Network Access Plan Vision Service Plan Insuance Company: VSP and Choice Networks June 2019	
Requirement	**VSP Plan**
1. Introduction	
Full name of the carrier:	**Vision Service Plan Insurance Company**
Full name of the network:	**VSP, Choice**
Carrier's Network ID Number:	**NAIC # 39616**
Type of Network and General Description:	**Vision Insurance**
Specific Geographic Area(s) Covered by the Network:	**Statewide**
Website Identification:	**vsp.com**
Contact Information:	john.humphreys@VSP.com
2. Network Adequacy and Corrective Action Processes	
a) Summary of the carrier's network adequacy standards and measurement results. This is a written summary of number of providers and facilities within a reasonable distance as reported on the Enrollment Document. If any network adequacy standards are not met, this section must identify the provider(s)/facility(ies) that are not adequate. This information will also be included on the Carrier Network Adequacy Summary and Attestations Form. The inclusion of measurement tables or specific data is not appropriate.	VSP continually assesses the doctor network to ensure adequate access for members. VSP's access standard is one doctor in a 10 mile radius urban/suburban and one doctor in a 25 mile radius for rural. VSP utilizes reports to analyze and determine the percentage of members that will have access to a doctor within a specified distance. VSP runs specific reports to determine if standards are being met and whether or not to apply appropriate interventions when gaps are identified.
b) The carrier's documented quantifiable and measureable process for monitoring and assuring the sufficiency of the network in order to meet the managed care needs of populations enrolled in managed care plans on an ongoing basis. This section requires a description of how telehealth is used (or not used) to meet healthcare needs and network adequacy standards.	VSP utilizes reports to continuously analyze and determine the percentage of members that have access to a doctor within a specified distance. Through this process VSP can determine if access standards are being met and whether appropriate interventions need to be implemented when a gap is identified. VSP does not use telehealth in the delivery of routine vision care services.
c) The factors the carrier uses to build its provider network, including a description of the networknd the criteria used to select and/or tier providers.	VSP continually assesses the doctor network to ensure adequate access for members. VSP's access standard is one doctor in a 10-mile radius urban/suburban and one doctor in a 25-mile radius for rural.
d) The carrier's quality assurance standards, which must be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care in a network. The inclusion of a corporate quality assurance manual is not appropriate, but a summary and reference to such a manual should be included.	VSP utilizes reports to analyze and determine the percentage of members that will have access to a doctor within a specified distance. VSP runs specific reports to determine if standards are being met and whether or not to apply appropriate interventions when gaps are identified.

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e) If a network is found to be inadequate, the carrier will explain/describe specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notification and communications with the Division, providers and policyholders. A summary of these corrective actions will be reported on the Carrier Network Adequacy Summary and Attestation Form.	Network Development handles access issues following established procedures to identify potential doctors in the area. If the network is found to be inadequate in accordance with Colorado's requirements, VSP shall file a corrective action plan explaining what steps will be taken to corrective the network deficiency.
f) The carrier's process to assure that a covered person is able to obtain a covered benefit, at the in-network level of benefit, from a non-participating provider should the carrier's network prove to not be sufficient.	VSP is in compliance with state regulations and in support of Members First, if a member states they are having trouble locating a VSP provider nearby or have been unable to schedule an appointment within a reasonable timeframe. If no exclusions apply, VSP will reimburse member comparable to VSP In-Network benefits (INN) In the event of a secondary coordination of benefits (COB), INN COB Allowances will be used). For Necessary Contact Lenses, member will be reimbursed up to INN cap amount.
g) The carrier's process for monitoring access to in-network physician specialist services for emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at its participating facilities	Not Applicable to Routine Vision Care Services
3. Network Access Plan Procedures for Referrals	
a) Location(s)/availability of a provider directory(ies), how often it is updated, and availability in other languages. A provider directory is a comprehensive listing, made available to covered persons and primary care providers, of the carrier's network of participating providers and facilities.	VSP's Members may access an online doctor directory or request a print directory by calling VSP Customer Service toll-free, All Doctor Directory updates are systematically refreshed the following Sunday evening and implemented change will appear on Provider Directory Monday morning. VSP's directory is available in other languages upon request.
b) Full description of the refererral process, including a minimum:	
(1) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a managed care plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers; and	Not Applicable to Routine Vision Care Services
(2) A process for timely referrals for access to specialty care.	VSP's Provider Reference Manual, providers are to "Refer patient to PCP, appropriate doctor or hosptial emergency room when the patient needs care
(3) A process for expediting the referral process when indicated by medical condition.	Not Applicable to Routine Vision Care Services
(4) A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse.	Not Applicable to Routine Vision Care Services
(5) A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.	Not Applicable to Routine Vision Care Services

