CHIRON, HANSATOME
- MORIA
- INNOVATOME
- AMADEUS

Topography:

The following topography equipment meets the criteria.

- Eyesys
- Tomey
- Humphrey
- Alcon
- Orbscan
- Technomed
- Par

IV. CREDENTIALING

IV. CREDENTIALING

WHAT IS CREDENTIALING?

Simply stated, Credentialing is the process that enables managed care networks to verify that its participating providers meet established levels of competency and quality before servicing its valued members. This is accomplished through a systematic, continuous, and verified review of the network providers' credentials and approval of such by a credentialing committee consisting of similarly licensed providers. The review includes and screens for the following:

Ophthalmologist (MD) and Doctor of Osteopathic Medicine (D.O.):

1. A completed credentialing application (see enclosed)
2. Five-year work history
3. Three professional references
4. Has and maintains a license in the state(s) where (s)he practices
5. Graduation from medical school and completion of residency
6. Valid DEA or state narcotics certification, as applicable
7. Board certification, if the practitioner states that (s)he is board certified
8. Has and maintains at least $1 million per occurrence and $3 million aggregate in professional liability insurance with no restrictions regarding refractive surgery
9. Has no history of Medicare/Medicaid fraud
10. Is not a convicted felon
11. Has no pattern of malpractice judgments or settlements involving issues related to patient safety or welfare, professional competence, or conduct unbefitting a physician.
12. LASIK settlements or judgments must not exceed three occurrences in the most recent 5 years.
    a. In addition to verification of the previously requested basic privileging requirements, those applicants who perform laser vision correction services shall provide a signed attestation of their completion of an approved laser and microkeratome manufacturer course for refractive surgeons,
13. LCA-Vision reserves the right to change the credentialing process as necessary.

WHY IS CREDENTIALING PERFORMED?

Credentialing is performed for three basic reasons:

1. One of LCA-Vision's goals is to ensure that its patients receive quality care from a panel of quality providers.

2. Our plan sponsors require that only credentialed providers service its patients in order to be compliant with the National Committee for Quality Assurance (NCQA) recommendations.

3. Thus, not only is credentialing an overall beneficial process, but it also has become an industry requirement for managed care providers. All managed care networks must abide by recommendations instituted by NCQA, and the credentialing process is one of those standards to which LCA-Vision must adhere.

HOW DO I COMPLETE THE CREDENTIALING APPLICATION?

To complete the application, simply follow the instructions below.

1. Complete all fields of the credentialing application. All boxes must be filled out with either your information or with an “N/A” (non-applicable).

2. Gather the following seven (7) items for submission:
    a. Curriculum Vitae.
    b. A copy of your Current State(s) License in which you currently practice, with expiration date(s).
    c. A copy of your Certificate of Insurance/Policy face sheet with professional (malpractice) liability coverage (with no restrictions regarding refractive surgery) totaling a minimum of $1 million per occurrence/$3 million per aggregate for MDs and DOs. The insurance expiration date must also be present on the face sheet.
    d. Drug Enforcement Administration and/or Controlled Dangerous Substance certificates (if applicable).
    e. Board certificates (if applicable).
    f. Educational Commission for Foreign Medical Graduates certificate (if applicable)
    g. Attestation of laser vision correction certification(s)

3. Return the application and all requested documents Remember, you cannot service or be paid for any **LASIK Network** patients unless you are credentialed.

CREDENTIALING STEPS

STEP 1:

After LCA-Vision receives your completed application.

- The Provider Relations department reviews the file to ensure that all required unexpired documents are enclosed.

- The application is then sent to our contracted Credentialing Verification Organization (CVO) who verifies that all information contained within the application is authentic. In addition, our CVO conducts primary source verification for each answer provided on your application (e.g. checks education, queries the Medicare/Medicaid database, and reviews the National Practitioner Data Bank for claims/settlements).

Normal verification requires 60 days to process. For more information, contact LCA-Vision's Provider Relations Department, at 800-688-4550, ext. 379 or 327.

STEP 2:

Once we receive the file from our CVO.

- Our Provider Relations Department reviews your file.

- Based upon pre-determined standards set by LCA-Vision, the Credentialing Committee approves or denies the application for network participation.

- A letter will be sent to notify you of the decision.

This process takes approximately one – two weeks.

Once the credentialing application has been approved, the provider is eligible to service patients, based upon the contracts that are signed and return.

The "Normal" credentialing process averages 45 business days.

CREDENTIALING STEPS
(Continued)

STEP 3:

Once approved, it is each provider's responsibility to continually maintain all credentialing requirements (e.g. current state license and current liability insurance coverage) in order to sustain his/her status as an LCA-Vision provider.

Thereafter, according to Quality Assurance guidelines, each provider must repeat the process at least every 36 months. This process is known as **recredentialing**. Our CVO will automatically send you a recredentialing application before your 36-month credentialing anniversary.

PLEASE PRINT OR TYPE

INSTRUCTIONS

1. This form should be typed or legibly printed in blue or black ink.

2. Complete each applicable section. If a section does not apply, check the N/A box.

3. Attach copies of supporting documents:
   - ☐ Curriculum Vitae
   - ☐ Current medical license(s)
   - ☐ DEA / DPA / TPA / CDS certificate(s)
   - ☐ A copy of your Certificate of Insurance/Policy face sheet with professional (malpractice) liability coverage (with no restrictions regarding refractive surgery) totaling a minimum of $1 million per occurrence/$3 million per aggregate for MDs and DOs, $1 million/$2 million for ODs. The insurance expiration date must also be present on the face sheet.
   - ☐ Board certificates(if applicable)
   - ☐ Documentation of laser vision correction experience (Refer to Provider Manual, Section VII, Credentialing, Item 15, for source of documentation).
   - ☐ ECFMG (if applicable)

4. Read, sign (in ink), and date the following:
   a. "Attestation of Credentials & Release Form with Acknowledgment of Penalty Statement" (page 11)

5. Practice Information (please check appropriate box)
   ☐Employed By Whom/What Corporation:_____
   ☐Subleased

6. Return Credential form to:

LCA VISION INC.
ATTN: PROVIDER RELATIONS DEPARTMENT
7840 MONTGOMERY ROAD
CINCINNATI, OH 45236

Telephone Number #1-800-688-4550, X 366 or 379

Please direct any questions to LCA VISION at the above address and telephone number.

LIST OF ABBREVIATIONS

ADA____Americans with Disabilities Act
CDS____Controlled Dangerous Substance
DEA____Drug Enforcement Administration
DPA____Diagnostic Pharmaceutical Agent
TPA____Therapeutic Pharmaceutical Agent
ECFMG__Educational Commission for Foreign Medical Graduates
UPIN____Universal Provider Identification Number

08/28/98

V. QUALITY ASSURANCE PROGRAM

V. QUALITY ASSURANCE PROGRAM

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INTRODUCTION
LCA-VISION
QUALITY ASSURANCE PROGRAM

LCA-Vision has established a network of qualified providers of laser vision correction services ("Network Providers") to provide such services to the members and enrollees of employers, employee organizations, health maintenance organizations and other third-party purchasers ("Purchasers") that want to include discounted laser vision correction services with their employee vision benefit plans.

LCA and the Network Providers affiliated with LCA are committed to providing quality laser vision correction services to the people we serve.

All Providers entering into the LCA Third Party Provider Agreement or any other applicable agreement entered into between LCA or its affiliates and the Provider to provide services as Network Providers, where not prohibited by law, shall be subject to the LCA-Vision Professional Network Medical Advisory Board Review and Quality Assurance Program. Nothing herein shall preclude the Provider from complying with any other applicable quality assurance programs required by any Plan Sponsor or federal or state regulatory agency.

The Quality Assurance Program now includes:

- **Network Medical Advisory Board**
  Develops and implements a Professional Peer Review program to ensure a higher level of quality assurance among network providers.
- **Patient (Member) Surveys**
  Systematic patient input on laser vision correction services provided.
- **Credentialing**
  Source verification of Providers by an outside firm to ensure National Committee for Quality Assurance (NCQA) levels. This includes verifying education, licenses, insurance, DEA and claims history from National Practitioners Data Bank (NPDB).
- **Continuing Education**
  Oversees development of and evaluates educational programs in improving quality of care.
- **Product Quality Assurance**
  Oversees evaluation of protocols/monitors results. Makes recommendations on implementation of new technology.
- **Outcomes Evaluations**
  Periodic review of post-operative data to produce outcomes studies.

- **Research**
  Designs, oversees, and participates in research projects as needed.

The Quality Assurance Program is mandatory for all affiliated Providers participating in LCA Provider Agreements and any other applicable agreement between LCA and Provider. The Network Medical Advisory Board is made up of at least five (5) voting Providers, including at least four (4) practicing ophthalmologists and at least one (1) practicing optometrist. Additional ophthalmologists or optometrists may be added to the panel from time-to-time as needed.

The charge of the Network Medical Advisory Board is to judiciously direct the Quality Assurance Program in such a manner as to continually ensure the delivery of quality laser vision correction services by LCA affiliated Providers and to respect the confidentiality of patient and Provider.

ARTICLE I

BYLAWS OF THE LCA-VISION NETWORK MEDICAL ADVISORY BOARD

A. PURPOSE

The LCA-Vision Network Medical Advisory Board ("Network Medical Advisory Board") shall be responsible for addressing the professional issues set forth in these Bylaws and as provided in the LCA Provider Agreement or any other applicable agreement entered into between LCA and the doctor ("Provider").

B. COMPOSITION

The Network Medical Advisory Board (the “Board”) shall consist of at least five (5) voting members. Members must be Providers affiliated with LCA and must be signatories to the LCA Third Party Provider Agreement or any other applicable agreement entered into between LCA and the Provider. At least four (4) members of the Board must be practicing ophthalmologists. At least one (1) member must be a practicing optometrist. The Medical Director of LCA-Vision (“Medical Director”) will be the Director of the Network Medical Advisory Board and shall serve as an ex-officio member, without a vote. The Director of the Network Medical Advisory Board may change the size of the Network Medical Advisory Board from time to time as appropriate. Network Medical Advisory Board members shall be selected as provided in Section I.

C. DUTIES

The Network Medical Advisory Board shall be responsible for recommending standards for instrumentation, examination procedures, treatment protocols, referral procedures, documentation and follow-up care. The Network Medical Advisory Board shall also be responsible to establish and/or modify the parameters for credentialing, reviewing referred Provider’s profiles and determining whether to discipline, suspend or terminate a Provider's participation in LCA’s network of Providers where the Provider: (1) consistently fails to adhere to the professional standards adopted by the Network Medical Advisory Board, or (2) engages in conduct which constitutes a material threat to the health, safety or welfare of patients. All actions of the Network Medical Advisory Board are subject to the review approval of the Board of Directors of LCA-Vision (“Board of Directors”).

D. PROCEDURE FOR PROVIDER REVIEW

If based upon information made available to the Network Medical Advisory Board from patient grievances or surveys, quality assurance and/or utilization management audits, or complaints from other Providers, the Board of Directors, Plan Sponsors or other sources, the Network Medical Advisory Board concludes that the Provider acted in a manner which (1) consistently fails to adhere to the Professional Standards adopted by the Network Medical Advisory Board (2) engaged in conduct which constitutes a material threat to the health, safety or welfare of patients, the Director can appoint a Fact Finding Committee of three (3) Providers who are similarly licensed as the Provider to investigate the matter. Written notice of the investigation shall be provided to the Provider by the Director of the Network Medical Advisory Board, including a summary of the nature of the allegations and the evidence which supports the need for the investigation, by certified mail. The Provider shall have thirty (30) days in which to respond to the allegations in writing. The Provider's written response shall be addressed to the Director of the Network Medical Advisory Board sent by certified mail. The Director of the Network Medical Advisory Board shall provide the Fact Finding Committee with a copy of the Provider's written response.

The Fact Finding Committee shall be appointed by the Director of the Network Medical Advisory Board and consist of at least three (3) Providers who are similarly licensed to the Provider under review. No member of the Fact Finding Committee shall be in direct economic competition with the Provider under review by practicing eye care in the same competitive geographic area.

The Fact Finding Committee shall commence an investigation within fifteen (15) days of appointment. The review may consist of, but is not limited to, a review of patient records, business records, audits, patient surveys, interviews with persons involved in any patient incident, or any other relevant documentation related to the case which triggered the review and any other case which the Fact Finding Committee learns of in the course of its review. All information reviewed or generated during the review process is deemed to be privileged and confidential subject to the protections set forth in the Health Quality Improvement Act of 1986 and the relevant state quality assurance and review statutes.

If the Provider wishes to attend a meeting of the Fact Finding Committee to address the allegations in person, the Provider shall make such arrangements through the Director of the Network Medical Advisory Board. Reasonable efforts shall be made to permit the Provider to attend a portion of the Fact Finding Committee's meeting to present his/her response and to answer any questions by

Fact Finding Committee members. Neither the Provider nor the Fact Finding Committee shall have legal counsel present at such meeting.

The recommended time frame for a review by the Fact-Finding Committee is thirty (30) days wherever possible. Meetings of the Fact Finding Committee may occur pursuant to a conference telephone call or similar communication equipment by means of which all persons participating in the meeting can hear each other and such participation shall constitute presence in person at the meeting. The Director may assign staff from Provider Relations to assist with arranging meetings, providing Committee members with documentation and recording the minutes of the Committee's meeting.

At the end of the investigation, the Fact-Finding Committee reports to the Director of the Network Medical Advisory Board in writing with a copy to the Provider. The Fact Finding Committee may:

a. Determine that no corrective action is warranted and, if appropriate, remove any reference to the investigation from the Provider's file;

b. Defer action for a reasonable time for good cause shown;

c. Issue a letter of reprimand, censure or warning to the Provider through the Director of the Network Medical Advisory Board; or

d. Recommend to the Board of Directors that it take action in connection with the Provider's network membership status, including, limitation, termination, suspension or revocation.

