

# Rosin Insurance Guide

# Vision Accepted Plans

VISION Ciao! Optical Plans	Ciao! Optical Plan ID	Type
AMBETTER-ROSIN	1825254	Vision/Medicaid
BCBS ANTHEM-ROSIN	1824515	Vision
BCBS OUT OF STATE-ROSIN	1824516	Vision
CIGNA-ROSIN	1824517	Vision
COMMERCIAL TPL	1824986	Vision
DAVIS VISION-ROSIN	1824518	Vision
ENVOLVE MEDICAID-ROSIN	1824525	Vision/Medicaid
EyeMed	Auto-Calculates	Vision
HC & FAMILY MEDICAID-ROSIN	1824527	Vision/Medicaid
MARCH MEDICAID-ROSIN	1824528	Vision/Medicaid
NVA-ROSIN	1824519	Vision
POINT COMFORT-ROSIN	1824529	Vision
SPECTERA-ROSIN	1824521	Vision
SUPERIOR VISION-ROSIN	1824522	Vision
UNUM-ROSIN (Formerly Always Vision)	1824523	Vision
VSP-ROSIN	1824524	Vision
VSP HERITAGE MEDICAID-ROSIN	1824530	Vision/Medicaid
WELLCARE-ROSIN	1825253	Vision/Medicaid

SAFETY Ciao! Optical Plans	Ciao! Optical Plan ID
AIR GAS SAFETY-ROSIN	1824531
ESSILOR SAFETY-ROSIN	1824532
PROTEC VSP-ROSIN	1825203
SAFE VISION-ROSIN	1825204
HOYA SAFETY-ROSIN	1825931
DURABAR SAFETY-ROSIN (Woodstock)	1825932

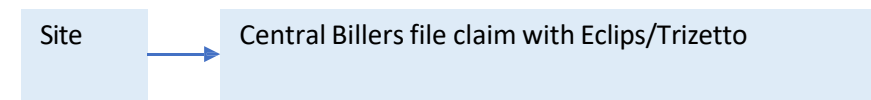
DISCOUNT Ciao! Optical Plans	Ciao! Optical Plan ID
AAA DISCOUNT-ROSIN	3289375
AARP DISCOUNT-ROSIN	3289376
BCBS IL DISCOUNT (Blue 365)	3289377

# Medical Accepted Plans

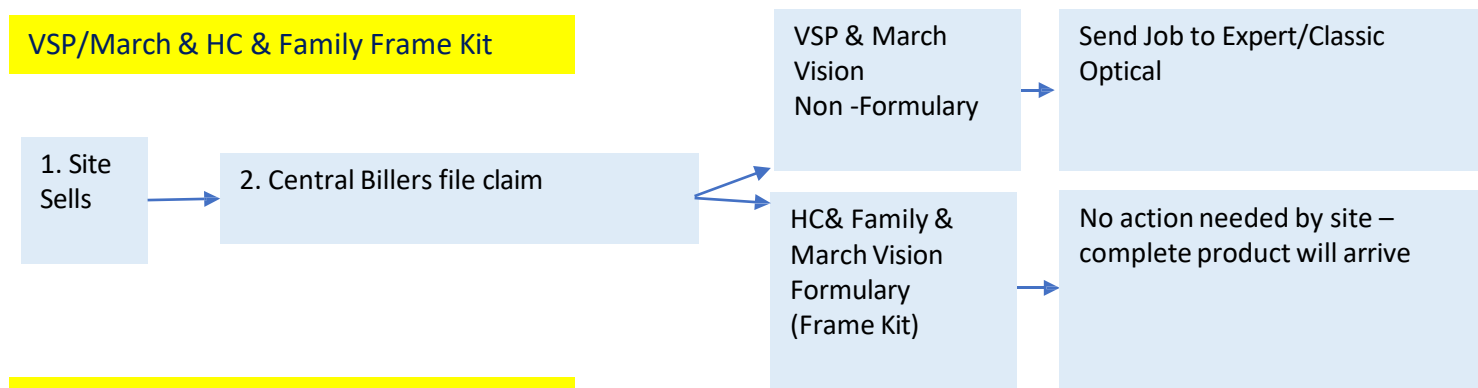
PLAN NAME	PLAN ID
MEDICAL AETNA HEALTH PLANS-ROSIN	1824471
MEDICAL ALL SAVERS-ROSIN	1825339
MEDICAL BCBS ANTHEM-ROSIN	1824472
MEDICAL BCBS OUT OF STATE-ROSIN	1824473
MEDICAL CIGNA-ROSIN	1824474
MEDICAL CLAIMS MANAGERMENTS CONSULT-ROSIN	1825347
MEDICAL COMMERCIAL TPL	1824987
MEDICAL FIRST HEALTH-ROSIN	1824475
MEDICAL GOLDEN RULE-ROSIN	1825342
MEDICAL HC & FAMILY MEDICAID -ROSIN	1824476
MEDICAL HEALTH LINK PPO-ROSIN	1824477
MEDICAL HUMANA-ROSIN	1825344
MEDICAL MEDICARE PART B-ROSIN	1824478
MEDICAL MEDICARE RAILROAD-ROSIN	1824479
MEDICAL MERITAIN HEALTH-ROSIN	1825343
MEDICAL MULTIPLAN PHCS-ROSIN	1824480
MEDICAL OXFORD-ROSIN	1825340
MEDICAL PHCS-ROSIN	1824481
MEDICAL QUARTZ BENEFITS-ROSIN	1824484
MEDICAL THE HARTFORD-ROSIN	1825345
MEDICAL TRICARE EAST-ROSIN	1824482
MEDICAL TRISTAR INSURANCE GROUP-ROSIN	1825346
MEDICAL UNITED HEALTH CARE COMM-ROSIN	1825341
MEDICAL UNITED HEALTH CARE UMR-ROSIN	1824483
MEDICAL ZURICH AMERICAN INS CO-ROSIN	1825348

# Rosin Insurance Flow

## Medical



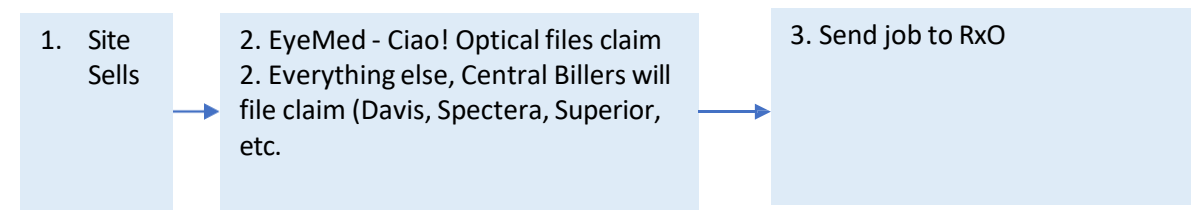
## VSP/March & HC & Family Frame Kit



**March Non-Formulary:** Pull frame from board and hold. Claim will be filed and packing slip sent to clinic for them to send to the lab.

**March & HC & Family (IDPA/Medicaid) Formulary:** Use Frame Kit, claim will order the frame and lens and complete pair will arrive at site.

## All Other Routine



# LABS

Ciao! Optical Plan Name	Ciao! Optical Plan ID	Type (Medical / Vision)	LAB
Ambetter		Vision/Medicaid	RxO
BCBS ANTHEM-ROSIN	1824515	Vision	RxO
BCBS OUT OF STATE-ROSIN	1824516	Vision	RxO
CIGNA-ROSIN	1824517	Vision	RxO
COMMERCIAL TPL	1824986	Vision	RxO
DAVIS VISION-ROSIN	1824518	Vision	RxO
ENVOLVE MEDICAID-ROSIN	1824525	Vision/Medicaid	RxO
EyeMed	Auto-Calculates	Vision	RxO
HC & FAMILY MEDICAID-ROSIN	1824527	Vision/Medicaid	Classic Optical
MARCH MEDICAID-ROSIN	1824528	Vision/Medicaid	Classic Optical (packing slip with non-formulary)
NVA-ROSIN	1824519	Vision	RxO
POINT COMFORT-ROSIN	1824529	Vision/Medicaid	RxO
SPECTERA-ROSIN	1824521	Vision	RxO
SUPERIOR VISION-ROSIN	1824522	Vision	RxO
UNUM-ROSIN (Formerly Always Vision)	1824523	Vision	RxO
VSP-ROSIN	1824524	Vision	Expert (packing slip)
VSP HERITAGE MEDICAID-ROSIN	1824530	Vision/Medicaid	Expert (packing slip)
WELLCARE-ROSIN		Vision/Medicaid	RxO

# BALANCES IN EHR

	EHR Fee Schedule	Copay in EHR	Balance Left in EHR	Ciao! Optical
Medical	Apply the Medical Fee Schedule <ul style="list-style-type: none"> <li>- If copay is owed, transfer copay to patient that pulls from insurance amount owed, the plan pays will be reduced.</li> <li>- If deductible, transfer whatever the patient is paying to the deductible from the insurance plan pays. The plan pays may be \$0. Claim will be filed to show patient applied money towards their deductible.</li> </ul>	Apply payment in EHR	Insurance amount owed – After Fee Schedule and Patient Payment Applied	Post in Ciao! <ul style="list-style-type: none"> <li>- If copay, make sure that's in the copay column and that the amount patient pays is correct</li> <li>- If deductible, amount also goes copay. If the insurance amount from EHR is \$0, there is \$0 in plan pays.</li> </ul>
Vision	Apply Routine Fee Schedule which will zero out claim	No	\$0	Post in Ciao!
Private Pay Service	N/A	Apply full payment in EHR	\$0	Post in Ciao!
Vision with Optos	<b>Vision:</b> Apply Routine Fee Schedule which will zero it out Example: 92014 & 92015 <b>Optos:</b> Apply to new invoice (patient invoice) – can't be on insurance invoice	<b>Vision:</b> No (because it's zero already) <b>Optos:</b> Apply payment in EHR	Both invoices should be \$0 – patient paid	Post in Ciao! – <i>can be done in a combined entry if the site is billing to the insurance carrier</i>
Medical and Routine Vision which will go to vision plan + Optos	<b>Medical:</b> Apply the Medical Fee Schedule <b>Vision:</b> Apply CPT codes to new invoice and apply Routine Fee Schedule which will zero itself out <b>Optos:</b> Apply to new invoice (patient invoice) – can't be on insurance invoice You will have 3 invoices in this example.	<b>Medical:</b> Apply copay to Medical invoice <b>Vision:</b> No (because it's zero already) <b>Optos:</b> Apply payment in EHR	<b>Medical:</b> Insurance amount owed – After Fee Schedule and Patient Payment Applied <b>Vision:</b> \$0 <b>Optos:</b> \$0	Post in Ciao! – <i>can be done in a combined entry if the site is billing to the insurance carrier</i>

# MEDICAL FEE SCHEDULES

# MEDICAL PLANS

1. Apply insurance fee schedule in Eclips
2. Apply patient copay
  - Copay will reduce the ultimate plan pays
  - **IMPORTANT – DO THIS IN ECLIPS PRIOR TO EVER ENTERING INTO CIAO! OPTICAL**
3. On the invoice screen (not the printed invoice) – take note of the Ins. Resp amount. This will be Plan Pays.
4. Take payment of copay or patient responsibility In Eclips – the only balance left should be insurance amount owed.
5. In Ciao! Optical –
  - Insurance Resp Amount (which you wrote down) = Plan Pays
  - Enter in Copays
  - Finish the formula where  $U\&C = \text{Plan Pays} + \text{Discounts}$  (said differently  $\text{Plan Discounts} = U\&C - \text{Plan Pays}$ )



# MEDICAL PLANS

=PLAN PAYS in Ciao! Optical – take note of it. This doesn't print on an invoice.

