Vision Care Plan (VCP)

PROVIDER MANUAL

Updated November 1, 2019

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Humana®

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Vision Care Plan Provider Manual

Vision Care Plan (VCP)

The majority of Humana's vision membership has moved to our Humana Vision Plan on the Insight network. Although you're contracted with Humana, you'll work with EyeMed for some Humana Vision Care Plan (VCP) functions. To ensure a consistent claims processing and eyewear experience for both VCP and Humana Vision members, you'll use EyeMed Vision Care's online claims system and contracted network labs.

EyeMed's inFocus communications portal is your source for information about working with EyeMed's systems and lab networks. You will use login credentials separate from those used for accessing the online claims system. Please familiarize yourself with inFocus.

EyeMed will continue to manage claims processing, recredentialing and quality assurance. Beginning July 1, 2019, EyeMed will also manage lab ordering and information updates.

Humana will continue to manage the network, contracting and member appeals.

NOTE: Effective July 1, 2019, authorizations and VisionPass forms will no longer be used. The claims process will begin directly from the Member Details screen on EyeMed's online claims system.

VCP offers managed and prepaid vision insurance plans to organizations that wish to provide comprehensive health benefits for their members. Our plans are purchased by many different types of organizations: corporations, labor unions, businesses of all sizes, school districts, state and local governments and health maintenance organizations.

Most plans cover an eye examination and, if necessary, corrective lenses and a frame. Coverage is usually either a predetermined cost per employee or based on actual utilization of the benefit.

Vision Care Plan (VCP) (continued)

Vision Care Plan network providers

As a network provider, you are our most important asset. VCP promotes better vision care and the welfare of our network providers. We are committed to high-quality service, and we are confident that you will find your membership with VCP to be valuable to your practice. In the event you are unsatisfied with a particular aspect of VCP, it is important that you discuss the matter with VCP staff only, not with your patients.

Credentialing and recredentialing

Ensure that you avoid unintentional termination due to noncompliance. Humana VCP participates in the Universal Credentialing process supported by the National Association of Vision Care Plans (NAVCP). Humana VCP partners with EyeMed and Aperture to complete initial credentialing and recredentialing of providers every three years in accordance with National Committee for Quality Assurance (NCQA) standards. Ensure Council for Affordable Quality Healthcare (CAQH) records are current and EyeMed has access to them. If you are contacted by EyeMed or Aperture on our behalf, please comply with the request for information within the time frame stated.

How the plan works

When a group buys a vision program from VCP, brochures describing the group's plan are prepared and distributed to members. Members are encouraged to make their appointments with VCP network providers, and more than 92% of our participants will use our network providers.

Providers will use EyeMed's online claims system to look up VCP members and view eligibility. The patient pays no more than a copayment, if applicable, and for material not covered by his or her plan. VCP pays the balance of your maximum allowed fee.

The following are generally included in the standard vision plan (coverage is established by the specific plan purchased by the member's group).

Eye examination

Generally, members are eligible for a covered routine vision examination (see page 11 for exam specifications) every 12 months and should be charged any applicable exam copayment. The provider is reimbursed for the level of examination service according to the VCP Provider Agreement.

Lenses

Most vision plans cover new lenses every 12 or 24 months (please view member eligibility to determine coverage), and the member should be charged any applicable copayment. Lenses are allowed only when deemed to be necessary in the doctor's professional judgment. Plano lenses are **NOT** covered unless the provider obtains prior approval.

Vision Care Plan (VCP) (continued)

Covered benefits

Some members have covered lens options. Please review the member's benefits carefully to avoid charging for covered options.

Frames

The member's eligibility will indicate 1) if the patient is entitled to a frame, and 2) the amount of the member's wholesale frame allowance. When showing your frame selection, please try to stay within the member's allowance. A member may also use his or her existing frame if it is still serviceable. If a member elects to use his or her own frame, we recommend you have the member sign a frame waiver (see page 20 for a copy of the Waiver of Liability).

Additional benefits

By using a participating provider, members may be eligible to receive up to a 20% retail discount on a second pair of eyeglasses, which is available for 12 months after the covered eye exam through the participating provider who sold the initial pair of eyeglasses. Members are directed to use **Humana.com** to find a participating provider.

Exam-only benefits

Some VCP members have an "exam-only" plan. These members may be eligible to receive up to a 20% retail discount on eyewear, which is available for 12 months after the covered eye exam through the participating provider who performed the exam.

Important notes

The plan allows the member to receive either contact lens services (including fit and follow-up) or frame and lens services. The member is NOT eligible for fitting when using benefit for glasses.

The system may allow you to select both contact lens fitting and glasses, which is in conflict with the member's benefits. Claims will be audited for overpayments.

Resources available to network doctors

Online tools

EyeMed's online claims system

This is a web-based portal where you will:

- Register for labs
- File claims
- Submit lab orders
- Download payment summaries
- Search claims history
- Set up your provider locator profile

Access the online claims system to complete the above actions.

If you have not completed the online claims account setup process, call **1-877-398-2682** for assistance.

inFocus

This is a provider communications portal that houses information you need to work with EyeMed's systems and lab networks.

Tools available on inFocus include:

- VCP Provider Manual
- VCP fee schedules
- How-to guides, job aids and system reference guides
- Options price lists
- EyeMed lab network listing
- Lab network catalogs
- News about VCP plans
- Forms for updating your information and adding new providers, plus a status tracker for these requests

A separate login is required for inFocus. Providers new to inFocus will receive an email with a username and a link for setting up a password.

Learn more about inFocus by viewing the inFocus overview flyer.

Sign in to inFocus to access the above tools.

Resources available to network doctors (continued)

Network administration

Provider forms

You must keep your information up to date by using our online forms. Access these forms to add a new location or provider, update practice location information or tax ID number, and more.

EyeMed pays claims by electronic funds transfer (EFT). Register for EFT by completing the online form. You'll need your bank account number, routing number, provider ID number and federal tax ID number. The online form may also be used to make updates to this information.

Please allow 15 business days for your request to be processed. Some changes may require additional paperwork and processing time.

Learn more about all the different forms available on inFocus by viewing the provider forms overview.

Customer Care

Contact VCP Customer Care at **1-866-537-0229** with questions about member eligibility or specific claims. Team members are available to assist you Monday – Saturday, 7:30 a.m. – 11 p.m., and Sunday, 11 a.m. – 8 p.m., Eastern time.

Professional Relations

Please contact VCP Professional Relations at **1-866-374-8805** with any questions regarding membership, quality improvement reviews or fees. Team members are available to assist you Monday – Saturday, 7:30 a.m. – 11 p.m., and Sunday, 11 a.m. – 8 p.m., Eastern time. You may also email Professional Relations at **humanavision@humana.com**.

