SuperiorVision™

2018 Provider Manual

from VersantHealth™

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Company overview and mission statement

Superior Vision Benefit Management, Inc. and its affiliates that provide services to health plans, including Superior Vision of New Jersey, Inc. and UVC Independent Practice Association, Inc. (collectively, "the "Company") provide comprehensive administration of routine and medical vision care programs for healthcare plans. The Company contracts with health maintenance organizations and other managed care entities for the coordination of the plan's vision benefits.

We recognize that providers in our network have the most direct line of contact with the members enrolled through our client health plan's programs. It is our goal to work cooperatively with each provider in our network 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 eye care practitioners a number of advantages, and we look forward to proving the strength of our service to you.

Mission statement

To help members enjoy the wonders of sight through healthy eyes and vision.

How the program works

The Company'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 Company or the health plan will distribute a list of participating eye care 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 the Company or the plan to request a referral or other type of authorization.

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

- Once the appointment has been scheduled, contact the Company 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 participating provider agreement with the Company and this Provider Manual. Please refer to the "Member Charges" section of this Provider Manual for details on allowable collections from the member.

- Each 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. The provider's choice of optical laboratory does not affect coverage determinations and reimbursements.

- You may electronically submit claims via the Company's website (www.superiorvision.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 the Company. Please refer to the "Claim Submission Requirements" section of this Provider Manual for further details on submitting claims, as well as the Company's reimbursement policies.

Statement of members' rights and responsibilities

The Company is committed to providing members enrolled through its clients with high-quality eye care and administrative services from the Company's participating providers and the Company's administrative staff. Member inquiries regarding this Statement should be directed to the Company's customer 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 the Company, 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 the Company's clients;

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

- Actively participate with the 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 the Company, the health plan 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 the Company, the health plan through which the member is enrolled, or a regulatory body (i.e., state Medicaid agency) as applicable;

- 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 health plan through which the member is enrolled.);

- Timely referral and access to medically-indicated specialty care (in accordance with referral protocols established by the health plan 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 the Company's members' rights and responsibilities policies.

Members have a responsibility to:

- Become informed about their member rights;

- Supply information (to the extent possible) that the Company, a participating provider, and/or the health plan 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 the Company, the health plan through which the member is enrolled, and a regulatory body (e.g., state Medicaid agency, as applicable;

- 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 or reschedule.

Eligibility verification procedures

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

I. Internet Website

Simply Log on to the Company's website (www.superiorvision.com) to obtain benefits information or verify eligibility.

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

- Click on "Providers" at the top of the page next to "member"
- Click on "PROVIDER LOGIN"
- Enter your username and password
- If there is more than one office, enter the zip code of the location
- Select the provider serving the member
- Enter the member's ID number, last name, and first name
- Click "Submit"
- You can also do an advance search by selecting "advance search" and entering the last 4 digits of the member's Social Security number and date of birth
- Select "Check Eligibility" in the upper left-hand corner of the screen

II. Voice Response Unit (VRU)

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

Enter your NPI Number and press the # key when completed. The system will state the participating provider name linked to the provider number entered. Please verify that NPI number entered is correct by pressing 1 for "yes" 2 for "no."

- Select option #1 for member benefits and eligibility verification
- If the member's ID number is alpha/numeric, press 2; otherwise, wait to enter the member's ID number
- Enter the member's ID number and press the # key when completed
- You may be asked to enter the member's date of birth in the MM DD YYYY format
- Enter the date of the appointment in the MM DD YYYY format
- The VRU will offer each benefit for which the member is eligible

The VRU will transfer you to a Company representative in the event the system is unable to process the requested eligibility verification. After hours calls are routed to Customer Service voice messaging and return calls are performed the next business day.

