PROVIDER MANUAL

BLOCK OVERVIEW
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COMPANY OVERVIEW AND MISSION STATEMENT

Block Vision, Inc. and its managed care affiliates, Block Vision of New Jersey, Inc., and UVC Independent Practice Association, Inc. (collectively, "Block Vision", "Block" or the "Company") provide comprehensive administration of vision care programs for healthcare plans. The Company contracts with health maintenance organizations and other managed care entities for the complete coordination of the plan's vision benefits. The Company and its affiliates currently arrange vision benefits for over three million covered lives nationwide.

We recognize that our contracted providers have the most direct line of contact with the members enrolled through our client healthplan's programs. It is our goal to form a cooperative partnership with each of our providers that will result in a mutually beneficial relationship. We have learned from our extensive experience in the industry how to continually monitor our systems and procedures to maximize the "provider friendliness" of our program. We believe participation on our panel offers eyecare practitioners a number of advantages, and we look forward to proving the strength of our service to you.

** MISSION STATEMENT **

It is the mission of Block Vision to provide the Company's clients and their enrollees, as well as participating providers, with the highest quality of vision program administration services available. For our clients, this means providing comprehensive administrative services that alleviate the healthplan of all burdens associated with its vision program. For the healthplan's enrollees, this ensures access to a panel of eyecare professionals whose high-quality services are monitored through the program's application and credentialing process. For our participating providers, this means a plan whose administrative procedures are straightforward and whose prompt payment cycle is timely and efficient. Block Vision is committed to simultaneously delivering superior administrative services to each of these constituent groups.

HOW THE PROGRAM WORKS

Block Vision's program has been carefully designed to provide members and providers alike with easy access to our services. Here's how a typical patient encounter works:

- The healthplan will distribute a list of participating eyecare providers to a new member who enrolls under the plan.

- When the member decides to seek vision care services, they simply call the participating provider of their choice to schedule an appointment. The member does not generally contact either Block or the plan to request a referral or other type of authorization (a few plans do require a referral; however, these will be noted in the plan-specific section of this Provider Manual).

- When scheduling an appointment, please inquire as to the member's plan coverage. Since Block Vision is the program administrator and not the actual healthplan with which the member is enrolled, most members will identify themselves by the name of the healthplan and are not familiar with the Block Vision name. Please be aware of the specific healthplans that Block provides service to and equate these calls with the Block Vision program. Some of Block Vision's client healthplans elect to notify members of Block Vision's management of their vision benefits, and these members may identify with the Block Vision name and/or the healthplan name.

- Once the appointment has been scheduled, contact Block Vision through its website or automated Telephone Voice Response Unit (VRU) to verify the member's eligibility and receive an eligibility verification number.

  Please refer to the "Eligibility Verification Procedures" section of this Provider Manual for general instructions. Please also note that each plan-specific section of this Provider Manual provides details on the format of the member I.D. numbers and any specific instructions necessary for verifying member eligibility or receiving prior authorization for those services for which prior services authorization is required under the plan.

  It is important that you verify member eligibility at the time the appointment is initially scheduled. In the event the member's eligibility status must be researched, this will allow sufficient time for the necessary research and follow-up with your office.

- On the day of the appointment, your services should be delivered in accordance with the Member's benefit coverage and the service standards set forth in your Vision Care Services Agreement with the Company and later sections of this Provider Manual. Please refer to the "Member Charges" section of this Provider Manual for details on allowable collections from the patient.

- Provider has the option of using the optical laboratory of his/her choice, subject to all applicable state and/or federal laws concerning self-referral. Provider's choice of optical laboratory does not affect coverage and reimbursements.

- You may electronically submit claims via the Company's website (www.blockvision.com) or in the ASC X12N 837 HIPAA standard format, either directly to the Company or through its clearinghouse. You may also utilize the CMS 1500 form for submitting paper claims to Block Vision. Please refer to the "Claim Submission Requirements" and "Claims Payment Procedures" sections of this Provider Manual for further details on submitting claims, as well as Block Vision's reimbursement policies.

STATEMENT OF MEMBERS' RIGHTS AND RESPONSIBILITIES

Block Vision is committed to providing members enrolled through its clients with high-quality eye care and administrative service from Block Vision's participating providers and the Company's administrative staff. Member inquiries regarding this Statement should be directed to Block Vision's Member Services department at its toll-free telephone number.

The following rights and responsibilities apply to all members:

Members have the right to:

- Receive information about Block Vision, its services, its participating providers and members' rights and responsibilities;

- Receive accurate benefit information in a timely manner, as well as to receive timely assistance when seeking to utilize their vision coverage;

- Timely access to care that does not have any communication or physical access barriers;

- Be treated with respect and recognition of their dignity and right to privacy (including the right to have your medical records and care kept private) and to receive eye care services in a non-discriminatory manner on the same basis as patients not enrolled through Block Vision's clients;

- Be free from any form of restraint or seclusion by use or means of coercion, discipline, convenience or retaliation;

- Actively participate with their Block Vision provider in making decisions about their eye care, including consent for or refusal of treatment;

- A candid discussion of appropriate or medically necessary treatment options for their eye care conditions, regardless of cost or benefit coverage. This includes the right to ask questions and to receive complete information relating to the member's visual and medical condition(s) and treatment options, including specialty care;

- Voice complaints or appeals about Block Vision, the healthplan through which the member is enrolled, or the care received and to receive access to the grievance process. This includes the right to receive assistance in filing an appeal and to receive a fair hearing from Block Vision, the healthplan through which the member is enrolled or other applicable regulatory body (i.e., state Medicaid agency such as the Kentucky Department for Medicaid Services, the Connecticut Department of Social Services or the New Jersey Division of Medical Assistance and Health Services (DMAHS));

- Receive eye care services from a different participating provider each time they access covered services within defined benefit frequency intervals;

- A reasonable opportunity to choose a primary care provider (PCP) and to change to another provider in a reasonable manner. (Selection of a PCP and any PCP changes are coordinated with the healthplan through which the member is enrolled.);

- Timely referral and access to medically-indicated specialty care (in accordance with referral protocols established by the healthplan through which the member is enrolled);

- Have access to medical records in accordance with applicable federal and state laws;

- Prepare Advance Medical Directives pursuant to applicable laws; and

- Make recommendations regarding Block Vision's members' rights and responsibilities policies.

Members have a responsibility to:

- Become informed about their member rights.

- Supply information (to the extent possible) that Block Vision, a participating provider and/or the healthplan through which the member is enrolled needs in order to arrange for or provide eye care services;

- Abide by the policies and procedures established by Block Vision, the healthplan through which the member is enrolled and any applicable regulatory body (e.g., state Medicaid agency such as the Kentucky Department for Medicaid Services, the Connecticut Department of Social Services or the New Jersey Division of Medical Assistance and Health Services (DMAHS));

- Become informed about service and treatment options and to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;

- Follow plans and instructions for care that they have agreed on with their participating provider;

- Actively participate in personal health and care decisions and to practice healthy lifestyles;

- Report suspected instances of fraud, waste and abuse; and

- Keep scheduled appointments or call the provider's office to cancel.

ELIGIBILITY VERIFICATION PROCEDURES

Providers may verify member eligibility 24 hours a day, 7 days a week through Block Vision's website or Voice Response Unit (VRU).

It is important that you verify member eligibility at the time the appointment is scheduled. In the event the member's eligibility status must be researched, this will allow sufficient time for the necessary research and follow-up with your office *prior* to the appointment.