IN1147 Posted  
Location: T047 - Triangle Visions - Gastonia  
Date of Service: 02/08/2023  
Posted Date: 02/08/2023 03:21:55 PM EST

ICD Codes - Click letter button to toggle on/off for all line items. Select the drop down to add additional ICD codes.  
A H40.051 B C D E F

(+)	Item ID Qty	ICD Code(s) Modifier(s)	Procedure/Product Code Provider	Insurance Staff Member	Usual/Cust Fee	Allowable	Ins. Res.	Ins. Adjust	Pt. Disc	Co-Pay	Pt. Res.	Total Pt. Tax	Pt. Balance Ins. Balance	
1 (+)	A		99214 - 99214- E&M Level 4 Est Smith	Blue Cross Blue Shield Of NC	\$200.00	\$74.29	\$34.29 46.16%	\$125.71	\$0.00	\$40.00	\$0.00 53.84%	\$40.00 \$0.00	\$0.00 \$34.29	
1 (+)	A		92134 - 92134 Retina OCT Smith	Blue Cross Blue Shield Of NC	\$120.00	\$39.59	\$39.59 100%	\$80.41	\$0.00	\$0.00	\$0.00 0%	\$0.00 \$0.00	\$0.00 \$39.59	
Totals					\$320.00	\$113.88	\$73.88	\$206.12	\$0.00	\$40.00	\$0.00 Tax: Total:	\$40.00 \$0.00 \$40.00	Account Balance \$0.00 Unappl. Pmts \$0.00 Pt. Balance \$0.00 Ins. Balance \$73.88	

=Patient Resp or Copays should be entered into COPAY column Ciao! Optical

PT BAL should always be \$0 (apply payments). Only BAL left is Ins. Balance.

**VERY IMPORTANT: In Ciao! Optical - DO NOT reduce Plan Pays by Copay Amount. We do this for Routine but not for Medical, this is already covered when you apply it in Eclips.**

# MEDICAL PLANS

PLAN NAME	PLAN ID
MEDICAL AETNA HEALTH PLANS-ROSIN	1824471
MEDICAL ALL SAVERS-ROSIN	1825339
MEDICAL BCBS ANTHEM-ROSIN	1824472
MEDICAL BCBS OUT OF STATE-ROSIN	1824473
MEDICAL CIGNA-ROSIN	1824474
MEDICAL CLAIMS MANAGER CONSULT-ROSIN	1825347
MEDICAL COMMERCIAL TPL	1824987
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MEDICAL UNITED HEALTH CARE COMM-ROSIN	1825341
MEDICAL UNITED HEALTH CARE UMR-ROSIN	1824483
MEDICAL ZURICH AMERICAN INS CO-ROSIN	1825348

All Medical Plans in Ciao! Optical are Bill Actual, meaning you need to invoice in Eclips, account for patient copay payments and then enter into Ciao! Optical.

INSURANCE BALANCE (Ins. Resp.) = PLAN PAYS in Ciao! Optical.

In Eclips, leave the insurance balance. Claims will be filed from here through Trizetto and adjusted when the EOB is received. Billers will manage this.

USE MEDICAL PLANS IN CIAO! OPTICAL INSURANCE SEARCH TO BYPASS CLAIM FORM SCREENS.

# ROUTINE FEE SCHEDULES

# CLASSIC OPTICAL PROCESS

Ciao! Optical Plan Name	Ciao! Optical Plan ID	Type (Medical / Vision)	LAB
HC & FAMILY MEDICAID-ROSIN	1824527	Vision/Medicaid	Classic Optical
MARCH MEDICAID-ROSIN	1824528	Vision/Medicaid	Classic Optical

In Ciao! Optical, use the applicable UPC. These are priced at \$0 and indicate a frame kit selection for biller.

- UPC 20500001821955 MARCH VISION FRAME
- UPC 20500003011408 FAMILY HOME NETWORK FRAME KIT (For HC & Family, IDPA, Medicaid)
- The billing team will file the claim and a complete pair will be manufactured and sent back the ordering site.
- If non-formulary frame selected for March Vision, billing team will send you a packing slip (similar to VSP) for you to send to Classic Optical.
  - In LPA, set to Rx Sun Authentics to bypass RxO.

## LAB ADDRESS FOR NON-FORMULARY:

Classic Optical  
3710 Belmont Ave  
Youngstown, OH 44505

# ROUTINE Bill Actual Plans - Ciao! Optical Formulary

Plan Pays + Discounts = Retail Price

Copays stand alone

If you have a copay amount, formula holds true.

If the patient pays 100% for the service – no entry needed. U&C will flow through as patient responsibility. Discounts will appropriately reduce U&C.

Copay for services and materials (not out-of-pockets will need to be adjusted/reduced from Plan Pays

Plan Pays = what the insurance pays us

Discounts = use the formula, this is different than plan write-offs sometimes

Copay = what the patient pays (represents copays and out-of-pocket amounts)

If the patient pays 100% for the service – no entry needed. U&C will flow through as patient responsibility.

**For exams and materials, if the patient has a true plan copay (typically on exams and materials), you will need to reduce this from PLAN PAYs (the contracted rate). This is only for routine only. Medical invoices come from Eclips and already accounted for the copay adjustment.**

**Note that in Ciao! Copay means both exam/focal type copay and patient responsibility. The only time you reduce Plan Pays is if there is a service or materials copay (excludes lens enhancements copays, out-of-pocket amounts).**

# EyeMed (always auto-calculates)

TYPE: Routine Vision Professional Services & Materials

PLAN ID: In Ciao! Optical – varies by member

PLAN NAME: In Ciao! Optical – varies by member

- NOTES:
- EyeMed is integrated with Ciao! Optical.
  - You can find member and check eligibility directly in Ciao! Optical using Name/DOB.
  - Ciao! Optical will automatically calculate and submit claims; no additional action required.
  - If you need to re-enter an order in Ciao (i.e., grey pencil on Staged screen) and the benefits are showing used, call EyeMed to cancel authorization.

Search For: EyeMed/MVC Mem ▾


Plan Name:

Plan ID:

Member ID:

Member First Name: Fake

Member Last Name: Patient

Member Date of birth: 1/1/2001 

Minimum required:

- First letter of First Name
- First letter of Last Name
  - DOB
  - or Plan ID
  - or at least first 3 digits of Member ID

Insurance screen will default to EyeMed. The patient's name and birthdate will pre-populate. Simply search and select the patient. Any other members on the patient's plan will also display.

ITEM	ACTION & NOTES
Exam	Routine exams and contact lens fittings are covered – member's responsibility is based on charges and plan coverage.
Frame	All frames available – member's responsibility is based on charges and plan coverage.
Lenses	All frames available – member's responsibility is based on charges and plan coverage.
Manufacturing	Order is placed with RxO (Rx Operations – Luxottica Lab Network).
Lab Processing Application (LPA)	Order as uncut, product to come, or complete.
Claims	Submit at Ready status – no additional action needed.

# VSP REIMBURSEMENT RATES- ROSIN

VSP Reimbursements	SIGNATURE PLAN	CHOICE PLAN
EYE EXAMINATIONS	PLAN PAYS	PLAN PAYS
Comprehensive Exam: New 92004   Est. 92014	\$68	\$62
Intermediate Exam: New 92002   Est. 92012	\$35	\$35
Refraction: 92015 ONLY	\$13.60	\$12.40
MATERIAL DISPENSING	PLAN PAYS	PLAN PAYS
Single Vision Lenses	\$30	\$17
Bifocal Lenses**	\$39	\$21.50
Trifocal Lenses	\$44.84	\$24.50
Lenticular Lenses	\$62.78	\$34.30
New Frame	\$34	\$20.50

NOTE: The U&C pricing for your 92 codes will include refraction amount. Only use the 92015 Only line if billing just for refraction.

The reimbursements for Exam fees listed on your VSP Assigned Fee Report include the Refraction. For Exam Plan Pays in this chart, the refraction has been deducted and listed separately.

Reduce if copay

**\*\*PROGRESSIVE LENS DISPENSING:**

For all Plans (Signature, Choice, & Advantage): You will receive your bifocal dispensing fee PLUS the applicable service fees for covered and non-covered progressives. Service fees are subject to change and may be found in the Lens Enhancement Chart.

- If covered, both the dispensing and applicable service fee are paid by VSP (Enter Disp. Fee + Service Fee in Plan Pays Column).
- If progressives are not covered, enter Dispensing Fee in Plan Pays and the applicable patient copay in the Patient Copay column.

**PATIENT CHARGES FOR NON-COVERED LENS ENHANCEMENTS:**

- **Signature:** Charge patient the listed copay in the VSP Signature Plan Lens Enhancements Chart or your usual and customary fee (RETAIL), whichever is lower.
- **Choice:** Charge patient the listed copay in the VSP Choice Plan Lens Enhancements Chart or 80% of your usual and customary fee (RETAIL), whichever is lower.
- **Advantage:** Charge the patient the lesser of 80% of your usual and customary (U&C) add-on fee or the VSP Advantage Plan Lens Enhancement Chart amount. For lens enhancements not listed, charge 80% of your U&C add-on fee. For non-covered lens enhancements, the charge back amount will be deducted from your VSP payment. You will not be charged for covered lens enhancements.

## VSP CONTACT LENS: Combined Allowance for Materials & Fit

Patient has allowance towards CL Fit & Materials. Benefits used on different DOS will require a call to VSP.