Access and service delivery standards

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

1. Office Hours: The provider must maintain office hours of at least 32 hours per week.

2. Appointment Standards: 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 or in the quality of services delivered to Members on the basis of race, color, sex, sexual preference, marital status, age, religion, place of residence, health status, handicap, disability, credit history, or source of payment. Providers must observe, protect, and promote the rights of Members as patients. Providers must provide care and services to Members on the same basis as they provide care and services to non-Members.

3. Instrumentation: In order to participate on the Company'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. Comprehensive Eye Examination Requirements: All examinations covered under the program must be comprehensive in nature and comply with applicable state requirements regarding examination standards. 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 intraocular pressure (IOP) 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:

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 disabled 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. Contact Lens Examination/Fitting Standards: When the member's benefit coverage includes contact lenses, the following additional tests/procedures are required for the fitting and assessment of contact lenses:

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 slit lamp; and
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; and
d. Follow-up care as appropriate.

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

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

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; and
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 and Eyewear (Note: applicable regulatory coverage guidelines may supersede these requirements.)

1. Non-Standard Eye Examination

a. Definition – A "Non-Standard Eye Examination" means any additional routine eye examination beyond the standard benefit coverage frequency. The provider must submit documentation supporting the clinical appropriateness of all Non-Standard Eye Examinations to the Company for a coverage determination before rendering a Non-Standard Eye Examination.

b. Coverage Criteria – Non-Standard Eye Examinations may be covered. Please refer to our Coverage Policy 13.16.00 – Eye Exams for Specific Criteria located in the Provider Portal.

2. Non-Standard Eyewear

a. Definition – "Non-Standard Eyewear" means eyewear (including both eyeglass lens and contact lenses) beyond the standard benefit coverage. Except as set forth below, the provider must submit documentation supporting the clinical appropriateness of all Non-Standard Eyewear to the Company for a coverage determination before 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; (ii) tinted lenses are covered when the member is

diagnosed with albinism, diseases of the retina, or (iii) when otherwise clinically indicated.

c. Coverage Criteria for Non-Standard Contact Lenses –Non-Standard Contact Lenses are covered when: (i) required for treatment of keratoconus; (ii) due to severe myopia, greater than 10 diopters; (iii) due to aphakia in children; or (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 +6.00 diopters sphere and/or + 3.00 diopters cylinder; (ii) lenses with prism when determined to be clinically appropriate by the provider; or (iii) polycarbonate lenses when determined to be clinically appropriate by the provider for children enrolled through Medicaid/CHIP programs.

8. Exclusion and Limitations: The following services and materials are generally excluded from coverage. Any exceptions to these exclusions and limitations 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, etc.), oversize lenses over 75mm, lamination of a lens or lenses, facets, or other cosmetic grinds or polishes
- Special mountings (other than standard zyl (zylonite), 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 eye care services and diagnostic procedures
- Any examination or corrective eye wear required by an employer as a condition of employment
- Conditions covered by Workers' Compensation

Eyewear policies

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

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

- 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 Company-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 benefit plans administered by the Company 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, must 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 this Provider Manual.

- Lens types other than those listed above (e.g., progressive multifocals, high-index, polycarbonates, etc.) 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 these lenses. The amount of this allowance is stated in the plan-specific section of this Provider Manual.

Utilization management

Substantially all of the programs administered by the Company provide coverage for routine 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, the Company has the right to review the request prior to authorizing such services or materials.

Additionally, when a member's benefit coverage includes medical eye care services and/or diagnostic procedures, the Company has the right to review the medical appropriateness of such services, at any time, as a condition of issuing payment. In such circumstances, the Company utilizes established Clinical Protocols to review the medical appropriateness of the requested services or materials. These Clinical Protocols have been developed by the Company 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 the Company's Provider Relations Department at 800-243-1401.

To request coverage for non-standard services or materials, the provider should contact the Company's customer services department at 800-243-1401 to discuss the nature of the request and supporting clinical information regarding the member's condition. The provider may also fax his/her request to the Company at 410-752-9184. The provider should submit all supporting documentation and/or clinical information necessary for the Company to process the request at the time of the request.

