vsp vision care

VSP New York Medicaid
Network Manual

Check out the **Manuals** on **VSPOnline**

Effective January 1, 2023

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VSP'S MEDICAID PLAN

VSP's Medicaid Plan is based on contracts with health care organizations (clients) to provide the vision care portion of the state's Medicaid program.

Clients are required to provide the minimum benefits specified by your state's Medicaid program, but may also offer enhanced benefits.

Please refer to **Client Detail pages** and/or **Medicaid Fee Schedules** for details about administration of basic state benefits. For state information, refer to the State Medicaid Manual.

ENROLLMENT/DOCTOR PARTICIPATION

Participation is voluntary. Only VSP doctors who have signed a Medicaid Plan Acknowledgment may provide services to Medicaid Plan members. All participating doctors are required to have a state Medicaid identification number.

Eligibility & Authorization

When you contact VSP for an authorization, please provide the following information:

- Last four-digits of the member's Social Security Number and date of birth or the entire client-assigned ID number
- Member's Medicaid number if different from Social Security Number
- Patient's date of birth
- Patient's HMO name

There are several ways to obtain an authorization:

VSP's Electronic Claim Submission System—Enter member's Social Security Number or client-assigned ID number using eyefinity's website and select "Check Patient Eligibility" to access eligible plans. You may wish to print the plan information to discuss plan coverages with your patients.

Customer Service—Call VSP at **800.615.1883**. You may select "1" to contact our automated Interactive Voice Response (IVR) system, or you may speak with a Customer Service Representative who will verify the patient's current eligibility, provide plan information, and issue an authorization.

Note: When the member's eligibility has been verified, VSP will provide an authorization number that is effective through the last day of the current month.

Coordination of Benefits

If the Medicaid patient has vision care coverage through any carrier other than VSP or another VSP plan, you must bill that carrier or the other VSP plan first. The VSP Medicaid Plan should be billed as secondary, where appropriate. For electronic claim submission, be sure to provide the patient's responsibility for exam and refraction separately.

EXAM COVERAGE

Routine eye exam coverage and timeframes are established by State regulations.

In addition to coverage for routine vision care services, Medicaid members are typically covered for services under Essential Medical Eye Care or Integrated Primary EyeCare Program. Any exceptions to this coverage are described in the Client Detail pages and/or the Fee Schedule.

For Telemedicine information refer to: Telemedicine.

Referrals

Follow all referral protocols set forth by your patient's health plan for any services beyond the scope of the patient's VSP plan. Typically, an HMO requires that patient referrals be coordinated by the primary care physician (PCP). However, a PPO usually allows patients to receive care from any medical provider without a PCP referral. Check Client Detail pages for any specific instructions or exceptions.

CPT Category II Codes for Eye Exams for Patients with Diabetes

As a health-focused vision care company, VSP highly encourages providers to use CPT Category II codes. The use of Category II codes for Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures helps confirm that you are providing the best quality patient care and further emphasizes the essential role Doctor of Optometry play in overall healthcare. Providing this information also decreases the administrative burden of pulling chart notes for requested patients.

WHAT ARE CPT CATEGORY II CODES?

- CPT Category II codes are tracking codes which facilitate data collection related to quality and performance measurement. They allow providers to report services based on nationally recognized, evidence-based performance guidelines for improving quality of patient care.
- CPT Category II codes describe clinical components, usually evaluation, management or clinical services.
- Category II codes are not to be used as a substitute for Category I codes.
- CPT Category II codes are comprised of four digits followed by the letter "F".
- CPT Category II codes are for reporting purposes only and are not separately reimbursable.

BILLING CPT CATEGORY II CODES

- CPT Category II codes are billed in the procedure code field, the same as CPT Category I codes.
- Bill CPT Category II codes with a $0.00 charge amount.
- If you receive a claim denial, your reporting code will still be included in the quality measure.

When billing eye exams for patients with diabetes use the following optometry-related CPT Category II codes, when applicable:

2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
Current Procedural Terminology (CPT) Category II codes developed by the American Medical Association (AMA)

MATERIALS COVERAGE

Note: Please refer to the Patient Record Report, authorization, or Client Detail pages to determine if any exceptions are covered by your state Medicaid Plan and/or by the client.

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

For more information, please refer to your Client Detail pages and/or Fee Schedule.

Dispensing of Spectacles

If a covered benefit, a dispensing fee may only be billed with a complete set of eyeglasses (frame and lenses). Please refer to your state provider manual for eligibility and state-specific guidelines.

Repair and Refitting Spectacles

If a covered benefit, bill repairs to eyeglasses using CPT code 92370 (repair and refitting of spectacles) or CPT code 92371 (repair of spectacle prosthesis for aphakia).

Do not bill a dispensing code for repairs.

Repair and refitting codes cannot be billed with material HCPCS codes (e.g., V2020) on the same date of service.

Please refer to your state provider manual for eligibility and state-specific guidelines.

Replacement

If a covered benefit, bill replacement frame and lenses using the appropriate frame or lens HCPCS code. Do not bill a dispensing code for replacement of just the frame or lenses.

A dispensing fee may only be billed, if you are replacing a complete set of eyeglasses (frame and lenses).

Please refer to your state provider manual for eligibility and state-specific guidelines.

Frames

Frame coverage is based on state regulations. Medicaid plans have an established allowance for the purchase of a new frame. For further information refer to your Client Detail pages and/or Fee Schedule.

Visually Necessary Contact Lenses

If a covered benefit, refer to Client Detail pages as specific criteria applies.

LABORATORY

You may use any lab of your choice on a private invoice basis or fabricate your own materials. Exceptions are noted in the Client Detail pages.

Contract labs that have agreed to provide lenses at a reduced price for VSP are identified in the National Contract Lab List in your VSP Provider Reference Manual. When using a contract lab on this list, please write "VSP Medicaid" and the authorization number on the private invoice to ensure reduced VSP Medicaid materials prices.

Lab Price Schedule

Note: The lab price schedule below is valid for Medicaid Plan prescriptions **only**. Please refer to the patient's authorization and the Medicaid Fee Schedule to determine if any exceptions are covered by your state Medicaid Plan and/or by the client.

COST

Single Vision	$12.15 per pair	
Bifocals	$21.55 per pair	
Trifocals	$30.55 per pair	
Covered Items	**Single Vision**	**Multifocal**
For higher powers add:	$3.65 per lens	$4.15 per lens
For lenticular add:	$11.85 per lens	$13.80 per lens
For slab off add:	$30.45 per lens	$30.45 per lens
For prism add:	$1.85 per lens	$1.85 per lens

Laboratories will charge your office on a private invoice basis. All items not listed are billed at the laboratory's private add-on prices. Doctor redos are billed by the laboratory at 50% of the scheduled fees.

Base lenses include:

- Rxs up to and including 7.00 sphere and 4.00 cylinder
- Plastic or glass lenses (including hardening)
- Zyl, metal, or carbon mounting
- Bifocal or trifocal Segment widths of 25 and 28
- All higher adds
- All base curves
- Press-on prism
- Eye size up to and including 55mm
- Shipping and handling charges to the office

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

The filing limit for submitting claims in most states is 180 days from the date of service. Exceptions are noted in the Client Detail pages.