Benefit Summary	How it works	CL Fit	Materials
If getting both on same date of service	Option 1 (Best Practice): If CLs exceed the allowance amount, use the entire allowance toward materials.	Take 15 % off U&C Remaining balance is Patient Pays/Copay Column in Ciao.	Enter entire allowance amount (i.e., \$200: \$100 per eye/line) in Plan Pays
If getting both on same date of service	Option 2: Allowance can be split between fit and materials. Maximum allowance that can be used toward the fit is \$60, remaining allowance to be used toward materials.	Take 15 % off U&C. Deduct the \$60 max allowance. The balance = Patient Pays/Copay Column in Ciao. (See Logic example below)	Remaining allowance
If just getting fit (materials on different DOS)	Option 1: Patient can decide where the allowance is applied. If they are going to get materials later, it's easier for them to pay Fit less 15% out-of-pocket and apply the whole allowance to materials.	Take 15 % off U&C Remaining balance is Patient Pays.	N/A
If just getting fit (materials on different DOS)	Option 2: They can use allowance toward fit only and use the remaining allowance towards materials when they return.	Take 15 % off U&C. Deduct the \$60 max allowance. The balance = Patient Pays/Copay Column in Ciao. (See Logic example below)	Call VSP for new authorization that reflects the remaining allowance.



# VSP CONTACT LENS: Combined Allowance for Materials & Fit

**Example:** If patient is just getting a fit and wants to use insurance allowance (purchasing materials on separate DOS)

**Contacts** Routine eye exam covered.

**Exam And Allowance** Take 15% off CL exam services before applying \$200.00 for CL exam services and materials. If patient receives CL exam services only, patient is responsible for CL exam services over \$60.

Contacts are instead of [lens, frame].

Logic behind calculations:

U&C	Discounted Price (U&C less 15%)	Max Allowance for CL Fit	Copay Patient Pays
\$105.00	\$89.25	\$60.00	\$29.25

Enter in Ciao! Optical:

CONTACT LENS EVALUATION/FIT			
U&C	Plan Pays	Discount	Copay
\$105.00	\$60.00	\$45.00	\$29.25

**Note this is just an example on how to enter. Your amounts will be different.**

CONTACT LENS MATERIALS			
U&C	Plan Pays	Discount	Copay
\$149.50	\$70.00	\$79.50	\$79.50
\$149.50	\$70.00	\$79.50	\$79.50

Enter the allowance amount in Plan Pays (\$200 - \$60 used = \$140)  
Ciao! will calculate the overage

# VSP CONTACT LENS: Separate allowance for Material & Fit

Patient has Separate benefits for CL Fit and Materials.  
Procedure is the same if benefits are used on different DOS.

Benefit Summary	How it Works	CL Fit	Materials
If getting both on same date of service	Patient will have two separate allowances, one for the CL Fit and one for Materials.	Patient Pays the VSP Copay amount (*usually \$60).  Plan Pays = U&C less 15% - \$60* (See Logic example below)	Use the full allowance amount.  Patient Pays overage above allowance – no additional discounts.
If just getting fit or materials on a different DOS  (Call & get new authorization)	Patient will have two separate allowances, one for the CL Fit and one for Materials.	Patient Pays the VSP Copay amount (*usually \$60).  Plan Pays = U&C less 15% - \$60* (See Logic example below)	Use the full allowance amount.  Patient Pays overage above allowance – no additional discounts.

# VSP CONTACT LENS: Separate allowance for Material & Fit

## Example

**Contacts** Routine eye exam covered.

CL Exam Services Charge the lesser of \$60 copay or 85% U&C  
CL Materials \$175

Contacts are instead of [lens, frame].

Logic behind calculations:

U&C	Discounted Price (U&C less 15%)	Patient Pays	Plan Pays
\$105.00	\$89.25	\$60.00	\$29.25

Enter in Ciao! Optical:

CONTACT LENS EVALUATION/FIT			
U&C	Plan Pays	Discount	Copay
\$105.00	\$29.25	\$75.75	\$60.00

Note this is just an example on how to enter. Your amounts will be different.

CONTACT LENS MATERIALS			
U&C	Plan Pays	Discount	Copay
\$170.99	\$87.50	\$83.49	\$83.49
\$170.99	\$87.50	\$83.49	\$83.49

Enter allowance amount in Plan Pays –  
Ciao! will calculate the overage

# VSP - FRAMES

- **Plan Pays = Wholesale Frame Allowance (WFA) + Frame Dispensing Fee**
  - If there is a frame copay, reduce Plan Pays by that amount (material copays will go on the focal type line).
- Patient Pays = Frame retail price – allowance less 20% off the overage.
- **In order to claim the full WFA amount, the Wholesale Frame Cost (WFC) = Retail Price x 45%** - must be greater than the WFA amount. If less, patient pays \$0 and we bill the lower amount which is WFC.
- Note:
  - For patients with fully covered frames (i.e., pediatrics), the patient pays \$0, and we get WFC + Frame Dispensing Fee
  - For plans that just have a total allowance (no signature, choice, advantage WFA, etc.). We collect the overage above the allowance amount (that will be in the copay column) + dispensing fee for frames and lenses.

VSP Reimbursements	SIGNATURE PLAN	CHOICE PLAN
	PLAN PAYS	PLAN PAYS
EYE EXAMINATIONS		
Comprehensive Exam: New 92004   Est 92014	\$68	\$62
Intermediate Exam: New 92002   Est 92012	\$35	\$35
Refraction: 92015	\$13.60	\$12.40
MATERIAL DISPENSING		
Single Vision Lenses	\$30	\$17
Bifocal Lenses**	\$39	\$21.50
Trifocal Lenses	\$44.84	\$24.50
Lenticular Lenses	\$62.78	\$34.30
New Frame	\$34	\$20.50

Wholesale Frame Allowance (WFA) is found under Frame Allowance on all Benefit Sheets.

Co-payments Exam \$10.00 Material \$10.00 01/01/2023
Frame Allowance Extra \$20 promotion on Altair Eyewear/Marchon frames and any other available frame promotions included below:
WFA73 \$190.00 for Columbia, Longchamp, McAllister, Nike or Pure brand frames through 01/31/2023. Patient receives 20% savings on frame overage.
WFA65 \$170.00 for Altair Eyewear/Marchon frames. Patient receives 20% savings on frame overage.
WFA58 \$150.00 for non-Altair Eyewear/Marchon frames. Patient receives 20% savings on frame overage.

- You will need the VSP Lens Enhancement Charts to calculate the patient’s out-of-pocket amount and enter it into Ciao! Optical. Contracted rates vary by site.

# VSP-LENSES

- For Lenses
  - Plan Pays the focal type line, reduce if materials copay. Materials copay goes in copay column.
  - Lens out of pocket amounts for enhancement also go in copay column and are determined by the following.
  - Use VSP’s Lens Enhancement charts to determine the copay amount for enhancements (Patient Pays)
    - Covered Enhancements – you will put the VSP Service Fee amount in the Plan Pays column (accounting for charge backs on front).**
    - Non-Covered Enhancements (covered with an additional copay owed by the patient) – you will put the patient copay in the Copay column. We don’t receive any extra money for these. Charge backs not applicable here.**
- Extra Notes:
  - For VSP Signature plans, when tint, photochromic & polycarbonate for kids is covered – there is \$0 charge to the patient. There is also no chargeback from VSP thus we don’t have Plan Pays but we will also not be charged for the product production/manufacturing (it’s a wash). We do not collect the service fee in these instances. Discount 100%.
  - On the VSP Choice plan, if the patient has anything that is fully covered, VSP doesn't apply a ‘chargeback’, but they do pay you for it, meaning they pay the ‘Service Fee’. The only exclusion to this is poly for kids or any patient who has a FEDVIP plan. The items that are fully covered can vary but could include the same as the Signature plan, things like photochromic, tints, etc.
  - We don’t use Unity lenses

VSP Reimbursements		SIGNATURE PLAN	CHOICE PLAN
EYE EXAMINATIONS		PLAN PAYS	PLAN PAYS
Comprehensive Exam: New 92004   Est 92014		\$68	\$62
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Lenticular Lenses		\$62.78	\$34.30
New Frame		\$34	\$20.50

# VSP-LENSES, Eyezen - Varilux - Add Ons

Frame

Lens

Order Worksheet

Measurements

Order Completion

Order Price Calculator

Plan Name: VSP-GOLDEN WC Type: Assignment  
Group #: Plan ID: 1814833

Services	Retail Price	Extended Price	Plan Pays	Discount	Copay
RX5228, Blk Grn, 53/17/140	\$191.00		\$ 101.35	\$ 89.65	32.80
Crizal Backside UV	\$15.00		\$ 0.00	\$ 15.00	10.00
UV Protection	\$0.00		\$ 0.00	\$ 0.00	0.00
Scratch Resistant	\$0.00		\$ 0.00	\$ 0.00	0.00
DST Processing	\$60.00		\$ 0.00	\$ 60.00	50.00
Crizal Sapphire HR Anti-Reflective	\$170.00		\$ 0.00	\$ 170.00	75.00
Blue Filter	\$0.00		\$ 0.00	\$ 0.00	0.00
EyeZen+1 Single Vision	\$160.00		\$ 23.38	\$ 136.62	30.00
Hi-Index 1.67	\$120.00		\$ 0.00	\$ 120.00	56.00

Benefit Calculation Notes

\$40 VSP Digital upcharge  
\$10 Technical Add-on

Base lens line, enter material copay (if applicable)  
\$15 Material Copay  
\$15 Light Filter

Hi-Index 1.67 for a DIGITAL lens

\*\*Example fees are based on VSP Standard Plan

## EyeZen

- DST Processing Line:
  - Eyezen Start = \$40 (Digital upgrade)
  - Eyezen 1 – 4 = \$40 + \$10 Technical Add-On
- Focal Type Line (EyeZen Single Vision) = Material Copay + \$15 Light Filter

## Varilux X Fit & Comfort Max

- Focal Type Line = VSP Lens Copay/Patient Pays + \$10 Custom Measurement
- Other add-on options: Oversize Frame and Rimless

PLAN DETAILS

Co-payments Exam \$15.00 Material \$15.00

Frame Allowance Extra \$20 promotion on Altair Eyewear/Marchon frames and any other available frame promotions included below:  

WFA73

\$190.00 for bebe, Calvin Klein, Calvin Klein Jeans, Flexon or Nine West brand frames through 03/31/2022. Patient receives 20% savings on frame overage.  

WFA65

\$170.00 for Altair Eyewear/Marchon frames. Patient receives 20% savings on frame overage.  

WFA57

\$150.00 for non-Altair Eyewear/Marchon frames. Patient receives 20% savings on frame overage.

Example

MATERIAL DISPENSING	VSP Signature PLAN PAYS
Single Vision Lenses	\$38.38
Bifocal Lenses**	\$57.00
Trifocal Lenses	\$65.36
Lenticular Lenses	\$91.50
New Frame	\$44.35

# VSP ROSIN PROCESS

Enter in accurate AUTH #s for VSP in the Assignment Claim Form. This will show in the history for the billers.