If there is an adverse recommendation by the Fact Finding Committee based upon the professional competence or conduct of the Provider which constitutes a material threat to the health, safety or welfare of patients which is reportable (on a voluntary or mandatory basis) to the National Practitioner Data Bank by LCA and, which, if approved by the Board of Directors, would result in:

(1) the Provider's participation in LCA's network of Providers being limited or suspended for a period of more than thirty (30) days, or (2) the Provider's termination from the network of Providers, the Provider shall have the right to a hearing and appellate review as set forth in Article III hereof prior to consideration by the Board of Directors.

If the adverse recommendation by the Fact Finding Committee is not based upon the professional competence or conduct of the Provider which constitutes a material threat to the health, safety or welfare of patients which is reportable (on a voluntary or mandatory basis) to the National Practitioner Data Bank by LCA, but results in a letter of reprimand, warning or censure, the Provider shall have the right to place a

written objection or explanation in his/her file and submit such written objection or explanation to the Board of Directors. The Board of Directors has the authority to

review the investigation conducted by the Fact Finding Committee, if the Board of Directors deems such a review necessary and chooses to support or overturn the decision of the Fact Finding Committee.

In emergency or unusual situations and based upon his/her belief that grounds for summary action exist, the Director of the Network Medical Advisory Board with the concurrence of the Chair of the Network Medical Advisory Board, or in his/her absence, the Vice-Chair of the Network Medical Advisory Board shall have the right to suspend temporarily the ability of any Provider to see patients pursuant to any LCA Third Party Agreement or any other applicable agreement entered into between LCA and Provider. The Director of the Network Medical Advisory Board shall give prompt written notice of such action to the affected Provider by certified mail, with a copy to the Board of Directors. The patients of a suspended Provider shall be assigned to another Provider by the Director, taking into consideration, where feasible, the patient's choice. The Director of the Network Medical Advisory Board shall appoint a Fact Finding Committee within three (3) business days of such summary action. The Fact Finding Committee shall consider the summary suspension at the earliest opportunity but in no event later than fifteen (15) calendar days from the date of suspension. The Fact Finding Committee may modify or revoke the suspension.

Summary suspension action may take place only where there is an immediate threat to patient health, welfare or safety or there has been revocation or suspension of the Provider's license.

Information relating to the nature of the grievance or the status of the Provider will be treated confidentially by the Network Medical Advisory Board except to the extent that disclosure may be required by reasonable interpretation of applicable federal, state or local law or to advise Plan Sponsor's Participants or Members in accordance with the terms set forth in any LCA Third Party Provider Agreement or any other applicable agreement entered into between LCA and Provider.

E. OFFICERS

The officers of the Network Medical Advisory Board shall be a Chair and a Vice-Chair. The officers shall be elected from among the members of the Network Medical Advisory Board, by a majority vote of the members of the Network Medical Advisory Board at its first meeting each calendar year. The Medical Director of LCA-Vision shall serve as the Director of the Network Medical Advisory Board.

F. MEETINGS

The Network Medical Advisory Board shall have a minimum of two (2) meetings per calendar year and such other meetings as scheduled by the Chair or as requested by the Director of the Network Medical Advisory Board, or Board of Directors. A quorum of Network Medical Advisory Board Members must be present in order for such meetings to be held. A quorum shall consist of a majority of the voting members of the Network Medical Advisory Board. The action of a majority of the members present and voting at any meeting shall be the action of the Network Medical Advisory Board. For purposes of determining a quorum, one or more Board members may participate in a meeting of the Network Medical Advisory Board by means of a conference telephone call, or similar communication equipment by means of which all persons participating in the meeting can hear each other and such participation shall constitute presence in person at the meeting. Each member shall be provided adequate notice of each meeting, and notice shall be duly made by mail to the address of each member as maintained by LCA-Vision and mailed at least ten (10) days prior to the meeting, or made in person or by telephone at least forty-eight (48) hours in advance of the meeting.

G. STAFF SUPPORT

The Director of the Network Medical Advisory Board shall assign a staff member to assist the Network Medical Advisory Board and, when necessary, to the Fact Finding Committee and Credentialing Committee to aid in the scheduling of meetings, producing minutes of meetings, and gathering and presenting relevant information related to the purposes of the Network Medical Advisory Board.

H. TERM

The voting members of the Network Medical Advisory Board shall serve for a term of two (2) years.

I. SELECTION

The Medical Director of LCA-Vision shall select and appoint the members of the Network Medical Advisory Board. Only Providers who are signatories to the LCA Third Party Provider Agreement or any other applicable agreement entered into between the Provider and LCA or its affiliates will be selected as a voting member. Additional members must be approved by the Network Medical Advisory Board members.

J. REMOVAL

The term of service of any member of the Network Medical Advisory Board shall terminate automatically if such member ceases to meet the qualifications and requirements set forth in this Article I. In addition, any member of the Network Medical Advisory Board may be removed by the Director with the support of a majority vote of the Network Medical Advisory Board, if it is determined to be in the best interest of LCA, LCA's third-party payers or plan sponsors, patients, or other applicable programs to do so.

K. VACANCIES

A vacancy on the Network Medical Advisory Board shall be filled in accordance with the selection procedure in Section (I). The replacement must meet the requirements for the position, which has been vacated.

L. AMENDMENTS

Recommended amendments to these Bylaws of the Network Medical Advisory Board proposed by its Director or Chairperson may be made by majority vote of the members present and voting at any meeting of the Network Medical Advisory Board. These recommended amendments shall be submitted by the Board of Directors.

M. CONFIDENTIALITY

Network Medical Advisory Board members shall sign a Confidentiality and Notification Statement agreeing to abide by LCA's policies and procedures regarding all information which is discharged, shared or any deliberations which occur pursuant to the Professional Peer Review processes, including Fact finding and Credentialing, set forth herein and all applicable federal, state and local laws and the rules of all applicable federal and state regulatory agencies regarding Professional Peer Review information. A copy of such Confidentiality and Notification Statement is attached hereto as Exhibit A. All surveyors or others being provided with access to Professional Peer Review information in accordance with applicable federal, state or local law or applicable contractual arrangements with LCA or its Providers shall be required to sign the Confidentiality and Notification Statement set forth in Exhibit A-1.

ARTICLE II

PROVIDER CREDENTIALING PROTOCOLS

A. PROVIDER CREDENTIALING PROTOCOL

1. STANDARD

The Credentialing Committee of the Network Medical Advisory Board shall be responsible for determining which eye care professionals will be in LCA's network of Providers in accordance with the parameters set forth by the Network Medical Advisory Board. This decision will be governed by a simple majority vote with each member of the Credentialing Committee having one vote. The Board of Directors of LCA-Vision shall have final approval of such credentialing decisions. The Credentialing Committee shall be empowered to credential any Provider if the Provider fulfills the criteria based on the following parameters:

Ophthalmologist (MD) and Doctor of Osteopathic Medicine (D.O.):

1. A completed credentialing application (see enclosed)
2. Five year work history
3. Three professional references
4. Has and maintains a license in the state(s) where (s)he practices
5. Graduation from medical school and completion of residency
6. Valid DEA or state narcotics certification, as applicable
7. Board certification, if the practitioner states that (s)he is board certified
8. Has and maintains at least $1 million per occurrence and $3 million aggregate in professional liability insurance with no restrictions regarding refractive surgery
9. Has no history of Medicare/Medicaid fraud
10. Is not a convicted felon
11. Has no pattern of malpractice judgments or settlements involving issues related to patient safety or welfare, professional competence, or conduct unbefitting a physician.
12. Lasik settlements or judgments must not exceed three occurrences in the most recent 5 years.
13. In addition to verification of the previously requested basic privileging requirements, those applicants who perform laser vision correction services shall provide attestation of their;
    a. certificate of completion of an approved laser and microkeratome manufacturer course for refractive surgeons;
14. LCA-Vision reserves the right to change the credentialing process as necessary.

2. COMPLIANCE

All Providers for compliance with the terms of the Professional Network

Medical Advisory Board Review and Quality Assurance Program shall, upon request by the Credentialing Committee or its staff, submit a completed credentialing application, current state medical license and certificate of professional liability insurance, the necessary releases or information required to obtain the information set forth in (a) or (b) above, a five year work history, a hospital affiliation letter for ophthalmologists and osteopaths only, and any necessary and usual credentialing or application fees.

3. LICENSE AND INSURANCE MAINTENANCE

Provider will be required to furnish the Credentialing Committee of the Network Medical Advisory Board with evidence of current state medical license and professional liability insurance certification upon expiration of either. Provider will be notified in writing, thirty (30) days prior, that their respective state license and/or professional liability insurance will be expiring. If notice of renewed license and insurance certification has not been received thirty (30) days after the expiration date, Provider will be notified in writing to forward a renewed notice of state license and/or professional liability insurance to the Credentialing Committee of the Network Medical Advisory Board. If notice of renewed state license and/or professional liability insurance has not been received by the Credentialing Committee of the Network Medical Advisory Board, the Provider will be notified in writing by the Director of the Network Medical Advisory Board that he/she is summarily suspended unless renewal notice(s) of said documentation are received immediately and that, the Credentialing Committee has recommended that the Provider's credentialed status be terminated, and that the Provider's LCA Third Party Provider Agreement or any other such applicable agreement between LCA and the Provider as well as possible termination of the Provider's real estate sublease, employment relationship, franchise agreement or other such applicable agreement, depending upon the nature of the business relationship between a specific provider and LCA be terminated as well. Notice of termination shall be submitted to the Board of Directors for final approval.

4. SUSPENSION AND REMEDIATION

If notice of renewed state license and/or professional liability insurance has not been received by Network Medical Advisory Board by the expiration date(s), the Director of the Network Medical Advisory Board will both write and telephone the Provider informing them that his/her credentialed status is suspended, he/she is in violation of his/her contractual arrangement with LCA and that the matter will be forwarded to the Credentialing Committee of the Network Medical Advisory Board for action as set forth in Section A Paragraph 3 hereof. In the event, the Provider's credentialed status is terminated by the Credentialing Committee, the Provider shall have ten (10)

calendar days to submit in writing to the Board of Directors a letter explaining his/her position on the matter.

Reinstatement of credentialed status will be granted immediately upon receipt of renewed state license and/or professional liability insurance by the Network Medical Advisory Board within thirty (30) calendar days of the expiration date(s). The Provider will be notified in writing of his/her reinstated credentialed status.

A denial of network membership by the Credentialing Committee of the Network Medical Advisory Board which was based upon the professional competence or conduct of the Provider which constitutes a material threat to the health, safety or welfare of patients which is reportable (on a voluntary or mandatory basis) to the National Practitioner Data Bank by LCA, may be appealed in accordance with the Hearing and Appeals process set forth in Article III herein applies.

A denial of an application for initial or recredentialing by the Credentialing Committee is reportable where the Provider files an application for membership in the LCA Network of Providers where the application is denied for reasons based upon the professional competence or conduct of the Provider which constitutes a material threat to the health, safety or welfare of patients.

5. STAFF SUPPORT

The Director of the Network Medical Advisory Board shall assign a staff member to the Credentialing Committee to aid in obtaining and processing applications, maintaining Provider files, scheduling meetings, producing minutes of meetings and gathering and presenting relevant information related to the purposes of the Credentialing Committee.

6. CONFIDENTIALITY AND SECURITY

All credentialing files are considered confidential and will be made available only to members of Network Medical Advisory Board and Credentialing Committee.

B. RECREDENTIALING PROTOCOL

Providers will be recredentialed a minimum of every three (3) years and will receive written notice prior to the recredentialing procedure. However, the Credentialing committee can review a provider at any time and make a recommendation to revoke network participation for any of the reasons specified in the *Denial Process* section below.

1. STANDARD

The Credentialing Committee of the Network Medical Advisory Board, upon the examination of the Provider's application for recredentialing and its accompanying documentation, member complaints, quality assurance and utilization reviews and audits, member satisfaction surveys and any external credentialing report, shall be responsible for determining which eyecare professionals will be in LCA's network of Providers in accordance with parameters set forth by the Network Medical Advisory Board. The Board of Directors of LCA Vision Corporation shall have final approval of such recredentialing decisions.

If Provider Services finds sufficient evidence to recommend "not to re-appoint" the provider as a network provider, the file is sent to the Credentialing Committee for consideration. The file is then reviewed as defined below in *Credentialing Committee Action.*

2. STANDARD

Once the provider returns the Recredentialing Application with the appropriate attachments, all relevant issues are examined and documented in the provider's credentialing file. The Recredentialing Process includes verification of the following for all Providers:

a. Completed Recredentialing Application - a completed and signed application, with all required unexpired supporting documentation and release forms,

b. Current Valid License - primary source verification from the appropriate state licensing board(s), indicating that the provider has a current license, the license number, expiration date, TPA certification, and any current or previous restrictions placed upon the license,

c. Current Professional (Malpractice) Liability Insurance - primary resource verification from current malpractice liability carrier including claims history, dates, coverage amounts equivalent to $1,000,000 per occurrence/$3,000,000 per annual aggregate (with no restrictions regarding refractive surgery for ophthalmologists and osteopaths).

d. National Practitioner Data Bank - primary source verification report from the National Practitioner Data Bank indicating any prior claim settlements or judgments.

e. Department of Health and Human Services Medicare/Medicaid Status - primary resource verification through DHHS Cumulative Sanction Report, and

f. Physical/Mental Health and Professional Status - Lack of impairment due to chemical dependency/substance abuse, history of loss of license and/or felony convictions, and history of loss or limitations of privileges or disciplinary actions.