Submit Medicaid claims:

- Electronically through eClaim on eyefinity.com.
- Via paper on a typewritten or computer-generated standard CMS-1500 form.
- Enter the authorization number in Box 23 of the CMS-1500 form. Use the appropriate Place of Service and Type of Service codes from your state Medicaid manual, and submit the CMS-1500 form directly to VSP for processing after providing services. It is not necessary to include the lab's invoice for materials.

VSP will only reimburse claims received for patients who are eligible at the time of service.

All Medicaid claims must be billed with the appropriate diagnosis codes:

Exams:

Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings
Z01.020	Encounter for examination of eyes and vision following failed vision screening without abnormal findings
Z01.021	Encounter for examination of eyes and vision following failed vision screening with abnormal findings
Z13.5	Encounter for screening for eye and ear disorders
Z46.0	Encounter for fitting and adjustment of spectacles and contact lenses

Exams or Materials:

H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.31	Anisometropia
H52.32	Aniseikonia

H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye
H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
H53.001	Unspecified amblyopia, right eye
H53.002	Unspecified amblyopia, left eye
H53.003	Unspecified amblyopia, bilateral
H53.011	Deprivation amblyopia, right eye
H53.012	Deprivation amblyopia, left eye
H53.013	Deprivation amblyopia, bilateral
H53.021	Refractive amblyopia, right eye
H53.022	Refractive amblyopia, left eye
H53.023	Refractive amblyopia, bilateral
H53.031	Strabismic amblyopia, right eye
H53.032	Strabismic amblyopia, left eye
H53.033	Strabismic amblyopia, bilateral
H53.141	Visual discomfort, right eye
H53.142	Visual discomfort, left eye
H53.143	Visual discomfort, bilateral
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
Z96.1	Presence of intraocular lens - COB only, will be accepted without refractive error diagnosis.
H49.01 – H49.9	Paralytic Strabismus
H50.00 – H50.9	Other strabismus
H51.0 – H51.9	Other disorders of binocular movement

Any exceptions are noted in the Client Detail pages.

Medical eyecare services performed in bordering states are reimbursed per Essential Medical Eye Care Medicaid fee schedule for the state in which you reside.

You are responsible for verifying the accuracy of your payment. For Medicaid patients, overpayments must be corrected within 60 days.

Coordination of Benefits

Coordination of benefits is available in most states. Exceptions are noted in the Client Detail pages. If the patient has other vision coverage, coordinate benefits and bill the other carrier. Medicaid is the payor of last resort.

For Electronic Claims

- Exam only claims (with or without a refraction) can be submitted electronically as long as a routine or refractive diagnosis is present,
- When you receive payment from the primary plan, keep a copy of the original CMS-1500 form showing the exam and refraction services submitted to the primary plan, along with the Explanation of Payment or Explanation of Benefits from the health plan/Medicare, in the patient's file.

Note: Enter exam and refraction separately with this exact language in box 19: "secondary COB claim patient resp EXAM $XX.XX REFRACTION $XX.XX." (Indicate the dollar amount of the patient's responsibility in place of the XX.XX).

For Paper Claims

- When you receive payment from the primary plan, send a copy of the original CMS-1500 form showing the exam and refraction services submitted to the health plan, along with the Explanation of Payment or Explanation of Benefits from the health plan, to VSP. Don't send a summary.

Refer to the Coordination of Benefits (COB) section of the **VSP Manual** for complete information.

NEW YORK MEDICAID CLIENT DETAILS

Member Identification Number

Members are reported as follows:

Centers Plan for Healthy Living – 11-digit all numeric ID number (not Client Identification Number), located on the health plan card

Prime Health Choice – 9-digit Social Security number

Patient Eligibility and Services

The following clients may have coverage exceptions for specific Medicaid populations. Please make sure to check eligibility before providing services to patients as coverage can vary by client. Special handling information is available for the following clients:

- Prime Health Choice

Medicaid Appointment Availability Requirements

The following access standards are required for participation in the VSP New York Medicaid Doctor Network:

- 24-hour access to provide instruction on how and where to obtain services
- 60 minute (maximum) wait time from scheduled appointment time
- 30 calendar days (maximum) for scheduling or rescheduling routine, preventative eye exams
- Urgent care during office hours should be seen within 24 hours based on patient condition
- Emergent care should be directed to the appropriate emergency facility

Exam

Centers Plan for Healthy Living, Prime Health Choice

20 and under: Members are not covered.

21 and over: Members are covered in full for an exam every 24 months.

Exception: Prime Health Members are eligible for an exam every 12months.

Materials Eligibility

Centers Plan for Healthy Living, Prime Health Choice

20 and under: Members are not covered.

21 and over: Members are covered for a pair of eyeglasses every 24 months.

TWO PAIR IN LIEU OF BIFOCALS

The patient may receive two pairs of single vision lenses, one for distance vision and one for near vision, in lieu of bifocal eyeglasses, if either of the following conditions exists:

For patients less than 70 years of age

- Two pair of eyeglasses, instead of bifocals, may be ordered/dispensed when medically necessary, e.g., medical, physical and/or psychological condition(s) may preclude a patient from wearing a bifocal lens; previous attempts to wear bifocal lenses were unsuccessful; patient has a condition which results in frequent falls and injuries.

For patients 70 years of age or older

- Enrollees who are at least 70 years of age may receive two complete pair of eyeglasses (for both distance and reading), instead of bifocal lenses.

Visual necessity must be documented in the patient's medical record. Call VSP at **800.615.1883** for the **second authorization number**.

LENS OPTIONS

The materials and services listed below are covered if visually necessary.

Bill with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

- Polycarbonate lenses (21 and over)
  - Patient must be monocular with functional vision in only one eye, or have a history of auto aggressive behavior with a history of breaking glasses.
- Tints
  - Tints are covered if the patient has photophobia.
- High index lenses
  - Only covered for 10D or greater

VISUALLY NECESSARY CONTACT LENSES AND FITTING/DISPENSING

Materials, fitting and dispensing require a KX modifier.

Bill with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

Low Vision

Low vision evaluations, low vision aids, and fitting of low vision aids are covered if visually necessary. Call VSP at **800.615.188**3 to obtain an authorization number for Low Vision claim(s).

Exam Services

To report low vision evaluations, use CPT codes 92002-92014.

Low Vision Aids

All acceptable types of low vision aids including microscopes and telescopes must be utilized in selecting an appropriate low vision aid. Please submit a manufacturer's invoice.

Bill with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

Vision Therapy

Exam services (92060) and training sessions (92065) are allowed for six months only. Call VSP at **800.615.1883** to obtain an authorization number for Low Vision claim(s).

At the end of the six-month training period, if it is necessary to extend training sessions, call VSP for an authorization. Detail the progress made, the anticipated treatment plan, and the prognosis in the patient's medical record.