The eligibility verification number furnished to the provider is unique to that patient and date of service and must be entered on the claim form for processing. It is important to notify Block Vision if there is a change in the date of service for any eligibility verification number obtained.

I. Internet Website (www.blockvision.com)

Simply log on to Block Vision's website to obtain benefits information, verify eligibility and obtain an eligibility verification number. There is no limit to the number of eligibility verifications you may obtain during a website visit.

Please follow the instructions set forth below to access the website:

- Click on "Provider Log In" in the upper left-hand corner of the screen
- After reading important information about the website click on "Continue to Provider Login Page"
- Select "Provider Login"
- Select "Provider" from dropdown box
- Enter your NPI Number
- Enter the password you selected the first time you accessed the website
- Select the "Eligibility Verification" menu item

Please follow the instructions included in the Provider Web Manual under the section captioned "Eligibility Verification and Obtaining an Authorization." The Provider Web Manual may be viewed on-line or you may download a copy from the Block Vision website.

II. Voice Response Unit (VRU)

In order to access Block Vision's VRU, please call **(866) 819-4298** and follow the prompts, using your telephone keypad, as follows:

- Enter your NPI Number; press the # key when completed. The system will state the participating provider's name linked to the provider number entered. Please verify that the NPI number entered is correct.
- Select option #1 for member benefits and eligibility verification
- If the member's identification number is alpha/numeric, press 2; otherwise, wait to be prompted to enter the member ID
- Enter the member ID number; press the # key when completed
- You may be asked to enter the member's date of birth in the MM DD YYYY format

- Select option # 1 to authorize services and to hear benefits
- You may be prompted to enter your Block Vision Location Code
- Enter the date of the appointment in MM DD YYYY format
- The VRU will offer each benefit for which the member is eligible; press 1 to include the benefit in your eligibility verification; press 2 to decline the benefit and move to the next benefit

The VRU will transfer you to a Block Vision representative in the event the system is unable to process the requested eligibility verification.

ACCESS AND SERVICE DELIVERY STANDARDS

While the exact schedule of covered services and benefit allowances will vary from plan to plan, Block Vision maintains a series of access and service delivery standards which must be followed for all of the Company's contracted plans. Participating providers are required to comply with all of the following:

1. The provider must maintain normal office hours of at least 32 hours per week.

2. Members must be offered an appointment within two weeks of the date of request. Compliance with this standard is measured based upon the provider's first available appointment and not when the appointment is actually scheduled, as we recognize the member may impose certain availability restrictions, for which the provider cannot be accountable. The standard in-office waiting time for a wellness vision appointment is within 30 minutes of the scheduled appointment, and the standard for in-office waiting time for a medical eye care appointment is within 45 minutes of the scheduled appointment. All providers are required to accept new patients. Provider shall not differentiate or discriminate in the provision of services to members in any way.

3. In order to participate on Block Vision's provider panel, a practitioner's facility must include the following instrumentation:
    a. Projector/Acuity Charts (far/near)
    b. Keratometer
    c. Direct Ophthalmoscope
    d. Binocular Indirect Ophthalmoscope (with appropriate auxiliary lenses) or Slit Lamp Biomicroscope (with appropriate auxiliary lenses)
    e. Retinoscope or Autorefractor
    f. Phoropter/Refractor
    g. Tonometer
    h. Color Vision Test
    i. Lensometer

4. All examinations covered under the program are to be comprehensive in nature, must comply with applicable state mandates regarding examination standards and, at a minimum, shall include the following:

Comprehensive Eye Examination Requirements

A comprehensive eye examination shall be performed in accordance with state guidelines and shall include, at a minimum, the following:

a. Case History:
- Chief complaint/reason for seeking service
- Patient medical and eye history
- Current medications
- Allergies
- Present prescription (if any)

b. Visual Acuities:
- Unaided - distance and near
- Habitual - distance and near

c. Ocular Health:
- External - biomicroscopy of structures
- Internal – ophthalmoscopy (including dilation when clinically indicated or required under state law)
- Tonometry - pressures, instrument used, time of day
- (Note: A reasonable attempt at obtaining IOP's shall be made unless, in the provider's professional opinion, it is contraindicated.)

d. Preliminaries:
- Confrontation visual fields
- Pupillary responses - direct, consensual, proximal
- Cover test - far and near
- Ocular motility testing - rotations, versions, saccades

e. Refraction:
- Objective testing - far and near
- Subjective testing - far and near

f. Binocular Coordination Testing:
- Gross convergence testing
- Amplitude of accommodation
- Phorias and fusional vergences - far and near

g. Diagnosis/Prognosis/Patient Instructions

NOTE:
1. All findings should be recorded in positive terms.
2. The handwriting on the clinical record must be clear enough so that another clinician could understand the test results and other notations and arrive at the same diagnosis.

At least 30 minutes shall be allocated per complete examination. More time may be needed for contact lens patients and for the elderly or cases with existing pathologies. This amount of time will allow for a complete examination to be done along with all of the necessary patient record documentation.

5. When the member's benefit coverage includes contact lenses, the following additional tests/procedures are required for the fitting and assessment of contact lenses:

Contact Lens Examination/Fitting Standards

A contact lens examination and fitting shall include, at a minimum, the following:

a. Keratometry or ophthalmometry;
b. History relating to lens wear (previous wear, allergies, etc.);
c. Fitting or assessment of fit with slitlamp;
d. Visual acuities with lenses in place.

The patient must also receive the following:

a. Instruction on insertion and removal of lenses;
b. Appropriate care (disinfecting) system and its use;
c. Wearing instructions;
d. Follow-up care as appropriate.

Contact Lens Standards

The following standards are recommended for contact lens patients:

a. Patient shall receive a diagnostic evaluation prior to the time of dispensing.
b. A sixty-day clinical adaptation period should be used for all patients who are newly fitted for contact lenses.
c. A thorough evaluation should be made of all contact lens users at each follow-up visit.
d. All contact lens patients should have written instructions that advise them of proper wear, hygiene and maintenance of their lenses.

6. When the member's benefit coverage includes eyewear, the following additional standards are required:

Eyewear Dispensing Standards

Dispensing shall be performed by duly certified and licensed personnel. The provider performing the dispensing of eyewear should note on the record the following:

a. Frame size;
b. Appropriate lens material;
c. Appropriate tints, when indicated;
d. Pupillary distance;
e. Base curve of lens, when indicated;
f. Follow-up adjustments for a period of six months;
g Verification of eyewear after fabrication (compliance with ANSI standards--Z80)

Advice should be offered to the patient on eyewear selection. The provider is required to maintain the proper number of frames within the specified frame allowance covered by the plan. All eyewear must be made available to the member as soon as received from the laboratory; eyewear turnaround time must be no more than five business days.

7. Coverage Determinations for Non-Standard Services/Eyewear (Note: applicable regulatory coverage guidelines may supersede these recommendations)

1. Non-Standard Eye Examination

a. Definition – additional routine eye examinations beyond the standard benefit coverage frequency. Provider must submit documentation supporting the clinical appropriateness of all Non-Standard eye examinations to the Company for a coverage determination prior to rendering the Non-Standard eye examinations.

b. Coverage Criteria – additional routine eye examinations are covered: (i) when recommended by the school nurse, teacher or due to other school reasons; and (ii) due to presence of diabetic retinopathy, glaucoma, cataracts, following cataract surgery or when otherwise clinically indicated.