The Recredentialing Process also includes the following verification procedures for ophthalmologists and osteopaths:

Valid DEA Certificate - Drug Enforcement Agency (DEA) certificate or verification through National Technical Information Service (NTIS) database indicating that the provider has a DEA license, the number, the expiration date, and any restrictions placed upon the DEA license when applicable and not prohibited by state law.

3. DENIAL PROCESS

Denials for recredentialing will be based upon one or more of the following reasons:

1. failure to meet credentialing or recredentialing criteria,
2. lack of a defined network need,
3. specific documented customer service issues, or
4. termination of any applicable LCA Third Party Provider Agreement or any other applicable agreement entered into between LCA or its affiliates and the Provider.

The basis for denial, along with the specific issue, will be included in a written notice from the Medical Director of the Network Medical Advisory Board to the Provider.

A denial of renewal of Network Membership by the Credentialing Committee of the Network Medical Advisory Board which was based upon the professional competence or conduct of the Provider which constitutes a material threat to the health, safety or welfare of patients which is reportable (on a voluntary or mandatory basis) to the National Practitioner Data Bank by LCA, may be appealed in accordance with the Hearing and Appeals process set forth in Article III herein applies.

4. SUSPENSION

A Provider can be reviewed for compliance with this Article II at any time. If

a material Provider issue is brought to the attention of the Credentialing Committee, the Credentialing Committee shall bring the appropriate information before the Network Medical Advisory Board, which may recommend that the Provider be temporarily suspended in accordance with the procedure set forth in Article I Section D.

C. MEMBERSHIP

The Credentialing Committee shall be appointed by the Director of the Network Medical Advisory Board and consist of at least three (3) Providers who are similarly licensed to the Provider under review.

ARTICLE III

HEARING AND APPEALS PROCESS

A. RIGHT TO HEARING AND APPEAL

1. The Provider shall have the right to a hearing pursuant to this Article III in the following circumstances:

   a. The Fact Finding Committee of the Network Medical Advisory Board makes an adverse recommendation based upon the professional competence or conduct of the Provider which constitutes a material threat to the health, safety or welfare of patients which is reportable (on a voluntary or mandatory basis) to the National Practitioner Data Bank by LCA, and, which, if approved by the Board of Directors, would result in: (i) the Provider's participation in LCA's network of Providers being limited or suspended for a period of more than thirty (30) days, or (ii) the Provider's termination from LCA's network of Providers.

   b. The Credentialing Committee denies the application of a Provider for membership in the LCA network of Providers for reasons based upon the professional competence or conduct of the Provider, which constitutes a material threat to the health, safety or welfare of patients.

2. Notice of the adverse recommendation or denial set forth in Section A Paragraph 1 herein shall be given in writing by certified mail or delivered to the affected Provider by the Director of the Network Medical Advisory Board within ten (10) calendar days after the Fact Finding Committee or Credentialing Committee delivers its adverse recommendation or denial to the Director of the Network Medical Advisory Board. The notice shall state that the Provider has thirty (30) calendar days following receipt of such notice to request a hearing in connection with the adverse recommendation or denial, shall summarize the Provider's rights during such hearing and refer the Provider to Article III hereof for the rights, obligations and rules relating to such hearing and shall contain a concise statement of the reasons for the adverse recommendation or denial.

B. LIMITATION ON CONTRACTUAL RELATIONSHIPS

Nothing in this Article III shall establish for any person the right to a hearing upon termination of Provider pursuant to terms of a written LCA Third Party Agreement or any other applicable written agreement between Provider and LCA or its affiliates where the termination is based upon issues which are not related to the professional competence or conduct of the Provider which constitutes a material

threat to the health, safety or welfare of patients which is reportable to the National Practitioner Data Bank (on a voluntary or mandatory basis) by LCA. In all such situations, the terms of the written agreement shall take precedence over these Bylaws and shall control the relationship between the Provider and LCA.

C. REQUEST FOR HEARING

The affected Provider shall have thirty (30) calendar days after receipt of written Notice of an adverse recommendation to request a hearing in connection therewith. Such a request must be in writing and must be mailed or delivered to the Director of the Network Medical Advisory Board.

Failure to make such a request within the time specified, unless for good cause shown of an emergency nature, shall be deemed a waiver of the right of the affected Provider to any further hearing or appeal, and in such case the recommendation of the Fact Finding Committee of the Network Medical Advisory Board or the denial of The Credentialing Committee as set forth in Section A hereof shall be referred to the Board of Directors for a final decision which shall be subject to no further review or appeal. Such final decision shall be made by the Board of Directors within forty-five (45) calendar days from the expiration of the afore-mentioned time period, shall be in writing and shall be submitted to the affected Provider with a copy to the Director of the Network Medical Advisory Board.

D. NOTICE OF HEARING

Upon timely receipt of a request for hearing, the Director of the Network Medical Advisory Board shall set a date, time and place for the hearing, which date shall not be less than thirty (30) calendar days after the date of the Notice, and shall send a written Notice of the same to the requesting affected Provider with a list of witnesses (if any) expected to testify at the hearing on behalf of LCA.

E. COMPOSITION OF HEARING PANEL

1. Where the Fact Finding Committee of the Network Medical Advisory Board or Credentialing Committee makes an adverse recommendation or denial of application as set forth in Section A hereof, the Director of the Network Medical Advisory Board shall appoint a five (5) member hearing Board and shall designate one of the members of the Board as Chairperson.

   At least three (3) of the members of the hearing Board shall be Providers who are similarly licensed as the affected Provider, but who are not rendering services in the same geographic area as the affected Provider. In no event shall any hearing Board member have actively participated in the consideration of the adverse recommendation or previously recommended any disciplinary action at issue be appointed as a member of the hearing

Board. No member of the hearing Board shall be in direct economic competition with the affected person. The hearing committee may include members who are not affiliated with LCA-Vision.

2. Where the Director of the Network Medical Advisory Board makes an adverse recommendation in the first instance, at least three (3) of the members of the hearing Board shall be Providers who are similarly licensed as the affected Provider, but who are not rendering services in the same geographic area as the affected Provider. In no event shall any hearing Board member have actively participated in the consideration of the adverse recommendation or previously recommended any disciplinary action at issue be appointed as a member of the hearing Board. No member of the hearing Board shall be in direct economic competition with the affected person. The hearing committee may include members who are not affiliated with LCA-Vision.

F. CONDUCT OF HEARING

The following rules shall apply to the conduct of the hearing:

1. The parties shall be the affected Provider and LCA-Vision. If, without good cause, the affected person fails to appear and proceed at the hearing, he/she shall be deemed to have waived all rights to any further hearing or appellate review and shall be deemed to have accepted the adverse recommendation or denial of application.

2. The Chairperson of the Hearing Board shall:
   (a) preside over the hearing
   (b) determine the order of presentation
   (c) assure that all parties have a reasonable opportunity to present evidence, and
   (d) maintain appropriate decorum.

3. The parties shall have the following obligations:

   a. A representative of LCA-Vision, as applicable shall specify the Network Medical Advisory Board, Director of the Network Medical Advisory Board or Board of Directors, recommendations and present any witnesses and/or documentary evidence in support thereof.

   b. The affected person shall support his/her challenge to the Network Medical Advisory Board, Director of the Network Medical Advisory Board or Board of Directors, recommendations by an appropriate showing that the reasons therefore lacked a factual basis or that recommendation of the Director of the Network Medical Advisory Board or Board of Directors was arbitrary, unreasonable, capricious or discriminatory.

c. After the affected person has concluded his/her presentation, the representative of LCA-Vision will have an opportunity to rebut any matters put into evidence by the affected person with additional witnesses and/or documentary evidence.

The Chairperson of the hearing Board may vary this procedure if he/she deems it necessary.

4. Each party shall have the right to call and examine voluntary witnesses, to introduce written evidence, to ask questions of the other party's witnesses on any matter relevant to the issues, to rebut any evidence and to present arguments.

5. Rules of evidence as applied in judicial proceedings shall not be followed. Any relevant evidence shall be admitted. The Chairperson of the Board may determine whether evidence is obviously irrelevant and to be disregarded by the hearing Board.

6. Prior to or during the hearing, either party may submit a written memorandum concerning any relevant issue. Such memorandum shall become a part of the hearing record. Either party may utilize legal counsel in the preparation of such memorandum.

7. At any time during the hearing, any member of the hearing board may address questions to the parties or witnesses.

8. The hearing Board may recess from time to time if necessary to complete its work.

9. The hearing shall be steno graphically transcribed and each party, may at its own cost, obtain a copy of the transcript.

10. Each party may have legal counsel or another representative present to advise him/her; however, such counsel or representative may not participate in the hearing, unless otherwise agreed by both parties, since the purpose of the hearing is to resolve matters relating to professional competency and conduct and the rules of evidence as applied in judicial proceedings will not be followed.

11. A hearing advisor, who may be an attorney-at-law, may be appointed if the Chairperson of the Board so desires. The function of the hearing advisor will be to advise the Board Chairperson on questions of procedures; however, the hearing advisor shall not participate in the deliberation or decision of the hearing Board.

12. Within twenty-eight (28) calendar days after final adjournment of the hearing, the hearing Board shall prepare a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Board of Directors with a copy to the Director of the Network Medical Advisory Board. The hearing Board shall send a copy of the written report and recommendation to the parties involved.

G. RESPONSE TO DECISION OF HEARING BOARD

1. If the recommendation of the hearing Board is adverse to the affected Provider, the Provider shall have ten (10) calendar days after receipt of notice thereof to submit in writing to the Board of Directors with a copy to the Director of the Network Medical Advisory Board a response to the decision of the hearing Board by certified mail. Failure to make such a request within the time specified shall be deemed a waiver of the right of the affected Provider to submit a response and in such case; the Board of Directors shall consider the recommendation of the hearing Board and make a final decision which shall be subject to no further review or appeal. Any such decision shall be made by the Board of Directors within forty-five (45) calendar days after the expiration of the aforementioned ten (10) day period, shall be in writing and shall be submitted to the affected Provider with a copy to the Director of the Network Medical Advisory Board.

    a. The affected Provider shall have access to the report and recommendation of the hearing Board and, at his/her expense, may obtain a copy of the transcript of the hearing and all other materials favorable or unfavorable, considered in making the adverse recommendation against him/her.

    b. The Board of Directors shall have access to the report and recommendations of the hearing Board and all other materials favorable or unfavorable, considered in making the adverse recommendation against the Provider.

    c. New or additional matters not previously reflected in the record shall not be introduced to the Board of Directors by either party.

    d. A review advisor, who may be an attorney-at-law, may be appointed by the Board of Directors if the Board so desires. The function of the review advisor shall be to advise the Board of Directors on questions of procedure. The review advisor shall not participate in deliberation or decision of the review committee.

e. Within twenty-eight (28) calendar days after conclusion of the deliberations of the Board of Directors, the Chairperson of the Board of Directors shall make a written report and shall submit a copy of the written report to the affected Provider with a copy to the Director of the Network Medical Advisory Board and the Board of Directors.

H. FINAL DECISION BY BOARD OF DIRECTORS

After receipt of any response submitted by the Provider to the adverse recommendation of the hearing Board, the Board of Directors shall make a final decision. Any such decision shall be made by the Board of Directors and shall be within forty-five (45) calendar days after the time for receipt of the aforementioned response by the Provider, shall be in writing and shall be submitted to the affected Provider and the Director of the Network Medical Advisory Board.

I. LIMITATIONS ON HEARING AND APPEAL

Anything contained herein to the contrary notwithstanding, with respect to any specific adverse recommendation or decision, no person shall be entitled to more than one hearing and appellate review under this Article III.

EXHIBIT A

LCA-VISION

CONFIDENTIALITY AND NOTIFICATION STATEMENT

(To be signed by Provider serving in a Professional Peer Review capacity at the request of LCA-Vision)

I, _____ have been requested to participate in a Professional Peer Review capacity in connection with a credentialing, quality assessment/quality improvement and/or utilization management review on behalf of LCA-Vision ("LCA"). I understand that all records and information to which I have access during the Professional Peer Review process are protected as a record for Professional Peer Review and quality assurance as defined in the Health Quality Act of 1986 and the Professional Peer Review statutes of the state in which the Professional Peer Review activity is being conducted.

In recognition of LCA's policy of confidentiality of LCA's credentialing, quality assessment/quality improvement and utilization management review records and information, and of the importance of such confidentiality to the performance of effective credentialing, quality assessment/quality improvement and utilization management review, and further, in recognition that the information and these records were both generated, and disclosed to me in reliance upon that confidentiality, I understand that I am expected:

1) To preserve the confidentiality of those records to the extent allowed by law, disclosing information only as necessary for completion of the Professional Peer Review process; and

2) To notify LCA prior to the disclosure of information apart from the Professional Peer Review process, whether pursuant to a subpoena or otherwise, and to cooperate with any efforts of LCA to contest that disclosure.

_____ _____
Signature Date

_____
Title

EXHIBIT A-1

LCA-VISION

CONFIDENTIALITY AND NOTIFICATION STATEMENT

(To be signed by company surveyors or others requesting access to credentialing, quality assessment/quality improvement and utilization management review information.)

_____ ("Company") has requested to inspect LCA Provider credentialing, quality assessment/quality improvement and/or utilization management review of LCA-Vision ("LCA") which are protected as a quality improvement record for Professional Peer Review and quality assurance as defined in the Health Quality Improvement Act of 1986 and the Professional Peer Review statutes of the state in which the Professional Peer Review activity is being conducted.