For all vision therapy services, bill with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

Patient Responsibility

COVERED SERVICES/MATERIALS

NOTE: It's the doctor's responsibility to verify the eligibility status of each patient at the time of service and obtain the appropriate authorization. Failure to obtain authorization does not create a payment liability for the patient.

You must accept payment by VSP as payment in full for services rendered and make no additional charge to any person for covered services, less any applicable copays.

NON-COVERED SERVICES/MATERIALS

Frame: If a non-covered frame is chosen, the patient pays the full cost of the frame.

If the patient or guardian requests any non-covered service and/or material, you may bill the patient your usual and customary fees for the non-covered services or materials if all of the following requirements are met. For exceptions, please refer to Covered Services section.

- The patient or guardian must be informed prior to services being rendered that this is a non-covered service or material. Advise the patient or patient's guardian of payment responsibilities before providing services.
- Provide the patient with information regarding the necessity, options, and charge(s) for the service/material(s).
- The patient or guardian must sign an Agreement of Financial Responsibility form or equivalent that clearly states the patient is aware they are choosing to purchase non-covered services or materials as a private-patient. Keep the form in the patient's records.

Do not bill VSP for these non-covered services or materials. Treat this as a private-pay transaction and follow your private-pay patient policy.

Repair

Reimbursement is available for repair or replacement of eyeglass parts in situations where the damage is the result of causes other than defective materials or workmanship. Repair is unlimited. Authorization is required. Call VSP at **800.615.1883** for an authorization number.

Replacement

Authorization is required. Call VSP at **800.615.1883** for an authorization number.

Eyeglasses

- One replacement is available for lost, stolen, or broken eyeglasses every two years. The replacement eyeglasses should duplicate the original prescription and frames. Add modifier RB to the fitting and material procedures codes when billing for a complete replacement.
- If the change in prescription is 0.50 diopter or greater in sphere or cylinder in one or both eyes.
- During a two-year period, the member may change the frame size, style or material if a:

    - Change in prescription is 0.50 diopter or greater in sphere or cylinder in one or both eyes.
    - The new prescription requires a larger frame.
    - The member is being treated for an allergic reaction to certain frame material.
    - Member has had a recent growth spurt or a significant loss/increase in weight

Visually Necessary Contact Lenses

May be replaced when lost or damaged.

Post-Cataract

Verify if coverage is available on Patient Record Report.

Aphakic with IOL (pseudophakia):
Post-surgical exam and one pair of eyeglasses or contact lenses after each cataract surgery with IOL insertion (diagnosis code Z96.1 is covered once per lifetime per operative eye.

Aphakic without IOL:
In addition to the post-surgical exam, aphakic patients who do not have an IOL (aphakia diagnosis codes H27.01, H27.02, or H27.03 are covered for the following lenses or combination of lenses when visually necessary:

- Bifocal lenses in frames; or
- Lenses in frames for distance vision and lenses in frames for near vision (two pairs of glasses); or
- Conventional contact lenses for distance vision, eyeglasses for near vision to wear with contact lenses and eyeglasses to wear when the contact lenses have been removed.

LENS MATERIALS

The following enhancements are covered following cataract extraction when visually necessary and documented by the treating physician:

- Tints (V2744 - V2745)
- Anti-reflective coating (V2750)
- UV lenses (V2755)
- Oversize lenses (V2780)

Bill visually necessary lens enhancements using the corresponding HCPCS code or miscellaneous HCPCS code with lab invoice based on fee schedule with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file

FRAMES

Only standard frames are covered (V2020).

Prime Health Choice members

Members are covered in full for exams every 12 months and materials every 24 months with a $200 material allowance to apply towards eyeglasses (lens and frame) or elective contact lenses. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance.

Timely Filing

File claims within 90 days of the date of service to ensure compliance with New York Medicaid guidelines for encounter data submission. Claims that are not filed within this timeframe may be denied.

Essential Medical Eye Care

Essential Medical Eye Care provide supplemental medical eyecare coverage for the detection, treatment and management of ocular and/or systemic conditions that produce ocular or visual symptoms. Members may see their VSP doctor when such a condition is suspected.

Covered benefits are administered according to the VSP policies and procedures in effect upon the date of service. Please click on the appropriate link below to view covered procedure codes for your state. Please note codes are only covered when appropriate based on your scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

Senior Whole Health: Members are not eligible to receive Essential Medical Eye Care services.

Essential Medical Eye Care

ELIGIBILITY & AUTHORIZATION

Eligibility is provided directly by Centers Plan for Healthy Living. For additional questions about eligibility, paper claims and benefits, check your patient's ID card for information and the contact phone number. Keep a copy of the ID card in your patient's file.

SAMPLE ID

REFERRAL PROCESS

Patients have direct access to any participating VSP Integrated Primary EyeCare provider. Participating providers are listed on the Centers Plan for Health Living website at **www.centersplan.com**. Services that are approved will be applied to the member's medical benefit.

> Note: Integrated Primary EyeCare patients can only be referred to another doctor or refused service if the service required is beyond the scope of your licensure.

REIMBURSEMENT

Centers Plan for Healthy Living handles reimbursement and pays claims daily following state and federal regulations. Reimbursement is based on your current VSP contracted rates.

SUBMITTING CLAIMS

Please refer to the patient's ID card from Centers Plan for Healthy Living for directions on submitting claims.

> Only claims covered up to the scope of Integrated Primary Eyecare should be submitted to Centers Plan for Healthy Living. Continue to submit claims for routine eyecare to VSP.

Americans with Disability Access Guidelines

Offices are required to meet the ADA Accessibility Guidelines (ADAAG), which are available from the Department of Justice at **800.USA.ABLE** or from The Access Board's website at **www.access-board.gov**. For information and technical assistance contact the United Sates Department of Justice Civil Rights Division at **800.514.0301** or **http://www.ada.gov/.**

Critical Incident Reporting

Contact the appropriate heath plan directly to report critical incidents, such as patient abuse, neglect, exploitation, rights violations or serious injury. Use the standard contact information provided on the patient's card if one has not been provided below.

Please be sure to specifically state this is a reporting of a “Critical Incident” as a safeguard to ensure all involved recognize this type of call. This will ensure the right escalation process is followed and appropriate protective services can be notified.

Centers Plan for Healthy Living
Julie Seifert
JSeifert@centersplan.com
718.215.7000 x3126

Senior Whole Health of New York
Quality Management Director
617.494.5353

VSP NEW YORK MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 1/1/14

Reimbursement for routine vision care services is based on the lesser of the billed amount or the maximum allowable reimbursement as reflected on this fee schedule. Fees are subject to change with notification from VSP.

Note: S0580 (Polycarbonate add-on, per lens) is a temporary HCPCS code. The “Calculate HCPCS and Continue” button on eClaim does not populate these temporary codes. To ensure correct payment, please manually enter S0580 when billing for these services.