2. Non-Standard Eyewear

a. Definition – eyewear beyond the standard benefit coverage. Except as set forth in d. below, provider must submit documentation supporting the clinical appropriateness of all Non-Standard eyewear to the Company for a coverage determination prior to dispensing the Non-Standard eyewear.

b. Coverage Criteria for Non-Standard Eyeglass Lens Types – non-standard eyeglass lens types are covered as follows: (i) plano (non-prescription) lenses are covered when required for protective purposes when the member is limited to vision in only one eye; and (ii) tinted lenses are covered when the member is diagnosed with albinism, diseases of the retina or when otherwise clinically indicated.

c. Coverage Criteria for Non-Standard Contact Lenses – when contact lenses are beyond the standard benefit coverage, the contact lenses will be covered when: (i) required for treatment of keratoconus; (ii) due to severe myopia, greater than 10 diopters; (iii) due to aphakia in children; and (iv) otherwise clinically indicated.

d. Non-Standard Eyewear Not Requiring Coverage Determination – the following Non-Standard eyewear does not require a coverage determination: (i) high index lenses for lens prescriptions greater than $\pm$6.00 diopters sphere and/or $\pm$ 3.00 diopters cylinder; (ii) lenses with prism when determined to be clinically appropriate by the provider; and (iii) polycarbonate lenses when determined to be clinically appropriate by the provider for children enrolled through Medicaid/CHIP programs.

8. The following services/materials are generally excluded from coverage. Any exceptions will be noted in the plan-specific section of this Provider Manual as applicable.

- Safety lenses and frames
- Two pairs of frames and lenses in lieu of bifocals
- Replacement of lost or damaged frames or lenses
- Tinted lenses and photo-chromatic lenses
- Aniseikonic lenses, blended or progressive bifocals, sunglasses, special occupational lenses, special coatings (e.g.., hard, anti-reflective), oversize lenses

over 75mm, lamination of a lens or lenses, facets or other cosmetic grinds or polishes
- Special mountings (other than standard zyl, standard metal or standard half-eyes)
- Orthoptics, vision training, low vision aids, or any supplemental training
- Non-prescription (plano) eyewear or eyewear with a prescription of less than ± 0.50 diopters
- Medical eyecare services and diagnostic procedures
- Any examination or corrective eye wear required by an employer as a condition of employment
- Conditions covered by Worker's Compensation

EYEWEAR POLICIES

Block Vision does not own, manage or maintain any financial interest in the supply of eyewear through its managed care program.

- Provider has the option of using the optical laboratory of his/her choice, subject to all applicable state and/or federal laws concerning self-referral.

- Eyeglass frames are to be dispensed from the provider's usual stock of frames available to all patients. The provider is not required to purchase a frame kit or maintain a collection of Block-designated frames. However, the provider *is* required to maintain a minimum number of in-stock frames within the plan's stated benefit allowances. Unless otherwise stated in the plan-specific section of this Provider Manual, this in-stock selection shall include at least 30 frames (10 each for men, women and children) within the plan's benefit allowances.

- Most of Block's contracted programs provide coverage for "standard" lens types, as defined below:

Single Vision	7 x 25 Trifocal
FT-25 Bifocal	7 x 28 Trifocal
FT-28 Bifocal	Aspheric-Lenticular/Single Vision
Round Bifocal	Aspheric-Lenticular/Round Bifocal

  Such lenses will be provided in glass or plastic. Tinted lenses are covered only for aphakia and pseudo-aphakia.

- Lenses must contain a total refractive value of at least ± 0.50 diopter in at least one eye in order to qualify for eyewear coverage.

- All lens add-ons, such as tints and coatings, will be charged to the member at the provider's usual and customary fees, less any applicable discount as outlined in the plan-specific section of the Provider Manual.

- Lens types other than those listed above (e.g., progressive multifocals, high-index, polycarbonates) are considered to be specialty lenses, which are generally not covered under commercial or Medicare benefit plans. However, the commercial or Medicare member is generally entitled to an allowance toward the provider's usual and customary charge for the lenses. The amount of this allowance is specified in the plan-specific section of the Provider Manual.

The following specialty lens types are covered for Medicaid and CHIP members (or related public assistance programs, e.g. Family Health Plus and NJ FamilyCare) in accordance with applicable state guidelines:

- For members age 21 and over, polycarbonate lenses (or at the provider's discretion mid-index lenses) for lens prescriptions greater than or equal to ±6.00 diopters sphere and/or greater than or equal to ±3.00 diopters cylinder. In order to ensure proper reimbursement, provider must indicate on the claim submission that high-index lenses were dispensed and send a copy of the lab invoice to Block Vision.

- For members under age 21, polycarbonate lenses dispensed for protective purposes for all lens prescriptions up to or greater than or equal to ±6.00 diopters sphere and up to or greater than or equal to ±3.00 diopters cylinder. In order to ensure proper reimbursement, provider must indicate on the claim submission that polycarbonate lenses were dispensed and send a copy of the lab invoice to Block Vision.

UTILIZATION MANAGEMENT

Substantially all of the programs administered by Block Vision provide coverage for wellness vision benefits which are available on demand, subject to the member's eligibility for such benefits, and a review of the medical appropriateness of such services is not necessary. However, if a request is made for coverage of non-standard services or materials, Block Vision has the right to review the request prior to authorizing such services/materials.

Additionally, when a member's benefit coverage includes medical eye care services and/or diagnostic procedures, Block Vision has the right to review the medical appropriateness of such services, at any time, as a condition of issuing payment. In such circumstances, Block Vision utilizes established Clinical Protocols to review the medical appropriateness of the requested services or materials. These Clinical Protocols have been developed by Block Vision based upon the *American Academy of Ophthalmology's Preferred Practice Patterns* and the *American Optometric Association's Optometric Clinical Practice Guidelines.* A copy of the Clinical Protocols is available upon request by contacting Block Vision's Provider Relations Department at 800-243-1401.

To request coverage for non-standard services or materials, provider should contact Block Vision's Member Services staff at (1-800-243-1401) to discuss the nature of the request and supporting clinical information regarding the member's condition. Provider may also fax his/her request to Block Vision at 410-752-9184. Provider should submit all supporting documentation and/or clinical information necessary for Block Vision to process the request at the time of the request.

When utilization management decisions are made by Block Vision, Block Vision makes the decision and notifies the requesting provider (e.g., in New Jersey, notice is given by telephone and in writing) of the decision on the same day that the decision was made in accordance with the following timeframes, unless a shorter timeframe is required by applicable law:

- Decisions regarding requests for authorization for non-urgent care are made within two business days of Block Vision's receipt of the request.

- Decisions regarding requests for authorization for urgent care are made within one day of Block Vision's receipt of the request.
- Decisions regarding requests for concurrent review are made within one day of Block Vision's receipt of the request.
- Decisions regarding retrospective review are made within thirty days of Block Vision's receipt of the request (unless a shorter timeframe is required by applicable law).

All coverage determinations will be communicated in writing. Any provider wishing to discuss a coverage denial with the individual who reviewed the request on behalf of Block Vision may do so by contacting Block Vision's Utilization Management Department at 800-243-1401 to arrange for such discussion.

Coverage denials may be appealed by the member or the provider acting on behalf of the member. Management of the appeals process is generally retained by Block Vision's clients and is not delegated to Block Vision. Block Vision's notification of the coverage denial will include the procedure for submission of an appeal, including the timeframe for submitting the appeal and the address to which the appeal should be sent.