In recognition of LCA's policy of confidentiality of LCA's credentialing, quality assessment/quality improvement and utilization management review records and information, and of the importance of such confidentiality to the performance of effective credentialing, quality assessment/quality improvement and utilization management, and further, in recognition that the information and these records were both generated, and disclosed to Company in reliance upon that confidentiality, pursuant to the terms of the Agreement entered into by and between Company and LCA and in furtherance of the Professional Peer Review process, Company understands that it and its employees, agents or subcontractors involved in the review process shall be expected:

1) To preserve the confidentiality of LCA's records to the extent allowed by law, disclosing information only as necessary for completion of the survey process; and

2) To notify LCA prior to the disclosure of information apart from the survey process, whether pursuant to a subpoena or otherwise, and to cooperate with any efforts of LCA to contest that disclosure.

_____ _____
Signature Date

_____
Title

_____
Name of Organization or Affiliation

VI. PATIENT SATISFACTION SURVEY

VI. PATIENT SATISFACTION SURVEY

The following Patient Satisfaction Survey will be sent to each patient one month from their treatment date. The surveys will be returned to Provider Relations at LCA-Vision.

The results of these surveys will be tabulated and sent to the provider on a quarterly basis. If there are any particular issues discovered in the patient survey, prior to the quarterly report, the provider will be contacted.

Patient Satisfaction Survey

Laser Vision Correction Member Satisfaction Survey

Have you or a family member recently had Laser Vision Correction surgery? ☐ YES ☐ NO

If yes, who received Laser Vision Correction in your household? ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

What was the date of the treatment? _____/_____/_____

*You were referred to Dr.*_____

Did the referred Doctor perform your Laser Vision Correction? ☐ YES ☐ NO

If No, did you select another in-network surgeon? ☐ YES ☐ NO

*Which surgeon performed the treatment?*_____

Why did you choose this particular surgeon?

☐ IN-NETWORK ☐ REPUTATION ☐ PRICE ☐ LOCATION ☐ OTHER

How would you rate your overall level of satisfaction?

☐ EXTREMELY SATISFIED ☐ VERY SATISFIED ☐ SATISFIED ☐ SOMEWHAT UNSATISFIED ☐ UNSATISFIED

Overall, did you feel your benefit was of value? ☐ YES ☐ NO

Would you recommend Laser Vision Correction to a friend or family member? ☐ YES ☐ NO

If no, please indicate why you would not recommend:

_____

_____

Recommendations to improve service:

_____

_____

U.S. LASER NETWORK

VIII. FEE ARRANGEMENT

VIII. FEE ARRANGEMENT

This section outlines the covered services and the fee structure that is referenced in the Provider Agreement. The Provider Information form that was completed when you received the Provider Agreement asked for the current Patient Standard Fee. This section includes the Patient Standard Fee form. In the event of a standard fee change, this form needs to be completed and sent to LCA-Vision 60 days prior to the effective fee change.

VIII. FEE ARRANGEMENT

COVERED SERVICES

Specifically, covered services include:

PRE-PROCEDURE:

The explanation of laser vision treatment, the determination of your patient candidacy, and the process of planning.

PROCEDURE (Treatment)

The laser vision treatment procedure itself.

POST-PROCEDURE:

The variety of medical materials and attention required to monitor the healing process.

Monitoring Examinations (Post Procedure)

- **Recommended Schedule**
  - 1 Day
  - 1 Week
  - 1 Month
  - 3 Months

Retreatments – Per the Laser Manufacturer's Policy

PAYMENT ARRANGEMENTS

Provider hereby agrees to accept from members as compensation in full for covered services an amount equal to provider's standard fee minus 15% or promotional fee minus 5% plus $100 per eye, where applicable.

PRICES ARE EXAMPLES ONLY. FEES ARE DETERMINED BY PROVIDER'S OWN DISCRETION.		
BILATERAL LASIK	**STANDARD FEE**	**PROMOTIONAL FEE**
Standard Fee	$4,000	$3,000
Patient Discount	(15%) - 600	(5%) -150
Net Cost to Patient	$3,400	$2,850
Net Amount Paid to Provider (including any facility fee where applicable)	**$3,400**	**$2,850**
Co-Management Fee (if applicable and where permitted by law, paid by Provider to Affiliated Optometrist and/or Ophthalmologist)		

U.S. LASER NETWORK

PATIENT STANDARD FEE DISCLOSURE FORM

If the Standard Fee changes for LASIK and/or PRK Treatments, please complete this form and fax to LCA-Vision at #513-792-5623 forty-five (45) days prior to the effective date.

Physician's Name:_____

Address:_____

City, State, Zip:_____

Work Phone:_____Fax #:_____ E-Mail:_____

Patient's Standard Fee for LASIK Treatment changed to $_____,

Effective Date:_____/_____/_____

(Month) (Day) (Year)

Patient's Standard Fee for PRK Treatment changed to $_____,

Effective Date:_____/_____/_____

(Month) (Day) (Year)

The provider agrees that this Patient Standard Fee will be charged until LCA-Vision is otherwise notified in writing.

Form completed by:_____Date:_____

For LCA-Vision use
Received by:_____Date:_____
Faxed back to provider by:_____Date faxed back:_____

LCA-Vision Inc., 7840 Montgomery Road, Cincinnati, OH 45236
FAX# 513-792-5623 E-MAIL ADDRESS: managedcare@lca.com

VIII. MISCELLANEOUS

U.S. LASER NETWORK

PROVIDER/LASER FACILITY

CHANGE OF INFORMATION FORM

Please fax this form to LCA-Vision at (513) 792-5623 anytime you have a change in the provider's and/or laser facility's address, phone, fax, or e-mail.

Physician's Name:_____

Address:_____

City, State, Zip:_____

Work Phone:_____ Fax #:_____ E-Mail:_____

Laser Facility::_____

Address:_____

City, State, Zip:_____

Work Phone:_____ Fax #:_____ E-Mail:_____

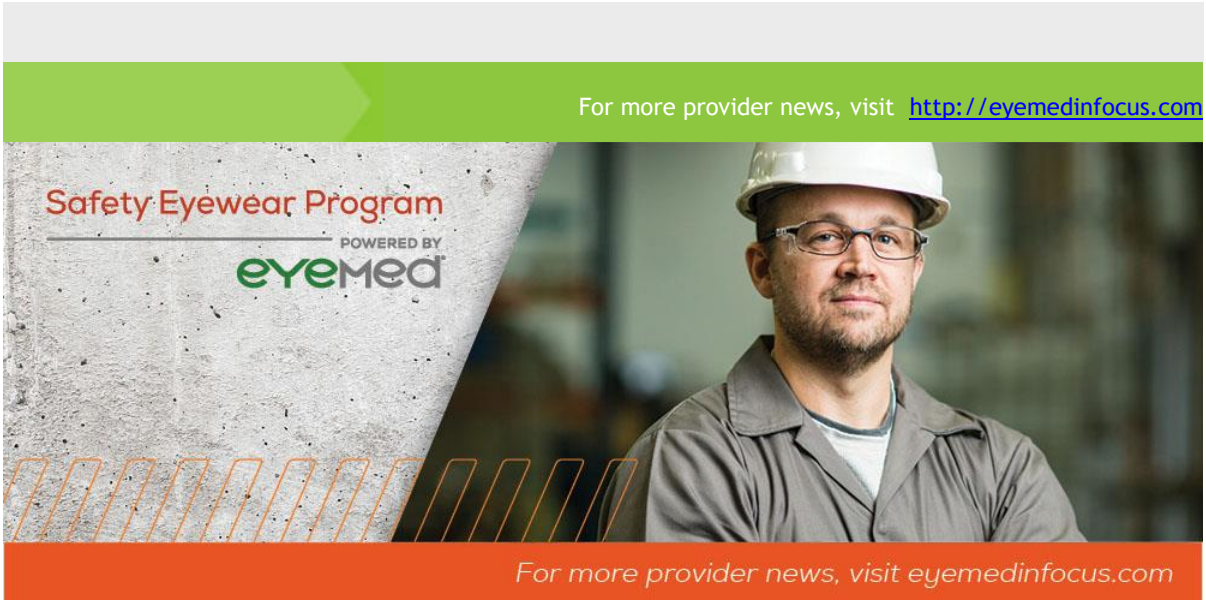
Form completed by:_____ Date:_____

LCA-Vision, Inc., 7840 Montgomery Road, Cincinnati, OH 45236
Fax #513/792-5623 E-MAIL ADDRESS: managedcare@lca.com

Sample Provider Communication

Empire BlueCross

An Anthem Company



When opportunity knocks, get ready

A nearby employer is participating in the Safety Eyewear Program

Effective May 1, 2019, EyeMed is offering the Safety Eyewear Program Powered by EyeMed to employers who desire it, in addition to routine vision care. We're happy to let you know that a nearby employer, XXX, with XXX eligible Anthem/Empire members, is participating in this safety eyewear program.

We've made it easy for you to take action now so you're ready to service these patients when they come in.

Whether you use the EyeMed lab network or not:

- View the fee schedule.

If you use the EyeMed lab network:

- Register for a safety lab.
- Get familiar with the digital safety frame catalog for all available styles, colors and sizes and the safety lens catalog.

If you don't use the EyeMed lab network:

- Use your existing frame selection as long as it includes at least 8 ANSI-approved frames and lens requirements that meet the latest criteria in the Provider Manual.

For Pearle licensed operators:

- Use existing frame, lens and lab procedures for safety.

Members may also have vision benefits above and beyond the safety Eyewear Program offered by their employer. Be sure to check for all benefits available to them.

Be ready to serve patients who need on-the-job eyewear protection. Visit inFocus for all Safety Eyewear Program resources.

Section 6

Reporting Services

Empire BlueCross

An Anthem Company

Sample Reports

Empire BlueCross

An Anthem Company

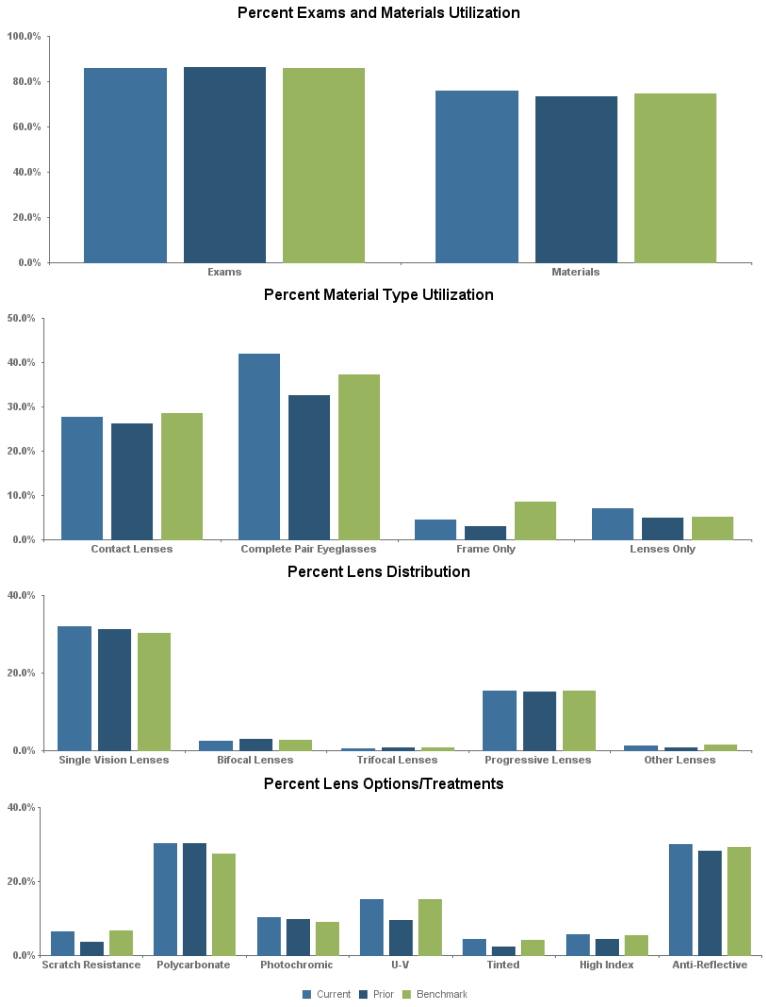
Vision - Utilization Summary

Key Indicators	Current	Prior
Members	26,209	28,420
Member Months	314,507	341,035
Unique Claimants	7,543	7,617
Average Paid Amount per Claimant	$119	$118

Percent Claimants Receiving Services	Current	Prior	Benchmark
Exams	85.7%	86.3%	85.8%
Materials	75.6%	73.2%	74.5%
Contact Lenses	27.6%	26.2%	28.5%
Complete Pair Eyeglasses	41.8%	32.6%	37.3%
Frame Only	4.4%	2.9%	8.4%
Lenses Only	7.0%	4.9%	5.0%
Single Vision Lenses	31.9%	31.2%	30.2%
Bifocal Lenses	2.4%	2.9%	2.5%
Trifocal Lenses	0.4%	0.6%	0.6%
Progressive Lenses	15.2%	15.1%	15.4%
Other Lenses	1.2%	0.6%	1.3%

Percent Lens Options/ Treatments	Current	Prior	Benchmark
Scratch Resistance	6.4%	3.5%	5.8%
Scratch Resistance - Children	1.1%	0.6%	0.9%
Polycarbonate	30.2%	30.3%	27.8%
Polycarbonate - Children	7.2%	7.4%	6.4%
Photochromic	10.1%	9.7%	9.2%
Photochromic - Children	1.9%	1.8%	1.7%
U-V	15.0%	9.5%	13.7%
Tinted	4.2%	2.3%	3.9%
High Index	5.6%	4.4%	5.4%
Anti-Reflective	29.9%	28.1%	29.8%

	Frame Purchases Distribution by Retail Price							
	$0-$100	$101-$130	$131-$160	$161-$190	$191-$220	$221-$250	$251+	Total
Total Frames	78	65	47	46	30	27	46	**339**
Percent Total	**23.0%**	**19.2%**	**13.9%**	**13.6%**	**8.8%**	**8.0%**	**13.6%**	**100.0%**