Exam Services

92002	Intermediate exam, new patient	$50.00
92004	Comprehensive exam, new patient	$65.00
92012	Intermediate exam, established patient	$45.00
92014	Comprehensive exam, established patient	$60.00
92015	Refraction is included in the fee for the exam service	$0.00

Dispensing and Material Services

92340	Fitting of spectacles, except for aphakia; monofocal	$19.00
92341	Fitting of spectacles, except for aphakia; bifocal	$22.00
92342	Fitting of spectacles, except for aphakia; multifocal	$22.00
92352	Fitting of spectacle prosthesis for aphakia; monofocal	$21.00
92353	Fitting of spectacle prosthesis for aphakia; multifocal	$26.00
92370	Repair and refitting spectacles, except aphakia	$5.00
92371	Repair and refitting spectacles, aphakia	$5.00

Frames

V2020	Frames (includes case)	$15.00
V2025	Deluxe frame Must be billed with modifier KX. See VSP New York Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	$20.00
V2756	Eye glass case	$0.00

Spectacle Lenses

Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$7.38
V2101	Sphere, ± 4.12 to ± 7.00d	$7.38
V2102	Sphere, ± 7.12 to ± 20.00d	$11.21
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$7.38
Single Vision Lenses, per lens:		
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$7.38
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$11.21
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$11.21
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$7.38
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$7.38
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$11.21
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$11.21
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$11.21
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$11.21
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$11.21
V2114	Spherocylinder, sphere over ± 12.00d	$11.21
V2115	Lenticular, myodisc	$20.00
V2118	Lens, aniseikonic single	$20.00
V2121	Lenticular lens, single	$20.00

Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$13.43
V2201	Sphere, ± 4.12 to ± 7.00d	$13.43
V2202	Sphere, ± 7.12 to ± 20.00d	$18.20
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$13.43
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$13.43
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$18.20
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$18.20
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$13.43
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$13.43
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$18.20

V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$18.20
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$18.20
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$18.20
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$18.20
V2214	Spherocylinder, sphere over ± 12.00d	$18.20
V2215	Lenticular, myodisc	$27.50
V2218	Lens aniseikonic bifocal	$27.50
V2219	Lens bifocal seg width over	$11.00

Trifocal Lenses, per lens: Trifocal lenses are only allowed by the Medicaid Plan when visually necessary. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
V2300	Sphere, plano to ± 4.00d	$18.53
V2301	Sphere, ± 4.12 to ± 7.00d	$18.53
V2302	Sphere, ± 7.12 to ± 20.00d	$23.43
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$18.53
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$18.53
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$23.43
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$23.43
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$18.53
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$18.53
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$23.43
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$23.43
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$23.43
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$23.43
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$23.43
V2314	Spherocylinder, sphere over ± 12.00d	$23.43
V2315	Lenticular, myodisc	$34.81
V2318	Lens aniseikonic trifocal	$34.81
V2319	Lens trifocal seg width > 28	$15.50
V2320	Add over 3.25d	$8.50
V2321	Lenticular lens, trifocal	$34.81
V2399	Specialty trifocal	$23.43
Variable Asphericity Lenses, per lens:		
V2410	Single vision, full field, glass or plastic	$24.80
V2430	Bifocal, full field, glass or plastic	$33.50
V2499	Other type	$33.50
Miscellaneous Covered Options and Services, per lens:		
V2700	Balance lens	$10.00
V2710	Slab off prism, glass or plastic	$15.00
V2715	Prism	$1.00

Trifocal Lenses, per lens: Trifocal lenses are only allowed by the Medicaid Plan when visually necessary. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
V2718	Press-on lens, Fresnell prism	$12.00
V2770	Occluder lens	$1.50
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See VSP New York Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
S0580	Polycarbonate lens	$7.00
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromic, any lens material)	$2.00
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$25.00
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate	$35.00
V2799	Miscellaneous vision service	Submit invoice for pricing*

Repair and Refitting

92370	Repair and refitting spectacles, except aphakia	$5.00
92371	Repair and refitting spectacles, aphakia	$5.00

Visually Necessary Contact Lenses

Visually Necessary Contact Lenses: Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP New York Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file. Modifier RP must be used to indicate the replacement of contact lenses.		Maximum allowance per eye
V2500	PMMA, spherical	$80.00
V2501	PMMA, toric or prism ballast	$95.00
V2502	PMMA, bifocal	$95.00
V2503	PMMA, color vision deficiency	$95.00
V2510	Gas permeable, spherical	$95.00
V2511	Gas permeable, toric or prism ballast	$110.00
V2512	Gas permeable, bifocal	$125.00
V2513	Gas permeable, extended wear	$125.00
V2520	Hydrophilic, spherical	$100.00
V2521	Hydrophilic, toric or prism ballast	$110.00
V2522	Hydrophilic, bifocal	$110.00
V2523	Hydrophilic, extended wear	$125.00
V2530	Scleral, gas impermeable	$125.00

V2599	Contact lens, other type	$125.00
Visually Necessary Contact Lens Fitting and Dispensing: Service must be billed with modifier KX. See VSP New York Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$250.00
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$150.00
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$250.00
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$125.00
92326	Replacement of contact lens	$65.00

Low Vision Services

Low Vision services are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
92002	Intermediate exam, new patient - Bill for low vision exam.	$50.00
92004	Comprehensive exam, new patient - Bill for low vision exam.	$65.00
92012	Intermediate exam, established patient - Bill for low vision exam.	$45.00
92014	Comprehensive exam, established patient - Bill for low vision exam.	$60.00
92354	Fitting of spectacle mounted low vision aid; single element system	$10.00
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	$10.00
V2600	Hand held low vision and other nonspectacle mounted aids	Submit invoice for pricing*
V2610	Single lens spectacle mounted low vision aids	Submit invoice for pricing*
V2615	Telescopic and other compound lens systems, including distance	Submit invoice for pricing*

Vision Therapy

Vision Therapy services must be billed with modifier KX. See VSP New York Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$15.00
92065	Orthoptic training; performed by a physician or other qualified health care professional	$8.00

* Please refer to the Contacting VSP by Mail section of the **VSP Manual**.

NEW YORK IPA AGREEMENT

Eastern Vision Service Plan IPA, Inc. IPA Agreement

EASTERN VISION SERVICE PLAN IPA, INC.
IPA AGREEMENT
FOR THE STATE OF NEW YORK

Purpose. VSP desires to arrange for its Network Doctors to provide professional services to enrollees of health maintenance organizations. In New York State, VSP is not authorized to engage in such activity. Accordingly, VSP has organized a subsidiary called EASTERN VISION SERVICE PLAN IPA, INC. ("EVSP IPA"), which is authorized to contract with Participating Providers and HMOs, for the purpose of arranging for such Participating Providers to provide health care services to the HMOs' Members. In order for Network Doctors to participate in HMO contracts through EVSP IPA, Network Doctors must have direct contracts with EVSP IPA. This Agreement is intended to create such contractual relationship without otherwise changing the existing contracts between VSP and its Network Doctors.