When utilization management decisions are made by the Company, the Company makes the decision and notifies the requesting provider of the decision/coverage determination in the manner required by applicable law on the same day that the decision/coverage determination was made.

Such decisions for Medicare plans are made in accordance with the following timeframes, unless a shorter timeframe is required by applicable law:

- Decisions regarding requests for authorization for Medicare standard organization determinations (non-urgent care) are made within 14 calendar days of the Company's receipt of the request.
- Decisions regarding requests for Medicare expedited organization determinations are made within 72 hours of the Company's receipt of the request. Members or providers (on the member's behalf) can request expedited organization determinations when the member or the member's provider believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy.

State required timeframes for the Company to render standard, expedited, concurrent, and/or retrospective utilization management decisions vary according to states laws and regulations. The Company will abide by all applicable state and/or federal laws and rules on utilization management decision timeframes and notice requirements.

. Any provider wishing to discuss a coverage denial with the individual who reviewed the request on behalf of the Company may do so by contacting the Company'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 the member's behalf. Management of the appeals process is generally retained by the Company's clients and is not delegated to the Company. The Company'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 the Company electronically, either through the Company's internet website or through its contracted healthcare clearinghouse, or via paper claims through the mail or facsimile. When submitting paper claims, a provider should use the CMS 1500 form.

All claims must be submitted to the Company within 90 days of the date of service, or as otherwise required by applicable law. The Company may not honor any claims submitted after 90 days, or such longer period of time required by applicable law.

All claim submissions by providers shall be deemed to be the 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.

The provider must submit a separate claim for each encounter. The provider should include all services rendered during the encounter on a single claim.

I. Internet Website (superiorvision.com)

Providers are encouraged to submit claims for all covered services through the Company's website.

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

- Click on "Providers" at the top of the page next to "member"
- Click on "PROVIDER LOGIN"
- Enter your username and password
- If there is more than one office, enter the zip code of the applicable location
- Select the provider servicing the member
- Enter the member's ID number, last name, and first name
- Select "Submit a Claim"
- Enter the diagnoses, date of service, procedure codes, and modifiers (if applicable)
- Enter the charges in the field provided
- Click on "Save Service". Once a service is saved, you may select the pencil icon to edit or modify your entry or select "X" to remove the service.
- Select "Submit Claim" when you have completed entering all of the claim information.
- You can choose "print confirmation" from the next page to print a copy for your records.

How to view claims:

- From the member information page, enter the primary member information in the fields provided.
- Click on View Claims.
- Claims history for processed claims on this member will be displayed. This does not include claims currently in process.

II. Healthcare Clearinghouse Claim Submissions

The Company's contracted healthcare clearinghouse is RelayHealth. The RelayHealth Payer ID is 3402. Providers must use this ID number when submitting electronic claims to the Company through RelayHealth. Please call the Company's EDI department at 800-243-1401 to register for use of RelayHealth.

III. ASC X12N 837 HIPAA Standard Format – Direct

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

IV. Paper Claims – CMS 1500 Claim Form

The Company accepts the CMS 1500 (version 02/12) claim form for claims processing purposes for all covered services. 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 the Company must report to its health plan clients on the number of members seeking services, as well as the types of services rendered.

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

Claims Department
Superior 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 a "clean claim," 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 the Company in Section 23 of the claim form.

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

- Section 24 may include *either* the Company's contracted fee schedule for exams and eyewear (as applicable) *or* the provider's 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-specific compensation rates, regardless of billing methodology.

- The provider's NPI number must be included in Box 33a and the company location number (the location number assigned to you by the Company) must be included in Box 33b of the paper claim form.