Updates

Occasionally, it will be necessary to issue an update to this manual. This will happen for one of the following reasons:

- There has been a change of existing policy
- An amendment to the manual is required to clarify a policy or procedure

Eligibility

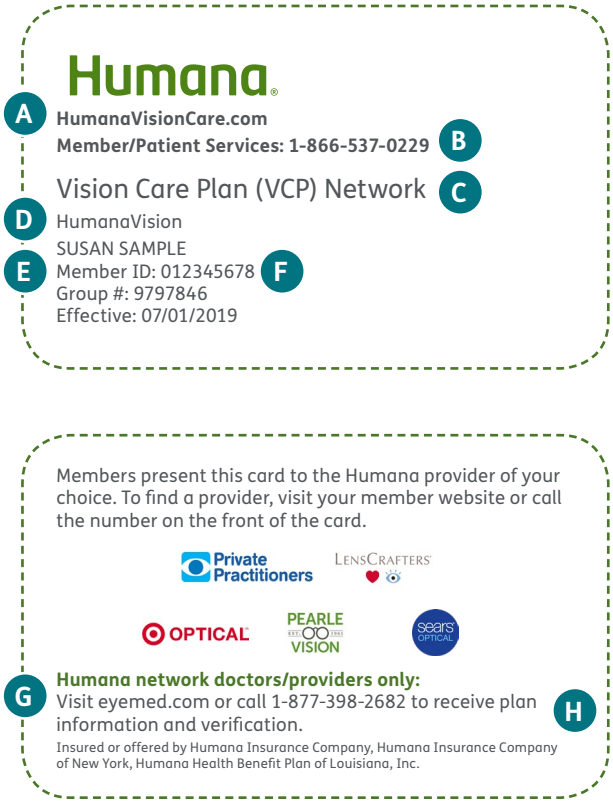
Access online training guides for verifying eligibility, conducting member searches and viewing member benefits on inFocus.

Many members will have a Humana member ID card with a Vision Care Plan member ID, though some members may not have an ID card and may use a Social Security number as the ID. All new members are issued ID cards. Eligibility may be verified online or by calling Customer Care.

Note:

Humana VCP members may present an ID card with the product name HumanaVision. In this case, confirming the provider network reads as Vision Care Plan (VCP) Network ensures your patient is a VCP member.

Below is a sample Vision Care Plan (VCP) ID card for reference, along with labels for key fields.



A: The website members utilize

B: The Customer Care phone number members utilize

C: The provider network servicing the member

D: The Humana product name

E: The Humana Vision Care Plan member ID number

F: The group's identifying number

G: The website providers utilize

H: The Customer Care phone number providers utilize

Eligibility (continued)

Online

Use the online claims system to check eligibility and file claims, except when the benefits are excluded from the lab network, need special processing or are for an emergency pair of eyewear.

You may also check eligibility via email.
Send your request to eyemedinfocus.com/emailus.

Phone

Please contact VCP Customer Care at **1-866-537-0229**.
From provider options, select "member eligibility and benefits."

These calls are automatically routed to the interactive voice response (IVR) system.

Please have the following information available prior to calling:

- **Member name**
- **Member ID**
- **Patient name**
- **Patient date of birth**

Member eligibility will be confirmed or denied by the IVR. If the member cannot be located via IVR, your call will be directed to a Customer Care specialist.

Vision Care Plan – standards of access

For elective visits, providers should see patients within four weeks of their request for an appointment. Patients should be seen no more than 30 minutes after their scheduled appointment time.

Submitting claims

Access online training guides for submitting claims on inFocus.

Authorizations and VisionPass forms will no longer be used effective July 1, 2019. You will begin the claims process directly from the Member Details screen on EyeMed's online claims system.

Online

Submit all claims requiring lab orders directly through EyeMed's online claims system.

- Use CPT codes to indicate the services performed—S codes are not accepted
- Also submit all applicable ICD-10 diagnosis codes when filing a claim
- The online claims system lets you note primary and high-risk diagnoses, including abnormal pupil, ARMD, cataract, diabetes, diabetic retinopathy, glaucoma, hypercholesterolemia and hypertension
- You can also use CPT II codes to denote the patient's risk for diabetic retinopathy

If you use the lab network, you'll file all claims online with a few exceptions for special services.

Hard copy/paper

For hard copy claims and special processes, refer to Preferred Claims Codes.

- Codes not on this list may be denied based on the member's plan and benefits
- Any plans, services or materials requiring a CMS 1500 hard copy submission are not eligible for lab ordering

If you submit a hard copy claim for materials that should have been submitted to a lab through the online claims system, you will be reimbursed for the dispensing and materials components. You will be responsible for all lab and eyewear fabrication costs, and you can't bill the member for the balance.

If your system setup allows you to use the lab of your choice, you will also use the online claims system. If you choose to submit a claim on paper, order the eyewear with your lab of choice as a private pay transaction. Then submit a CMS 1500 form to Humana for payment. Do not order with the lab using a CMS 1500 form.

You'll continue to submit paper claims to the following addresses:

Routine vision claims

Humana
P.O. Box 14313
Lexington, KY 40512-4313

State of Florida (group) claims

Humana
P.O. Box 14312
Lexington, KY 40512-4312

If you wish to submit your claims to a physical street address, you may send them to:

Humana
Attention: Vision Claims
2432 Fortune Drive
Lexington, KY 40509

Claims requiring reconsideration due to partial or incorrect payment may be faxed with a cover letter explaining the issue in detail. Fax to 1-800-417-3813.

Routine eye examination specifications

Your assigned eye examination fees are based on the following two levels of service: intermediate and comprehensive. The following are the minimum guidelines, tests and procedures required for each level.

Intermediate service

This level of service provides evaluation of a new or existing condition with or without mydriasis. To qualify under VCP, an intermediate service must include appropriate evaluation and recording of data in each of the following areas:

- **Case history**
- **Health status of the visual system – must include** external examination and internal examination with direct and/or indirect ophthalmoscopy
- **Refractive status – must include** the determination of the refractive state and corrected visual acuities
- **Binocular function**
- **Diagnosis and treatment plan**

Comprehensive service

This level of service provides evaluation of the complete visual system with or without cycloplegia or mydriasis. The comprehensive services constitute a single service entity but need not be performed at one session. All tests must be carefully recorded with quantitative measurements wherever possible. To qualify under VCP, a comprehensive service must include appropriate evaluation and recording of data in each of the following areas:

- **Patient's history** (personal and family medical history, personal and family ocular history, and chief complaint)
- **Visual acuity** (unaided or acuity with present correction)
- **External examination**
- **Pupillary examination**
- **Visual field testing** (confrontation)
- **Internal examination** (direct or indirect ophthalmoscopy recording cut disc ratio, blood vessel status and any abnormalities)
- **Biomicroscopy** (binocular or monocular)
- **Tonometry**
- **Refraction** (with recorded visual acuity)
- **Extraocular muscle balance assessment**
- **Other tests and procedures** that may be indicated by case history of objective signs and symptoms discovered during the eye examination
- **Diagnosis and treatment plan**

Copayments and other member charges

Please inform the patient that VCP will provide materials for basic visual needs only. Choosing elective items such as lens options or a more expensive frame is strictly voluntary.