Best Practice is to pull 1 auth for services and materials at one time. If separate and unique, need to make sure both services and materials contain the correct Auth # with the correct order type. DO NOT PLACE 0s or 1234.

**Plan Information**  
Plan Name: VSP-ROSIN  
Phone #:   
Open Hours:   
Plan ID: 1824524

**Plan Type:** Assignment  
**Authorized:** ☐ Frame ☐ Lens  
☐ Contacts ☒ Exam  
**Exam Auth:**

**Customer Plan Information**  
Employment Status:  Employer:   
Student Status:  Marital Status:   
Relation to Primary Member:   
Is condition related to employment? ☐ Yes ☐ No ☒ Unknown  
Is customer's need accident related? ☐ Yes ☒ No  
Is there a secondary plan? ☐ Yes ☒ No

**Primary Member Plan Information**  
First Name:  MI:  Last Name:   
Address:   
ZIP Code:  City:  State:   
Member ID:  SSN:  Phone:   
Gender: ☐ Male ☐ Female Employment Status:   
Employer:  Marital Status:   
DOB:  Student Status:

**Customer Information**  
Member ID:   
SSN:   
DOB:

**Customer Order Summary**  
Customer Order Id: 10000683629084 EPP: No Dispense Date: N/A Dispensing Associate: N/A Delivery Method: N/A  
Prescription Type: Contacts Single Vision  
Doctor: Beasley, Courtney  
Date Written: 2/10/2023  
Expiration Date: 2/10/2024  
Plan Name: VSP-ROSIN  
Plan ID: 1824524  
Group #: 2  
Customer:   
Member ID: 1  
Primary Member:   
Authorized: Contacts  
Material Auth: 87836650  
Plan type: Assignment

	SPH	CYL	AXIS	BC	DIA	COLLECTION	COLOR
OD(R)	-4.00			8.6	14.1	Clariti 1 Day	VISI VISITNT
OS(L)	-4.00			8.6	14.1	Clariti 1 Day	VISI VISITNT

	Pack Size	Annual Supply	Qty
OD(R)	90	N	2
OS(L)	90	N	2

Shipping Location Type: Customer Primary  
Shipping Type: Standard

Showing 1 to 1 of 1 entries

Customer Order Location 29084 457569 [Logout](#)

If selling an exam and materials – for the exam sale in Ciao! Optical, you only need to select Exam and then enter the auth.  
For materials, select either Frame, Lens, Frame & Lenses for a complete pair, or contacts and then enter the auth #.

# VSP ROSIN PROCESS

Enter Frame Details in the Patient's Profile Notes Section.

David Naprstek

First Name: David, Last Name: Naprstek, MI: [blank]

Address: 2900 Maple Ave Apt 25E, City: Downers Grove, State: Illinois, Country: United States

Phone: 815 9094735, Email: Dave.naprstek@icloud.com

Special Processing Type: [blank]

Estimated Delivery Date: Friday, August 18, 2023

Assign Tray ID: VSP

Manufacturing Notes: FRAME MAKE AND MODEL MUST BE ENTERED HERE

**Profile Notes:** Sale Date: Enter in Make Model and Frame Details in Patient's Profile Notes

David Naprstek

First Name: David, Last Name: Naprstek, MI: [blank]

Address: 2900 Maple Ave Apt 25E, City: Downers Grove, State: Illinois, Country: United States

Phone: 815 9094735, Email: Dave.naprstek@icloud.com

Special Processing Type: [blank]

Estimated Delivery Date: Friday, August 18, 2023

Assign Tray ID: VSP

Manufacturing Notes: FRAME MAKE AND MODEL MUST BE ENTERED HERE

**Profile Notes:** Sale Date: Enter in Make Model and Frame Details in Patient's Profile Notes

Mohammed Ahmed Kahn

First Name: Mohammed, Last Name: Ahmed, MI: Kahn

Address: 2900 Maple Ave Apt 25E, City: Downers Grove, State: Illinois, Country: United States

Phone: 815 9094735, Email: Dave.naprstek@icloud.com

Special Processing Type: [blank]

Estimated Delivery Date: Friday, August 18, 2023

Assign Tray ID: VSP

Manufacturing Notes: FRAME MAKE AND MODEL MUST BE ENTERED HERE

**Profile Notes:** Sale Date: Enter in Make Model and Frame Details in Patient's Profile Notes

If you want, you can still put frame details here BUT then you still need to add it to profile section too. These notes transfer to LPA.

This will allow billers to easily see frame details. This is required for Blue Tags and Generic UPCs (AST, ACQ). Once you add the note, it will time stamp it so billers can see details here in Ciao! Optical.



# EXPERT LAB



## ☐ **Welcome Kits Will Be Arriving**

- These Include Prepaid Shipping Labels
- Replacement Will Ship With Completed Eyeglasses
- Always Use The Pre-paid Shipping Label

## ☐ **RX/Remake Form**

- Allow 1 RX Change (Within 6 Months)
- Quality Issues : Use RX Form, Indicate “Please Recheck”
- All Other Remakes Will Be Processed In Ciao! And Send TO RxO

## ☐ **Send Order To Lab AFTER The Claim Has Been Filled With The Billing Team**

- Billing Team Will Provide A Packing Slip That Must Be Sent Out With The Eyeglasses
- You Can Put Multiple Orders In The Box As Long As The Frame And Packing Slip Don’t Get Mixed Up

## ☐ **Address for Expert Lab:**

Expert Optics  
305 Earl Road  
Shorewood, IL 60404

**NOTE:** All Multiple Pair Units Will be Transmitted to RxO

# Otis & Piper (VSP Sight For Students)

- Use VSP Plan ID
- Use a frame from the Frame Kit and UPC **20500001939094** in Ciao! Optical (OTIS AND PIPER KIDS FRAME priced at \$0)
- Use your VSPONE who will provide a complete pair to you.
- Dispensing fee is \$25.

VSP Choice Plan®

Effective June 27, 2023

Charge patients the listed copay or 80% of your usual and customary fee (U&C), whichever is lower.

ASPHERICAL AND SPHERICAL LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
AA	Aspheric Plastic 1.50	\$10	\$21	\$31	\$14	\$21	\$35
AB	High-index Plastic 1.53–1.60/Trivex	\$29	\$27	\$56	\$33	\$27	\$60
AH	High-index Plastic 1.66/1.67	\$48	\$35	\$83	\$58	\$40	\$98
AJ	High-index Plastic 1.70 and Above	\$68	\$43	\$111	\$78	\$40	\$118
AD	Polycarbonate	\$14	\$21	\$35	\$14	\$21	\$35
AE	(Lab Use Only)	--	--	--	--	--	--
AF	High-index Glass 1.60–1.80 (Clear)	\$35	\$25	\$60	\$85	\$53	\$138

DIGITAL ASPHERIC LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
BA	Digital Aspheric Lenses – Plastic	\$24	\$21	\$45	\$34	\$21	\$55
BA + BB	Digital Aspheric Lenses – High-index Plastic 1.53–1.60/Trivex	\$16	\$12	\$45 + \$28	\$16	\$12	\$55 + \$28
BA + BH	Digital Aspheric Lenses – High-index Plastic 1.66/1.67	\$37	\$21	\$45 + \$58	\$40	\$28	\$55 + \$68
BA + BJ	Digital Aspheric Lenses – High-index Plastic 1.70 and Above	\$57	\$29	\$45 + \$86	--	--	--
BA + BD	Digital Aspheric Lenses – Polycarbonate	\$10	\$0	\$45 + \$10	\$10	\$0	\$55 + \$10

OCCUPATIONAL LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
CA	(Lab Use Only)	--	--	--	--	--	--
CE	(Lab Use Only)	--	--	--	--	--	--

POLARIZED LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
DA	Polarized Lenses – Plastic A	\$36	\$21	\$57	\$48	\$29	\$77
DA + DB	Polarized Lenses – High-index Plastic 1.53–1.60/Trivex	\$47	\$29	\$57 + \$76	\$59	\$36	\$77 + \$95
DA + DH	Polarized Lenses – High-index Plastic 1.66/1.67	\$55	\$34	\$57 + \$89	\$67	\$41	\$77 + \$108
DA + DJ	Polarized Lenses – High-index Plastic 1.70 and Above	\$70	\$38	\$57 + \$108	--	--	--
DA + DD	Polarized Lenses – Polycarbonate	\$13	\$18	\$57 + \$31	\$13	\$18	\$77 + \$31
DE	Polarized/Laminated Lenses – Glass	\$49	\$29	\$78	\$63	\$38	\$101

BIFOCAL LENS STYLES (MARK BIFOCAL BOX)			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
IA	Near Variable Focus – Plastic	--	--	--	\$26	\$24	\$50
IA + IB	Near Variable Focus – High-index Plastic 1.53–1.60/Trivex	--	--	--	\$11	\$13	\$50 + \$24
IA + II	Near Variable Focus – High-index Plastic 1.66/1.67	--	--	--	\$27	\$23	\$50 + \$50
IA + IJ	Near Variable Focus – High-index Plastic 1.70 and Above	--	--	--	\$36	\$24	\$50 + \$60
IA + ID	Near Variable Focus – Polycarbonate	--	--	--	\$7	\$13	\$50 + \$20
GA	Blended Bifocal – Plastic	--	--	--	\$14	\$16	\$30

PLASTIC DYES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
MM	(Lab Use Only)	--	--	--	--	--	--
MN	Plastic Dyes – Solid Color (Except Pink I and II)	\$5	\$10	\$15	\$5	\$10	\$15
MP	Plastic Dyes – Gradient	\$7	\$10	\$17	\$7	\$10	\$17

+This lens enhancement code is always in conjunction with a base lens enhancement code [shaded], e.g., IB is charged with IA.  
Please note: For children, handicapped patients, or for patients under the Federal Plan, there is no Service Fee for covered polycarbonate lenses when dispensed.

# VSP Choice Plan

Effective June 27, 2023

Charge patients the listed copay or 80% of your usual and customary fee (U&C), whichever is lower.