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

Claim payment procedures and electronic funds transfer (EFT)

The Company adjudicates all claims for covered services in accordance with applicable state prompt pay laws and/or applicable Medicaid or Medicare regulations. Superior Vision offers providers payment through Electronic Funds Transfer (EFT) direct deposit, which includes electronic remittance advice (ERA). Providers may enroll in the program by visiting www.instamed.com/eraeft. Providers who are not enrolled in EFT will receive paper checks.

If the Company does not adjudicate a Clean Claim within the timeframe required under applicable law or program requirements, the provider shall be entitled to receive interest calculated and paid in accordance with the applicable state or federal prompt pay law. The Company reserves the right to audit any claim in accordance with applicable state or federal laws or regulations.

Providers are encouraged to use the Company's website to obtain the status of a claim. If the claim is marked as "paid" and more than 20 days from the date of the check has passed and the provider has not received the check, the provider may contact the Company to trace the check. The Company 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 60 days of the date of payment unless the provider notifies the Company within such 60 day period that the provider disputes the amount paid. Any claim dispute must be submitted by the provider to the Company, 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, charges for non-covered services/items, and/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 the Company. Providers are also ***not*** permitted to balance bill members for the difference between the provider's usual and customary charges for covered services/items and the reimbursement amount agreed to between the Company and the provider.

- Members must 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 such services/items and must include the amount the member will be required to pay. Failure to give the required notice and obtain the acknowledgment will result in the member's non-liability for such charges. The Company bears no financial responsibility for these charges.

Fraud, waste, and abuse, Deficit Reduction Act, False Claims Act

The Company has established a fraud, waste, and abuse program to identify and investigate suspected fraudulent claims and other types of waste or abuse for the vision care programs administered by the Company. In order to prevent, identify, and investigate fraudulent, wasteful, or abusive activities, the Company enforces benefit frequency limitations, monitors both individual claims and provider claims submission patterns, and monitors complaint patterns. A copy of the Company's policy on fraud and abuse is available on our website at: www.provider.superiorvision.com or by contacting the Company's provider relations department at 800-243-1401.

The Centers for Medicare & Medicaid Services (CMS) requires providers and staff who provide services to a Medicare Advantage plan to complete Medicare Compliance Program training. This is required at the time of contracting and annually thereafter. This requirement applies to all provider office staff with access to Medicare patient information. In order to meet this requirement, all Superior Vision providers are required to complete the CMS FWA and General Compliance training within 90 days of contracting and annually thereafter using the Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training. The materials can be accessed using the following link and are also posted on the Company's website (www.superiorvision.com):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

The Deficit Reduction Act of 2005 (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 (FCA); applicable state law pertaining to civil or criminal penalties for false claims; and whistleblower protections. The Company is committed to educating 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 services or items billed to receive reimbursement that cannot be substantiated, such as billing for services not rendered, 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 the Company of any suspected fraud, waste, or abuse pertaining to the Company or the services provided to members. Suspected fraudulent activity may be reported to the Company at 800-243-1401 or by email to compliance@superiorvision.com.

Quality Assurance (QA) program

The Company 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 the Company'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 participating provider agreement. The QA program requirements apply to all providers, and periodic QA inquiries to a provider's 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, the provider will be notified of such concern and, when possible, offered the opportunity to jointly establish with the Company a corrective action plan. In accordance with the participating provider agreement, a provider's program participation may be terminated immediately if the contracting health plan requests such action or if the situation presents a danger to the health and safety of members.

The following is a summary of the QA program elements, as well as information on how a provider 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 are QA Analysts that are 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. The QA subcommittees meet on an as-needed basis to address issues within the subcommittee's scope. Meeting minutes are recorded to document the Committee's and subcommittee's actions.

New provider credentialing

All providers first joining the Company'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). The Company also performs primary source verification of certain information given by the provider in his/her provider enrollment application, either directly or through Aperture, which is a 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 from which the provider graduated. The Company notifies the provider of any information obtained by the Company during the credentialing process that varies substantially from the information which the provider submitted to the Company, and affords the provider the right to correct any erroneous information. Providers also have the right to review information used by the Company 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 the Company's credentialing policy is available to providers upon request. The credentialing policy provides a complete description of the Company's process and requirements for new provider credentialing.