Individuals making utilization management decisions on behalf of the Company do not receive financial incentives in connection with the utilization management decision making process. Therefore, there are no financial incentives for individuals making utilization management decisions on behalf of the Company that encourage decisions that result in underutilization. The Company does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.

CLAIM SUBMISSION REQUIREMENTS

Providers may submit claims to Block Vision electronically, either through Block Vision's internet website or through its contracted healthcare clearinghouse, or via paper claims through the mail or facsimile.

All claims must be submitted to Block Vision within 90 days of the date of service, or as otherwise required by applicable law (e.g. claims for services rendered to members enrolled through a New Jersey or Maryland healthplan must be submitted to Block Vision within 180 days of the date of service). Block Vision may not honor any claims submitted after 90 days, or such longer period of time permitted by applicable law (e.g. 180 days under New Jersey and Maryland law).

All claim submissions by provider shall be deemed to be provider's certification as to the completeness and truthfulness of all encounter data and other information included on the claim, regardless of the means by which the claim is submitted.

When submitting claims for frame reimbursement based on the provider's wholesale cost, "wholesale cost" means the provider's actual cost of purchasing the frame. Cost data shall be compared against the manufacturer's published price data, exclusive of any buying group discounts or bulk quantity pricing incentives.

Provider shall submit a separate claim for each encounter and each claim must include the eligibility verification number issued by Block Vision for that encounter. Provider should include all services rendered during the encounter on a single claim. If, however, due to provider's organizational structure, professional services and eyewear are billed separately, a separate eligibility verification number should be obtained for the professional services and for the eyewear and the corresponding eligibility verification number for the professional services and the eyewear should be included on each claim.

I. Internet Website (www.blockvision.com)

Providers are encouraged to submit claims for all covered services through Block Vision's website.

Please follow the instructions set forth below to access the website:

- Click on "Provider Log In" in the upper left-hand corner of the screen
- After reading important information about the website click on "Continue to Provider Login Page"
- Select "Provider Login"
- Select "Provider" from dropdown box
- Enter your NPI Number
- Enter the password you selected the first time you accessed the website
- Select the "Enter Claims" menu option

Please follow the instructions included in the Provider Web Manual under the section captioned "Entering a Claim" for all direct data entry claim submissions made through the Block Vision website. The Provider Web Manual may be viewed on-line or you may download a copy from the Block Vision website.

The website may also be used to check the status of a previously submitted claim (see section of Provider Web Manual captioned "Claims Status").

II. Healthcare Clearinghouse Claim Submissions

Block Vision's contracted healthcare clearinghouse is Practice Insight. The **Payer ID** to utilize when submitting electronic claims to Block Vision through Practice Insight is **BV001.** Please call Block Vision's EDI Department at 800-243-1401 to facilitate this connection.

III. ASC X12N 837 HIPAA Standard Format - Direct

Any provider wishing to submit claims in the ASC X12N 837 format directly to Block Vision should contact Block Vision's EDI Department at 800-243-1401.

IV. CMS 1500 Claim Form

Block Vision accepts the CMS 1500 claim form for claims processing purposes for all services covered under the program. It is crucial that all areas of the claim form be correctly completed and the claim submission include any required attachments or other data necessary to process the claim, as **incomplete claim forms will be returned to the provider for completion prior to processing**. This is required because Block Vision must report to its healthplan clients on the number of members seeking services, as well as the type(s) of services rendered.

All paper claims must be submitted to Block Vision at the following address:

Claims Department
Block Vision
939 Elkridge Landing Rd, Suite 200
Linthicum, Maryland 21090

When completing the CMS 1500 claim form please note the following:

- In order for a claim to be considered "clean," the following sections of the claim form **must** be completed: 1a., 2. – 7., 11.c., 12. – 14., 21., 23. – 33. Please include the eligibility verification number issued by Block Vision in Section 23 of the claim form.

- The name of the healthplan through which the member is enrolled must appear in Section 11c. Please note that Block Vision is **not** the insurance plan name or program name for government programs (e.g. Medicaid, CHIP, Medicare).

- Section 24. may include *either* the Block Vision contracted exam and eyewear (where applicable) reimbursement rates *or* your usual and customary fees for services and eyewear rendered. Claims will be processed in accordance with the contracted fee schedule and/or the applicable Plan Benefits/Compensation Schedule, regardless of billing methodology.

- Your NPI number must be included in Box 33a and the Block Vision location number (the location number assigned to you by Block Vision) must be included in Box 33b of the paper claim form.

- All claim forms must be signed by the patient at the time services are rendered (Section 12.) as a means of verifying receipt of services, unless the patient's signature is on file with your office, and you indicate that on the claim form.

CLAIM PAYMENT PROCEDURES

Block Vision adjudicates all claims for covered services in accordance with applicable state prompt pay law, as well as applicable Medicaid and Medicare regulations for claims submitted for covered services rendered to Medicaid or Medicare members. If Block Vision does not adjudicate a clean claim within the timeframe required under applicable law, provider shall be entitled to receive interest calculated and paid in accordance with the applicable state or federal prompt pay law. Block Vision also reserves the right to audit any claim in accordance with the state or federal laws or regulations applicable to such claims audit.

Providers are encouraged to use Block Vision's website to obtain the status of a claim. If the claim is marked as "paid" and more than twenty days from the date of the check has passed and provider has not received the check, provider may contact Block Vision to trace the check. Block Vision will research any lost check for up to one year from the date of issue.

Unless otherwise required by applicable law, all claim payments are deemed final within sixty days of the date of payment unless provider notifies Block Vision within such sixty day period that provider disputes the amount paid. Any claim dispute must be submitted by provider to Block Vision, in writing, either by mail to the address noted above for submission of paper claims, or by fax to 443-451-6012. Such correspondence must specify the amount disputed and include all supporting documentation.

MEMBER CHARGES

The provider is responsible for collecting from the member all co-payments and/or charges for non-covered services/items or services/items which exceed the benefit allowances. Payment is due at the time services are rendered, unless other arrangements have been established between the provider and the member.

Please remember the following policies, which must be adhered to at all times:

- Providers are ***not*** permitted to bill the member for any amounts due from Block Vision. Providers are also ***not*** permitted to balance bill members for the difference between provider's usual and customary charges for *covered* services/items and the reimbursement amount agreed to between Block Vision and the provider.

- Members are to be informed and acknowledge in **writing** their agreement to pay for all requested non-covered services/items or services/items whose retail cost exceeds the plan's benefit allowances. Such notification and acknowledgment of charges must be coordinated **in advance** of the provision of said services/items and must include the amount the member will be required to pay. Failure to give such notice and receive such acknowledgment will result in the member's non-liability for such charges. Block Vision bears no financial responsibility for such situations.

FRAUD, WASTE AND ABUSE, DEFICIT REDUCTION ACT AND FALSE CLAIMS ACT

Block Vision has established a fraud and abuse detection program to identify and investigate suspected fraudulent claims and other types of program waste or abuse for the vision care programs administered by the company on behalf of its clients. In order to prevent, identify and investigate fraudulent and abusive activities, Block Vision enforces benefit frequency limitations, monitors both individual claims and provider claims submission patterns and monitors complaint patterns. A copy of Block Vision's Policy Statement – Fraud & Abuse is available on our website at: www.blockvision.com/provider_newsletter.html.