Network Access Plan Vision Service Plan Insuance Company: VSP and Choice Networks June 2019	
Requirement	**VSP Plan**
(6) A health benefit plan that offers variable deductibles, coinsurance, and/or copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment	Not Applicable to Routine Vision Care Services
C. The carrier's process allowing members to access services outside the network when necessary.	If the Member's plan includes out-of-network benefits, the Member can obtain services from any non-preferred provider. Member submitted claims must be received within 365 days from the date of service; however there are some client, state and federal exceptions that may allow more or less days.
4. Network Access Plan Disclosures and Notices	
A. In the network access plan for each network offered, a carrier shall explain its method for informing covered persons of the plan's services and features through disclosures and notices to policyholders.	VSP provides its clients with a benefit summary for the client to provide to their eligible employees
B. Required disclosures, pursuant to § 10-16-704(9), C.R.S., shall include	
(1) The carrier's grievance procedures, which shall be in conformance with Division regulations concerning prompt investigation of health claims involving utilization review and grievance procedures;	VSP is responsible for resolving complaints/grievances within 30 calendar days of receipt unless State or Federal regulations or client requirements specify differently. In the event that VSP receives a request to resolve a complaint/grievance in less than 30 calendar days, every effort is made to accommodate the request. All complaints/grievances are processed according to State regulations regarding patient confidentiality. Doctors, members and/or their authorized representative may appeal in writing, verbally, electronically or by contacting VSP's Customer Care Department. Instructions for requesting an appeal are included in the Explanation of Coverage (EOC), denial notification letter and/or Explanation of Payment. VSP staff will conduct internal appeal reviews. Different staff, other than those responsible for the day to day payment of claims and of the initial denial, will handle the appeal.
(2) The extent to which specialty medical services, including but not limited to physical therapy, occupational therapy, and rehabilitation services are available;	Not Applicable to Routine Vision Care Services
(3) The carrier's procedures for providing and approving emergency and non-emergency medical care;	Not Applicable to Routine Vision Care Services
(4) The carrier's process for choosing and changing network providers;	Not Applicable to Routine Vision Care Services
(5) The carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities;	VSP promotes cultural competency among its employees and VSP network doctors to ensure interactions with members are made with an awareness of and sensitivity to differences in culture, ethnicity, gender, age, disability, religion, social class and/or sexual orientation, especially as they relate to vision health care as described in policy C-007Cultural Compentency & Language Assitance Program.
(6) The carrier's documented process to identify the potential needs of special populations; and	Same as item #5 above.

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(7) The carrier's methods for assessing the health care needs of covered persons, tracking and assessing clinical outcomes from network services, assessing needs on an on-going basis, assessing the needs of diverse populations, and evaluating consumer satisfaction with services provided.	The goal of the VSP C&L Program is detailed in the Quality Management and Improvement Work Plan and updated quarterly. The Quality Management department evaluates the overall program for effectiveness annually. The effectiveness of the program is based on various quality measurements such as member complaints, appeals, trending and member satisfaction.
5. Plans for Coordination and Continuity of Care	
A. The carrier's documented process for ensuring the coordination and continuity of care for covered persons referred to specialty providers.	Not Applicable to Routine Vision Care Services
B. The carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources.	Not Applicable to Routine Vision Care Services
C. The carrier's documented process for ensuring appropriate discharge planning.	Not Applicable to Routine Vision Care Services
D. The carrier's process for enabling covered persons to change primary care providers.	Not Applicable to Routine Vision Care Services
E. The carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process must include an explanation of how covered persons shall be notified in the case of a provider contract termination, the carrier's insolvency, or of any other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner.	If a participating VSP provider is terminated from the network, VSP will make a good faith effort to provide written notice of a provider's termination within fifteen (15) working days to the impacted members who have seen the terminating doctor within the previous six (6) months.
F. A carrier must file and make available upon request the fact that the carrier has a "hold harmless" provision in its provider contracts, prohibiting contracted providers from balance-billing covered persons in the event of the carrier's insolvency or other inability to continue operations in compliance with § 10-16-705(3), C.R.S. network access plan requirements and demonstrations.	VSP Network Provider Agreement (NDA) includes a "Hold Harmless' provision, where the ND agrees that neither ND, nor any permitted agent, trustee and/or assignee of ND may initiate or maintain any action at law against a VSP Patient for sums owed to ND by VSP. In the event ND submits a claim late and/or VSP, due to insolvency or otherwise, is financially unable to pay all or any part of ND's fee for Covered Services, he/she will not look to the VSP Patient for such payment. This hold harmless provision shall survive the expiration or termination of this Agreement."
6. Patients with Special Needs	
The carrier must describe its process to address the needs, including access and accessibility of services, of policyholders and/or enrollees with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and/or mental disabilities.	VSP promotes cultural competency among its employees and VSP network doctors to ensure interactions with members are made with an awareness of and sensitivity to differences in culture, ethnicity, gender, age, disability, religion, social class and/or sexual orientation, especially as they relate to vision health care as described in policy C-007Cultural Compentency & Language Assitance Program.
7. Grievance and Appeal Procedures	