Network Doctor, VSP and EVSP IPA agree as follows:

1. Notwithstanding any other provision of the Network Doctor Agreement or this IPA Agreement ("Agreement"), the parties agree to be bound by the "Standard Clauses," which are annexed hereto as Appendix A and hereby made a part of the Agreement. In the event of any inconsistencies or contrary language between the Standard Clauses and any other part of the Agreement (including, but not limited to, this Agreement, any appendices, other amendments or exhibits), the parties agree that the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses. Except as otherwise provided herein, the parties are fully bound by the Standard Clauses.

2. Each VSP Network Doctor is eligible to become an EVSP IPA Participating Provider. When participating in EVSP IPA contracts, such Participating Providers shall be referred to as "Participating Providers." This Agreement shall set forth the terms and conditions of all services that Participating Providers render through EVSP IPA. Any inconsistent term contained in the Network Doctor Agreement shall not apply to any activities conducted by Participating Providers through EVSP IPA.

3. Participating Provider Services to Participants

   3.1 Participating Provider hereby agrees to provide the Services to Participants of all Plans covered by, and pursuant to the terms and conditions set forth in, EVSP IPA's Payor Contracts. Services shall also be provided in accordance with this Agreement, and as provided by policies of EVSP IPA and the Plans in effect from time to time.

   3.2 Participating Provider shall comply with applicable EVSP IPA policies and procedures. EVSP IPA procedures do not include utilization management and prior authorization protocols; with respect to policies and procedures involving utilization management and prior authorization protocols, Participating Provider must comply with the policies and procedures applicable under the terms of any relevant contractual relationship between Eastern Vision Service Plan, Inc., ("EVSP") and any management service agreements in place between EVSP and any Department of Health-licensed HMO.

   3.3 Participating Provider shall provide appropriate services for Participants under Participating Provider's care, including arranging for services by an EVSP IPA Participating Provider in the event of Participating Provider's absence, or if none is available, another Participating Provider otherwise affiliated with the Participant's Plan. Participating Provider shall be responsible for

securing the agreement of any non-EVSP IPA covering Participating Provider (i) to provide services to Participants in accordance with the terms and conditions of this Agreement and (ii) to accept compensation in accordance with this Agreement.

3.4 Participating Provider shall: maintain patient-care, financial and administrative records relating to Services provided to Participants in accordance with legal requirements and EVSP IPA policies; assure privacy and confidentiality of Participant's patient-care records and other EVSP IPA information; cooperate with EVSP IPA in complying with reporting requirements imposed by Payors and government regulators; provide services to all Participants with the same quality of care, and in the same manner, as Participating Provider provides services to any other patient; and permit EVSP IPA and Payors, at reasonable times and to the extent permitted by law, to inspect and duplicate records in possession of Participating Provider relating to Services supplied to Participants.

3.5 Participating Provider shall render services to Participants in an economic and efficient manner consistent with standards of care generally accepted in the medical community. Participating Provider shall not discriminate in the treatment of Participants on the basis of color, race, creed, age, gender, sexual orientation, disability, place of origin, religion, place of residence, source of payment, including Medicare and Medicaid, or type of illness, and shall make Participating Provider's services available to Participants in the same manner as Participating Provider renders to non-Participants.

3.6 (a) Participating Provider shall maintain such books, records and papers and provide such information to EVSP IPA, any Payor and regulatory authorities, as may be necessary for compliance by such Payor or EVSP IPA with applicable federal and state laws. Records shall be retained by Participating Provider for a minimum of five years, and (in the case of medical records) six years from the date of services or six years from the Participant's age of majority, whichever is later. Such records and information (including all financial data and reports and information concerning the appropriateness and quality of services provided) shall upon request, and to the extent required and permitted by law, be open to inspection during normal business hours by, and copies shall be provided without charge to, EVSP IPA, the applicable Payor, the New York State Department of Health and other applicable local, state and federal regulators, and additionally in the case of records pertaining to Medicaid reimbursable services, the U.S. Department of Health and Human Services, the Comptroller General of the United States, The Comptroller and Attorney General of New York State, the applicable County Department of Social Services, and their duly authorized representatives.

(b) Participating Provider and EVSP IPA each agree to preserve the confidentiality of, to provide or provide access to, and to disclose the information contained in all records required to be maintained pursuant to this Section in compliance with any applicable federal and state laws, rules and regulations regarding patient consent and the confidentiality of medical information and patient records, including, but not limited to, Section 1106 of the Social Security Act and regulations promulgated thereunder, in effect from time to time.

(c) Participating Provider shall be responsible for obtaining Participant's consent to the disclosure of private and medical record information by Participating Provider and EVSP IPA in connection with any such disclosures required under this Agreement or otherwise in connection with the provision by Participating Provider of Covered Services to such Participant.

(d) Participating Provider agrees that none of the obligations related to this Section 3.6 shall terminate upon termination of the Agreement whether by rescission or otherwise.

3.7 In the event that any of EVSP IPA's Payor Contracts terminates for any reason, or in the event of Payor insolvency, Participating Provider agrees to continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services to the affected Participants, as required by this Agreement, provided that the confinement or course of treatment was commenced during the paid premium period. In addition, in the event that any of EVSP IPA's Payor Contracts terminates for any reason, Participating Provider agrees to provide care to each such Payor's enrollees pursuant to the terms of such Payor Contract for up to 180 days following the notice of termination, or until the Payor makes other arrangements, whichever occurs first. This Section shall survive the termination of this Agreement.

4. Authority of EVSP IPA to Create and Manage Contracts

4.1 Participating Provider hereby authorizes EVSP IPA, on behalf of Participating Provider, to negotiate Payor Contracts (and Addenda to such contracts) with Payors, in order to establish the terms and conditions under which Participating Provider will render services to Participants of each such Payor. As part of these negotiations, EVSP IPA shall establish Payment Systems with each Payor.

4.2 EVSP IPA shall give Participating Provider prompt written notice whenever EVSP IPA enters into a new Payor Contract. Any services that Participating Provider thereafter renders to a Participant of such Payor shall be subject to the terms and conditions of such Payor Contract.

4.3 Participating Provider agrees that Payors may use Participating Provider's name, office address, telephone number and classification of services in any roster of EVSP IPA Participating Providers to be distributed to Participants or potential Participants by Payor in its marketing literature.

5. Compensation of Participating Provider for Services

5.1 Participating Provider shall be bound by the Payment System for each such Payor Contract, and shall accept payments thereunder as full and complete compensation for Services that are Covered Services rendered to Participants. Except as stated below, Participating Provider shall look solely to EVSP IPA for payment, which shall be made in accordance with the requirements of this Agreement, and as quickly as practicable following claims adjudication and receipt of payment by EVSP IPA from the applicable Payor. In the event that the applicable Payor fails to submit payment to EVSP IPA within the time frames established in EVSP IPA's contract with such Payor or as otherwise required by law, EVSP IPA shall notify Participating Provider. Participating Provider shall thereafter look directly to the Payor, and not to EVSP IPA, for payment. EVSP IPA will provide reasonable assistance to Participating Provider to achieve such collections, including assigning to Participating Provider EVSP IPA's rights to receive payment from the Payor for the Services rendered by Participating Provider.