The Deficit Reduction Act of 2005 (the "DRA") requires that any entity that receives or makes annual Medicaid payments under a State plan of a least $5 million must establish written policies regarding: the Federal False Claims Act (the "FCA"); applicable State law pertaining to civil or criminal penalties

for false claims; and whistleblower protections. Block Vision is committed to educating its network providers about the policies it has established regarding the DRA and FCA in order to prevent, detect, investigate and address any issue pertaining to false claims. Examples of false claims are those billed to receive reimbursement that can not be substantiated such as: billing for services not rendered or services rendered by a provider other than the billing provider; or altering and/or falsifying documentation.

The Federal Anti-Kickback Statute provides that anyone who knowingly and willfully accepts or solicits any remuneration (including any kickback, incentive or bribe) directly or indirectly, overtly or covertly, in cash or in kind, to influence the referral of federal health care program business may face criminal charges, civil penalties and/or exclusion from participation in federal healthcare programs.

The Federal Physician Self-Referral Statute (Stark Law) prohibits physicians from referring designated health services to entities in which they have a financial interest (ownership or control) unless an exception applies.

Providers are encouraged and expected to notify Block Vision of any suspected fraud or abuse pertaining to the Company. Suspected fraudulent activity may be reported to Block Vision at 800-243-1401/Press 3/Press 2, or by email to compliance@blockvision.com.

QUALITY ASSURANCE PROGRAM

Block Vision maintains a comprehensive Quality Assurance (QA) Program to ensure the delivery of high-quality services to members enrolled under the program. The program is designed to assist providers by establishing program policies and procedures regarding service standards. The program has been designed to comply with standards established by the National Committee for Quality Assurance (NCQA), the most widely accepted policy-making body in the managed healthcare industry. The program's activities are based upon applicable NCQA standards and include the items listed in this section. A copy of the QA Program Manual is available upon request by contacting Block Vision's Provider Relations Department at 800-243-1401.

All participating providers are required to cooperate fully with the QA process. Failure to do so may result in termination of the provider's Vision Care Services Agreement. QA program requirements apply to all providers, and periodic QA inquiries to your office should *not* be viewed as a threat to your program participation. Should any finding of the QA program indicate a quality-of-care concern, you will be notified of such concern and, when possible, offered the opportunity to jointly establish with Block Vision a corrective action plan. In accordance with the Vision Care Services Agreement, a provider's program participation may be terminated immediately if the contracting healthplan requests such action or if the situation presents a reasonable danger to the health and safety of members.

Following is a summary of the QA program elements, as well as information on how you may be asked to participate in the QA process:

- **QA Program Structure**

  The Quality Assurance (QA) Program is executed through the efforts of the

Company's QA Committee, full-time QA staff members, including the Company's Clinical Director and QA Director, the Company's Medical Director, and a team of regional optometric consultants.

Daily program activities are carried out under the supervision of the Company's management staff. These individuals work closely with the Company's Clinical Director to develop quality standards and appropriate means for gauging compliance with these standards, as well as appropriate action to be taken in the event a quality concern is revealed. There is a QA Coordinator who is responsible for carrying out service delivery studies and other non-credentialing activities. The Company's credentialing coordinators are responsible for gathering all credentials for new providers, verifying pertinent information with primary sources and periodic provider recredentialing.

The QA Committee meets periodically to set policy and to review and act upon findings of the daily QA process. QA subcommittees meet on an as-needed basis to address issues within such subcommittee's purview. Meeting minutes are recorded to document the Committee's and any subcommittee's actions.

- **New Provider Credentialing**

All providers first joining Block's vision panel are required to complete our Provider Enrollment Application listing general practice, academic, licensure and administration information. Providers are also required to submit evidence of professional liability coverage, stating coverage period, coverage amount and the named insured(s).

Block Vision also performs primary source verification of certain of the information given by the provider in his/her Provider Enrollment Application, either directly or through CreDentals/VerifPoint, an NCQA accredited credentials verification organization. Primary verification is performed with the State licensing body, the National Practitioner Databank, and when the State licensing body does not perform primary verification of graduation/degree from optometry/medical school, with the academic institution the provider graduated from. Block Vision notifies the provider of any information obtained by Block Vision during the credentialing process that varies substantially from the information which the provider submitted to Block Vision, and affords the provider the right to correct any erroneous information. Providers also have the right to review information used by Block Vision to support the credentialing process and to be informed of the status of their credentialing application upon request. The Company's credentialing application cover letter furnished to new provider applicants includes the procedure to follow to request the status of the application or to review information used in support of the credentialing process.

A copy of Block Vision's Credentialing Policy is available to providers upon request. The Credentialing Policy provides a complete description of Block Vision's process and requirements for new provider credentialing.

- **Provider Recredentialing**

To ensure that Block Vision maintains current information on all participating providers, recredentialing is performed on two levels, as follows:

1. Annual license renewal is verified with the State licensing board. The participation of any provider whose license is not renewed will be terminated.

2. Documentation of professional liability coverage renewal must be submitted annually, immediately upon renewal. Block Vision tracks the expiration date of professional liability coverage and, shortly before expiration, notifies the provider of the need to submit evidence of renewal. Failure to supply such documentation will result in the provider's inability to obtain member eligibility verification until such time that malpractice coverage renewal documentation is received.

3. Once every three years, at a minimum, Block Vision will ask the provider to review and update all information in the Company's provider database. The provider will be supplied with a credentialing application for completion. This level of recredentialing also includes a repeat of the *primary verification process* described in the New Provider Credentialing' Section above. The recredentialing process also includes a review of quality indicators with respect to the provider's panel participation, such as service delivery study findings, as well as member satisfaction survey results and member complaint history, as applicable.

4. Block Vision notifies the provider, in writing, of any information obtained by Block Vision during the recredentialing process that varies substantially from the information which the provider submitted to Block Vision, and affords the provider the right to correct any erroneous information within thirty (30) days of the Company's notification. Providers also have the right to be informed of the status of their recredentialing application and to review information used by Block Vision to support the recredentialing process. Each of these requests should be communicated in writing and sent by mail or fax to the Company as follows:

Block Vision
939 Elkridge Landing Rd, Suite 200
Linthicum, Maryland 21090
Attention: Quality Management Department
Fax: 410-625-1596

The request should include the following information:

- Provider Last Name, First Name and Classification
- Practice Address(es)
- Phone Number

- Statement that provider is requesting a status of his/her recredentialing application *or, as applicable,* statement that provider is requesting to review information collected in support of his/her recredentialing application
- Signature of requestor and date

A copy of Block Vision's Recredentialing Policy is available to providers upon request. The Recredentialing Policy provides a complete description of Block Vision's process and requirements for provider recredentialing.

- **Contractual Quality Standards**

All providers agree to adhere to the standards set forth in the "Access and Service Delivery Standards" section of this Provider Manual. Provider compliance with such standards is monitored through the Provider Audit Program and Service Delivery Studies, both described below.

- **Provider Audit Program**

In order to monitor compliance with the "Access and Service Delivery Standards" set forth in this Provider Manual, Block Vision, or one of its designated representatives, may visit contracted panel members for a review of the facility and/or member records or require the provider to complete a self-audit tool. A site audit may also be conducted as part of ongoing monitoring and/or if there is a pattern of member complaints relating to the provider's office.

Facility audits encompass a review of the facility, including review of instrumentation and eyewear dispensary, as well as review of patient records to ensure that professional services delivered to the program's members are in accordance with the plan's standards and are properly documented.