Benchmark based on total Vision large group block of business

Audit Parameters Trail

Parameter Name	Parameter Value
Anthem Account Control ID	W0004156
Anthem Account Control Name	ABC COMPANY
Master Segmentation ID	W0004156-00002
Master Segmentation Name	Total Account
Group ID(s)	00046 ;001451 ;00217962 ;006418 ;06418 ;130808 ;165006 ;165019 ;165096 ;165101 ;166297 ;170015 ;175035 ;195431 ;196427 ; 196463 ;196468 ;201018 ;275087 ;275384 ;275791 ;275883 ;276630 ;294572 ;295522 ;377132 ;720890 ;834~003330052 ; 834~003330094 ;C11665 ;C17616 ;C19903 ;C20980 ;C21218 ;C22610 ;MO5009 ;MO5069 ;V00046 ;V06418 ;W11336
Subgroup ID(s)	
Plan Code(s)	
Plan Type Code(s)	
Benefit Package ID(s)	
Claim Code ID(s)	
Group Status	NA
Rating Relation Code	
Department Number	
Clock Number	
Association	
Client ID	
Claim Reporting Code ID 1	
Claim Reporting Code ID 2	
Claim Reporting Code ID 3	
Employer Group Reporting Code ID 1	
Employer Group Reporting Code ID 2	
Employer Group Reporting Code ID 3	
Fully Insured Indicator	
Member Network ID	
Package Number	
Medicare Indicator (Medicare Primary)	
Par Plan ID/Participating Plan Code	
Plan Group Code	
CDHP Category Code	
Primary Coverage Indicator (Anthem Primary)	
Time Period	Custom

Vision - Monthly Member Utilization Detail

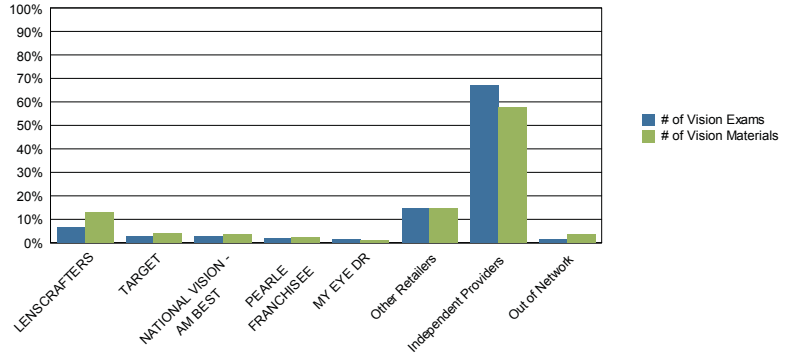
				Exams			Eyewear Materials			Contact Lenses Materials			Total Materials			
Reporting Period	Subscribers	Members	Unique Claimants	Exams	Percent Utilization Exams	Paid Amount Exams	Eyewear	Percent Utilization Eyewear	Paid Amount Eyewear	Contact Lenses	Percent Utilization Contacts	Paid Amount Contacts	Total Materials	Percent Utilization Materials	Paid Amount Materials	Total Paid Amount
Feb 2018	13,280	28,379	461	352	1.2%	$15,746	218	73.2%	$21,568	83	27.9%	$11,850	298	1.1%	$33,418	$49,164
Mar 2018	13,247	28,320	885	680	2.4%	$29,627	471	80.5%	$45,827	116	19.8%	$19,007	585	2.1%	$64,835	$94,462
Apr 2018	13,211	28,226	836	651	2.3%	$28,663	390	75.4%	$39,016	134	25.9%	$20,458	517	1.8%	$59,474	$88,137
May 2018	13,174	28,169	640	491	1.7%	$21,387	296	74.9%	$28,009	106	26.8%	$16,749	395	1.4%	$44,758	$66,145
Jun 2018	13,114	28,068	605	482	1.7%	$21,389	286	73.3%	$27,855	111	28.5%	$18,069	390	1.4%	$45,924	$67,313
Jul 2018	13,204	28,177	800	616	2.2%	$26,172	352	69.7%	$34,131	155	30.7%	$23,508	505	1.8%	$57,639	$83,811
Aug 2018	11,722	24,326	683	533	2.2%	$22,828	293	72.9%	$28,739	111	27.6%	$18,187	402	1.7%	$46,926	$69,754
Sep 2018	11,780	24,376	660	510	2.1%	$22,262	324	76.2%	$30,484	105	24.7%	$15,861	425	1.7%	$46,345	$68,607
Oct 2018	11,697	24,176	826	666	2.8%	$28,814	399	74.3%	$37,753	145	27.0%	$23,510	537	2.2%	$61,264	$90,078
Nov 2018	11,667	24,138	655	508	2.1%	$21,625	341	79.7%	$31,704	90	21.0%	$12,967	428	1.8%	$44,671	$66,296
Dec 2018	11,636	24,079	723	561	2.3%	$24,005	359	74.5%	$32,932	131	27.2%	$23,753	482	2.0%	$56,685	$80,690
Jan 2019	11,739	24,073	702	502	2.1%	$21,737	342	71.7%	$31,312	137	28.7%	$21,862	477	2.0%	$53,175	$74,912
Total	**12,456**	**26,209**	**7,543**	**6,535**	**24.9%**	**$284,255**	**4,045**	**74.8%**	**$389,329**	**1,418**	**26.2%**	**$225,783**	**5,409**	**20.6%**	**$615,112**	**$899,367**

Vision - Network Utilization

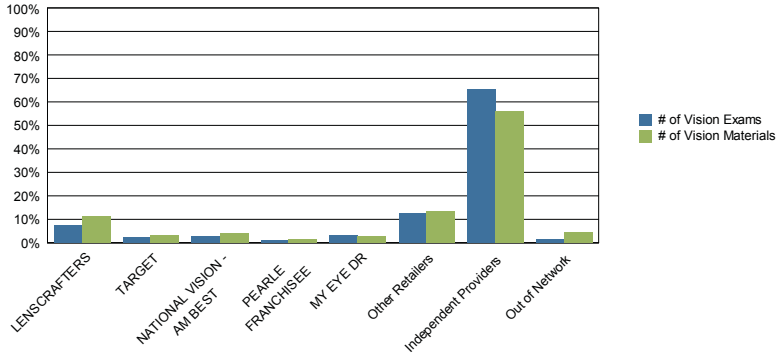
Network Choice	Current			Prior			Variance	Benchmark	
Network	Network Utilization	Network Savings Dollars	Network Savings Percentage	Network Utilization	Network Savings Dollars	Network Savings Percentage	Network Savings Dollars	Network Utilization	Network Savings Percentage
In Network	97.3%	$897,654	45.0%	97.7%	$944,258	46.3%	-4.9%	96.3%	46.2%
All Retailers	32.0%	$294,535	44.2%	30.5%	$288,405	45.2%	2.1%	34.3%	44.8%
All Independent Providers	65.3%	$603,119	45.4%	67.3%	$655,853	46.9%	-8.0%	62.1%	46.9%
Out of Network	2.7%	$0	0.0%	2.3%	$0	0.0%	0.0%	3.7%	0.0%
Total	**100.0%**	**$897,654**	**44.5%**	**100.0%**	**$944,258**	**45.9%**	**-4.9%**	**100.0%**	**45.4%**

Network	Number of Exams	Paid Amount Exams	Percent Paid Amount of Total Exams	Materials	Paid Amount Materials	Percent Paid Amount of Total Materials	Percent of Transactions on Weekends
Retailers							
LENSCRAFTERS	437	$14,195	5.0%	695	$73,195	11.9%	31.8%
TARGET	189	$7,697	2.7%	223	$24,833	4.0%	34.5%
NATIONAL VISION - AM BEST	182	$5,155	1.8%	183	$16,951	2.8%	17.6%
PEARLE FRANCHISEE	134	$5,787	2.0%	125	$12,079	2.0%	25.9%
MY EYE DR	106	$4,450	1.6%	72	$9,196	1.5%	14.2%
Other Retailer	974	$35,844	12.6%	808	$82,297	13.4%	22.2%
Independent Providers							
SIMON BRETT	70	$4,130	1.5%	61	$6,823	1.1%	0.0%
GONZALEZ LAUREN	55	$3,245	1.1%	48	$5,584	0.9%	0.0%
FINNEGAN GARY	31	$1,860	0.7%	25	$3,114	0.5%	5.6%
ALFRED ANGELA	25	$1,375	0.5%	25	$3,507	0.6%	0.0%
PIGGOTT LORETTA	33	$1,760	0.6%	24	$3,099	0.5%	0.0%
Other Independent Provider	4,190	$194,188	68.3%	2,928	$358,814	58.3%	10.8%
Out of Network	109	$4,569	1.6%	192	$15,621	2.5%	28.5%
Total	**6,535**	**$284,255**	**100.0%**	**5,409**	**$615,112**	**100.0%**	**16.6%**

Exams and Materials by Provider



Benchmark Exams and Materials by Provider

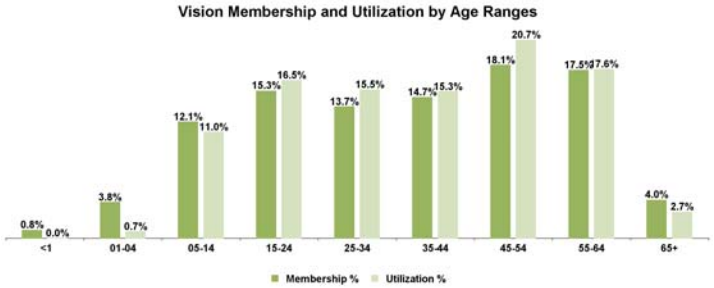


Benchmark based on total Vision large group block of business

Vision Membership

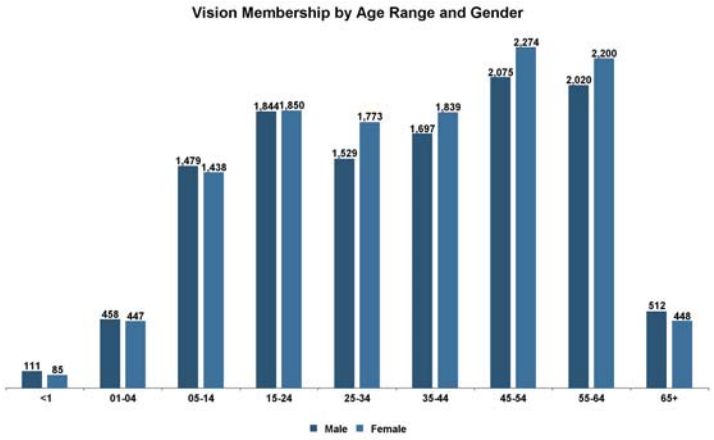
Membership by Contract Type

Contract Type	Vision		
	Average Current Period	Average Prior Period	Percent Change
Subscriber	6,058	6,345	-4.5%
Subscriber & Spouse/Dependent	3,623	3,604	0.5%
Subscriber & Child/Children	1,984	1,986	-0.1%
Family	14,935	16,487	-9.4%
Other	0	0	0.0%
Total Members	**26,600**	**28,422**	**-6.4%**
Total Contracts	**12,602**	**13,328**	**-5.4%**
Average Members per Contract	2.1	2.1	-1.0%



Membership by Age/Gender

Age Range	Current			Prior		
	Male	Female	Total	Male	Female	Total
<1	111	85	196	127	107	234
01-04	458	447	905	596	574	1,170
05-14	1,479	1,438	2,917	1,823	1,818	3,641
15-24	1,844	1,850	3,694	2,326	2,257	4,583
25-34	1,529	1,773	3,302	2,002	1,940	3,942
35-44	1,697	1,839	3,536	2,140	2,099	4,239
45-54	2,075	2,274	4,349	2,484	2,591	5,075
55-64	2,020	2,200	4,220	2,271	2,378	4,649
65+	512	448	960	536	438	974
Total Members	**11,725**	**12,354**	**24,079**	**14,305**	**14,202**	**28,507**
Members Avg Age	36.0	36.5	36.2	35.2	35.4	35.3
Average Age - Benchmark	34.7	35.3	35.0	34.4	35.0	34.7



Benchmark based on total Vision large group block of business

Sample Data Sharing Agreement

Empire BlueCross

An Anthem Company

CONFIDENTIALITY AGREEMENT

[redacted]

1. [redacted]

2. [redacted]

3. [redacted]

4. [redacted]

5. [redacted]

[redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

11. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted]

17. [redacted]

18. [redacted]

19. [redacted]

20. [redacted]

21. [redacted]

22. [redacted]

23. [redacted]

24. [redacted]

[redacted]

ANTHEM:	**RECIPIENT**:
Anthem, Inc. on behalf of itself and its affiliates and subsidiaries	_____
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date
Notice Address:	**Notice Address**:_____
220 Virginia Avenue	_____
Indianapolis, IN 46204	_____
Attn: General Counsel	_____