Charges that a VCP patient may pay under the standard plan include, but are not limited to, exam and eyewear copayments, lens options, frame overages and contact lens overages.

Copayments

Most VCP plans require copayments for exams and eyewear. Applicable copayments should be charged to the patient on his or her first visit for the services provided. For example, if an eye examination is the only service provided, collect the examination copayment but not a material copayment.

The patient pays no more than a copayment, if applicable, and for material not covered by his or her plan. VCP pays the balance of your maximum allowed fee.

Copayment amounts are located on the member benefit details page and are standard for most plans. There are two types of copayments:

1. Exam copayment: Collect this amount when an eye examination is provided.
2. Lens and frame copayments: Collect this amount only when material services are provided.

Contact lenses

If the patient chooses contact lenses in lieu of eyeglasses, refer to the contact lens program information.

Lens options

If the patient chooses lens options not covered by his or her plan, you must charge the patient the fees shown on the VCP Options Price List Charge Back Schedule.

Covered lens options

Some patients have covered lens options. Prior to rendering services, please review the patient's benefits carefully to prevent charging patients in error for covered lens options.

Frame overages

All vision plans contain a limit on the amount a patient is allowed for a frame. The allowance is indicated on the member benefit details page. If the patient chooses a frame that costs more than the group's allowance, you are to charge the patient the difference between the wholesale frame cost and frame allowance, multiplied by 2. (Refer to page 19 for more information regarding the provision of frames.)

Frame overage example

Wholesale frame cost	$65
Frame allowance	- $40
Difference	$25
	x 2
Member pays	**$50**

Coordination of benefits

Some patients will be eligible for vision care under more than one plan, either through another carrier or through a second VCP. The purpose of coordinating benefits is to reduce the additional expenses, which the patient would pay for a single set of services.

- Coordination of benefits reimbursements are based on what VCP would have paid as primary, less the amount the primary carrier actually paid.
- Married employees who work for the same company may use their duplicate eye care coverage in one of two ways:
  - Patient may obtain services under both plans and will be responsible for all copayment(s), lens options and frame overages, or
  - Patient may choose to receive one set of services and their secondary coverage may be used to coordinate the primary plan's copayment(s), lens options and frame coverage up to what VCP would have paid as primary.

VCP is the primary payer, and services included in a comprehensive eye exam (including dilation and refraction) are not reimbursed separately unless the contract with the client specifically permits it. VCP will coordinate benefits when proper paperwork has been submitted (including an Explanation of Benefits (EOB) or remittance from another carrier showing non-payment of a portion of the claim).

- Claims for refraction only will be denied unless they are for members of groups that have specific contract provisions for coordination of benefits
- Dilation-only claims may not be submitted
- If the guidelines are not followed, the claim will be denied and you may be responsible for returning money to the member

Determining primary and secondary plans

- If the patient is the employee, the plan is considered primary
- If the patient is the dependent, the plan is considered secondary
- For dependent children, the parent whose birthday comes first in the year is considered the primary plan

Prior authorization

VCP provides vision care necessary to the visual health and welfare of the patient. A network provider may prescribe special materials, such as high-index lenses, polycarbonate lenses or medically necessary contact lenses, if they are necessary for the patient's visual welfare. Find additional guidance for medically necessary contact lenses on page 29. To obtain prior authorization for medically necessary eyewear or contact lenses, submit the appropriate Authorization Request form and receive approval before proceeding with the services.

Download a form by selecting the appropriate link:

Medically Necessary Contact Lens Prior Authorization Request Form
Medically Necessary Eyewear Prior Authorization Request Form

Submit a copy of the patient's form, along with all required documentation, as indicated on the form.

If the authorization is denied, it becomes the patient's responsibility to pay any additional costs.

If the authorization is approved, an approval form will be returned to you. Attach the approval form to the claim when submitting for payment.

Many patients want cosmetic additions that are optional for their visual welfare. The patient pays for any additional options according to the **VCP Patient Options Price List** or your usual and customary fees, whichever is less.

VCP Quality Improvement Program

Professional review is an important concept in the healthcare field. Professional review is designed to ensure both quality of services and fiscal integrity of associated third-party programs and is customarily provided by most healthcare professions. State and national governments demand a professional review to protect the consumer of healthcare services.

Professional review is a basic concept in service contracts such as those issued by VCP to its groups. VCP compiles statistics and data involving VCP network providers and their treatment of VCP patients. These statistics result in a doctor profile which indicates such factors as prescribing rates, range of prescriptions, patient complaint rates, average age of patients, average costs, etc. The information is handled in a strictly confidential manner.

When a network provider's profile indicates a major departure from the profiles of other network providers, it is brought to the network provider's attention by the VCP Professional Relations staff. The network provider may be asked to justify that his or her VCP profile reflects a consistent manner of practice for private patients as well as VCP patients.

When it appears that a VCP network provider may have exercised poor professional judgment, the facts of the matter may be investigated and submitted to a Quality Improvement committee. The committee may request a re-examination of the patient or that the network provider appear before the committee to discuss the case.

VCP hopes that all network providers recognize the need and obligation to their patients, to the groups buying the plan, and to their profession for this activity and accept this action with cooperation and understanding. In signing your Network Doctor's Agreement, you have agreed to this procedure.

VCP has established a quality improvement review program, which exists to monitor the quality of care provided to VCP patients by VCP network providers and to ensure that VCP policies and procedures are being followed by the network provider and his or her staff.

Most reviews reveal a high degree of integrity and compliance with VCP policies and procedures on the part of our network providers. In cases where VCP policies have been violated, appropriate action is taken by VCP. In some cases, the doctor may be required to make refunds to patients or to VCP. In other cases, the doctor may be called to appear before a VCP review committee before further action is taken. In extreme cases, the doctor may be removed from membership.