5.2 Prior to providing any such non-Covered Service, Participating Provider shall advise the Participant that the service is not covered and that Participant will have liability for payment. This paragraph 5.1.2 shall survive the termination of this Agreement for any reason. Where Participating Provider has not been given a list of covered services by the Plan and/or Participating Provider is uncertain as to whether a service is a Covered Service, Participating

Provider shall make reasonable efforts to contact the relevant Department of Health-licensed HMO and/or their contracted manager EVSP in order to obtain a coverage determination prior to providing the service.

5.3 Participating Provider shall only bill EVSP IPA (unless otherwise directed by EVSP IPA), for any Services that are Covered Services that are rendered to Participants. However, Participating Provider shall be entitled to bill Participants (or other parties responsible for Participant's medical expenses) only for (i) services that are not covered by the Payor's Plan which are delivered to Participant on a fee for service basis, but only if Participating Provider has complied with the requirements of Paragraph 5.1.2 prior to providing the non-Covered Service, (ii) co-payments (or permitted deductibles imposed by the Plan pursuant to a point-of-service contract), as specifically provided in the Participant's evidence of coverage, and (iii) any applicable co-insurance. Participating Providers shall be solely responsible for the billing and collection of any of the foregoing that may apply.

5.4 Participating Provider agrees to provide billing information to EVSP IPA using the billing identification number and other information required by the applicable Payor. Participating Provider understands that failure to submit claims under the correct identification number may result in denial by the Payor of all payments and may result in the Payor's excluding Participating Provider from continued participation.

5.5 All Payments to Participating Provider shall be in accordance with any applicable laws and regulations of the State in which Participating Provider practices, and any contrary provision of this Agreement shall be automatically amended to be in accordance with requirements of applicable law.

5.6 Primary responsibility for issuing payments to Participating Providers for Covered Services provided to New York HMO Participants has been assigned to Eastern Vision Service Plan, Inc. through management services agreements among Eastern Vision Service Plan, IPA, Inc., Eastern Vision Service Plan, Inc., and New York HMOs. Notwithstanding, Eastern Vision Service Plan, IPA, Inc. shall retain primary responsibility for compensating Participating Providers for Covered Services provided to New York HMO Participants pursuant to this Agreement. To the extent that Participating Provider has any complaints with respect to receipt of payments from Eastern Vision Service Plan, Inc., those complaints should be directed to Eastern Vision Service Plan IPA, Inc.

6. Credentialing

6.1 Participating Provider represents and warrants that all information given to EVSP IPA as part of Participating Provider's application or otherwise in connection with the creation of this Agreement is true and complete. Participating Provider authorizes EVSP IPA to obtain, from time to time as part of EVSP IPA's credentialing and quality assurance programs, Participating Provider's credentialing and/or employment history from any Hospital, facility or employer with which Participating Provider has been affiliated during the 10 years preceding such verification, and any professional society, liability insurer, the National Practitioner Data Bank, and any other appropriate source. Participating Provider also agrees to cooperate in the credentialing process of each Payor with which EVSP IPA contracts, and authorizes EVSP IPA to provide credentialing information to any such Payor that requests such information as part of such Payor's credentialing process. Participating Provider holds harmless EVSP IPA, its officers, directors, the members of EVSP IPA's Credentialing Committee and all Payors from any liability resulting from EVSP IPA's good faith use of any such information.

6.2 Participating Provider's credentials are subject to periodic review. Participating Provider specifically agrees that (subject to Participating Provider's rights under applicable state or federal law) Participating Provider holds harmless, and agrees not to bring any claims or actions against, EVSP IPA or any Payor that arises out of EVSP IPA's or the Payor's credentialing decisions and use of credentialing information that are made in good faith. In the event that EVSP IPA is required to carry out any credentialing decision that is imposed upon EVSP IPA and/or Participating Provider by a Payor, Participating Provider agrees to pursue any rights and grievances solely against the Payor, and not against EVSP IPA.

6.3 Participating Provider shall notify EVSP IPA, and authorizes EVSP IPA to notify the Payor (which EVSP IPA agrees to do), within five calendar days of the occurrence of any of the following:

6.3.1 Any action taken to restrict, suspend or revoke any license or certification of Participating Provider, including DEA status, or disciplinary action initiated or taken against Participating Provider by a government agency, Medicare or Medicaid program, health care facility, review organization or professional society;

6.3.2 Any suit or other legal or governmental proceeding (including arbitration or administrative action) brought against any Participating Provider and the final disposition of such action;

6.3.3 Any other situation which might materially affect Participating Provider's ability to properly carry out Participating Provider's obligations under this Agreement;

6.3.4 Any change in name, address, telephone number, license number or other information set forth in the EVSP IPA Application or otherwise submitted to EVSP IPA by Participating Provider.

6.4 Participating Provider shall maintain professional liability insurance with carriers authorized in the State(s) in which Participating Provider practices medicine, covering Participating Provider for all professional activities while this Agreement is in effect, with appropriate limits mutually agreeable to EVSP IPA, which if Participating Provider is a physician shall be not less than $1-million per occurrence/$3-million annual aggregate. All insurance policies shall include any necessary tail coverage. Participating Provider shall provide EVSP IPA with certificates of insurance evidencing such insurance, which certificate shall require the carrier to give EVSP IPA 10 days prior notice of the termination of or material change in such insurance coverage.

7. Encounter Information, Etc

Participating Provider shall deliver to EVSP IPA all reasonably requested billing and encounter information. Participating Provider shall advise EVSP IPA of any collections of co-insurance, co-payment, deductibles (imposed by a Payor pursuant to a point of service contract) and amounts payable by other sources through coordination of benefits ("COB"), in accordance with applicable policies. COB shall be pursued from the primary carrier whenever the Payor is the secondary payor, and Participating Provider shall have the sole obligation to collect any such applicable COB, which collections shall be retained by Participating Provider as an offset against payment for such services from EVSP IPA.

8. Utilization Management, etc

8.1 Participating Provider agrees to cooperate fully with all policies and protocols for utilization management (including but not limited to EVSP IPA administration of referrals), quality assurance, credentialing, Participating Provider grievances, information maintenance, reporting and the like that EVSP IPA shall implement or administrate in accordance with Payor Contracts and regulatory requirements.

8.2 When appropriate, in conformity with Participants' rights to select among all participating plan Participating Providers and the Participants' clinical needs, Participating Provider shall use best efforts to refer Participants to other EVSP IPA Participating Providers. In the event that there is no appropriate EVSP IPA Participating Provider for a required Service, Participating Provider shall contact EVSP IPA, which shall assist Participating Provider in making suitable arrangements for such Service.

8.3 EVSP IPA may from time to time distribute and revise a policies and procedures manual (the "Manual"), a copy of which shall be provided to Participating Provider. The Manual may contain a detailed description of Covered Services under each Plan subject to this Agreement, the conditions of such coverage and the policies or procedures adopted by EVSP IPA for the administration of the terms and conditions of this Agreement. EVSP IPA may amend the Manual from time to time and shall provide Participating Provider with a copy of any such Agreement. Participating Provider and EVSP IPA shall each be governed by the provisions of the Manual in the performance of their duties and obligations under this Agreement. If the provisions of the Manual are inconsistent with this Agreement, this Agreement shall be controlling.