Provider recredentialing

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

Annual review

Annual license renewal is verified with the state licensing board. The participation of any provider whose license is not renewed and in good standing will be terminated.

Documentation of professional liability coverage renewal must be submitted annually, immediately upon renewal. The Company 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 and may result in termination from the network.

Triennial review

Once every three years, at a minimum, the Company 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, member satisfaction survey results, and member complaint history, as applicable.

The Company notifies the provider, in writing, of any information obtained by the Company during the recredentialing process that varies substantially from the information which the provider submitted to the Company, and affords the provider the right to correct any erroneous information within 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 the Company 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:

Attention: Credentialing Department
Superior Vision
939 Elkridge Landing Rd, Suite 200
Linthicum, Maryland 21090
Fax: 410-625-1596

The request should include the following information:

- Provider's last name, first name, and classification
- Practice addresses
- Phone number
- A statement that the provider is requesting a status of his/her recredentialing application or, as applicable, a statement that the provider is requesting to review information collected in support of his/her recredentialing application
- Signature of the requestor and date

A copy of the Company's recredentialing policy is available to providers upon request. The recredentialing policy provides a complete description of the Company'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, which are described below.

Provider audit program

In order to monitor compliance with the access and service delivery standards set forth in this Provider Manual, the Company, or one of its designated representatives, may visit participating providers for a review of the facility and/or member records. The Company may also 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 a 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 participating provider agreement with the Company. 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 or federal law). For Medicare members, CMS requires record retention for a period of not less than 10 years, or such longer period of time as may be required by law. Provider must maintain 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. The Company 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 the provider's office.

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

Member satisfaction

The Company monitors member satisfaction in two ways: tracking complaints and grievances and member satisfaction surveys.

Tracking complaints and grievances

The first form of gathering member feedback is through tracking complaints and grievances filed by members who have utilized their vision benefits and are unhappy with their experiences.

- 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.

Definitions and timeframes to resolve complaints and grievances vary depending on federal and state regulations. The Company will abide by the applicable state and/or federal law or rule.

The Company's clients frequently delegate to the Company the complaint and/or grievance resolution process. Even in the absence of a formal delegation, it is part of the Company's standard program management services to record, research, and resolve complaints and grievances and the Company cooperates with the client's complaint and grievance resolution processes.

Members or providers who wish to file a complaint or grievance should contact the Company's customer services department. The Company is committed to responding to all complaints and grievances as expeditiously as the member's visual health condition requires. Company representatives investigate all complaints thoroughly and objectively, where applicable. Participating providers are required to cooperate with any request for information related to a complaint or grievance investigation.

It is the Company's policy to resolve all complaints and grievances within 15 days of receipt of all necessary information, not to exceed 90 days from the date that the Company received the complaint or grievance, or such shorter timeframe as is required by applicable law. A resolution will be reached within 24 hours of receipt when the complaint or grievance is identified as urgent. These timeframes may be extended by up to 14 days in certain circumstances at the member's request.

The complaint or 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 or 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 or the client's appeals process.

Providers should recognize that the Company may resolve a complaint or 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.

Member satisfaction surveys

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 the Company 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 the Company's QA staff.

As directed by the client health plan, the Company sends the results of the member satisfaction surveys to the applicable client health plan, who in turn may send such results to the appropriate state agencies.

Provider corrective action plans, peer review, and appeal processes

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 to cooperate with the Company and fully participate in its grievance procedures to resolve member complaints and/or grievances related to the provision of services. Although the Company has the right to terminate a provider who violates certain provisions of this manual or 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 process guides the Company's actions when a quality concern or deficiency is noted as a result of member feedback, provider audits, or 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 Complaints and Grievances Department 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 corrective action plan. All final determinations made by the Complaints and Grievances Department will be binding upon the provider, subject to the providers' 30 day right of appeal as described below.