Occasionally, the quality improvement review uncovers evidence of serious problems, such as fraud. These cases require a review by the Humana Quality Committee, and, if serious enough, VCP is required to report the information to the appropriate regulatory agency, such as the State Board of Optometry.

Quality reviews

Quality reviews are performed by licensed, practicing optometrists and ophthalmologists who are completely familiar with VCP policies and procedures.

There are two ways in which a review may be performed: either at your office location or through the mail.

Patient satisfaction

Annual member satisfaction surveys may be conducted. Several key areas are identified annually and are discussed with respective department leaders. These results are used to create action plans for improvement.

Problem resolution

When a patient expresses a concern, Customer Care attempts to resolve the member's concern over the phone. If unsuccessful, the member is advised to submit a formal written letter to the following:

Humana Vision Care Plan
Grievance & Appeals Department
P.O. Box 14729
Lexington, KY 40512

Most concerns seem to be the result of misunderstanding or inadequate communication between the patient and the doctor. If it is found that the doctor used poor professional judgment, the facts are reviewed and submitted to the Vision Care Plan Quality Improvement committee and necessary disciplinary action is taken. The action may range from refunding of fees paid by VCP to suspension from VCP provider membership.

The Vision Care Plan Physician Advisory committee

The Physician Advisory committee establishes VCP policy and procedures. The committee is composed primarily of practicing optometrists and ophthalmologists.

The committee meets regularly to set the overall policy of the corporation. Their primary concerns are:

- The welfare of the patient
- The needs of the group
- The needs of our network providers
- Preservation of the doctor/patient relationship
- Quality control of professional services and materials

Providing lenses

Most VCP plans provide lenses every 12 or 24 months, if necessary, for the patient's visual welfare. However, there are limitations. VCP is designed to cover the patient's needs as opposed to patient's wants. Lenses are covered only when deemed to be necessary in the doctor's professional judgment.

The patient's materials copayment covers single-vision, lined bifocal or lined trifocal lenses that are clear, nonaspheric and made of standard glass or standard plastic. Aspheric lenticular single vision or 22mm round-segment lenses in clear plastic are also covered when required after cataract surgery.

Patient options

Members may desire additional cosmetic lens features. Many lens options are available to members at fixed prices. Unless a member has covered options, he or she should pay out-of-pocket for lens options at the date of service. Examples of lens options include progressive lenses, anti-reflective coatings, photochromic tints, etc. It is important to check the patient's benefits for specific details about the patient's coverage.

The VCP Options Price List (OPL)/Charge Back Schedule includes the patient payment amount and the charge back amount for each lens and option. The charge back amount is the amount you will pay for lenses and options ordered through EyeMed's lab network. These charges are deducted from your payments from EyeMed.

You can download the VCP OPL/Charge Back Schedule to see the prices for lenses and options.

There's a separate VCP Ray-Ban & Oakley OPL/Charge Back Schedule for authorized retailers of Ray-Ban and Oakley products.

Reference the Progressive lens and anti-reflective classification document to see which brands are in each designated tier.

VCP covers polycarbonate lenses for all members younger than 19. Do not charge members who are younger than 19 for the nonaspheric polycarbonate material.

Non-Patient OPL lens options

Although the OPL is comprehensive, members may wish to order other lens options. Members are responsible for your usual and customary fee for any option not listed on the OPL. Members may be eligible to receive, at provider's discretion, up to a 20% retail discount on items not offered by the plan.

Covered options

Member groups may elect to cover certain lens options. Please consult the member's benefit details for covered options. Members should not be charged for covered options, and providers will not be charged for ordering those options from an EyeMed network lab.

Providers who fabricate lenses outside of the EyeMed lab network may not charge members for covered options. We will reimburse you for these upgrades at rates comparable to lab pricing. Contact VCP Professional Relations at **1-866-374-8805** if you have questions. Team members are available to assist you Monday – Saturday, 7:30 a.m. – 11 p.m., or Sunday, 11 a.m. – 8 p.m., Eastern time.

Important!

Always advise the patient of any additional expenses before performing services or ordering materials.

Progressive non-adapt policy

Many VCP patients, especially first-time progressive lens patients, expect a refund of the progressive option charge if they are unable to adapt to the lenses. In an effort to alleviate any confusion, we suggest that you provide your patients with a statement such as:

I understand that if I am unable to adapt to the progressive lens within six (6) months, the laboratory will replace the progressive lenses with regular single vision, bifocal or trifocal lenses at no additional charge. I also understand that any money paid toward the cost of the progressive lenses will not be refunded.

I have signed this statement prior to the lenses being ordered and a copy will be given to me for my records and one will be kept in my original file.

_____

Patient's signature and date

Should your patient require a remake on progressive lenses, please remember that changing the frame voids the manufacturer's warranty. Because VCP does not cover remakes on lenses under warranty, it is your responsibility to discuss payment with the lab if you change the frame on a remake.

Providing frames

Most VCP members have covered frame benefits at intervals of 12 or 24 months. Frames may be sent to the lab along with the order for eyeglasses.

Dispensing frames

The patient's benefit details will indicate if the patient is entitled to a frame and the patient's frame allowance, which is based on wholesale pricing. Frames provided to VCP patients must be of high quality. You may not supply discontinued frames or those not listed in the current Frames Data® Price Book. Patients may use an existing frame if it is still serviceable. See the frame Waiver of Liability section below for details.

Frame allowances

You may view a member's wholesale frame allowance by checking the patient's eligibility and benefits online. VCP will reimburse the provider up to the amount of the frame allowance. Please try to stay within this allowance when assisting the patient in selecting a frame. It is the patient's choice to exceed the allowance and pay any additional frame overage.

Wholesale cost

VCP considers the wholesale frame cost to be the wholesale cost paid by the doctor or that listed in the Frames Data Price Book, whichever is lower. This value is subject to audit by VCP.

Frame overages

If a patient chooses a frame with a wholesale cost that exceeds his or her wholesale frame allowance, charge the overage to the patient on the date of service. To calculate overage, charge the patient the difference between the wholesale frame cost and frame allowance, multiplied by 2. (See page 12 for an example.)

Frame Waiver of Liability

VCP encourages our network providers to use a frame Waiver of Liability form when a patient elects to use his or her frame. In the event of loss, damage or breakage, this waiver releases the provider and the contracted lab from liability to replace the lost, broken or damaged frame. (See page 20, Waiver of Liability.)

Record keeping

VCP reserves the right to require an invoice showing the cost and date of purchase for any frame furnished under the VCP program. VCP also reserves the right to refuse payment for any frame if these guidelines are not followed.