8.4 Anything contained herein to the contrary notwithstanding, Participating Provider shall comply fully with and abide by the rules, policies and procedures established by the applicable Payor, provided that Payor has given EVSP IPA at least 30 days prior written notice of the implementation thereof or change thereto, including rules, policies and procedures pertaining to quality improvement/management, utilization management, member grievances and Participating Provider credentialing.

9. Term and Termination

9.1 The initial term of this Agreement shall be for one year, commencing on the date hereof. The term of this Agreement shall be automatically renewed from year-to-year thereafter, except as otherwise provided herein.

9.1.1 This Agreement may be terminated by Participating Provider without cause, upon 90 days prior written notice.

9.1.2 Either party to this Agreement may exercise a right of non-renewal at the end of the initial term and each renewal term. Such right of non-renewal shall be exercised by delivering written notice thereof to the other party at least 60 days prior to the applicable Expiration Date. Such exercise of non-renewal shall not constitute a termination for purposes of Section 4406-d of the New York Public Health Law ("PHL"). Anything contained herein to the contrary notwithstanding, EVSP IPA shall not exercise its right of non-renewal solely because of any reason set forth in PHL Section 4406-d(5).

9.2 If EVSP IPA believes that Participating Provider is in material breach of any provision of this Agreement, EVSP IPA may deliver to the Participating Provider a written notice of proposed contract termination (the "Termination Notice"). Such Termination Notice shall set forth the reason for the proposed action, and shall also contain any other information required by PHL Section 4406-d(2)(b) and regulations, if any, promulgated thereunder. EVSP IPA may terminate this Agreement after the 60th day following Participating Provider's receipt of the Termination Notice, upon three days additional notice, unless either (i) Participating Provider has cured the default to the reasonable satisfaction of the EVSP IPA, or (ii) Participating Provider has delivered a written request for a hearing to review the proposed termination.

9.2.1 If Participating Provider has requested a hearing pursuant to Section 9.2(ii), above, such hearing shall be held in accordance with PHL Section 4406-d(2)(c-f) and regulations, if any, promulgated thereunder, before a hearing committee appointed by EVSP IPA. The determination of the hearing committee, including termination of the Participating Provider, may be submitted to arbitration in accordance with the provisions of the Network Doctor Agreement and of Section F of Appendix A.

9.2.2 This Agreement shall be terminated or suspended, in the sole discretion of EVSP IPA, immediately in the event that Participating Provider's professional license is revoked, suspended or otherwise limited; Participating Provider fails to maintain all policies of insurance required by this Agreement; Participating Provider is terminated or sanctioned for cause by any government program (e.g., Medicare, Medicaid, etc.), hospital professional staff, professional organization, or accreditation body; Participating Provider is convicted of (or pleads no contest to) a crime; or EVSP IPA makes a determination that Participating Provider has engaged in fraudulent activity with respect to any health care services or claims. EVSP IPA shall deliver to Participating Provider a Termination Notice which shall, to the extent required by law, be subject to the review process described in Public Health Law Section 4406-d.

9.3 This Agreement may be terminated by Participating Provider upon not less than 60 days prior written notice, if EVSP IPA is in material breach of any provision of this Agreement. Such notice of intended termination shall set forth the facts underlying the claim of material breach. This Agreement shall terminate on the date specified in such notice unless EVSP IPA has sooner cured the material breach.

9.4 Participating Provider agrees that termination of this Agreement for any reason shall simultaneously terminate Participating Provider's right to participate under any contracts that were created or arranged by EVSP IPA. Participating Provider agrees that upon termination of this Agreement, EVSP IPA (i) shall terminate Participating Provider's participation under any Payor Contract, and (ii) shall cause each Payor to terminate its respective agreement with Participating Provider under any direct contract or other agreement that EVSP IPA has arranged.

9.5 Upon termination of this Agreement for any reason, Participating Provider shall fully cooperate with EVSP IPA and each Payor, to enable the transfer of each Participant assigned to Participating Provider to another Participating Provider affiliated with his/her respective Payor.

10. Relationship of Parties

Participating Provider and EVSP IPA are independent contracting parties. This Agreement does not make EVSP IPA an employer or a partner of Participating Provider.

11. Dispute Resolution

11.1 The parties will use their best efforts to mutually resolve any conflicts arising hereunder, and shall in the first instance submit to any internal grievance system established by EVSP IPA or the Plan.

11.2 In the case of a dispute arising out of EVSP IPA's implementation of any requirements imposed upon EVSP IPA by a Payor, Participating Provider shall pursue any grievance solely against such Payor and the decision of the Payor's internal grievance system shall be final and binding on Participating Provider. Participating Provider shall neither maintain any grievance thereof against EVSP IPA, or its shareholders, officers, directors, agents or committee members, nor appeal such final decision or to seek financial or other compensation from EVSP IPA for any damages allegedly arising therefrom.

11.3 In the case of any dispute arising hereunder, other than disputes described in Paragraph 11.2, above, that cannot be resolved through the process described in Paragraph 11.1, the dispute shall be resolved by final and binding arbitration as stated in the Network Doctor Agreement and in Section F of Appendix A. The Commissioner of Health of New York State shall be given copies of all requests for arbitration and arbitrators' awards, but shall not be bound by any such arbitrators' decisions.

12. Miscellaneous

12.1 This Agreement may not be assigned by Participating Provider. Participating Provider agrees that EVSP IPA may assign this Agreement to a subsidiary or affiliate independent practice association operated by EVSP IPA, or another proper entity in accordance with applicable laws and regulations, as part of a reorganization, acquisition, merger or similar transaction involving the business of EVSP IPA. Any assignee shall be bound by and comply with all of EVSP IPA's obligations hereunder.

12.2 EVSP IPA may revise this Agreement to make any amendments required by law, regulation or any Payor, which shall take effect upon three days' notice to Participating Provider. In addition, EVSP IPA may propose any other amendment to this Agreement by written notice to Participating Provider, which amendment shall become effective after 30 days, unless Participating Providers sooner delivers written objection to EVSP IPA, which objection shall automatically serve as Participating Provider's termination notice under Section 9.1.1. Each material amendment of this Agreement shall be submitted to the Department of Health for approval at least 30 days in advance of its anticipated execution. No material amendment shall be effective unless it has been approved by the Commissioner of Health.

12.3 Participating Provider shall not, except as may be required to carry out the duties and obligations hereunder, without the prior written consent of EVSP IPA disclose or cause to be disclosed to a third party, or make or cause any unauthorized use of (i) any EVSP IPA policies, procedures, systems, methods, manuals, forms, software, payment rates, customer lists, trade secrets or other proprietary information of EVSP IPA, or (ii) any term or condition of this Agreement, its exhibits, attachments or schedules. The obligations of Participating Provider under this Section shall not apply to information which: (i) is a matter of public knowledge or becomes a matter of public knowledge after the Effective Date, (ii) was lawfully obtained by Participating Provider on a non-confidential basis other than in the course of performance under this Agreement, or (iii) is provided to a Participant as a necessary part of medical treatment.