- **Clinical Recordkeeping Standards**

Providers are required to maintain clinical records in accordance with the requirements set forth in their Vision Care Services Agreement with Block Vision. Such requirements include, but are not limited to, maintenance of clinical records for a period of no less than six years (or such other period required by applicable State and Federal law; e.g. CMS requires record retention for a period of not less than ten (10) years, or such longer period of time as may be required by law; and in New Jersey, medical records must be kept for ten (10) years following the member's most recent services or until the member reaches age 23, whichever is longer), and the maintenance of the confidentiality of such records in accordance with all State and Federal laws regarding the confidentiality of patient records. All clinical records must be legible, well organized and maintained in accordance with prevailing professional standards and practices. Block Vision may periodically request copies of medical records in order to determine compliance with the Company's recordkeeping standards, as well as for the purposes of vision benefit payment, treatment and operations.

- **Service Delivery Studies**

  The Company periodically performs Service Delivery Studies to measure compliance with the Access and Service Delivery Standards outlined in this Provider Manual. Examples of Service Delivery Studies include initiatives measuring appointment wait time, materials turnaround time and compliance with comprehensive examination standards. In designing such studies, the QA staff gives careful consideration to the limitations placed on the time of its participating providers and their employees and every effort is made to minimize the burden on your office.

  Providers are expected to cooperate fully with Block's implementation of these studies. Any problematic findings are individually communicated to the provider.

- **Member Satisfaction**

  Block Vision monitors member satisfaction in two ways.

  The first form of gathering member feedback is through tracking complaints and grievances filed by members who have utilized their vision benefit and are unhappy with their experience. A "complaint" is an oral or written communication of concern or dissatisfaction with any aspect of the eye care encounter, including dissatisfaction with professional services or eyewear received through the program. A complaint may be filed by a member, a member's representative or the provider. A "grievance" is an oral or written expression of dissatisfaction about any matter related to administration of the vision benefit, other than a coverage denial issued by the Company through its Utilization Management program. In New Jersey, any complaint that cannot be resolved in five (5) business days becomes a grievance.

  The Company's clients frequently delegate to the Company the complaint/grievance resolution process. Even in the absence of formal delegation, it is part of the Company's standard program management services to record, research and resolve complaints/grievances and the Company cooperates with the client's complaint/grievance resolution process if such function is retained by the client. For New Jersey Medicaid and NJ FamilyCare members enrolled through AMERIGROUP New Jersey, AMERIGROUP New Jersey handles all complaints, grievances and appeals.

  Members or providers who wish to file a complaint or grievance should contact Block Vision's Member Services Department. Block Vision is committed to responding to all complaints/grievances as expeditiously as the member's visual health condition requires. Block representatives investigate all complaints thoroughly and objectively. Participating providers are required to cooperate with any request for information related to a complaint/grievance investigation.

  It is the Company's policy to resolve all complaints/grievances within fifteen days of receipt of all necessary information, not to exceed ninety days from the date that the Company received the complaint/grievance, or such shorter time frame as is required by applicable law (e.g., in New Jersey, complaints are resolved within five (5) business days). A resolution will be reached within 24 hours of receipt when the

complaint/grievance is identified as urgent. These timeframes may be extended by up to fourteen days in certain circumstances at the member's request.

The complaint/grievance decision is telephonically communicated to the individual who filed it within one business day of the determination being made, although written confirmation of the determination may also be made, depending upon case circumstances, or as required by applicable law.

For any complaint/grievance that is not resolved in the member's favor, the notification process includes written notification of the member's appeal rights, which either follow the Company's appeals process if such process is delegated to the Company or follow the client's appeals process if management of such process is retained by the client.

Providers should recognize that Block Vision may resolve a complaint/grievance in favor of the member for the sake of achieving member satisfaction, and that such an action does not necessarily imply wrongdoing on behalf of the provider.

The second form of gathering member feedback is through Member Satisfaction Surveys. Each quarter, survey forms are provided to randomly selected members who have utilized services requesting their feedback on all aspects of their vision encounter. Survey outcomes are monitored, with low-scoring providers targeted for a closer review. Total number of surveys returned, source of dissatisfaction and long-term trended results are all factors considered by Block in analyzing survey results.

Participating providers who consistently receive low scores on satisfaction surveys and/or who are the subject of a high number of complaints will be expected to address the situation through implementation of a Corrective Action Plan, as described below, in conjunction with Block's QA staff.

As directed by the client healthplan, Block Vision sends the results of the member satisfaction surveys to the applicable client healthplan, who in turn may send such results to the appropriate state agencies (e.g.., AMERIGROUP New Jersey will send the results to the Division of Medical Assistance and Health Services (DMAHS)).

- **<u>Provider Corrective Action, Peer Review and Appeal Process</u>**

  The Company has a progressive corrective action process designed to allow the provider a fair opportunity to satisfactorily resolve any administrative or quality-related issues. Each provider is also obligated under his/her contract with the Company to cooperate with the Company and fully participate in its grievance procedures to resolve member complaints/grievances related to the provision of services. Although the Company has the right to terminate a provider who violates certain provisions of his/her contract with the Company, whenever practical, it is the Company's goal to work with the provider to devise and implement a Corrective Action Plan for resolving the situation.

  While the exact course of action may vary by individual situation and the

requirements of applicable law, the following provider notification/request for action process guides the Company's actions when a quality concern/deficiency is noted as a result of member feedback, provider audits and other QA mechanisms:

1. Upon initial identification of a problem, the Company will send a certified letter to the provider summarizing the concern and requesting a proposed Corrective Action Plan (or rebuttal) within 10-30 days, depending on the circumstances.
2. If no response is received or if the provider's response does not indicate a willingness to cooperate, the Company will forward a second certified letter restating the concern and notifying the provider that his/her panel participation will be terminated if a satisfactory response is not received within 30 days.
3. If a proposed Corrective Action Plan is received from the provider, the Company's QA committee will review the plan and respond in writing to the provider. Such response may take the form of full approval, rejection or suggestions for modification, and will also include a schedule for follow-up of the plan. All final determinations made by the QA committee will be binding upon the provider, subject to the providers' 30 day right of appeal as described below.

The Company's QA program also draws on the resources and expertise of the Company's regional optometric consultants. The Company confers with these consultants both on an ongoing basis and when individual case circumstances warrant, or should a provider against whom the Company's QA committee renders a non-acceptance decision, disciplinary decision or termination decision wish to appeal such decision. Any request for appeal shall be made by the provider, in writing, within 30 days of the date of the decision (or such shorter period of time specified by the Company if the circumstances warrant or as otherwise required by applicable law). The Company will select one QA committee member who participated in the non-acceptance decision, disciplinary decision or termination decision and two regional optometric consultants to hear the appeal of the decision made by the Company's QA committee (or subcommittee thereof).

In the event the termination is due to quality of care concerns, the Company will notify the appropriate authorities.

- **Provider Satisfaction**

Block Vision is also committed to achieving a high level of satisfaction among its contracted provider panel. To this end, provider feedback is requested through the Company's annual Provider Satisfaction Surveys. Similar to the Member Satisfaction Surveys described above, the provider survey form asks providers to offer feedback regarding Block's administrative policies and procedures. Management uses these survey results to evaluate the Company's operations and procedures and to identify opportunities for improvement.

Of course, providers are encouraged to contact our Provider Relations staff with any questions, concerns or suggestions for improvement at any time.

- **Interaction with Healthplan QA Programs**

  The Company works with each healthplan for which it administers vision benefits to establish a cooperative and productive QA program that satisfies the standards and protocols of each healthplan's quality assurance program.