Sample Ad Hoc Reports

Empire BlueCross

An Anthem Company

SAMPLE GROUP
REPORTING PERIOD: 01/01/2021 - 12/31/2021

NETWORK_TIER	SERVICE_TYPE	JAN_21	FEB_21	MAR_21	APR_21	MAY_21	JUN_21	JUL_21	AUG_21	SEP_21	OCT_21	NOV_21	DEC_21	TOTAL
TIER_1	Hospital - Outpatient	$2,521,560	$1,900,231	$2,404,187										**$6,825,978**
TIER_1	Hospital - Inpatient	$1,554,523	$1,367,627	$625,249										**$3,547,399**
TIER_3	Hospital - Outpatient	$530,506	$510,675	$664,666										**$1,705,846**
TIER_3	Hospital - Inpatient	$361,065	$842,855	$118,818										**$1,322,739**
TIER_1	Medical Care	$218,762	$276,770	$282,380										**$777,912**
TIER_1	Office Visits And Treatment	$223,599	$208,342	$251,239										**$683,179**
TIER_1	Facility Outpatient Surgery	$197,460	$171,998	$171,861										**$541,319**
TIER_2	Anesthesia	$156,818	$121,414	$136,623										**$414,855**
TIER_1	Diagnostic X-Ray	$121,753	$97,180	$104,261										**$323,194**
TIER_2	Facility Outpatient Surgery	$82,880	$101,419	$123,579										**$307,879**
TIER_3	Psychiatric	$88,019	$92,389	$126,723										**$307,131**
TIER_2	Office Visits And Treatment	$110,692	$85,815	$100,379										**$296,886**
TIER_3	Office Visits And Treatment	$61,776	$78,973	$82,927										**$223,677**
TIER_4	Hospital - Outpatient	$61,836	$60,101	$91,333										**$213,270**
TIER_2	Diagnostic X-Ray	$62,326	$53,034	$72,589										**$187,949**
TIER_3	Diagnostic X-Ray	$69,313	$54,280	$62,221										**$185,814**
		$6,422,889	**$6,023,103**	**$5,419,034**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$17,865,025**

SAMPLE GROUP
REPORTING PERIOD: 01/01/2021 - 12/31/2021

PRODUCT	PROVIDER_NAME	SERVICE_TYPE	JAN_21	FEB_21	MAR_21	APR_21	MAY_21	JUN_21	JUL_21	AUG_21	SEP_21	OCT_21	NOV_21	DEC_21	TOTAL
PPO	ABC HOSPITAL	IP - MEDICAL - RESPIRATORY	$0	$281,222											**$281,222**
PPO	ABC HOSPITAL	OP - OTHER ONCOLOGY	$60,310	$134,728	$74,197										**$269,234**
PPO	ABC HOSPITAL	OP - SURGERY	$55,049	$96,882	$110,818										**$262,749**
PPO	ABC HOSPITAL	IP - SURGICAL - OTHER SURGICAL		$214,398	$0										**$214,398**
PPO	ABC HOSPITAL	IP - MEDICAL - OTHER MEDICAL	$172,448	$18,838	$0										**$191,286**
PPO	ABC HOSPITAL	OP - EMERGENCY ROOM NO SURGER	$43,672	$33,653	$53,501										**$130,826**
PPO	ABC HOSPITAL	IP - UNKNOWN	$0	$130,026											**$130,026**
PPO	XYZ MEDICAL CENTER	IP - MEDICAL - OTHER MEDICAL	$15,737	$54,281	$34,738										$104,756
PPO	ABC HOSPITAL	OP - RADIOLOGY - CT / MRI / PET	$37,618	$27,493	$28,968										**$94,080**
HDHP	ABC HOSPITAL	IP - SURGICAL - OTHER SURGICAL	$79,578												**$79,578**
HDHP	ABC HOSPITAL	OP - PT/OT/ST	$19,817	$34,177	$22,568										**$76,562**
HDHP	ABC HOSPITAL	OP - OTHER ONCOLOGY	$0	$0	$73,216										**$73,216**
			$484,229	**$1,025,698**	**$398,007**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,907,933**

SAMPLE GROUP
REPORTING PERIOD: 01/01/2021 - 12/31/2021
TIER 4 PROVIDERS

PRODUCT	PROVIDER_NAME	SERVICE_TYPE	JAN_21	FEB_21	MAR_21	APR_21	MAY_21	JUN_21	JUL_21	AUG_21	SEP_21	OCT_21	NOV_21	DEC_21	TOTAL
PPO	MEDICAL CENTER	OP - OTHER UNCLASSIFIED	$0	$0	$48,587										**$48,587**
PPO	MEDICAL CENTER	IP - SURGICAL - MUSCULOSKELETAL	$37,170												**$37,170**
PPO	ABC HOSPITAL	IP - MEDICAL - OTHER MEDICAL	$29,275												**$29,275**
PPO	CLEVELAND CTR EATING DISORDER	OP - OTHER PSYCHIATRIC		$19,190	$6,565										**$25,755**
PPO	MEDICAL CENTER	OP - EMERGENCY ROOM NO SURGER	$6,651	$7,308	$9,700										**$23,660**
HDHP	MHSA FACILITY	IP - ALCOHOL & DRUG ABUSE	$21,125												**$21,125**
HDHP	ABC HOSPITAL	OP - EMERGENCY ROOM NO SURGER	$7,837	$3,795	$7,515										**$19,147**
HDHP	SMITH JOHN J	PR - OTHER - PHYSICAL THERAPY	$3,484	$11,600	$3,487										**$18,571**
HDHP	MEDICAL CENTER	OP - SURGERY	$17,987		$0										**$17,987**
HDHP	MEDICAL CENTER	OP - EMERGENCY ROOM NO SURGER	$6,282	$7,025	$3,193										**$16,500**
HDHP	DOE JANE	PR - MEDICAL - NEUROLOGY		$0	$15,897										**$15,897**
			$129,812	**$48,918**	**$94,944**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$273,673**

SAMPLE GROUP
REPORTING PERIOD: 01/01/2021 - 12/31/2021

PRODUCT	NETWORK_TIER*	BILLED	NOT_COVERED	COVERED	SAVINGS	ALLOWED	DEDUCTIBLE	COINSURANCE	COPAYMENT	MEMBER_SANCTIONS	COB_SAVINGS	OTHER	NON_HRA_PAID	HRA	BENEFIT	SAVINGS %	PAID BY TIER
EPO	TIER_1	$4,513,948	$423,103	$4,090,845	$2,247,266	$1,843,579	$538,987	$134,748	$0	$0	$11,861	$0	$1,157,984	$0	$1,157,984	54.9%	53.0%
EPO	TIER_2	$744,943	$63,159	$681,784	$284,942	$396,842	$115,513	$26,037	$0	$0	$581	$0	$254,711	$0	$254,711	41.8%	11.7%
EPO	TIER_3	$2,875,896	$310,646	$2,565,250	$1,329,705	$1,235,545	$416,699	$56,623	$0	$0	$385	$42	$761,797	$0	$761,797	51.8%	34.9%
EPO	TIER_4	$305,567	$292,120	$13,447	$2,020	$11,427	$2,113	$0	$0	$0	$64	$0	$9,249	$0	$9,249	15.0%	0.4%
		$8,440,354	**$1,089,027**	**$7,351,327**	**$3,863,934**	**$3,487,393**	**$1,073,311**	**$217,408**	**$0**	**$0**	**$12,891**	**$42**	**$2,183,741**	**$0**	**$2,183,741**	**52.6%**	**100.0%**
PPO	TIER_1	$29,673,195	$2,205,356	$27,467,840	$14,259,689	$13,208,151	$562,479	$486,609	$153,584	$0	$190,317	($880)	$11,816,042	$0	$11,816,042	51.9%	66.8%
PPO	TIER_2	$3,699,962	$282,772	$3,417,190	$1,708,338	$1,708,852	$96,179	$118,005	$42,792	$0	$16,188	$0	$1,435,687	$0	$1,435,687	50.0%	8.1%
PPO	TIER_3	$11,109,419	$2,876,350	$8,233,070	$3,557,241	$4,675,828	$177,365	$323,988	$57,700	$0	$90,568	($2,547)	$4,028,755	$0	$4,028,755	43.2%	22.8%
PPO	TIER_4	$2,433,171	$1,514,119	$919,053	$430,019	$489,033	$9,403	$32,910	$4,022	$0	$23,999	$0	$418,700	$0	$418,700	46.8%	2.4%
		$46,915,748	**$6,878,596**	**$40,037,152**	**$19,955,287**	**$20,081,865**	**$845,427**	**$961,512**	**$258,098**	**$0**	**$321,072**	**($3,428)**	**$17,699,184**	**$0**	**$17,699,184**	**49.8%**	**100.0%**
	TIER_1	$34,187,144	$2,628,458	$31,558,685	$16,506,955	$15,051,730	$1,101,466	$621,357	$153,584	$0	$202,178	($880)	$12,974,026	$0	$12,974,026	52.3%	65.3%
	TIER_2	$4,444,905	$345,931	$4,098,974	$1,993,280	$2,105,694	$211,692	$144,043	$42,792	$0	$16,769	$0	$1,690,398	$0	$1,690,398	48.6%	8.5%
	TIER_3	$13,985,315	$3,186,995	$10,798,320	$4,886,946	$5,911,373	$594,064	$380,611	$57,700	$0	$90,953	($2,506)	$4,790,551	$0	$4,790,551	45.3%	24.1%
	TIER_4	$2,738,738	$1,806,238	$932,500	$432,040	$500,460	$11,517	$32,910	$4,022	$0	$24,063	$0	$427,949	$0	$427,949	46.3%	2.2%
		$55,356,102	**$7,967,623**	**$47,388,479**	**$23,819,221**	**$23,569,258**	**$1,918,738**	**$1,178,920**	**$258,098**	**$0**	**$333,963**	**($3,386)**	**$19,882,924**	**$0**	**$19,882,924**	**50.3%**	**100.0%**

SAMPLE GROUP
REPORTING PERIOD: 01/01/2021 - 12/31/2021
HCC >=$50,000

PRODUCT	LAST_NAME	FIRST_NAME	RELATION	GENDER	BIRTHDATE	DIAGNOSIS_DESCRIPTION	HOSPITAL_PAID	PROFESSIONAL	TRIHEALTH_PROVIDERS	NON_TRIHEALTH_PROVIDERS	TOTAL_FOR_MEMBER
HDHP	NORTH	ALPHA	CHILD	F	01/01/1111	COMPRESSION OF BRAIN	$79,578	$23,971	$0	$103,548	$103,548
HMO	SOUTH	BETA	SELF	M	01/01/1111	ATHEROSCL AUTOL VEIN BP GRAFT EXT GANGREN RT LE(	$84,942	$17,853	$95,516	$7,280	$102,796
EPO	EAST	CHI	SELF	M	01/01/1111	MALIGNANT NEOPLASM UNS PART LEFT BRONCHUS/LUI	$96,975	$3,527	($8,701)	$109,202	$100,501
PPO	WEST	DELTA	SELF	F	01/01/1111	MULTIPLE MYELOMA NOT HAVING ACHIEVED REMISSIOI	$93,800	$4,571	$284	$98,087	$98,371

SAMPLE GROUP
CLAIMS DENIED 01/01/2021 - 03/31/2021

CLAIM_NUMBER	MEMBER_ID	MEMBER_NAME	BILLING_PROVIDER	BILLING_TIN	RENDERING_PROVIDER	RENDERING_NPI	NETWORK_STATUS	DENIAL_CD	DENIAL_REASON	CPT_CODE	CPT_DESCRIPTION	DIAGNOSIS	SERVICE_DATE	BILLED_AMOUNT	NOT_COVERED_AMOUNT	ALLOWED_AMOUNT	PLAN_PAID
21022CL0835	1212121212	SMITH, Jane	ABC PROVIDER	123456789	HARRISON FORD	7777777777	IN	RDUPN0	CLAIM INCURRED PRIOR TO MEMBER ELIGIBILIT	29884	KNEE ARTHROSCOPY/SURGERY	S83411A	01/20/2021	$1,673	$1,673	$0	$0
21022CL0837	3131313131	DOE, JANE	ABC PROVIDER	123456789	HARRISON FORD	7777777777	IN	RDUPN0	CLAIM INCURRED PRIOR TO MEMBER ELIGIBILIT	29824	SHO ARTHRS SRG DSTL CLAVICL(	M19012	02/26/2021	$335	$335	$0	$0
21022CL0838	4141414141	JONES, JIM	ABC PROVIDER	123456789	HARRISON FORD	7777777777	IN	RCXTT0	CLAIM INCURRED AFTER MEMBER TERMINATED	29824	SHO ARTHRS SRG DSTL CLAVICL(	M19012	02/26/2021	$1,675	$1,675	$0	$0
21022CL0839	5151515151	JOHNSON, SUE	ABC PROVIDER	123456789	HARRISON FORD	7777777777	OUT	RCXTT0	CLAIM INCURRED AFTER MEMBER TERMINATED	20611	DRAIN/INJ JOINT/BURSA W/US	M7501	03/04/2021	$256	$256	$0	$0

Section 7

Enrollee and Provider Communication Support

Empire BlueCross

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Sample Welcome Packet

Empire BlueCross

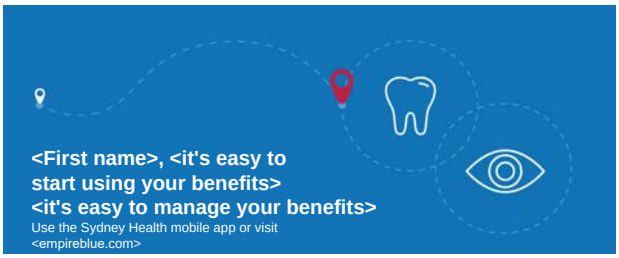
An Anthem Company

SUBJECT LINE:
[For new members:] Welcome to your vision plan
[For returning members:] Are you ready to use your vision plan?

[For new members:] We'll help you make the most of your benefits.
[For returning members:] We'll walk you through the steps.

View email in a browser

Empire BlueCross



<Log in><Check your benefits>

Thanks for choosing Empire for your vision benefits. Follow these steps to access all of your benefits and make the most of your plan:

Use our Sydney Health mobile app or log in to empireblue.com> to check your benefits and claims.

<You'll need to register before you can access your account.>

View and download your digital ID card.

It's available on the Sydney Health app and works just like the printed one. You can fax or email it from the app.

Schedule a preventive care checkup.

You can search for an eye doctor in your plan's network using our app or website. Your vision plan covers one checkup each year.

We're here to help

Your vision care is an important part of your overall health. If you have questions, please chat with us through **Sydney Health**.