GLASS TINTS AND COLOR COATINGS				SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay	
MQ	(Lab Use Only)	--	--	--	--	--	--	
MR	Glass Tints Solid (Except Pink I and II and Yellow)	\$16	\$18	\$34	\$24	\$20	\$44	
MS	Glass Color Coatings – Solid	\$22	\$20	\$42	\$22	\$20	\$42	
MT	Glass Color Coatings – Gradient	\$25	\$21	\$46	\$25	\$21	\$46	

PHOTOCHROMICS				SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay	
PM	Photochromics – Glass	\$15	\$18	\$33	\$23	\$18	\$41	
PR	Photochromics – Plastic	\$45	\$30	\$75	\$45	\$30	\$75	

OTHER COATINGS				SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay	
QM	Anti-reflective Coating A	\$21	\$20	\$41	\$21	\$20	\$41	
QT	Anti-reflective Coating C	\$41	\$27	\$68	\$41	\$27	\$68	
QV	Anti-reflective Coating D	\$52	\$33	\$85	\$52	\$33	\$85	
QP	Mirror – Solid and Single Gradient (Includes Base Color)	\$26	\$23	\$49	\$26	\$23	\$49	
QR	Ski Type (Includes Base Tint and Backside Color)	\$30	\$25	\$55	\$30	\$25	\$55	
QQ	Scratch-resistant Coating A – Factory Applied	\$7	\$10	\$17	\$7	\$10	\$17	
QS	Scratch-resistant Coating B – Other Approved Coatings	\$15	\$18	\$33	\$15	\$18	\$33	

OVERSIZE				SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay	
RM	Frames Stamped 61mm Eye Size or Greater – Plastic	\$5	\$6	\$11	\$6	\$8	\$14	
RN	Frames Stamped 61mm Eye Size or Greater – Glass	\$7	\$6	\$13	\$10	\$8	\$18	

MISCELLANEOUS				SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay	
SP	High Luster Edge Polish	\$6	\$10	\$16	\$6	\$10	\$16	
SQ	Edge Coating	\$17	\$19	\$36	\$17	\$19	\$36	
SR	Faceted Lenses (Includes Polishing)	\$41	\$25	\$66	\$41	\$25	\$66	
SW	Rimless Drill	\$25	\$5	\$30	\$25	\$5	\$30	
SV	UV Protection	\$6	\$10	\$16	\$6	\$10	\$16	
BV	UV Protection – Backside	\$7	\$3	\$10	\$7	\$3	\$10	
LF	Light Filter	\$11	\$4	\$15	\$11	\$4	\$15	
TA	Technical Add-On	\$8	\$2	\$10	--	--	--	
SH	(Lab Use Only)	--	--	--	--	--	--	
ST	(Lab Use Only)	--	--	--	--	--	--	

DOCTOR SUPPLIED*				SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay	
IM	Plastic Dyes – Solid Color (Pink I and II)	\$5	--	--	\$5	--	--	
IN	Plastic Dyes – Solid Color (Except Pink I and II)	\$5	\$10	\$15	\$5	\$10	\$15	
IP	Plastic Dyes – Gradient	\$7	\$10	\$17	\$7	\$10	\$17	
IV	UV Protection	\$6	\$10	\$16	\$6	\$10	\$16	

\*In-office Lab: For the patient lens enhancements your office can fulfill in-house, you'll be reimbursed this listed fee for covered lens enhancements. For all other lens enhancements, this will be included in the patient copay you collect from the patient.

VSP Choice Plan

Effective June 27, 2023

Charge patients the listed copay or 80% of your usual and customary fee (U&C), whichever is lower.

PROGRESSIVE				
Code	Lens Enhancement Description	Charge Back	Service Fee <sup>1</sup>	Patient Copay
CM	Custom Measurements (on Eligible Progressive N or O) Lenses	\$2	\$8	\$10
NA	Progressive N – Plastic	\$95	\$80	\$175
NA + NB	Progressive N – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$175 + \$47
NA + NH	Progressive N – High-index Plastic 1.66/1.67	\$48	\$30	\$175 + \$78
NA + NJ	Progressive N – High-index Plastic 1.70 and Above	\$77	\$48	\$175 + \$125
NA + ND	Progressive N – Polycarbonate	\$15	\$20	\$175 + \$35
NA + NP	Progressive N – Polarized	\$51	\$31	\$175 + \$82
OA	Progressive O – Plastic	\$79	\$71	\$150
OA + OB	Progressive O – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$150 + \$47
OA + OH	Progressive O – High-index Plastic 1.66/1.67	\$48	\$30	\$150 + \$78
OA + OJ	Progressive O – High-index Plastic 1.70 and Above	\$77	\$48	\$150 + \$125
OA + OD	Progressive O – Polycarbonate	\$15	\$20	\$150 + \$35
OA + OP	Progressive O – Polarized	\$51	\$31	\$150 + \$82
FA	Progressive F – Plastic	\$54	\$51	\$105
FA + FB	Progressive F – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$105 + \$47
FA + FH	Progressive F – High-index Plastic 1.66/1.67	\$48	\$30	\$105 + \$78
FA + FJ	Progressive F – High-index Plastic 1.70 and Above	\$77	\$48	\$105 + \$125
FA + FD	Progressive F – Polycarbonate	\$15	\$20	\$105 + \$35
FA + FP	Progressive F – Polarized	\$51	\$31	\$105 + \$82
FE	Progressive F – Glass/High-index Glass (Clear)	\$59	\$51	\$110
JA	Progressive J – Plastic	\$46	\$49	\$95
JA + JB	Progressive J – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$95 + \$47
JA + JH	Progressive J – High-index Plastic 1.66/1.67	\$48	\$30	\$95 + \$78
JA + JJ	Progressive J – High-index Plastic 1.70 and Above	\$77	\$48	\$95 + \$125
JA + JD	Progressive J – Polycarbonate	\$15	\$20	\$95 + \$35
JA + JP	Progressive J – Polarized	\$51	\$31	\$95 + \$82
JE	Progressive J – Glass/High-index Glass (Clear)	\$56	\$49	\$105
KA	Progressive K – Plastic	\$28	\$27	\$55
KA + KB	Progressive K – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$55 + \$47
KA + KH	Progressive K – High-index Plastic 1.66/1.67	\$48	\$30	\$55 + \$78
KA + KJ	Progressive K – High-index Plastic 1.70 and Above	\$77	\$48	\$55 + \$125
KA + KD	Progressive K – Polycarbonate	\$15	\$20	\$55 + \$35
KA + KP	Progressive K – Polarized	\$51	\$31	\$55 + \$82
KE	Progressive K – Glass/High-index Glass (Clear)	\$53	\$27	\$80

1.The Service Fee for progressives is paid in addition to your VSP Choice Plan bifocal lens dispensing fee.  
Please note: For children, handicapped patients, or for patients under the Federal Plan, there is no Service Fee for covered polycarbonate lenses when dispensed.

PROGRESSIVE CATEGORIES <sup>2</sup> AS OF 6/27/2023		
Custom	N	Unity® Via Elite II, Hoyalux iDMyStyle 2, Hoyalux iD LifeStyle 3, Maui Jim Passport 2.0, Shamir Autograph III^, Shamir Autograph Intelligence^, Varilux X Fit Technology^, ZEISS SmartLife Individual
	O	Unity Via Plus II/Mobile II/Wrap II, Array 2^, Kodak Unique DRO, Shamir Autograph II+^, Varilux Physio W3+, Varilux X Design Technology^, ZEISS SmartLife Superb^/Plus/Pure
Premium	F	Unity Via II, Hoyalux Summit, Shamir Spectrum+, Varilux Comfort Max, Varilux Physio DRx, ZEISS Progressive Light V
	J	Ethos® Plus, Amplitude BKS, Kodak Precise, Shamir Element, Varilux Comfort 2, ZEISS Progressive Light H
Standard	K	Ethos, Accolade, Hoyalux GP Wide, Image, Ovation, Shamir Genesis HD, synchrony Easy View HD, ZEISS Progressive Light D

2. For a full list of progressives, please refer to the Product Index in the Manuals on VSPOnline at [eyefinity.com](#).  
^This progressive lens is customizable for the most precise prescription.

The VSP formulary is administered by Plexus Optix, Inc. and Plexus reserves the right to make any modifications or adjustments to any or all of the fees in this chart at any time.

# VSP Signature Plan®

Effective June 27, 2023

Charge patients the listed patient copay or your U&C fee, whichever is lower.

ASPHERICAL AND SPHERICAL LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
AA	Aspheric Plastic 1.50	\$10	\$13	\$23	\$14	\$14	\$28
AB	High-index Plastic 1.53–1.60/Trivex	\$29	\$22	\$51	\$33	\$22	\$55
AH	High-index Plastic 1.66/1.67	\$48	\$28	\$76	\$58	\$32	\$90
AJ	High-index Plastic 1.70 and Above	\$68	\$34	\$102	\$78	\$32	\$110
AD	Polycarbonate	\$19	\$14	\$33	\$19	\$14	\$33
AE	(Lab Use Only)	--	--	--	--	--	--
AF	High-index Glass 1.60–1.80 (Clear)	\$35	\$20	\$55	\$85	\$42	\$127

DIGITAL ASPHERIC LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
BA	Digital Aspheric Lenses – Plastic	\$26	\$14	\$40	\$31	\$14	\$45
BA + BB	Digital Aspheric Lenses – High-index Plastic 1.53–1.60/Trivex	\$16	\$11	\$40 + \$27	\$16	\$11	\$45 + \$27
BA + BH	Digital Aspheric Lenses – High-index Plastic 1.66/1.67	\$37	\$19	\$40 + \$56	\$40	\$25	\$45 + \$65
BA + BJ	Digital Aspheric Lenses – High-index Plastic 1.70 and Above	\$57	\$25	\$40 + \$82	--	--	--
BA + BD	Digital Aspheric Lenses – Polycarbonate	\$10	\$0	\$40 + \$10	\$10	\$0	\$45 + \$10

OCCUPATIONAL LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
CA	(Lab Use Only)	--	--	--	--	--	--
CE	(Lab Use Only)	--	--	--	--	--	--

POLARIZED LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
DA	Polarized Lenses – Plastic A	\$36	\$17	\$53	\$48	\$23	\$71
DA + DB	Polarized Lenses – High-index Plastic 1.53–1.60/Trivex	\$47	\$23	\$53 + \$70	\$59	\$29	\$71 + \$88
DA + DH	Polarized Lenses – High-index Plastic 1.66/1.67	\$55	\$27	\$53 + \$82	\$67	\$33	\$71 + \$100
DA + DJ	Polarized Lenses – High-index Plastic 1.70 and Above	\$70	\$30	\$53 + \$100	--	--	--
DA + DD	Polarized Lenses – Polycarbonate	\$13	\$14	\$53 + \$27	\$13	\$14	\$71 + \$27
DE	Polarized/Laminated Lenses – Glass	\$49	\$23	\$72	\$63	\$30	\$93

BIFOCAL LENS STYLES (MARK BIFOCAL BOX)			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
IA	Near Variable Focus – Plastic	--	--	--	\$26	\$20	\$46
IA + IB	Near Variable Focus – High-index Plastic 1.53–1.60/Trivex	--	--	--	\$11	\$10	\$46 + \$21
IA + II	Near Variable Focus – High-index Plastic 1.66/1.67	--	--	--	\$27	\$18	\$46 + \$45
IA + IJ	Near Variable Focus – High-index Plastic 1.70 and Above	--	--	--	\$36	\$19	\$46 + \$55
IA + ID	Near Variable Focus – Polycarbonate	--	--	--	\$7	\$10	\$46 + \$17
GA	Blended Bifocal – Plastic	--	--	--	\$14	\$13	\$27

PLASTIC DYES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
MM	(Lab Use Only)	--	--	--	--	--	--
MN	Plastic Dyes – Solid Color (Except Pink I and II)	\$5	\$8	\$13	\$5	\$8	\$13
MP	Plastic Dyes – Gradient	\$7	\$8	\$15	\$7	\$8	\$15

+This lens enhancement code is always in conjunction with a base lens enhancement code [shaded], e.g., IB is charged with IA.  
Please note: If the patient is covered for plastic dyes, glass tints, or photochromics, there is no Service Fee for those lens enhancements.  
Additionally, for children or handicapped patients, there is no Service Fee for covered polycarbonate lenses when dispensed.