Waiver of Liability

Due to the fact my frame is not new and not under manufacturer's warranty, the provider has notified me that neither my plan nor my provider will be responsible for any loss/breakage of my frame(s) during shipping or breakage while at the laboratory. In the event of loss and/or breakage, I agree to be personally and fully responsible for any expenses associated with loss and/or breakage of my frame(s), including charges for shipping and insurance and excess prescription lens cost.

Patient's acknowledgement and agreement to pay:

Member's signature _____ Date _____

Physician/provider's signature _____ Date _____

4030 West Boy Scout Blvd., Ste. 1000, Tampa, FL 33607

1-866-537-0229

Humana®

Using the EyeMed lab network

Introduction

You will use EyeMed's lab network to order eyewear for Humana VCP patients. If your setup allows you to use non-network labs, you can skip this section.

You will receive updates about the lab network, lab products and claims processes directly from EyeMed. Visit inFocus to access how-to guides, job aids and more.

The VCP Options Price List (OPL)/Charge Back Schedule includes the patient payment amount and the charge back amount for each lens and option. The charge back amount is the amount you will pay for lenses and options ordered through EyeMed's lab network. These charges are deducted from your payments from EyeMed.

You can download the VCP OPL/Charge Back Schedule to see the prices for lenses and options.

There's a separate VCP Ray-Ban & Oakley OPL/Charge Back Schedule for authorized retailers of Ray-Ban and Oakley products.

Reference the Progressive lens and anti-reflective classification document to see which brands are in each designated tier.

Labs

Approximately 100 labs participate on EyeMed's lab network, including Essilor labs, Walman labs and Luxottica Lab Services (LLS).

Access the complete list of EyeMed network labs and online training guides for managing lab accounts on inFocus.

Registering for labs

To use the EyeMed lab network, you must register for at least one lab before filing your first claim. You can register through EyeMed's online claims system.

Once you've signed in, click on Manage My Profile, then on Lab Accounts. To register with a lab, you will need to agree to that lab's terms and conditions. You can add other labs at any time; you'll choose the one you want to use when placing the order.

Download the lab registration job aid on inFocus for more information.

Product catalogs

When you order eyewear for Humana VCP members, you'll choose from the products available in EyeMed's product catalogs.

EyeMed's lab network gives you access to hundreds of lenses and treatments featuring state-of-the-art technology that helps you provide your patients with quality vision correction.

Product catalogs are located within the Labs menu on inFocus, and they vary based on the lab you use. You will find catalogs for Essilor and Walman Labs and for Luxottica Lab Services (LLS).

Note: Ray-Ban products are available to authorized retailers through Luxottica Lab Services (LLS).

Lab orders

Placing and managing orders

To place lab orders in the EyeMed lab network, submit the order through the online claims system at the same time you file the claim. Send the frame to the lab along with a copy of the order confirmation, which you'll print from the online claims system. If you choose to drop-ship a frame, ensure the patient's name is included on the frame order. The frame must be received within 90 days of placing the order; otherwise, the lab will cancel the job and void the claim.

Note: Labs on the EyeMed lab network cannot accept the CMS 1500 claim form for VCP orders.

The lab will send the completed eyewear back to your office, usually within one week from receipt of the frame. Occasionally, it may take longer.

Always double-check your order before submitting it. Once it has been submitted, it is "in process." If you have to cancel it, the lab will bill you as a private pay transaction.

Canceling an order

When using the lab network, you'll need to void the entire claim if you need to cancel the eyewear portion. Labs can cancel orders at their discretion, but they can't void a claim without your approval. Contact the lab directly to cancel the materials portion of the order. The lab will void the claim with your approval, transmit the information to EyeMed, and the member's eyewear benefit will be reset in about 24 business hours.

If the lab has already pulled and cut the lens by the time you cancel, you may be responsible for paying the charge back for the base lens.

If you're voiding the order because the member canceled it, you can charge the member the base lens fee—but be sure you have a written policy on remakes and refunds so members know up front what they're responsible for. If the member complains on this issue, we'll ask you to show us your refund policy.

Emergencies

In the event of an emergency, you may use a non-contracted lab to meet urgent member needs.

An emergency is defined as when, in your professional opinion, there's a critical patient visual need that can't be addressed through normal contract lab services, such as:

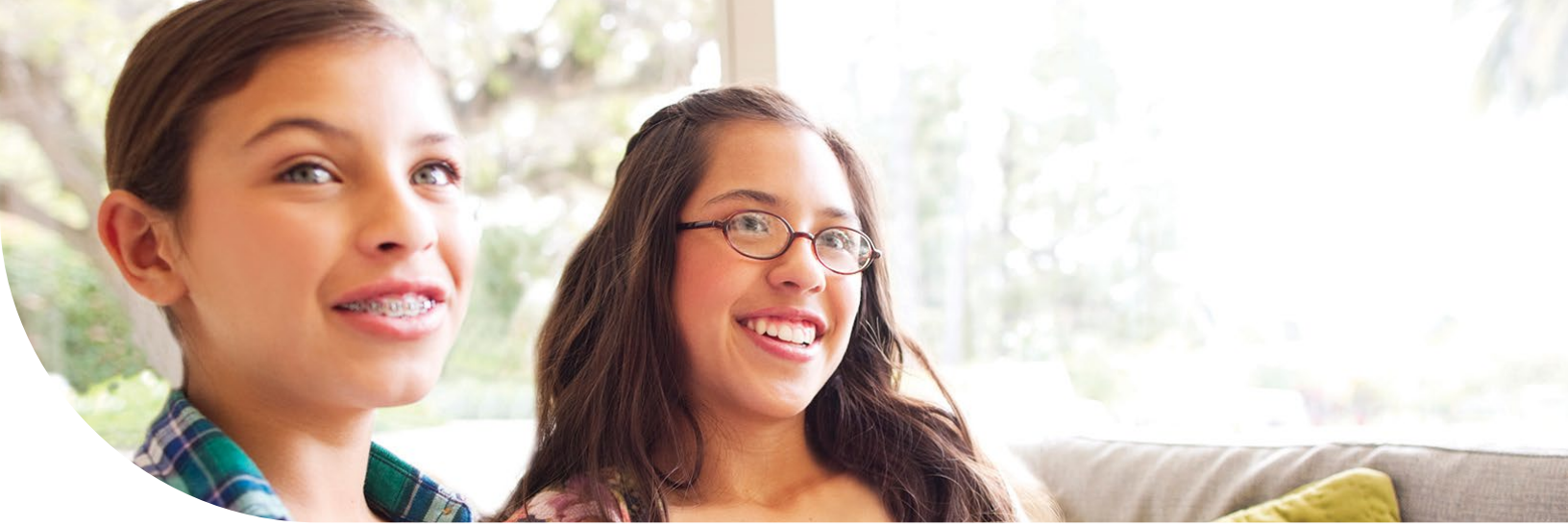
- A member's safety and/or well-being is at risk without the immediate delivery of prescription eyewear.
- The member is unable to function at work or school and doesn't have an alternate pair of glasses or contact lenses.
- The member requires lenses or lens options you deem necessary based on your professional judgment, but which aren't offered in our product catalog.