The Company's QA program 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 if a provider wishes 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 decision and two regional optometric consultants to hear the appeal of the decision made.

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

Provider satisfaction

The Company 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 the Company'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 health plan QA programs

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

Privacy requirements

I. HIPAA

Providers must abide by all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the federal standards for privacy of individually identifiable health Information issued under HIPAA 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"). All terms used in this section, but not defined in this section, shall have the meaning given to those terms in the HIPAA Privacy Rule or HITECH.

A. The Company 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. This may include the Company using or disclosing Protected Health Information to perform the functions, activities, or services which it is contracted to perform for or on behalf of its clients, including the Company's arranging for the provision of covered eye care services to members enrolled through its clients, payment for covered eye care services, and administrative and other services. The Company may also use Protected Health Information for the proper management of the Company or to carry out the legal responsibilities of the Company. The Company has implemented reasonably appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information. Other uses and disclosures of Protected Health Information by the Company will only be made with the member's authorization, or as otherwise permitted under applicable state or federal laws. The Company 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. The Company expects that providers are familiar with, and have educated their staff regarding, the HIPAA Privacy Rule and HITECH. Providers 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 the Company and/or any plan has disclosed to provider or which provider holds or has collected for the Company and/or any plan:

1. Providers are prohibited from using or disclosing Protected Health Information for any purposes other than the purposes stated in this Provider Manual and/or in the provider's participating provider agreement.

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

3. Providers agree to maintain appropriate safeguards to ensure that Protected Health Information is not used or disclosed except as provided in this Provider Manual, the provider's participating provider agreement, or as required by state or federal law, regulation, or rule.

4. Providers agree to immediately report to the Company in writing any unauthorized acquisition, access, use, or disclosure of Protected Health Information that is in violation of the provisions of this Provider Manual or the provider's participating provider agreement, including any Breach, and in no case more than two business days after becoming aware of such violation.

5. Providers agree to ensure that any subcontractor or agent to whom providers disclose Protected Health Information received from the Company or any plan will agree to the same restrictions and conditions that apply to providers with respect to such Protected Health Information. Providers further agree that, if at any time a provider becomes aware that any subcontractor or agent has violated these restrictions and conditions, the provider will require such subcontractor or agent to immediately take action to mitigate against damage caused by such violation.

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

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

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

9. Providers agree to grant the Company and/or any plan access at any time during the provider's regular business hours to Protected Health Information received from or held for the Company and/or any plan.

10. Providers agree to incorporate any amendments, corrections, or additions to Protected Health Information when notified by the Company and/or a 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 these requirements shall be a breach of the provider's participating provider agreement, and the Company may terminate the participating provider agreement and/or provider's participation on any plan provider panel effective immediately upon advance written notice to the provider, which notice shall set forth the reason for such termination. This provision shall be deemed to amend and supplement the provider's participating provider agreement, and shall be in addition to all other rights of termination which the Company may have under the provider's participating provider agreement.

12. Providers will make available to their patients (a) their own Protected Health Information for purposes of review or amendment, and (b) 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. Providers will also make available to the Company or any plan information required by the Company or the plan to respond to a request by a patient of a 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 the provider's participating provider agreement, the provider will return to the Company or destroy as much as possible of the Protected Health Information that the provider has received from the Company or that the provider has created or collected on behalf of the Company, or will provide a written explanation to the Company 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 participating provider agreement and shall survive termination of the participating provider agreement.

II. Gramm-Leach-Bliley Act ("GLBA")

All terms used in this section, but not otherwise defined in this section, shall have the same meaning given to such terms in GLBA. Providers must comply with all present and future privacy requirements mandated by GLBA, including, without limitation, the following provisions:

1. Providers will neither use nor disclose Non-public Personal Financial Information received from or on behalf of the Company 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 the provider's participating provider agreement.