# VSP Signature Plan

Effective June 27, 2023

Charge patients the listed patient copay or your U&C fee, whichever is lower.

GLASS TINTS AND COLOR COATINGS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
MQ	(Lab Use Only)	--	--	--	--	--	--
MR	Glass Tints Solid (Except Pink I and II and Yellow)	\$16	\$14	\$30	\$24	\$17	\$41
MS	Glass Color Coatings – Solid	\$22	\$16	\$38	\$22	\$16	\$38
MT	Glass Color Coatings – Gradient	\$25	\$17	\$42	\$25	\$17	\$42

PHOTOCHROMICS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
PM	Photochromics – Glass	\$15	\$14	\$29	\$23	\$14	\$37
PR	Photochromics – Plastic	\$47	\$23	\$70	\$47	\$23	\$70

OTHER COATINGS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
QM	Anti-reflective Coating A	\$21	\$16	\$37	\$21	\$16	\$37
QT	Anti-reflective Coating C	\$41	\$20	\$61	\$41	\$20	\$61
QV	Anti-reflective Coating D	\$52	\$23	\$75	\$52	\$23	\$75
QP	Mirror – Solid and Single Gradient (Includes Base Color)	\$26	\$18	\$44	\$26	\$18	\$44
QR	Ski Type (Includes Base Tint and Backside Color)	\$30	\$20	\$50	\$30	\$20	\$50
QQ	Scratch-resistant Coating A – Factory Applied	\$7	\$8	\$15	\$7	\$8	\$15
QS	Scratch-resistant Coating B – Other Approved Coatings	\$15	\$14	\$29	\$15	\$14	\$29

OVERSIZE			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
RM	Frames Stamped 61mm Eye Size or Greater – Plastic	\$5	\$5	\$10	\$6	\$6	\$12
RN	Frames Stamped 61mm Eye Size or Greater – Glass	\$7	\$5	\$12	\$10	\$6	\$16

MISCELLANEOUS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
SP	High Luster Edge Polish	\$6	\$8	\$14	\$6	\$8	\$14
SQ	Edge Coating	\$17	\$15	\$32	\$17	\$15	\$32
SR	Faceted Lenses (Includes Polishing)	\$41	\$20	\$61	\$41	\$20	\$61
SW	Rimless Drill	\$25	\$5	\$30	\$25	\$5	\$30
SV	UV Protection	\$6	\$8	\$14	\$6	\$8	\$14
BV	UV Protection – Backside	\$7	\$3	\$10	\$7	\$3	\$10
LF	Light Filter	\$11	\$4	\$15	\$11	\$4	\$15
TA	Technical Add-on	\$8	\$2	\$10	--	--	--
SH	(Lab Use Only)	--	--	--	--	--	--
ST	(Lab Use Only)	--	--	--	--	--	--

DOCTOR SUPPLIED*			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
IM	Plastic Dyes – Solid Color (Pink I and II)	\$5	--	--	\$5	--	--
IN	Plastic Dyes – Solid Color (Except Pink I and II)	\$5	\$8	\$13	\$5	\$8	\$13
IP	Plastic Dyes – Gradient	\$7	\$8	\$15	\$7	\$8	\$15
IV	UV Protection	\$6	\$8	\$14	\$6	\$8	\$14

Please note: If the patient is covered for plastic dyes, glass tints, or photochromics, there is no service fee for those lens enhancements.  
\*In-office Lab: For the patient lens enhancements your office can fulfill in-house, you'll be reimbursed this listed fee for covered lens enhancements. For all other lens enhancements, this will be included in the patient copay you collect from the patient.

VSP Signature Plan

Effective June 27, 2023

Charge patients the listed patient copay or your U&C fee, whichever is lower.

PROGRESSIVE				
Code	Lens Enhancement Description	Charge Back	Service Fee¹	Patient Copay
CM	Custom Measurements (on Eligible Progressive N or O) Lenses	\$2	\$8	\$10
NA	Progressive N – Plastic	\$95	\$65	\$160
NA +NB	Progressive N – High-index Plastic 1.53–1.60/Trivex	\$25	\$17	\$160 + \$42
NA +NH	Progressive N – High-index Plastic 1.66/1.67	\$48	\$24	\$160 + \$72
NA +NJ	Progressive N – High-index Plastic 1.70 and Above	\$77	\$38	\$160 + \$115
NA +ND	Progressive N – Polycarbonate	\$18	\$15	\$160 + \$33
NA +NP	Progressive N – Polarized	\$51	\$25	\$160 + \$76
OA	Progressive O – Plastic	\$75	\$45	\$120
OA + OB	Progressive O – High-index Plastic 1.53–1.60/Trivex	\$25	\$17	\$120 + \$42
OA + OH	Progressive O – High-index Plastic 1.66/1.67	\$48	\$24	\$120 + \$72
OA + OJ	Progressive O – High-index Plastic 1.70 and Above	\$77	\$38	\$120 + \$115
OA + OD	Progressive O – Polycarbonate	\$18	\$15	\$120 + \$33
OA + OP	Progressive O – Polarized	\$51	\$25	\$120 + \$76
FA	Progressive F – Plastic	\$54	\$36	\$90
FA +FB	Progressive F – High-index Plastic 1.53–1.60/Trivex	\$25	\$17	\$90 + \$42
FA +FH	Progressive F – High-index Plastic 1.66/1.67	\$48	\$24	\$90 + \$72
FA +FJ	Progressive F – High-index Plastic 1.70 and Above	\$77	\$38	\$90 + \$115
FA +FD	Progressive F – Polycarbonate	\$18	\$15	\$90 + \$33
FA +FP	Progressive F – Polarized	\$51	\$25	\$90 + \$76
FE	Progressive F – Glass/High-index Glass (Clear)	\$59	\$36	\$95
JA	Progressive J – Plastic	\$46	\$34	\$80
JA +JB	Progressive J – High-index Plastic 1.53–1.60/Trivex	\$25	\$17	\$80 + \$42
JA +JH	Progressive J – High-index Plastic 1.66/1.67	\$48	\$24	\$80 + \$72
JA +JJ	Progressive J – High-index Plastic 1.70 and Above	\$77	\$38	\$80 + \$115
JA +JD	Progressive J – Polycarbonate	\$18	\$15	\$80 + \$33
JA +JP	Progressive J – Polarized	\$51	\$25	\$80 + \$76
JE	Progressive J – Glass/High-index Glass (Clear)	\$56	\$34	\$90
KA	Progressive K – Plastic	\$30	\$20	\$50
KA +KB	Progressive K – High-index Plastic 1.53–1.60/Trivex	\$25	\$17	\$50 + \$42
KA +KH	Progressive K – High-index Plastic 1.66/1.67	\$48	\$24	\$50 + \$72
KA +KJ	Progressive K – High-index Plastic 1.70 and Above	\$77	\$38	\$50 + \$115
KA +KD	Progressive K – Polycarbonate	\$18	\$15	\$50 + \$33
KA +KP	Progressive K – Polarized	\$51	\$25	\$50 + \$76
KE	Progressive K – Glass/High-index Glass (Clear)	\$50	\$20	\$70

1.The Service Fee for progressives is paid in addition to your VSP Signature Plan bifocal dispensing fee.  
Please note: For children or handicapped patients, there is no Service Fee for covered polycarbonate lenses when dispensed.

PROGRESSIVE CATEGORIES² AS OF 6/27/2023		
Custom	N	Unity® Via Elite II, Hoyalux iDMyStyle 2, Hoyalux iD LifeStyle 3, Maui Jim Passport 2.0, Shamir Autograph III^, Shamir Autograph Intelligence^, Varilux X Fit Technology^, ZEISS SmartLife Individual
	O	Unity Via Plus II/Mobile II/Wrap II, Array 2^, Kodak Unique DRO, Shamir Autograph II+^, Varilux Physio W3+, Varilux X Design Technology^, ZEISS SmartLife Superb^/Plus/Pure
Premium	F	Unity Via II, Hoyalux Summit, Shamir Spectrum+, Varilux Comfort Max, Varilux Physio DRx, ZEISS Progressive Light V
	J	Ethos® Plus, Amplitude BKS, Kodak Precise, Shamir Element, Varilux Comfort 2, ZEISS Progressive Light H
Standard	K	Ethos, Accolade, Hoyalux GP Wide, Image, Ovation, Shamir Genesis HD, synchrony Easy View HD, ZEISS Progressive Light D

2. For a full list of progressives, please refer to the Product Index in the Manuals on VSPOnline at **eyefinity.com**.  
^This progressive lens is customizable for the most precise prescription.

The VSP formulary is administered by Plexus Optix, Inc. and Plexus reserves the right to make any modifications or adjustments to any or all of the fees in this chart at any time.



# Advantage Network

Effective June 27, 2023

Charge patients the listed patient copay or 80% of your U&C fee, whichever is lower. If no patient copay is listed, charge 80% of your U&C.