To handle the emergency, send the job to the lab of your choice, treating it as a private pay lab transaction. Submit a CMS 1500 form in hard copy to receive payment for the dispensing and materials components. You will be responsible for lab charges. You may then be asked to complete an emergency service claim explanation form.

Note: You may not balance-bill the member for any difference in reimbursement from the schedule if you order a lens that's not in one of our catalogs.

The following situations are not considered an emergency:

- Requests for faster turnaround time for convenience (like a trip, vacation or similar event)
- A desire for faster service
- When the patient has another serviceable pair of glasses or contact lenses



Returns, refunds and remakes

Remake policy

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

Qualifying requests

You can request a no-charge first-time remake from a network lab one time per job within six months of the date of delivery for the following reasons:

- Power changes (excludes power changes resulting in plano lenses)
- Axis changes
- Base curve changes
- Segment height/segment style changes due to non-adaptation (e.g., FT28 to Executive)
- Lens style change (except when going from a lower to higher technology like from a bifocal to a progressive)
- Transcription errors (not including transcription errors involving tints, photochromics, frames or coatings)
- Material change (e.g., glass to plastic, plastic to poly, plastic to high index plastic or glass)
- Lab errors
- Progressive lenses under warranty

Exclusions

You can't receive a free lens remake for the following:

- Frame change remakes without a change in lens prescription
- Subsequent remakes after the first one (excludes lab errors)
- Patient's upgrade requests
- Lost materials
- Materials broken or damaged by the patient
- Any lenses with upgrades
- Changes requested after six months of delivery

Labs do not offer free remakes for changes to the frame only.

No questions asked

If you have a "no questions asked" return policy that allows patients to replace frames if they're not satisfied, call us at **1-866-374-8805** to have the patient's benefits reinstated. You will be charged for the lab work based on the OPL/Charge Back Schedule.

Returns for quality or defects

If you're not satisfied with the end product, the lab will honor reasonable remake requests. Any financial issues resulting from the manufacturer's warranty should be handled between you and the lab.

Returns, refunds and remakes (continued)

Handling remake requests

- Remakes for lab errors are processed free of charge.
- For a free first-time remake, return the lenses to the same lab (within six months of the original delivery date) along with the original invoice/shipping slip, an explanation of why you're returning the lenses and any supporting documentation.
- Patients are responsible for the cost to change a frame:
  - Handle it as a private pay transaction
  - Fax the request to the lab and ship the new frame to the lab with the existing pair of glasses
- If a patient wants to change to a lesser technology from a more advanced lens type (for instance, from a progressive lens to a bifocal), work with the lab to determine applicable charges. Patients are expected to pay any charges above and beyond the original order.
- For progressive lenses:
  - When a patient can't adapt to progressive lenses while they're under warranty, the lab will remake the lenses one time at no charge in the same design and material (or lesser-priced design and material). (See page 18 for the Progressive non-adapt policy.)
  - If the patient still can't adapt to the second (remade) glasses with progressive lenses, request another remake to switch the patient back to lined bifocals, but you'll have to pay full invoice cost for this additional remake. If this happens, follow the same remake/return process outlined above.

Note

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

In-office lab programs

In-office finishing

With the Single Vision In-Office Finishing Program, you can offer same-day service by using your in-house edging equipment. There are a few program requirements. You must:

- Have in-office finishing capabilities
- Produce eyewear that meets ANSI standards

To activate the program, sign in to the online claims system and select “Manage My Profile” in the left-hand navigation. Select “In-Office Finishing” from the sub-menu. Follow the on-screen instructions, which include agreeing to the program’s terms and conditions. When you submit a claim for eyewear you’ll finish yourself, choose the In-Office Finishing button on the Claims Entry screen.

Lens-only program

In this program, you receive surfaced, edged lenses directly from the lab without sending a frame. You can use the lens-only program for most jobs. If a submitted order cannot be filled for a specific frame or lens the lab may notify you if they identify the issue prior to starting the order.

Some frames or lens edging may require sending the frame to the lab:

- Three-piece/drilled rimless
- Wrap frames with a base curve higher than 6
- In-line/double-groove frames
- U-bevel frames (zyl frames with deep groove)
- Mini/shallow-bevel frame (too small for standard bevel)

To participate in the lens-only program, you must have a tracer calibrated within manufacturer tolerances and according to manufacturer’s suggested schedule with the ability to download and transmit trace data in the Vision Council standard format.

You can submit lens-only orders through the online claims system. Look for the “Lens Only with Trace” button. Upload a trace file in either .txt or .xml format. Or you can submit a lens-only order with a reference to an archived trace file. Just include the prior order or invoice number in the online system’s reference field. If the lab needs an updated trace file, send it separately from the original order. Due to tracer variances, minor finishing may be required to fit the lens.

As always, double-check your order before you submit it, because changes to submitted orders may result in it becoming a private pay transaction.

The standard remake policy applies with a few exceptions:

- Lens fitting issues due to tracer calibration that exceed manufacturer tolerances or are outside the suggested calibration schedule
- Damage or breakage during lens fitting
- Fitting issues related to the trace data supplied (unless caused by lab error)

For more information, see the Lens Only Program Flyer.

In-office lab programs (continued)

Uncuts

With our uncut lens program, you can receive surfaced lenses directly from Luxottica Lab Services, enabling you to control quality and complete the edging and mounting in-office.

Any provider can participate in the uncut lens program, and most products and services are eligible for uncut ordering. To participate, you'll need an edger and must have the ability to edge and mount frames within manufacturer tolerances. You'll also need to be registered with Luxottica Lab Services.

Submit orders through the online claims system and choose "uncut" as the job type from the available job type list.

Uncut lens ordering can't be used for:

- Tint
- Mirror
- Lab-applied UV
- Glass
- Balanced lenses
- Slab off
- Certain complex frames that require specific mounting or bevels

The standard remake policy applies, with a few exceptions:

- Damage or breakage during edging and/or mounting of the lens
- If you're unable to complete the edging or mounting, and must send it to the lab for completion

Note

If you provide an edge-treatment service like a polish edge or a roll and polish, you must choose that option in the available treatments when you place the order. Doing so will generate the member benefit for the service allowing you to enter the usual and customary charge. This will not trigger a charge back since this service will be provided by you.