PRIVACY REQUIREMENTS

I. Health Insurance Portability and Accountability Act of 1996 and the Federal Standards for Privacy of Individually Identifiable Health Information promulgated thereunder at 45 C.F.R. part 160 and part 164, Subparts A and E (the "HIPAA Privacy Rule" and the Health Information Technology for Economic and Clinical Health Act ("HITECH") in the American Recovery and Reinvestment Act of 2009 and its implementing regulations in 45 C.F.R. part 164, subpart D; all terms used in this section but not otherwise defined herein, shall have the same meaning given to such terms in the HIPAA Privacy Rule or HITECH)

A. Block Vision uses or discloses Protected Health Information to perform the functions, activities or services which it is contracted to perform for or on behalf of its clients. These functions, activities and services primarily involve Block Vision's arranging for the provision of covered eye care services to members enrolled through its clients (Treatment), Payment for covered eye care services, and administrative and other services constituting Health Care Operations. Block Vision may also use Protected Health Information for the proper management of Block Vision or to carry out the legal responsibilities of Block Vision. Block Vision has implemented reasonably appropriate administrative, technical and physical safeguards to protect the privacy of Protected Health Information. Block Vision may use or disclose Protected Health Information without the member's authorization for Treatment, Payment and Health Care Operations as permitted under the HIPAA Privacy Rule. Other uses and disclosures of Protected Health Information by Block Vision will only be made with the member's authorization, or as otherwise permitted under the HIPAA Privacy Rule. Block Vision will give members the right of access to inspect and obtain a copy of their Protected Health Information in a Designated Record Set in accordance with the HIPAA Privacy Rule.

B. Block Vision expects that Provider is familiar with, and Provider has educated his/her staff regarding, the HIPAA Privacy Rule and HITECH. Provider shall comply with all applicable provisions of the HIPAA Privacy Rule and HITECH, including, without limitation, the following provisions with regard to provider's use and disclosure of Protected Health Information which Block Vision and/or any Plan (as such term is defined in provider's Vision Care Services Agreement) has disclosed to provider or which provider holds or has collected for Block Vision and/or any Plan:

1. Provider is prohibited from further using or disclosing Protected Health Information for any purposes other than the purposes stated in this Provider Manual and/or in provider's Vision Care Services Agreement.

2. Provider is prohibited from further using or disclosing Protected Health Information in a manner that would be prohibited by the HIPAA Privacy Rule if disclosure was made by Block Vision and/or any Plan, or if either provider, Block and/or any Plan is otherwise prohibited from making such disclosure by any present or future state or federal law, regulation or rule.

3. Provider agrees to maintain appropriate safeguards to ensure that Protected Health Information is not used or disclosed except as provided in this Provider Manual, provider's Vision Care Services Agreement or as required by state or federal law, regulation or rule.

4. Provider agrees to immediately report to Block in writing any unauthorized acquisition, access, use or disclosure of Protected Health Information that is in violation of the provisions set forth herein and/or provider's Vision Care Services Agreement, including any Breach, and in no case more than two business days after becoming aware of such violation.

5. Provider agrees to ensure that any subcontractor or agent to whom provider discloses Protected Health Information received from Block and/or any Plan will agree to the same restrictions and conditions that apply to provider with respect to such Protected Health Information. Provider further agrees that, if at any time Provider becomes aware that any subcontractor or agent has violated these restrictions and conditions, provider will require such subcontractor or agent to immediately take action to mitigate against damage caused by such violation.

6. Provider agrees to notify Block in writing within three business days of any material alteration of an individual's Protected Health Information made at the individual's request, which Block and/or any Plan has disclosed to provider or which provider holds or has collected for Block and/or any Plan. Provider further agrees to provide Block and/or Plan, as applicable, within three business days and at no charge to Block and/or Plan (1) a copy of the altered Protected Health Information, (2) an explanation of such alteration, and (3) the reason for such alteration. Block and/or Plan, as applicable, will make the alteration and explanatory documents a part of the individual's Protected Health Information. Provider shall also make the alteration and explanatory documents a part of the individual's Protected Health Information. Provider is not required to notify Block of alterations to an individual's Protected Health Information which are made in the ordinary course of routine record keeping conducted by provider.

7. Provider agrees to incorporate into Protected Health Information any amendments or corrections received from Block and/or any Plan. Provider further agrees to make such amendment or correction in the manner and within the time limits mandated by the HIPAA Privacy Rule.

8. Provider agrees to make available to applicable state and federal agencies and their agents such of provider's internal practices, books and records as are related to the use and disclosure of Protected Health Information received from or kept for Block and/or any Plan.

9. Provider agrees to grant Block and/or any Plan access at any time during provider's regular business hours to Protected Health Information received from or held for Block and/or any Plan.

10. Provider agrees to incorporate any amendments, corrections or additions to Protected Health Information when notified by Block and/or Plan that the information is inaccurate or incomplete or that other documents are to be added as required by or allowed by the HIPAA Privacy Rule.

11. Any breach of the requirements set forth herein shall be a breach of provider's Vision Care Services Agreement, and Block may terminate the Vision Care Services Agreement and/or provider's participation on any Plan provider panel effective immediately upon advance written notice to provider, which notice shall set forth the reason for such termination. This provision shall be deemed to amend and supplement Article IV.C. (3) of provider's Vision Care Services Agreement, and shall be in addition to all other rights of termination which Block may have under provider's Vision Care Services Agreement.

12. Provider will make available to his/her patients (i) their own Protected Health Information for purposes of review or amendment, and (ii) information required to provide an accounting to the patient of all disclosures of that patient's Protected Health Information as required under the HIPAA Privacy Rule as modified by HITECH. Provider will also make available to Block or any Plan information required by Block or the Plan to respond to a request by a patient of provider for an accounting to such patient of disclosures of that patient's Protected Health Information in accordance with the HIPAA Privacy Rule as modified by HITECH.

13. Upon termination of provider's Vision Care Services Agreement, provider will return to Block or destroy as much as possible of the Protected Health Information that provider has received from Block or that provider has created or collected on behalf of Block, or will provide a written explanation to Block as to why it is not feasible to return or destroy the Protected Health Information.

14. The terms and conditions contained herein override and control any conflicting term or condition of the Vision Care Services Agreement and shall survive termination of the Vision Care Services Agreement.

II. <u>Gramm-Leach-Bliley Act ("GLBA"; all terms used in this section but not otherwise defined herein, shall have the same meaning given to such terms in GLBA)</u>

Provider must comply with all present and future privacy requirements mandated by GLBA, including, without limitation, the following provisions:

1. Provider will neither use nor disclose Nonpublic Personal Financial Information received from or on behalf of Block and/or any Plan with respect to members or former members for any purpose other than to carry out the activities and functions as specified in this Provider Manual and/or provider's Vision Care Services Agreement.

2. Provider will not develop, use or disclose any list, description or other grouping of members or former members using Nonpublic Personal Financial Information received from or on behalf of Block and/or any Plan, except as permitted by this Provider Manual, provider's Vision Care Services Agreement or in writing by Block.

3. Provider will develop, implement, maintain and use appropriate administrative, technical and physical safeguards, in compliance with GLBA and the regulations issued or to be issued by the Insurance Commissioner of the state in which provider practices to preserve the integrity and confidentiality of and to prevent non-permitted use or disclosure of Nonpublic Personal Financial Information provider receives from or on behalf of Block and/or any Plan. Provider will restrict access to Nonpublic Personal Financial Information to those employees who have a need to know that information in order to provide members covered benefits and services under their Plan. Provider will document and keep all safeguards current.