Section 8

Claims Processing

Empire BlueCross

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Claims Processing Flowchart

Empire BlueCross

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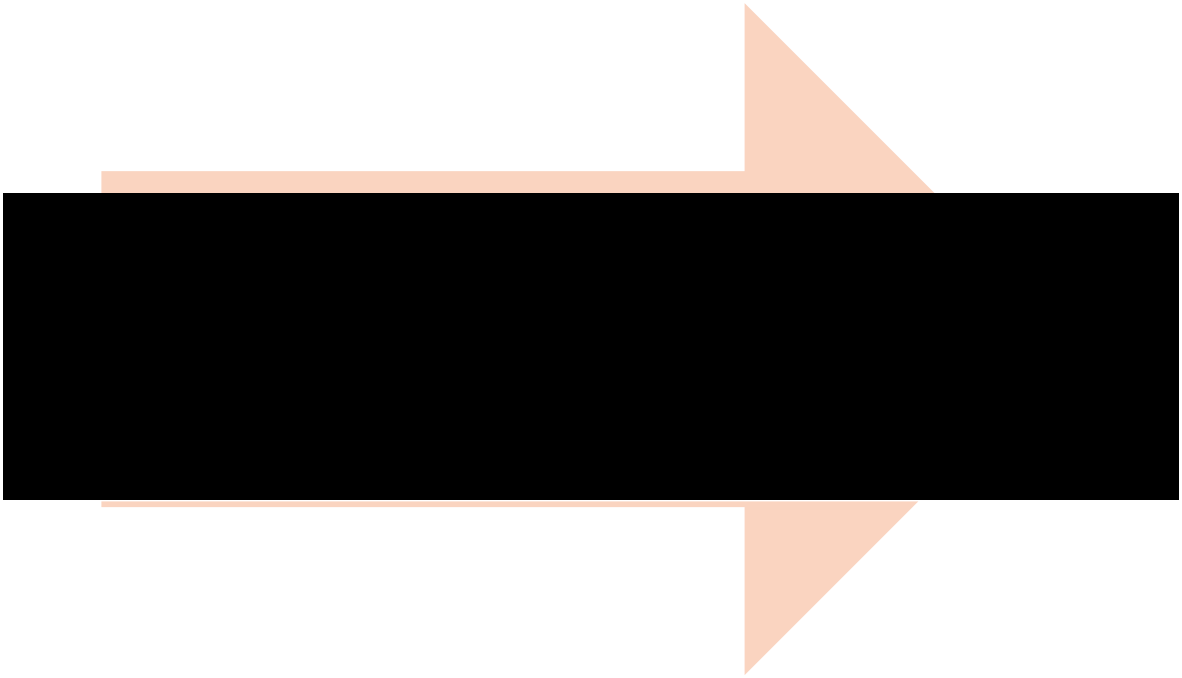
Claims Process Flow

Claims Process for Provider Electronic Claims



Claims Process for Provider Paper Claims

Sample Data Elements

Empire BlueCross

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Field #	Field Name	Definition	Length	Type	Usage	Valid Values /Defaults
1	Adjustment / Void Flag	Indicator used to distinguish the type of claims.	1	A	Situational	A=adjusted Claim, V=voided Claim, Blank = Original Claim
2	EyeMed Group ID	Code which uniquely identifies a specific client plan in EyeMed's system	13	A	Required	
3	Filler Indicator 1	Placeholder for future functionality	1	A	Required	Blanks
4	Claim Number	Number which uniquely identifies an EyeMed claim.	12	N	Required	
5	Date of Service	Date the service was incurred.	8	Date	Required	CCYYMMDD
6	Claim Received Date	Date the claim was received by EyeMed. Adjustments and Voids have the same Claim Receive Date as the original Claim.	8	Date	Situational	CCYYMMDD
7	Claim Paid Date	Date the claim was paid to the submitting entity (provider or member).	8	Date	Required	CCYYMMDD
8	Check Number	Identifies the check number that included the provider OR member payment for this claim.	8	N	Required	
9	Invoice Number	Number which uniquely identifies an EyeMed billing invoice.	12	N	Required	
10	Invoice Date	Date the FFS invoicing process created the invoice.	8	Date	Situational	CCYYMMDD
11	Payment Amount	Dollar amount associated with this service line that is reimbursed to the provider for In Network claims and to the member for Out of Network Claims.	11	N	Situational	Default=.00
12	Bill Amount	Dollar amount associated with this service line which is billed back to the plan (Contract Amount). This is always zero in the case of Fixed Fee plans.	11	N	Situational	Default = zeros 99999999.99 or -999999.99
13	FFS Administrative Fee	Dollar amount associated with this service line which is billed as an administrative processing fee. This Is always zero in the case of Fixed Fee plans and Fee For Service plans with a Fixed Fee Administration component.	11	N	Situational	Default = zeros 99999999.99 or -999999.99
14	Retail Amount	Retail dollar amount associated with this service line prior to any discount or Third Party Benefit. This is also known as the Submitted Amount or U & C.	11	N	Situational	Default = zeros 99999999.99 or -999999.99
15	Member Out-Of-Pocket	The amount payable by the member for the submitted charges (includes copay and charges that exceed the plan benefit). Also known as Patient Responsibility.	11	N	Situational	Default = zeros 99999999.99 or -999999.99
16	Third Party Discount	Discount on submitted charges required by the benefit plan.	11	N	Situational	Default = zeros 99999999.99 or -999999.99
17	Copay Amount	The amount the member is required to pay for covered services as specified by the plan.	11	N	Situational	Default = zeros 99999999.99 or -999999.99
18	Filler 1	Placeholder for future amount field functionality.	11	N	Default	0
19	Filler 2	Placeholder for future amount field functionality.	11	N	Default	0
20	Filler 3	Placeholder for future amount field functionality.	11	N	Default	0
21	Network Indicator	Indicator used to distinguish if the claim was in-network, out-network, or out-of-area	2	A	Required	IN= in-network, ON= out-of-network, OA= out of area
22	Package ID	Determines if the Service is part of a package	9	A	Situational	
23	Service Code	Code identifying the service performed. For vision exams, this is typically a CPT Code. For materials (frames, lenses, contact lenses), this is typically a HCSPCS Code (ICD9 Code).	9	A	Required	Default is 99999 "Miscellaneous Accessories"
24	Service Description	A description of the services received or the materials purchased.	25	A	Required	
25	Modifier Code 1	Claim Modifier - Service - May have service modifiers without claim modifiers.	2	AN	Situational	
26	Modifier Code 2	Claim Modifier - Service - May have service modifiers without claim modifiers.	2	AN	Situational	
27	Modifier Code 3	Claim Modifier - Service - May have service modifiers without claim modifiers.	2	AN	Situational	
28	Modifier Code 4	Claim Modifier - Service - May have service modifiers without claim modifiers.	2	AN	Situational	
29	Modifier Code 5	Claim Modifier - Claim - May have claim modifiers without service modifiers.	5	AN	Situational	
30	Modifier Code 6	Claim Modifier - Claim - May have claim modifiers without service modifiers.	5	AN	Situational	
31	Modifier Code 7	Claim Modifier - Claim - May have claim modifiers without service modifiers.	5	AN	Situational	
32	Modifier Code 8	Claim Modifier - Claim - May have claim modifiers without service modifiers.	5	AN	Situational	
33	Diagnosis Code 1	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
34	Diagnosis Code 2	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
35	Diagnosis Code 3	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
36	Diagnosis Code 4	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
37	Diagnosis Code 5	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
38	Diagnosis Code 6	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
39	Diagnosis Code 7	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
40	Diagnosis Code 8	Exam diagnosis code which is supplied only on exam-based services. This code is submitted by the provider. For HIPAA reasons, the field is available to TPAs and Resellers only. It will be defaulted to blanks for employer groups.	9	A	Situational	
41	Patient ID	Member ID of patient receiving services. The value is defaulted to the value sent in the member ID field of the membership file.	15	AN	Required	

Field #	Field Name	Definition	Length	Type	Usage	Valid Values /Defaults
42	Patient Social Security Number	Social Security Number of patient receiving services as sent in the SSN field of the membership file. If the Subscriber's SSN is sent for the patient, then the Subscriber's SSN will be displayed.	9	N	Situational	No dashes, zero filled
43	Patient First Name	First name of individual receiving services as sent in the membership file.	15	A	Required	
44	Patient Middle Initial	Middle initial of individual receiving services as sent in the membership file.	1	A	Situational	
45	Patient Last Name	Last name of individual receiving services as sent in the membership file.	20	A	Required	
46	Patient Gender	Gender of individual receiving services. This is translated (if different) into EyeMed values from the incoming membership file.	1	A	Situational	M=Male F=Female U=Unknown Default=Blank
47	Patient/Family Relationship	Relationship between patient and subscriber	1	A	Required	X=Self S=Spouse P=Domestic Partner C=Child O=Other Adult H=Head of Household (blank)= Unknown
48	Patient Date Of Birth	Birth date of individual receiving services as sent in the membership file.	8	Date	Situational	CCYYMMDD
49	Patient Address	Address of individual receiving services as sent in the membership file.	30	AN	Required	
50	Patient Address 2	Second line address of individual receiving services as sent in the membership file.	30	AN	Situational	
51	Patient City	Address city of individual receiving services as sent in the membership file.	20	A	Required	
52	Patient State	Postal abbreviation for the address state of the individual receiving services as sent in the membership file.	2	A	Required	
53	Patient Zip	Address Zip of the individual receiving services as sent in the membership file.	5	N	Required	
54	Patient Zip+4	Zip + 4 extension of the address for the individual receiving services as sent in the membership file.	4	N	Situational	
55	Client Group Number	Client Group Number as sent in the membership file.	20	AN	Situational	
56	Company Code	Company Code as sent in the membership file.	20	AN	Situational	
57	Division Code	Division code as sent in the membership file. If no value is found on the patient's record, the value will be pulled from the subscriber's record.	20	AN	Situational	
58	Location Code	Location code as sent in the membership file for the patient. If no value is found on the patient's record, the value will be pulled from the subscriber's record.	20	AN	Situational	
59	Patient Client Reporting 1	Client reporting code as sent in the membership file. If no value is found on the patient's record, the value will be pulled from the subscriber's record.	20	AN	Situational	
60	Patient Client Reporting 2	Client reporting code as sent in the membership file. If no value is found on the patient's record, the value will be pulled from the subscriber's record.	20	AN	Situational	
61	Patient Client Reporting 3	Client reporting code as sent in the membership file. If no value is found on the patient's record, the value will be pulled from the subscriber's record.	20	AN	Situational	
62	Benefit Option	The value sent on the membership file that EyeMed uses to map to benefit level. Typically, these codes looks like LEV1.	4	AN	Situational	
63	Benefit Level	The benefit level identifies the part of the benefit structure that the member's claim was incurred against for the date of service.	3	N	Required	
64	Subscriber ID	Benefit-holder (subscriber) member ID as sent in the member ID field of the membership file.	15	AN	Required	
65	Subscriber SSN	Benefit-holder (subscriber) Social Security Number. This value is only available if it is sent in the SSN field of the membership file.	9	N	Situational	No dashes, Zero-filled
66	Subscriber First Name	First name of benefit-holder (subscriber) as sent in the membership file.	15	A	Required	
67	Subscriber Middle Initial	Middle initial of benefit-holder (subscriber) as sent in the membership file.	1	A	Situational	
68	Subscriber Last Name	Last name of benefit-holder (subscriber) as sent in the membership file.	20	A	Required	
69	Subscriber Gender	Gender of benefit-holder (subscriber) as sent in the membership file.	1	A	Situational	M=Male F=Female U=Unknown Default=Blank
70	Subscriber Date Of Birth	Birth date of the benefit-holder (subscriber) as sent in the membership file.	8	Date	Situational	CCYYMMDD
71	Subscriber Address	Address of benefit-holder (subscriber) as sent in the membership file	30	AN	Required	
72	Subscriber Address 2	Street address of the benefit-holder (subscriber) as sent in the membership file.	30	AN	Situational	
73	Subscriber City	City of benefit-holder (subscriber) as sent in the membership file.	20	A	Required	
74	Subscriber State	Postal abbreviation for benefit-holder's state as sent in the membership file.	2	A	Required	
75	Subscriber Zip	Zip of benefit-holder (subscriber) as sent in the membership file.	5	N	Required	
76	Subscriber Zip+4	Four-digit zip extension for the benefit-holder's address as sent in the membership file.	4	N	Situational	
77	Provider ID	EyeMed-created value that uniquely identifies the EyeMed care giver who delivered services. Out-of-Network Provider IDs will be ON9999.	6	AN	Required	
78	Provider NPI	National Provider Identifier associated to the provider performing services.	10	N	Situational	
79	Filler	Future Use	10	N	Situational	
80	Tax Entity NPI	National Provider Identifier associated to tax entity receiving provider payment.	10	N	Situational	
81	Filler	Future Use	6	AN	Required	
82	Filler	Future Use	2	N	Required	
83	Provider First Name	First name of servicing provider. If the servicing provider is a business, the provider first name may be blank.	15	A	Situational	
84	Provider Last Name	Last name of servicing provider. If the servicing provider is a business, the provider last name may be blank.	20	A	Situational	
85	Business Name	Name of business providing services, if applicable.	30	A	Situational	
86	Filler	Future Use	30	A	Situational	
87	Provider Address	Servicing location address.	30	AN	Required	
88	Provider Address 2	Servicing location address2.	30	AN	Situational	
89	Provider City	Servicing location city.	20	A	Required	
90	Provider State	Servicing location state.	2	A	Required	
91	Provider Zip	Servicing location zip.	5	N	Required	
92	Provider Zip+4	Servicing location zip+4.	4	N	Situational	

Field #	Field Name	Definition	Length	Type	Usage	Valid Values /Defaults
93	Professional Designation	Identifies the provider as an optician, optometrist or an ophthalmologist.	6	AN	Situational	Periods are included.
94	Check Date	Date the claim was paid to the provider for in-network claims or to the member for Out-of-Network Claims.	8	Date	Situational	

Section 9

Medical Exception Program

Empire BlueCross

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Sample Medical Exception Form

Empire BlueCross

An Anthem Company

New York State Vision Program Medical Exception Request

You may be eligible for an annual eye exam through the medical exception program. Please review and follow the instructions within this form. **This form must include a signature from your provider indicating the qualifying medical condition.**

Section 1: TO BE COMPLETED BY MEMBER

Information about the employee seeking a medical exception. The employee's EyeMed Member ID Number can be found on their Vision ID Card or by contacting EyeMed at XXX-XXX-XXXX. The Employee email field must be completed for the employee to receive confirmation of approval.