Choose a frame type for every uncut order placed through the online claims system. This is important for frame types such as drill mounts and semi-rimless groove to ensure the member benefit is applied correctly. If you choose to complete a drill mount or semi-rimless frame, you'll see these options in the Usual & Customary screen. A charge back will not be assigned to these frames since you're performing the mounting.

For more on uncut lenses, see the Uncut flyer.

VCP contact lens programs

The standard VCP plan covers an eye examination, spectacle lenses and a frame. Many groups will provide coverage for contact lenses in place of or in addition to lenses and/or frames. VCP covers contacts when they are medically necessary for the member.

There are two types of coverage for contact lenses: elective and medically necessary.

1. Elective contact lenses (please see page 28)

- Patients with an elective contact lens benefit may use their contact lens allowance in place of all other benefits unless otherwise specified.
- All VCP patients will receive a 15% discount from the contact lens exam and fitting fee. After the discount, the patient pays any difference between the usual and customary fees and the elective contact lens allowance.
- If the patient has an "Exam and" or "Preferred" allowance benefit, then the patient will pay any applicable exam copayment.

2. Medically necessary contact lenses (please see page 29)

- In this situation, contact lenses are allowed in place of other benefits with prior authorization for specific visual conditions not corrected by spectacle lenses. VCP reimburses the provider according to the guidelines of the patient's group contract.

Eligibility

Review the member's benefits using the online claims system to determine the patient's eligibility before proceeding with a contact lens fitting. The patient must be eligible for exam and lenses to be eligible for the full contact lens benefit. After determining that the patient is eligible, see the appropriate contact lens procedures on the following pages.

Discount

Patients are eligible for a 15% discount on professional service fees for elective contact lenses (exam, fitting). Patients may be eligible to receive this discount, at provider's discretion, for 12 months after the covered eye exam.

Plan limitations

Items not covered under VCP contact lens program:

- Plano lenses to change eye color cosmetically
- Artistically painted lenses
- Additional office visits associated with contact lens pathology—major medical insurance often pays for contact lens pathology visits
- Contact lens modification, polishing or cleaning

Note: Medical eye conditions are not covered by VCP (e.g., eye infections, corneal abrasions, etc.). Refer patients with medical eye conditions to the patient's medical insurance company. Do not bill VCP for medical visits. Medical claims will be returned to your office.

Elective contact lenses

Contact lens allowance

Elective contact lenses take the place of all other material benefits. The patient may order spectacle lenses or contact lenses, unless otherwise specified by the patient's benefit details. There are three types of contact lens plans: Total Allowance, Exam and Allowance and Preferred.

"Preferred"

- Option A – Covers complete contact lens evaluation, fitting and one follow-up exam, and a choice of preferred contact lens types, which may vary according to availability. In addition to payment of the comprehensive exam, the total provider fee is $100. Collect patient copay.
- Option B – Covers complete contact lens evaluation, fitting and one follow-up exam, and materials allowance. Patient uses allowance toward the purchase of contact lenses of their choice. In addition to payment of the comprehensive eye exam, the provider will receive a $45 fitting fee and 100% of the patient allowance. The VCP payment for the exam, evaluation, fitting and follow-up is considered payment in full. The patient pays the exam copay and the balance above the allowance.

Preferred contact lenses

Ocular Science (OS) Edge III Thin; OS Z4, Cooper Silver 07, Ciba Softcon EW; or Disposables (limit two 2 boxes) – Softlens 66, Sequence II/Optima FL or Polyform Private Label – OSI

Please note: The contact lenses listed above are subject to availability. Contact ABB Optical Group **1-800-852-8089** for suggested substitutions.

"Total" Allowance example

To determine the "patient pays" total:
Add the net result of doctor's usual and customary rate for fitting and evaluation, less 15%, the contracted rate for the eye exam and the cost of contact lens materials. From this total, subtract the "Total" allowance as indicated by the patient's benefit details. Add the patient's exam copayment for a final "patient pays" total.

$ 45.00	Professional services (U&C fees; excludes exam)
- $ 6.75	15% discount
$ 38.25	
+ $ 32.00	Exam at VCP contracted rate less patient copay
+ $100.00	Materials
$ 170.25	
- $ 110.00	"Total" Allowance (VCP pays; amount may vary)
$ 60.25	
+ $ 10.00	Patient's exam copay (amount may vary)
$ 70.25	**Patient pays**

"Exam and" Allowance example

To determine the "patient pays" total:
Add together the net result of doctor's usual and customary rate for fitting and evaluation, less 15% and the cost of contact lens materials.
From this total, subtract the allowance as indicated by the patient's benefit details. Add the patient's exam copayment for a final "patient pays" total.

VCP reimburses the provider for the exam at the provider's contracted rate.

$ 45.00	Professional services (U&C fees; excludes exam)
- $ 6.75	15% discount
$ 38.25	
+ $100.00	Materials
$ 138.25	
- $ 110.00	Patient's Allowance (VCP pays; amount may vary)
$ 28.25	
+ $ 10.00	Patient exam copay (amount may vary)
$ 38.25	**Patient pays**

Medically necessary contact lenses

VCP is a routine vision plan. VCP provides coverage for medically necessary contact lenses as an additional coverage option for your patients. VCP will cover, in lieu of eyewear or elective contacts, medically necessary contact lens material and initial fitting for the following conditions:

- When visual acuity cannot be corrected to 20/70 in the better eye except by their use
- Anisometropia of greater than 3.00 diopters and asthenopia or diplopia, with spectacles
- Diagnosis of keratoconus supported by medical record documentation consistent with a two-line improvement of visual acuity with contact lenses as the treatment of choice
- Monocular aphakia or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life
- High ametropia of either +10D or -10D in any meridian

Medically necessary contacts are not covered for patients with a history of corneal or elective refractive surgery (e.g., Lasik, PRK, RK).

How to obtain prior authorization

- Submit the appropriate Authorization Request form and receive approval before proceeding with the services
- Click to download the Medically Necessary Contact Lens Prior Authorization Form
- Submit the completed authorization request, a copy of the patient's medical records and a manufacturer's contact lens billing invoice to VCP
- VCP will return the authorization, indicating approval and coverage amounts or denial
- Order and dispense materials after receiving the returned approval

Claims submission guidelines

- Submit the claim and a copy of the Prior Authorization approval
- Claims for follow-up visits and diagnostic tests (e.g., corneal topography) should be submitted to the patient's medical insurance carrier
- See page 10 for claim submission information

Provider payment

- The reimbursement covers the initial fitting and materials only.
- There is no copayment for the initial fitting and materials.
- You may not charge the patient the difference between your usual and customary fees for contact lens services and the amount VCP reimburses for the initial fitting and lenses.
- Contact lens fitting fee and materials are reimbursed on an invoice cost basis.
- Medically necessary contact lens benefit covers the first pair of lenses. At the provider's discretion, additional or companion lenses may be purchased by member at the provider's usual and customary fee less a 20% discount.