ASPHERICAL AND SPHERICAL LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
AA	Aspheric Plastic 1.50	\$10	\$21	80% of U&C	\$14	\$21	80% of U&C
AB	High-index Plastic 1.53–1.60/Trivex	\$29	\$27	80% of U&C	\$33	\$27	80% of U&C
AH	High-index Plastic 1.66/1.67	\$48	\$35	80% of U&C	\$58	\$40	80% of U&C
AJ	High-index Plastic 1.70 and Above	\$68	\$43	80% of U&C	\$78	\$40	80% of U&C
AD	Polycarbonate	\$14	\$21	\$35	\$14	\$21	\$35
AE	(Lab Use Only)	--	--	--	--	--	--
AF	High-index Glass 1.60–1.80 (Clear)	\$35	\$25	80% of U&C	\$85	\$53	80% of U&C

DIGITAL ASPHERIC LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
BA	Digital Aspheric Lenses – Plastic	\$24	\$21	80% of U&C	\$34	\$21	80% of U&C
BA + BB	Digital Aspheric Lenses – High-index Plastic 1.53–1.60/Trivex	\$16	\$12	80% of U&C	\$16	\$12	80% of U&C
BA + BH	Digital Aspheric Lenses – High-index Plastic 1.66/1.67	\$37	\$21	80% of U&C	\$40	\$28	80% of U&C
BA + BJ	Digital Aspheric Lenses – High-index Plastic 1.70 and Above	\$57	\$29	80% of U&C	--	--	--
BA + BD	Digital Aspheric Lenses – Polycarbonate	\$10	\$0	80% of U&C + \$10	\$10	\$0	80% of U&C + \$10

OCCUPATIONAL LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
CA	(Lab Use Only)	--	--	--	--	--	--
CE	(Lab Use Only)	--	--	--	--	--	--

POLARIZED LENS STYLES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
DA	Polarized Lenses – Plastic A	\$36	\$21	80% of U&C	\$48	\$29	80% of U&C
DA + DB	Polarized Lenses – High-index Plastic 1.53–1.60/Trivex	\$47	\$29	80% of U&C	\$59	\$36	80% of U&C
DA + DH	Polarized Lenses – High-index Plastic 1.66/1.67	\$55	\$34	80% of U&C	\$67	\$41	80% of U&C
DA + DJ	Polarized Lenses – High-index Plastic 1.70 and Above	\$70	\$38	80% of U&C	--	--	--
DA + DD	Polarized Lenses – Polycarbonate	\$13	\$18	80% of U&C	\$13	\$18	80% of U&C
DE	Polarized/Laminated Lenses – Glass	\$49	\$29	80% of U&C	\$63	\$38	80% of U&C

BIFOCAL LENS STYLES (MARK BIFOCAL BOX)			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
IA	Near Variable Focus – Plastic	--	--	--	\$26	\$24	80% of U&C
IA + IB	Near Variable Focus – High-index Plastic 1.53–1.60/Trivex	--	--	--	\$11	\$13	80% of U&C
IA + II	Near Variable Focus – High-index Plastic 1.66/1.67	--	--	--	\$27	\$23	80% of U&C
IA + IJ	Near Variable Focus – High-index Plastic 1.70 and Above	--	--	--	\$36	\$24	80% of U&C
IA + ID	Near Variable Focus – Polycarbonate	--	--	--	\$7	\$13	80% of U&C
GA	Blended Bifocal – Plastic	--	--	--	\$14	\$16	80% of U&C

PLASTIC DYES			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
MM	(Lab Use Only)	--	--	--	--	--	--
MN	Plastic Dyes – Solid Color (Except Pink I and II)	\$5	\$10	\$15	\$5	\$10	\$15
MP	Plastic Dyes – Gradient	\$7	\$10	\$17	\$7	\$10	\$17

+This lens enhancement code is always in conjunction with a base lens enhancement code [shaded], e.g., IB Is charged with IA.  
Please note: For children, handicapped patients, or for patients under the Federal Plan, there is no Service Fee for covered polycarbonate lenses when dispensed.

# Advantage Network

Effective June 27, 2023

Charge patients the listed patient copay or 80% of your U&C fee, whichever is lower. If no patient copay is listed, charge 80% of your U&C.

GLASS TINTS AND COLOR COATINGS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
MQ	(Lab Use Only)	--	--	--	--	--	--
MR	Glass Tints Solid (Except Pink I and II and Yellow)	\$16	\$18	\$34	\$24	\$20	\$44
MS	Glass Color Coatings – Solid	\$22	\$20	80% of U&C	\$22	\$20	80% of U&C
MT	Glass Color Coatings – Gradient	\$25	\$21	80% of U&C	\$25	\$21	80% of U&C

PHOTOCHROMICS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
PM	Photochromics – Glass	\$15	\$18	\$33	\$23	\$18	\$41
PR	Photochromics – Plastic	\$45	\$30	\$75	\$45	\$30	\$75

OTHER COATINGS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
QM	Anti-reflective Coating A	\$21	\$20	\$41	\$21	\$20	\$41
QT	Anti-reflective Coating C	\$41	\$27	\$68	\$41	\$27	\$68
QV	Anti-reflective Coating D	\$52	\$33	\$85	\$52	\$33	\$85
QP	Mirror – Solid and Single Gradient (Includes Base Color)	\$26	\$23	80% of U&C	\$26	\$23	80% of U&C
QR	Ski Type (Includes Base Tint and Backside Color)	\$30	\$25	80% of U&C	\$30	\$25	80% of U&C
QQ	Scratch-resistant Coating A – Factory Applied	\$7	\$10	\$17	\$7	\$10	\$17
QS	Scratch-resistant Coating B – Other Approved Coatings	\$15	\$18	\$33	\$15	\$18	\$33

OVERSIZE			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
RM	Frames Stamped 61mm Eye Size or Greater – Plastic	\$5	\$6	\$11	\$6	\$8	\$14
RN	Frames Stamped 61mm Eye Size or Greater – Glass	\$7	\$6	\$13	\$10	\$8	\$18

MISCELLANEOUS			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
SP	High Luster Edge Polish	\$6	\$10	80% of U&C	\$6	\$10	80% of U&C
SQ	Edge Coating	\$17	\$19	80% of U&C	\$17	\$19	80% of U&C
SR	Faceted Lenses (Includes Polishing)	\$41	\$25	80% of U&C	\$41	\$25	80% of U&C
SW	Rimless Drill	\$25	\$5	\$30	\$25	\$5	\$30
SV	UV Protection	\$6	\$10	\$16	\$6	\$10	\$16
BV	UV Protection – Backside	\$7	\$3	\$10	\$7	\$3	\$10
LF	Light Filter	\$11	\$4	\$15	\$11	\$4	\$15
TA	Technical Add-on	\$8	\$2	\$10	--	--	--
SH	(Lab Use Only)	--	--	--	--	--	--
ST	(Lab Use Only)	--	--	--	--	--	--

DOCTOR SUPPLIED*			SINGLE VISION			MULTIFOCAL	
Code	Lens Enhancement Description	Charge Back	Service Fee	Patient Copay	Charge Back	Service Fee	Patient Copay
IM	Plastic Dyes – Solid Color (Pink I and II)	\$5	--	--	\$5	--	--
IN	Plastic Dyes – Solid Color (Except Pink I and II)	\$5	\$10	\$15	\$5	\$10	\$15
IP	Plastic Dyes – Gradient	\$7	\$10	\$17	\$7	\$10	\$17
IV	UV Protection	\$6	\$10	\$16	\$6	\$10	\$16

\*In-office Lab: For the patient lens enhancements your office can fulfill in-house, you'll be reimbursed this listed fee for covered lens enhancements. For all other lens enhancements, this will be included in the patient copay you collect from the patient.

Advantage Network

Effective June 27, 2023

Charge patients the listed patient copay or 80% of your U&C fee, whichever is lower. If no patient copay is listed, charge 80% of your U&C.

PROGRESSIVE				
Code	Lens Enhancement Description	Charge Back	Service Fee <sup>1</sup>	Patient Copay
CM	Custom Measurements (on Eligible Progressive N or O) Lenses	\$2	\$8	\$10
NA	Progressive N – Plastic	\$95	\$80	\$175
NA + NB	Progressive N – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$175 + 80% of U&C2
NA + NH	Progressive N – High-index Plastic 1.66/1.67	\$48	\$30	\$175 + 80% of U&C2
NA + NJ	Progressive N – High-index Plastic 1.70 and Above	\$77	\$48	\$175 + 80% of U&C2
NA + ND	Progressive N – Polycarbonate	\$15	\$20	\$175 + \$35
NA + NP	Progressive N – Polarized	\$51	\$31	\$175 + 80% of U&C2
OA	Progressive O – Plastic	\$79	\$71	\$150
OA + OB	Progressive O – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$150 + 80% of U&C2
OA + OH	Progressive O – High-index Plastic 1.66/1.67	\$48	\$30	\$150 + 80% of U&C2
OA + OJ	Progressive O – High-index Plastic 1.70 and Above	\$77	\$48	\$150 + 80% of U&C2
OA + OD	Progressive O – Polycarbonate	\$15	\$20	\$150 + \$35
OA + OP	Progressive O – Polarized	\$51	\$31	\$150 + 80% of U&C2
FA	Progressive F – Plastic	\$54	\$51	\$105
FA + FB	Progressive F – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$105 + 80% of U&C2
FA + FH	Progressive F – High-index Plastic 1.66/1.67	\$48	\$30	\$105 + 80% of U&C2
FA + FJ	Progressive F – High-index Plastic 1.70 and Above	\$77	\$48	\$105 + 80% of U&C2
FA + FD	Progressive F – Polycarbonate	\$15	\$20	\$105 + \$35
FA + FP	Progressive F – Polarized	\$51	\$31	\$105 + 80% of U&C2
FE	Progressive F – Glass/High-index Glass (Clear)	\$59	\$51	\$110
JA	Progressive J – Plastic	\$46	\$49	\$95
JA + JB	Progressive J – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$95 + 80% of U&C2
JA + JH	Progressive J – High-index Plastic 1.66/1.67	\$48	\$30	\$95 + 80% of U&C2
JA + JJ	Progressive J – High-index Plastic 1.70 and Above	\$77	\$48	\$95 + 80% of U&C2
JA + JD	Progressive J – Polycarbonate	\$15	\$20	\$95 + \$35
JA + JP	Progressive J – Polarized	\$51	\$31	\$95 + 80% of U&C2
JE	Progressive J – Glass/High-index Glass (Clear)	\$56	\$49	\$105
KA	Progressive K – Plastic	\$28	\$27	\$55
KA + KB	Progressive K – High-index Plastic 1.53–1.60/Trivex	\$25	\$22	\$55 + 80% of U&C2
KA + KH	Progressive K – High-index Plastic 1.66/1.67	\$48	\$30	\$55 + 80% of U&C2
KA + KJ	Progressive K – High-index Plastic 1.70 and Above	\$77	\$48	\$55 + 80% of U&C2
KA + KD	Progressive K – Polycarbonate	\$15	\$20	\$55 + \$35
KA + KP	Progressive K – Polarized	\$51	\$31	\$55 + 80% of U&C2
KE	Progressive K – Glass/High-index Glass (Clear)	\$53	\$27	\$80

1. The Service Fee for progressives is paid in addition to your VSP Advantage Plan<sup>SM</sup> bifocal lens dispensing fee.  
Please note: For children, handicapped patients, or for patients under the Federal Plan, there is no Service Fee for covered polycarbonate lenses when dispensed.  
2. To determine the lens enhancement price, subtract your U&C price of the standard lens enhancement, (i.e., KA progressive), from your U&C price of the premium material lens enhancement, (i.e., KP polarized).