12.4 This Agreement is a complete statement of the entire understanding of the parties with respect to the subject matter hereof, and supersedes any previous agreement between the parties that relates to the subject matter covered by this Agreement. However, whenever any provision of this Agreement is inconsistent with any provision of a Payor Contract, the provisions of the Payor Contract shall prevail. Without limitation, to the extent that any Payor requires EVSP IPA to include specific provisions in its agreements with its Participating Providers, such Payor-specific provisions shall be annexed hereto as Attachment 12.4, and shall be incorporated into and become a binding part of this Agreement; however, such Payor-specific provisions shall only be binding as to services rendered by Participating Provider to the Participants of the specific Payor. EVSP IPA may revise Attachment 12.4 to add, delete or amend any provisions required by specific Payors, and (subject to requisite regulatory approvals) such amended Attachment 12.4 shall be effective upon delivery to Participating Provider.

12.5 Any notice required under this Agreement will be given in writing and sent return receipt requested by certified or registered mail, or by an overnight courier service that provides proof of delivery, and will be deemed received three days after deposited in the U.S. mails or one day after deposited with an overnight courier service, as the case may be. If the notice is to EVSP IPA, it will be sent to:

Vision Service Plan
Attention: Chief Executive Officer
3333 Quality Drive
Rancho Cordova, CA 95670

If to Participating Provider, notice will be sent to the last business address provided by Participating Provider to EVSP IPA at least 30 days prior to the giving of such notice. Any changes of either party's address will be designated by notice given as aforesaid.

12.6 Anything herein contained to the contrary notwithstanding, nothing in this Agreement shall be construed to make the Participating Provider liable for the acts or omissions of EVSP IPA or any Payor.

12.7 This Agreement will be governed by the laws of the State of New York. The captions used herein as headings for the various paragraphs hereof are for convenience only, and the parties agree that such captions are not to be construed to be part of this Agreement or to be used in determining or construing the intent or context of this Agreement. If any provision of this Agreement is held to be unenforceable, the remaining provisions of this Agreement shall remain in full force and effect.

12.8 The following provisions are incorporated herein in conformity with 11 N.Y.C.R.R. Part 101 (NYS Department of Insurance Regulation 164):

12.8.1 Participating Provider shall not, in the event of default by EVSP IPA, demand payment from any Payor for covered services rendered by Participating Provider to such Payor's Participants for which the in-network capitation payment was made by the Payor to EVSP IPA pursuant to their Financial Risk Transfer Agreement.

12.8.2 Participating Provider expressly agrees that the "hold harmless" provisions set forth in Section 5.2, above (which prohibit Participating Provider from collecting or attempting to collect from a Participant any amounts owed to Participating Provider for covered services, excluding permitted co-pays and deductibles (if applicable)), is in addition to

the protections afforded to Participant under New York State Insurance Law Section 4307(d); and

12.8.3 In the event that the Financial Risk Transfer Agreement between EVSP IPA and any Payor is terminated by the New York State Superintendent of Insurance pursuant to Section 101.9(a)(7) Insurance Regulation 164, this Agreement shall be assignable on a prospective basis (without any obligation to pay any amounts owed to Participating Provider by EVSP IPA) to each such Payor for a period of time which is determined by the Commissioner of Health (or the Superintendent of Insurance in the case of Payors not authorized under Public Health Law Article 44) to be necessary in order to provide the services that the Payor is legally obligated to deliver to its subscribers. No assignment under this Paragraph shall exceed 12 months from the date the Financial Risk Transfer Agreement is terminated by the Superintendent of Insurance.

12.9 EVSP IPA will not make, and will not cause or permit any Payor or other person to make, any payment to Participating Provider, whether directly or indirectly, as an inducement to reduce or limit medically necessary services furnished to Participant.

13. Definitions

For the purpose of this Agreement:

13.1 "Covered Services" shall mean all health care services to which Participants are entitled under their respective Plan with a Payor.

13.2 "Emergency" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, which may include severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunctions of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

13.3 "Financial Risk Transfer Agreement" shall mean a Payor Contract under which EVSP IPA assumes financial liability for the delivery of Services to Participants.

13.4 "EVSP IPA Participating Provider" shall mean all health care Participating Providers (including professionals, facilities and ancillary Participating Providers) who enter into an Agreement with EVSP IPA, and who thereby participate in EVSP IPA's panel of Participating Providers to provide their respective services to Payors.

13.5 "Payor" shall refer to a health maintenance organization authorized under Article 44 of the New York State Public Health Law that contracts with EVSP IPA to obtain the services of Participating Provider for the Participants of a Plan or Plans of Payor.

13.6 "Payor Contract" means the agreement between EVSP IPA and a Payor, which sets forth the terms under which Participating Provider shall provide Services to such Payor's Participants.

13.7 "Participants" shall mean those persons entitled to health care services through a Plan of a Payor.

13.8 "Payment System" shall be a fee schedule or other payment methodology arranged and negotiated by EVSP IPA with each Payor, and which shall establish the method of payments to be made for health care services rendered to such Payor's Participants.

13.9 "Plan" means a health care plan provided by a Payor.

13.10 "Services" means Vision Care Services.

The Parties hereby indicated their agreement to and acceptance of this Agreement by affixing their respective signatures in the spaces provided below.

VISION SERVICE PLAN

_____
Name of Participating Provider

By: _____
Signature

By: _____
Signature

Title: _____

Title: _____

EASTERN VISION SERVICE PLAN IPA, INC.

By: _____
Signature

Title: _____

APPENDIX A

New York State Department Of Health Standard Clauses For Managed Care Provider/IPA Contracts Appendix (Revised 3/1/11)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions For Purposes Of This Appendix

"Managed Care Organization " or "MCO " shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association " or "IPA " shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective 60 days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least 30 days, or 90 days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least 30 days in advance of implementation, including but not limited to:

    - quality improvement/management
    - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data
    - member grievances; and
    - provider credentialing

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for 24 hour coverage and back up coverage when the Provider is unavailable. The Provider may use a 24 hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.

8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance, and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

    a. the MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;
    b. the Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and

that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and

c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.
d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.
e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.
g. The Provider or IPA agrees , pursuant to 31 U.S.C.§1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying", Appendix ____ attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
h. The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (Block grant programs)
i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.
j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.
k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with all applicable

requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law§33.13.

C. Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least 90 days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law §4903.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six years after the date of service, and in the case of a minor, for three years after majority or six years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "provider" shall include the IPA and the IPA’s contracted providers if this Agreement is between the MCO and an IPA. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-Specific Provisions

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

In the event of conflict between the terms of this Addendum and the terms of the Agreement, the terms of this Addendum are controlling. All other terms and conditions contained in the Network Doctor Agreement remain in full force and effect.

vsp vision care

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