Claim information

Checking claim status

To check claims status, sign into the online claims system. You may also contact VCP Customer Care at **1-866-537-0229**. Team members are available to assist you Monday – Saturday, 7:30 a.m. – 11 p.m., and Sunday, 11 a.m. – 8 p.m., Eastern time.

Access online training guides for working with claims by signing into inFocus.

Appeals process

The VCP Appeal System is designed for review of claims that have been processed, but not paid. This will be noted on your Remittance Advice (RA) with the corresponding denial code. Proper procedure for the Claims Appeal System is to complete the Appeal Request form. Attach a copy of the claim, and mail it to the Grievance and Appeals Department for review. After the review is completed, the claim will receive an approval for payment or a final denial. (See Appeal Request form on page 32.)

Fraud warnings

Refer to our fraud warning statements

VCP network provider payments

VCP reimburses network providers according to a fee payment system, which enables us to reimburse you fairly and provide a vision care plan to groups at an attractive price. VCP pays network providers on a weekly basis. Your check will include payment for claims received and processed prior to the Tuesday before the check is released. The check includes the Disbursement Detail statement, which itemizes the claims paid each Wednesday. Disbursement details may also be accessed via the online claims system.

It is important to submit claims that indicate the doctor name and practice location where services were provided. The complete address should be used including city and ZIP code. Omission of this information may result in a delay of payment.

Maximum allowance

VCP establishes the maximum amount that network providers can be reimbursed for examinations and for lens and frame dispensing. The fees are the current maximum payable allowance and represent "payment in full" with the exception of any applicable copayments and options.

Important! According to the VCP Panel Agreement, you may not at any time charge the discount amount back to your patient.

Unpaid claims

If payment for a particular claim does not appear on the check, most likely it is due to one of the following reasons:

1. Doctor name or practice information is missing or incomplete
2. The claim is being returned to you for further information
3. The claim was submitted for someone other than the patient identified on the form
4. The claim arrived at the VCP office after the processing date deadline and will be included on the next check
5. The claim has not been received by VCP
6. The claim is being audited

Disbursement

Access the online claims system to view disbursements. For instructions regarding online claim submission, claim payment and how to read the disbursement details, visit inFocus.

Overpayment

We will not withhold any benefit payable, as an adjustment or correction of an overpayment made on a claim for the same covered person, unless we have clear documented evidence of the overpayment and written authorization from the provider allowing this withholding.

Appeal request form

Doctor information

Name _____

Address _____

City _____

State & ZIP _____

Telephone number (____) _____

Patient information

Name _____

Insured's name _____

Insured's SSN _____

Date of service _____

Plan/group name _____

I am appealing for:

INSTRUCTIONS TO VISION CARE PLAN PROVIDERS

This form is to be used to initiate a claim appeal. **All appeals or requested information must be received by VCP within 60 days from the date of the denial notice.** Fill out the form completely and keep a copy for your records. Send the form to Vision Care Plan. Attn: Claims Appeals, P.O. Box 14729 Lexington, KY 40512-4729. The appeal will be reviewed and you will be notified of the outcome within 60 days.

☐ Medical necessity ☐ Timeliness ☐ Other

Reason for request

_____

_____

_____

_____

_____ _____

Physician/provider's signature Date

PLEASE ATTACH COPIES OF ALL RELEVANT DOCUMENTS

For VCP use only

Date received _____

Letter of receipt sent _____

Resolution date _____

Peer review _____

Provider relations _____

Claims _____

Chief operation officer _____

Grievance and Appeals Department
P.O. Box 14729
Lexington, KY 40512-4729
1-866-537-0229

Humana®

Health Insurance Portability and Accountability Act (HIPAA) FAQs

FREQUENTLY ASKED QUESTIONS FOR VISION CARE PLAN PROVIDERS

The following information is provided as a courtesy to our providers to address frequently asked questions about HIPAA and is not intended as legal advice.

As a vision care provider, do I have to comply with HIPAA?

If you engage in electronic transactions for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers, then you will be considered a "Covered Entity" under HIPAA and must comply with the Privacy, Security and Electronic Transaction and Code set requirements.

If you do not engage in electronic transactions for which standards have been adopted by the Secretary under HIPAA, then you will not be considered a "Covered Entity" under HIPAA and will not have to comply with the Privacy, Security and Electronic Transactions and Code set requirements. However, by virtue of your relationships with health plans, insurers or facilities, you may be indirectly required through these relationships to comply in whole or in part with the HIPAA requirements.

Do I need to have a Business Associate Agreement with Vision Care Plan to see patients or submit claims?

No. HIPAA does not require that a Business Associate Agreement be in place for: 1) functions related to treatment; or 2) when a healthcare provider discloses protected health information to a health plan for payment purposes; or 3) when the healthcare provider simply accepts a discounted rate to participate in the health plan's network of providers.

Does Vision Care Plan have to provide me with written authorization from the patient in order for me to release supporting medical documentation for a claim?

No. Any function that falls under treatment, payment or healthcare operations ("TPO") does not require an authorization from the patient for protected health information to be released to the plan. Claims are considered "payment."

Does Vision Care Plan have to provide me with written authorization from the patient for me to assist with or provide protected health information for the patient grievance resolution process?

No. Any function that falls under treatment, payment or healthcare operations ("TPO") does not require an authorization from the patient for protected health information to be released to the plan. Resolution of patient grievances is considered "healthcare operations."

Does Vision Care Plan have to provide me with written authorization from the patient for me to allow a records review and/or site visit in connection with the credentialing, recredentialing or peer review process?

No. Any function that falls under treatment, payment or healthcare operations ("TPO") does not require an authorization from the patient for protected health information to be released to the plan. Credentialing, recredentialing and peer review activities are considered "healthcare operations."

Where can I go on the internet to get more help and information regarding HIPAA?

The Centers for Medicare & Medicaid Services (CMS) has information regarding HIPAA on its website. You can find this information at www.cms.gov.

Humana Vision Care Plan

4030 West Boy Scout Blvd., Ste. 1000, Tampa, FL 33607
Professional Relations **1-866-374-8805** | Customer Care **1-866-537-0229**

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