2. Providers will not develop, use, or disclose any list, description, or other grouping of members or former members using Non-public Personal Financial Information received from or on behalf of the Company and/or any plan, except as permitted by this Provider Manual, the provider's participating provider agreement or in writing by the Company.

3. Providers 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 the provider practices to preserve the integrity and confidentiality of and to prevent non-permitted use or disclosure of Non-public Personal Financial Information that the provider receives from or on behalf of the Company and/or any plan. Providers must restrict access to Non-public 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. Providers must document and keep all safeguards current.

4. Providers must require all of their subcontractors and agents to provide reasonable assurance, evidenced by written contracts between the providers and such subcontractors or agents, that the subcontractors or agents will comply with the same privacy and security obligations as the provider with respect to such Non-public Personal Financial Information.

5. Any breach of these requirements shall be a breach of the provider's participating provider agreement, and the Company may terminate the participating provider agreement and/or the provider's participation on any plan provider panel effective immediately upon advance written notice to the provider, which notice shall set forth the reason for such termination. This provision shall be deemed to amend and supplement the provider's participating provider agreement, and shall be in addition to all other rights of termination which the Company may have under the provider's participating provider agreement.

6. The terms and conditions contained herein override and control any conflicting term or condition of the participating provider agreement and shall survive termination of the participating provider agreement.

Security requirements

The Company expects that all providers are familiar with, and providers have educated their staff regarding, the Health Insurance Portability and Accountability Act's Security regulations 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"). All terms used in this section, but not defined in this section, shall have the meaning given to those terms in the HIPAA Security Rule or the Transactions Rule.

The Company 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 that the provider creates, receives, maintains, or transmits on behalf of the Company or any plan.

2. Report to the Company any Security Incident of which the provider becomes aware.

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

4. If the provider conducts Standard Transactions (as defined in 45 C.F.R Part 162), for or on behalf of the Company or any plan, the 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

The Company is committed to making arrangements to accommodate member's with special needs to ensure that such members 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 the Company of members with special needs so that appropriate accommodation can be made for such members. Due to varying individual needs, the Company 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, the Company employs bilingual (English and Spanish) customer services representatives and utilizes the services of LLE Link for translation assistance in processing calls in more than 150 other languages. The Company utilizes the services of the Maryland Relay Service (1-800-201-7165; or TTY 1-800-735-2258) for communication with individuals who are hearing impaired. The Company will also provide translation services in the 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 the provider an advance directive regarding the member's health care, the 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 services 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.

The Company 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.

Patient safety, adverse events, sentinel events, and quality issues

The Company is committed to promoting an environment that helps 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 the Company'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 health plan clients on whose panel the provider participates.

Providers must promptly report to the Company 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 provider. Sentinel events are any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient, 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 the Company'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:

- Providers may not highlight the Company's or the health plan's name in their advertising. Providers may include the health plan's name in a comprehensive list of managed care participation; however, neither the Company nor its clients may be singled out or treated differently from other health plans or companies in any way. Providers further agree not to directly solicit known health plan members in any way.

- Providers must be generally supportive of managed healthcare, the Company, and its client health plans in their communication with members. Providers must not encourage members to disenroll from the health plans and must not encourage participation in one health plan over another.

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

- Unless otherwise stated in the plan-specific sections of this Provider Manual, the Company's programs are limited to wellness vision services. When medical eye care and diagnostic procedures are not administered by the Company, the health plan 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 health plan.

Contacting the company

The Company's staff is available during regular business hours (9:00 am through 6:00 pm EST Monday through Friday, excluding holidays) and can be reached at the telephone numbers listed below. After hours callers to the Company's customer services department (both members and providers) have the opportunity to leave a recorded voicemail message for a return call the next business day. In order to access the customer 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 Company's website, superiorvision.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
Customer Service	(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:

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