Employee First Name: _____ Employee Last Name: _____

Employee ID: _____ Date of Birth: _____ Gender: _____

Work Email: _____

Phone #: _____ EyeMed Member ID #: _____

Section 2: TO BE COMPLETED BY YOUR PROVIDER.

Provider Attestation: I attest the above referenced patient has been diagnosed with the condition below.

- ☐ Diabetes
- ☐ Cataracts
- ☐ Keratoconus
- ☐ Eye surgery within the last two (2) years of current Rx
- ☐ Prescription medication causing vision changes

_____ _____

Provider Signature Date

Section 3: SUBMIT THE COMPLETED FORM

Please submit completed form via one of the following methods:

Email: xxx@eyemed.com

FAX: 513.XXX.XXXX

Mail: PO Box 123 Sampletown, NY 12345

The completed form, including provider signature, must be returned to Empire for final approval.

Section 10

Performance Guarantees

Empire BlueCross

An Anthem Company

ATTACHMENT 6

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Performance Guarantees RFP entitled: "New York State Vision Plan Services"**

Offeror Name: **Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross**

We have exceeded your expectations by offering [redacted]% of the requested fees at risk. In addition, we've also proposed more [redacted]. All are featured in red type.

Implementation Guarantee: The Offeror proposes to forfeit $[redacted] for each Calendar Day or part thereof, that all Implementation and Start-Up requirements are not met in the time frame stated in Section 3.2. This guarantee is not subject to the limitation of liability provisions of the Contract.

Network Access Urban Areas Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which less than [redacted] of urban Enrollees in New York State do not have Provider access that meets the Network Access-Urban Areas requirement listed in Section 3.3(1)(a) of the RFP.

Network Access Suburban Areas Guarantee: The Offeror proposes to forfeit $ [redacted] for each quarter in which less than [redacted] of suburban Enrollees in New York State do not have provider access that meets the Network Access-Suburban Areas requirement listed in Section 3.3(1)(a) of the RFP.

Network Access Rural Areas Guarantee: The Offeror proposes to forfeit $ [redacted] for each quarter in which less than [redacted] of rural Enrollees in New York State do not have provider access that meets the Network Access-Rural Areas requirement listed in Section 3.3(1)(a) of the RFP.

Turnaround Time for Receiving Eyewear Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which less than ninety-fine percent of all orders from a Participating Provider for covered eyewear are not shipped to the Participating Provider within seven Calendar Days after the order is received by the lab processing the eyewear.

Call Center Response Time Guarantee: The Offeror proposes to forfeit $ [redacted] for each quarter in which the the number of telephone calls answered within sixty seconds falls below ninety percent of all incoming calls.

Telephone Availability Guarantee: The Offeror proposes to forfeit $[redacted] for each quarter in which the Offeror's customer service toll-free telephone line is not operational and available to Members and Providers ninety-nine and five-tenths percent of the time.

Telephone Abandonment Rate Guarantee: The Offeror proposes to forfeit $ [redacted] for each quarter in which more than [redacted] of callers disconnect a call prior to the call being answered by a CSR.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**Performance Guarantees** **RFP entitled:** **"New York State Vision Plan Services"**

Telephone Blockage Rate Guarantee: The Offeror proposes to forfeit $ _[redacted]_ for each quarter in which more than [redacted] of incoming calls to the Offeror's telephone line are blocked by a busy signal.

Website Maintenance Guarantee: The Offeror proposes to forfeit $__[redacted]__for each Calendar Day beyond thirty Calendar Days notification by the Department that all Vision Plan benefit changes are not accurately updated to the Vision Plan's customized website.

Management Reports and Claims File Guarantee: The Offeror proposes to forfeit $__[redacted]__ for each Calendar Day the Department has not received the Vision Plan management report and claims file by their respective due date.

Enrollment Management Guarantee: The Offeror proposes to forfeit $ _[redacted]_ for *every two (2) business days* in which one hundred percent of the enrollment records that meet the quality standards for loading are not loaded in the Offeror's enrollment system after such enrollment records have been released by the Department.

Transition and Termination Guarantee: The Offeror proposes to forfeit $_[redacted]_ for each Calendar Day or part thereof that the Transition Plan requirements are not met.

Appendix A

New York State Subcontractors and Suppliers

Empire BlueCross

An Anthem Company

ATTACHMENT 12

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service	**New York State Subcontractors and Suppliers - RFP entitled: "New York State Vision Plan Services"**

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

As stated in Section 2 of this RFP, an Offeror is encouraged to use New York State businesses in the performance of Project Services. Please complete the following exhibit to reflect the Offeror's proposed utilization of New York State businesses.

Name(s) of New York Subcontractors and/or Suppliers	Address, City, State, and Zip Code	Description of Services or Supplies Provided	Estimated Value Over 1-Year Contract Period	Identify if Subcontractor and/or Supplier
Empire fully supports having a substantial presence in the state of New York. We proudly have been serving New York families and businesses since 1934. Empire is a local partner in the New York community, with locally based employees living and working in several locations across the state. While we are not identifying specific NYS businesses at this time in the fulfillment of the Department's vision contract, we will strongly consider our needs and use local resources as appropriate to further contribute to the economies of the state and the nation.				

A note about our binders and tabs: Our binders and tabs are made from Premium Grade polypropylene, which is an environmentally friendly material. Polypropylene is produced without using water and no harmful emissions are released.

Additionally, Polypropylene is:

- A strong, non-toxic, durable material
- 100% recyclable and biodegradable
- Free from chlorine and harmful additives

Since Polypropylene is up to 35 percent lighter than many traditional plastics, this helps to reduce transportation costs and the output of carbon dioxide. In a world where more companies are increasingly aware of the need to reduce our environmental impact, Polypropylene is considered the natural choice.

Proposal to Serve

New York State Department of Civil Service

New York State Vision Plan Services

FINANCIAL - REDACTED

January 1, 2022

Empire BlueCross

An Anthem Company

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New York State Department of Civil Service Financial Proposal - Redacted

Empire BlueCross

An Anthem Company

Section 1

Financial Proposal Requirements (Section 6)

Empire BlueCross

An Anthem Company

SECTION 6: FINANCIAL PROPOSAL

This section of the RFP sets forth the requirements for the Offeror's Financial Proposal submission and the cost structure required by the Department for Offerors to use in developing their submission. The Offeror's Financial Proposal must respond to all the following mandatory sections as set forth below in the formats as specified.

The sole compensation for the Contractor under the Contract will be payments based on the provisions set forth in this section of the RFP. The actual amount reimbursed to Participating Providers and Laser Vision Correction Providers is at the discretion of the Offeror provided that no liability is incurred by the Enrollee for covered services with the exception of applicable copayments. During the term of the Contract, amounts paid for which it is subsequently determined that the Contractor was not entitled, if any, must be refunded to the Department. Submission of an invoice and payment thereof shall not preclude the Department from recovery or offset of payment in any case where Project Services as delivered are found to deviate from the terms and conditions of the Contract.

If a significant change in benefits occurs during the term of the Contract which, determined by the Department in its sole discretion, materially impacts the Offeror's level of effort and/or cost, the State reserves the right to and, at its sole discretion may, renegotiate the unit rates contained in the *Participating Provider - Laser Vision Correction Surgery Fee Schedule and Administrative Fee* Form (Attachment 16).

Evaluation of Financial Proposals will be performed in accordance with the provisions presented in Section 7.3 of the RFP.

The Financial Proposal must consist of the following:

As the offeror, Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross (Empire) has responded to the below items related to our Financial Proposal:

6.1 Program Claims

Throughout the term of the Contract, the Offeror will be paid on a monthly basis for Vision Plan claims, including Participating Provider and Non-Network claims. The Non- Network claims are to be processed, for reimbursement to Enrollees and payment by the Department, based on the rates set forth in the *Non-Network Reimbursement Schedule* (Attachment 15).

Using the *Participating Provider/Laser Vision Correction Surgery Fee Schedule and Administrative Fee* Form (Attachment 16), the Offeror must provide the proposed fixed fee for each type of service listed for each year of the Contract. The Offeror shall charge the Vision Plan for covered services based on the type of service and the proposed fixed fees of this schedule, less any applicable copayments. The Offeror's proposed unit rates as set forth in the *Participating Provider - Laser Vision Correction Surgery Fee Schedule and Administrative* Fee Form (Attachment 16) must be guaranteed for the term of the Contract.

Please see the Vision Plan's claim utilization data for *Participating Providers, and Laser Vision Correction Participating Providers in Claims Utilization Data from 2016 to 2020* (Attachment 31).

Confirmed. For added clarity, the fixed fee provided for spectacle lenses reflects our cost for [redacted] lenses. The provided utilization reflects counts based on each individual lens. We have added the [redacted] notation where applicable.

6.2 Administrative Fees

1 The Offeror must submit a completed *Participating Provider/Laser Vision Correction Surgery Fee Schedule and Administrative Fee* Form (Attachment 16) which must include the Offeror's proposed per Enrollee per month fee for Administrative Fees charged to the Vision Plan. An Offeror's quoted Administrative Fee must include all direct and indirect costs, overhead, travel expenses, fees, and profit.

Confirmed. Please refer to Section 2 for the completed Attachment 16 document.

2 The Offeror will be bound by its quoted Administrative Fee, as proposed in the Offeror's Financial Proposal for the entire term of the Contract, unless amended in writing.

Confirmed. Our proposed administrative fee is guaranteed for [redacted] months.

3 Each month, the Offeror shall calculate the total Administrative Fee payable to the Offeror by multiplying the per Enrollee per month fee by the average number Enrollees in force for the assessed month as reported by the Offeror. The average number Enrollees for the assessed month reported by the Offeror shall be based on the enrollment files and enrollment updates the Department transmits to the Offeror as set forth in Section 3.7 of this RFP.

Confirmed.

4 The Department reserves the right to adjust the Administrative Fee charged by the Offeror based on a reconciliation of the Enrollee counts reported from the Department's NYBEAS by the Enrollee counts utilized by the Offeror to calculate the monthly Administrative Fee. The reconciliation will be performed by the Department on an annual basis using the average Enrollee count for the respective Plan Year. However, the Department may perform additional reconciliations throughout a given year if the average monthly Enrollee counts utilized by the Offeror differ significantly from the Department's Enrollee counts, as reflected in NYBEAS. In addition, the Administrative Fee shall be adjusted on an annual basis based on penalties due to the Department or payments due to the Offeror in accordance with the *Performance Guarantees* form (Attachment 6).

Confirmed.

Section 2

Fee Schedule and Administrative Fee Form (Attachment 16)

Empire BlueCross

An Anthem Company

ATTACHMENT 16

Participating Provider/Laser Vision Correction Surgery Fee Schedule and Administrative Fee Form - RFP entitled: "New York State Vision Plan Services"

Offeror Name: Empire HealthChoice Assurance, Inc., d/b/a Empire BlueCross

	Year 1	Year 2	Year 3	Year 4	Year 5
EXAMS					
Examination					
Occupational exam					
FRAMES					
Basic Frame					
Standard Frame					
Enhanced Frame					
LENSES					
Basic Plastic Single Vision Lenses					
Basic Plastic Bifocal Lenses					
Basic Plastic Trifocal Lenses					
Glass					
Polycarbonate Lenses					
High Index Lenses					
Photochromic Single Vision Lenses - Glass					
Photochromic Multi-Focal Lenses - Glass					
Photochromic Lenses - Plastic					
Plastic Progressive Lenses					
Ultraviolet Coating					
Tint					
Scratch Resistant Coating					

ATTACHMENT 16

Participating Provider/Laser Vision Correction Surgery Fee Schedule and Administrative Fee Form - RFP entitled: "New York State Vision Plan Services"

	Year 1	Year 2	Year 3	Year 4	Year 5
CONTACT LENSES					
Contact Lens Dispensing, established patient					
Contact Lens Dispensing, new patient					
Contact Lenses - Disposable					
LASER CORRECTION SURGERY					
Custom Intralase					
Custom Wavefront Lasik					
Photorefractive Keratecpomy (PRK)					
Traditional Intralase					

	Year 1	Year 2	Year 3	Year 4	Year 5
Administrative Fee (per Enrollee per month fee) Enrollees are defined as the policyholders, not their dependents.	PEPM	PEPM	PEPM	PEPM	PEPM

The Department will not accept fees with any variables or contingencies. An Offeror must fill in quotes in the space provided. The Department will not accept modifications to this attachment.

A note about our binders and tabs: Our binders and tabs are made from Premium Grade polypropylene, which is an environmentally friendly material. Polypropylene is produced without using water and no harmful emissions are released.

Additionally, Polypropylene is:

- A strong, non-toxic, durable material
- 100% recyclable and biodegradable
- Free from chlorine and harmful additives

Since Polypropylene is up to 35 percent lighter than many traditional plastics, this helps to reduce transportation costs and the output of carbon dioxide. In a world where more companies are increasingly aware of the need to reduce our environmental impact, Polypropylene is considered the natural choice.