4. Provider will require all of its subcontractors and agents to provide reasonable assurance, evidenced by written contract between provider and such subcontractor or agent, that subcontractor or agent will comply with the same privacy and security obligations as provider with respect to such Nonpublic Personal Financial Information.

5. Any breach of the requirements set forth herein shall be a breach of provider's Vision Care Services Agreement, and Block may terminate the Vision Care Services Agreement and/or provider's participation on any Plan provider panel effective immediately upon advance written notice to provider, which notice shall set forth the reason for such termination. This provision shall be deemed to amend and supplement Article IV.C. (3) of provider's Vision Care Services Agreement, and shall be in addition to all other rights of termination which Block may have under provider's Vision Care Services Agreement.

6. The terms and conditions contained herein override and control any conflicting term or condition of the Vision Care Services Agreement and shall survive termination of the Vision Care Services Agreement.

SECURITY REQUIREMENTS

Block Vision expects that provider is familiar with, and provider has educated his/her staff regarding, the Health Insurance Portability and Accountability Act's Security regulations as set forth in 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Security Rule") as applicable to a provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA, and regarding standard transactions regulations as set forth in 45 C.F.R. Part 160, 164, subparts A, C and E and Part 162 (the "Transactions Rule") . Block Vision further expects all providers covered by the HIPAA Security Rule and/or Transactions Rule to comply with all applicable provisions of the HIPAA Security Rule and/or Transactions Rule, including, without limitation the following:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information (as defined in the HIPAA Security Rule) that provider creates, receives, maintains, or transmits on behalf of Block Vision or any Plan (as defined in provider's Vision Care Services Agreement).

2. Report to Block Vision any Security Incident (as defined in the HIPAA Security Rule) of which provider becomes aware.

3. Ensure that any agent, including a subcontractor, to whom provider discloses Electronic Protected Health Information received from Block Vision or any Plan agrees in writing to implement reasonable and appropriate safeguards to protect such Electronic Protected Health Information.

4. If provider conducts Standard Transactions (as defined in 45 C.F.R Part 162), for or on behalf of Block or any plan, provider will comply, and will require each subcontractor or agent involved with the conduct of such Standard Transactions to comply, with all applicable requirements of the Transactions Rule.

MEMBERS WITH SPECIAL NEEDS

Block Vision is committed to making arrangements to accommodate member's with special needs to ensure that such member's have access to administrative and clinical services within the scope of the Company's program on the same basis as do members without special needs. Providers *must* notify Block Vision of members with special needs so that appropriate accommodation can be made for such members. Due to varying individual needs, Block Vision may determine the nature of the accommodation on a case-by case basis pursuant to the special need identified.

For those members that are non-English speaking, Block Vision employs bilingual (English and Spanish) Member Services representatives and utilizes the services of LLE Link for translation assistance in processing calls in more than 150 other languages. Block Vision utilizes the services of the Maryland Relay Service (1-800-201-7165; or TTY (text telephone) 1-800-735-2258) for communication with individuals who are hearing impaired. Block Vision will also provide translation services in provider's office to facilitate access to vision care services.

The health plan through which the member is enrolled is required by law to give the member written information concerning health care advance directives. If a member is not competent to make health care decisions due to a physical or mental change or condition as determined under applicable state law and gives provider an advance directive regarding the member's health care, provider is required to document the member's medical record with respect to the existence of the advance directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable law. The advance directive will serve as the member's instructions, as applicable, regarding the provision or withholding of eye care or the designation of another individual to make treatment decisions on the member's behalf if the member is or becomes unable to make his/her own decisions.

Block Vision is also committed to assisting in the coordination of care for members who are minors and require the involvement of a parent, guardian or other individual in making decisions concerning the minor's eye care.

Provider is required to cooperate with Block Vision in identifying and notifying Block Vision of members with special needs and in ensuring that such members have access to services on the same basis as do members without special needs.

PATIENT SAFETY/ADVERSE EVENTS/SENTINEL EVENTS/QUALITY ISSUES

The Company is committed to promoting an environment that helps participating providers improve the safety of their practices. This includes the collection of data regarding provider compliance with universal patient safety standards and making data regarding such findings available to the Company's client health plans and to members enrolled through such clients. To this end, the Company has adopted an Infection Control Policy which is based upon the "universal precautions" guidelines of the Centers for Disease Control (CDC) and that of the Occupational Safety and Health Administration (OSHA). A copy of the Infection Control Policy is available upon request by contacting Block Vision's Provider Relations Department at 800-243-1401.

The Company will include measurement of provider compliance with the Infection Control Policy in the site reviews it conducts of participating provider offices, with findings to be shared with the healthplan client(s) on whose panel the provider participates.

Providers must promptly report to Block Vision any adverse events, sentinel events or quality issues. Adverse events are defined as an injury to a member that occurred when receiving vision care from a participating provider. Sentinel events are any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Quality issues are related to the quality of care received. Quality of care refers to the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Please contact Block Vision's Quality Department at 800-243-1401 to report any adverse events, sentinel events or quality issues or if there are questions about such issues.

MISCELLANEOUS

Additional policies and procedures not previously addressed include the following:

- Participating providers may not highlight Block Vision or the healthplan's name in his/her advertising. Providers may include the healthplan's name in a comprehensive list of managed care participation; however neither Block nor its clients may be singled out in any way. Provider further agrees not to directly solicit known healthplan members in any way.

- Participating providers must be generally supportive of managed healthcare, Block Vision and its contracted healthplans in their communication with members. Providers must not encourage members to disenroll from the healthplan and must not encourage participation in one healthplan over another.

- In order for Block Vision's client health plans to comply with applicable law regarding notification to members of a provider termination, all participating providers are required to notify Block Vision if they elect to terminate their provider agreement with Block Vision in advance of the effective date of such termination within the time period specified in the provider agreement. Participating providers agree that in the event of expiration or termination of provider agreement with Block Vision, the health plan will notify members seen on a regular basis by the terminating provider of the provider's termination from the Block Vision network.

- Unless otherwise stated in the plan-specific sections of this Provider Manual, Block Vision's programs are limited to wellness vision services. When medical eyecare and diagnostic procedures are not administered by Block, the healthplan requires providers to refer the Member to the primary care physician in the event such services are determined to be necessary. Any questions regarding the rendering of such services must be directed to the healthplan.

CONTACTING BLOCK VISION

Block Vision's staff is available during regular business hours (9:00 am through 6:00 pm ET) and can be reached at the telephone numbers listed below. After hours callers to the Company's Member Services Department (both members and providers) have the opportunity to leave a recorded voice mail message for a return call the next business day. In order to access the Member Services Department night message system please call 866-819-4298.

Additionally, providers may access the Voice Response Unit (VRU) 24 hours a day, seven days a week to verify member eligibility and benefits coverage and to obtain an eligibility verification number.

Providers may also access the Block Vision website, www.blockvision.com, 24 hours a day, seven days a week for information regarding eligibility verification, benefits coverage, claim status and to submit claims.

Credentialing/Recredentialing	(800) 243-1401, ext. 2107
Member Services	(866) 819-4298
Provider Relations	(800) 243-1401, ext. 2107
Eligibility Verification Line	(866) 819-4298
Claims Administration	(866) 819-4298

For general information call or write:

Block Vision
939 Elkridge Landing Road
Suite 200
Linthicum, Maryland 21090
Call: (800) 243-1401