Network Access Plan Vision Service Plan Insuance Company: VSP and Choice Networks June 2019	
Requirement	**VSP Plan**
The carrier must describe its grievance procedures, which shall be in conformance with Division rules concerning prompt investigation of claims involving utilization review and grievance procedures.	VSP is responsible for resolving complaints/grievances within 30 calendar days of receipt unless State or Federal regulations or client requirements specify differently. In the event that VSP receives a request to resolve a complaint/grievance in less than 30 calendar days, every effort is made to accommodate the request. All complaints/grievances are processed according to State regulations regarding patient confidentiality. Doctors, members and/or their authorized representative may appeal in writing, verbally, electronically or by contacting VSP's Customer Care Department. Instructions for requesting an appeal are included in the Explanation of Coverage (EOC), denial notification letter and/or Explanation of Payment. VSP staff will conduct internal appeal reviews. Different staff, other than those responsible for the day to day payment of claims and of the initial denial, will handle the appeal.
8. Coordination and Continuity of Care Provisions	
a) A carrier and participating provider shall provide at least sixty (60) days written notice to each other before a provider is removed or leaves the network without cause.	
b) When a primary care provider is being removed, leaving the network, or is being nonrenewed, all covered persons who are patients of that primary care provider must be notified by the carrier, in writing, prior to termination. When the provider gives or receives the notice in accordance with this regulation, the provider shall supply the carrier with a list of those patients of the provider that are covered by a plan of the carrier. The carrier must supply the provider with a list of the provider's patients that are covered by the carrier.	Not Applicable to Routine Vision Care Services
c) Irrespective of whether it is for cause or without cause or due to non-renewal of a contract, the carrier must make a good faith effort to provide both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information contained in regulation, within fifteen (15) working days of receipt or issuance of a notice provided in accordance with this regulation. For short-term policies, this notice must be provided to all covered persons who are identified as patients by the provider, or who have been seen by the provider being removed or leaving the network within the period since the effective date of the policy for the covered person. For all other policies, this notice must be provided to all covered persons who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous six (6) months.	VSP runs a daily check for provider terminations in Colorado. If a termination is present, Sales Support and Member Communications are notified via email to initiated appropriate member notifications.
d) A covered person, in a short-term policy, must have been undergoing treatment, or have been seen at least once during the effective period of the policy, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.	Not Applicable to Routine Vision Care Services

Network Access Plan Vision Service Plan Insuance Company: VSP and Choice Networks June 2019	
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e) For all other policies, a covered person must have been undergoing treatment, or have been seen at least once in the previous twelve (12) months, by the provider being removed or leaving the network for that covered person to be considered in an active course of treatment.	Not Applicable to Routine Vision Care Services
f) A carrier shall establish reasonable procedures to transition the covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care when a covered person's provider leaves or is removed from the network.	Not Applicable to Routine Vision Care Services
g) A carrier must make available to the covered person a list of available participating providers who are accepting new patients in the same geographic area and specialty provider type, or a referral to a provider if there is no participating provider available, who is of the same provider or specialty type. The carrier must provide information about how the covered person may request continuity of care as required by this regulation	Not Applicable to Routine Vision Care Services
h) A carrier's transition procedures must provide that: (1) A carrier shall review requests for continuity of care made by the covered person or the covered person's authorized representative; (2) Requests for continuity of care must be reviewed by the carrier's Medical Director after consultation with the treating provider. This requirement applies to: (a) Patients who meet the applicable criteria listed in this regulation; and (b) Who are under the care of a provider who has not been removed or leaving the network for cause; (3) Any decisions made with respect to a request for continuity of care are subject to the plan's internal and external grievance and appeal processes in accordance with applicable state and federal laws and regulations; (4) The continuity of care period for covered persons what are undergoing an active course of treatment shall extend to the earlier of: (a) The termination of the course of treatment by the covered person or the treating provider; (b) Ninety (90) days after the effective date of the provider's departure or termination from the network, unless the carrier's Medical Director determines that a longer period is necessary; (c) The date that care is successfully transitioned to a participating provider; (d) Benefit limitations under the plan are met or exceeded; (e) The date that the coverage is terminated; or (f) The care is no longer medically necessary.	Not Applicable to Routine Vision Care Services

Network Access Plan Vision Service Plan Insuance Company: VSP and Choice Networks June 2019	
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(i) In addition to the provision of item 8. of Appendix B of this regulation, a continuity of care request may only be granted when the provider departing or terminated from the network: (1) Agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the carrier for that patient as provider in the original provider contract, or by the new payment and terms agreed upon and executed between the provider and the carrier; and (2) Agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the provider were still a participating provider.	Not Applicable to Routine Vision Care Services
(j) The obligation to hold the patient harmless for services rendered in the provider's capacity as a participating provider survives the termination of the provider contract. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except to the extent that the in-network relationship is extended to provide continuity of care.	Not Applicable to Routine Vision Care Services
(k) Nothing in this item 8. of Appendix B shall prohibit a carrier from excluding conditions from continuity of care provisions that are not covered due to a pre-existing condition exclusion.	Not Applicable to Routine Vision Care Services