PROGRESSIVE CATEGORIES <sup>3</sup> AS OF 6/27/2023		
Custom	N	Unity® Via Elite II, Hoyalux iDMyStyle 2, Hoyalux iD LifeStyle 3, Maui Jim Passport 2.0, Shamir Autograph III^, Shamir Autograph Intelligence^, Varilux X Fit Technology^, ZEISS SmartLife Individual
	O	Unity Via Plus II/Mobile II/Wrap II, Array 2^, Kodak Unique DRO, Shamir Autograph II+^, Varilux Physio W3+, Varilux X Design Technology^, ZEISS SmartLife Superb^/Plus/Pure
Premium	F	Unity Via II, Hoyalux Summit, Shamir Spectrum+, Varilux Comfort Max, Varilux Physio DRx, ZEISS Progressive Light V
	J	Ethos® Plus, Amplitude BKS, Kodak Precise, Shamir Element, Varilux Comfort 2, ZEISS Progressive Light H
Standard	K	Ethos, Accolade, Hoyalux GP Wide, Image, Ovation, Shamir Genesis HD, synchrony Easy View HD, ZEISS Progressive Light D

3. For a full list of progressives, please refer to the Product Index in the Manuals on VSPOnline at [eyefinity.com](#).  
^This progressive lens is customizable for the most precise prescription.

# Davis Vision

- Use the **DAVIS VISION-ROSIN 1824518** for all materials (Contact Lenses, Eyewear) and eye exam

	PATIENT PAYS	PLAN PAYS
Exam	Check plan details for exam copay	<ul style="list-style-type: none"><li>• \$50 (includes refraction), reduce if copay</li><li>• \$45 (Estes Express Lines &amp; General Electric)</li></ul>
CL Fit	Patient responsibility. Please refer to Plan Benefit sheet for provider supplied for any discount.	<ul style="list-style-type: none"><li>• \$0</li></ul>
Frames	Patient pays amount over allowance. See Plan Benefit sheet for any additional discounts	See Fee schedule for plan pay amounts. They vary by plan and frame category.
Lenses	Check plan detail for out-of-pocket amounts for material and enhancements.  Patient pays lens copay if present + upgrade amounts noted on plan summary/benefit sheet.	SV: \$35   BF: \$55   TF: \$65
Contact Lenses	Patient pays amount over allowance. See Plan Benefit sheet for any additional discounts	85% of allowance amount

**ATTACHMENT A  
ROSIN EYECARE**

	Davis Vision Standard Plans		
SERVICES / MATERIALS	Fashion Plan	Designer Plan	Premier Plan
<b>Spectacle Examination*</b> <i>* Includes Dilation, when professionally indicated</i>	\$50.00	\$50.00	\$50.00
<b>Frame†</b>			
Retail Credit	\$75.00	\$90.00	\$120.00
Reimbursement	\$42.75	\$51.30	\$68.40
<b>Spectacle Lenses</b>			
Single Vision	\$35.00	\$35.00	\$35.00
Bifocal	\$55.00	\$55.00	\$55.00
Trifocal	\$65.00	\$65.00	\$65.00
<b>Non-Plan Contact Lenses‡</b>			
Allowance	\$75.00	\$90.00	\$105.00
Reimbursement	\$63.75	\$76.50	\$89.25
<b>Medically Necessary Contact Lenses**</b> <i>** Prior approval necessary</i>	100% U&C	100% U&C	100% U&C
SPECTACLE LENS OPTIONS	PAID BY PATIENT		
Plastic or glass single vision, bifocal or Trifocal lenses	Included	Included	Included
Glass grey #3 prescription lenses	Included	Included	Included
Over-size lenses	Included	Included	Included
Post-cataract lenses	Included	Included	Included
Fashion, sun and gradient tinted plastic lenses	Included	Included	Included
Scratch resistant coating on plastic lenses			
Single Vision	\$20.00	\$20.00	\$20.00
Multifocal	\$20.00	\$20.00	\$20.00
Ultraviolet coating	\$12.00	\$12.00	\$12.00
PGX® (sun sensitive) glass lenses	\$20.00	\$20.00	\$20.00
Blended invisible bifocals	\$20.00	\$20.00	\$20.00
Intermediate Vision Lenses	\$30.00	\$30.00	\$30.00
Progressive addition lenses			
Standard Types	\$50.00	\$50.00	\$50.00
Premium Types	\$90.00	\$90.00	\$90.00
Anti-Reflective Coating			
Standard Types	\$35.00	\$35.00	\$35.00
Premium Types	\$48.00	\$48.00	\$48.00
Ultra Types	\$60.00	\$60.00	\$60.00
Polycarbonate lenses***	\$30.00	\$30.00	\$30.00
Polaroid	\$75.00	\$75.00	\$75.00
High index (thinner and lighter)	\$55.00	\$55.00	\$55.00
Transitions® Lenses			
Single Vision	\$65.00	\$65.00	\$65.00
Multifocal	\$65.00	\$65.00	\$65.00

\*\*\* No copayment applicable for dependent children, monocular patients and patients with a prescription of +/- 6.00 diopters.

**All prices illustrated are inclusive of any applicable member copayments.**

**† On other plans where the frame allowance differs, Rosin Eyecare shall be reimbursed at fifty-seven percent (57%) of the frame allowance.**

**‡ On other plans where the contact lens allowance differs, Rosin Eyecare shall be reimbursed at eighty-five percent (85%) of the contact lens allowance.**

**One (1) year warranty required on all plan-supplied eyeglasses.**

**ATTACHMENT A  
ROSIN EYECARE**

DELTA AIR LINES	
SERVICES / MATERIALS	PAID BY DAVIS VISION
<b>Spectacle Examination*</b>	
<i>* Includes Dilation, when professionally indicated</i>	\$50.00
<b>Frame</b>	
Retail Allowance	\$120.00
Reimbursement	\$68.40
<b>Spectacle Lenses</b>	
Single Vision	\$35.00
Bifocal	\$55.00
Trifocal	\$65.00
<b>Contact Lenses</b>	
Allowance	\$105.00
Reimbursement	\$89.25
<b>Medically Necessary Contact Lenses**</b>	100% U&C
<i>** Prior approval necessary</i>	
SPECTACLE LENS OPTIONS	PAID BY PATIENT
Plastic or glass single vision, bifocal or trifocal lenses	Included
Glass grey #3 prescription lenses	Included
Over-size lenses	Included
Post-cataract lenses	Included
Fashion, sun and gradient tinted plastic lenses	Included
Scratch resistant coating on plastic lenses	\$20.00
Ultraviolet coating	\$12.00
PGX® (sun sensitive) glass lenses	\$20.00
Blended invisible bifocals	\$20.00
Double Segment lenses	\$90.00
Progressive addition lenses	
Standard Types	\$50.00
Premium Types	\$90.00
Anti-reflective coating	
Standard Types	\$35.00
Premium Types	\$48.00
Polycarbonate lenses***	\$30.00
Polarized	\$75.00
High index (thinner and lighter)	\$55.00
Plastic photosensitive lenses	\$65.00

\*\*\* No copayment applicable for dependent children, monocular patients, and patients with a prescription of +/- 6.00 diopters or greater.

**All prices illustrated are inclusive of any applicable member copayments.**

**One (1) year warranty required on all plan-supplied eyeglasses.**

**ATTACHMENT A  
ROSIN EYECARE**

ESTES EXPRESS LINES	
SERVICES / MATERIALS	PAID BY DAVIS VISION
<b>Spectacle Examination*</b>	
<i>* Includes Dilation, when professionally indicated</i>	\$45.00
<b>Frame</b>	
Wholesale Credit**	\$45.00
Reimbursement	\$45.00
<b>Spectacle Lenses</b>	
Single Vision	\$35.00
Bifocal	\$55.00
Trifocal	\$65.00
<b>Contact Lenses</b>	
Allowance	\$105.00
Reimbursement	\$89.25
<b>Medically Necessary Contact Lenses***</b>	100% U&C
<i>*** Prior approval necessary</i>	
SPECTACLE LENS OPTIONS	PAID BY PATIENT
Plastic or glass single vision, bifocal or trifocal lenses	Included
Glass grey #3 prescription lenses	Included
Over-size lenses	Included
Post-cataract lenses	Included
Fashion, sun and gradient tinted plastic lenses	Included
Scratch resistant coating on plastic lenses	\$20.00
Ultraviolet coating	Included
Blended invisible bifocals	Included
Intermediate Vision lenses	\$30.00
Progressive addition lenses	
Standard Types	Included
Premium Types	\$40.00
Anti-reflective coating	
Standard Types	\$35.00
Premium Types	\$48.00
Polycarbonate lenses****	\$30.00
Polarized	\$75.00
High index (thinner and lighter)	\$55.00
Plastic photosensitive lenses	\$65.00

**All prices illustrated are inclusive of any applicable member copayments.**

**\*\* Charges in excess of the Patient Credit should be charged to the patient. The maximum charge will be two (2) times the difference between the actual wholesale price and the wholesale credit amount listed.**

**\*\*\*\* No copayment applicable for dependent children, monocular patients, and patients with a prescription of +/- 6.00 diopters or greater.**

**One (1) year warranty required on all plan-supplied eyeglasses.**

**ATTACHMENT A  
ROSIN EYECARE**

<b>FEDERAL EMPLOYEES FEP BLUEVISION AFFINITY PLAN</b>	
	<b>PAID BY PATIENT</b>
<b>FRAMES*</b>	
Priced up to \$70 Retail	\$40.00
Priced above \$70 Retail	\$40.00
	(plus 10% off the amount over \$70.00)
<b>LENSES (Uncoated Plastic)*</b>	
Single Vision	\$35.00
Bifocal	\$55.00
Trifocal	\$65.00
Lenticular	\$110.00
<b>LENS OPTION (Add to Lens Prices Above)*</b>	
Standard Progressive	\$60.00
Premium Progressive	\$110.00
Hi-Index	\$55.00
Glass Lenses	\$18.00
Polycarbonate Lenses	\$30.00
Polaroid	\$75.00
Scratch Resistant Coating	\$15.00
Anti-Reflective Coating	\$45.00
Ultraviolet Coating	\$15.00
Solid Tint	\$10.00
Gradient Tint	\$12.00
Photogrey	\$35.00
Transitions®	\$65.00
<b>EYE EXAMINATIONS</b>	
Routine Examination (includes dilation whenever professionally indicated)	15% off Usual & Customary
Contact Lens Fitting and Follow-up	20% off Usual & Customary
<b>CONTACT LENSES</b>	
Conventional	20% off Usual & Customary
Disposable/Planned Replacement	10% off Usual & Customary
<b>OTHER PRODUCTS</b>	
Non-prescription Sunglasses	20% off Usual & Customary
Other Ancillary Products/Solutions	10% off Usual & Customary

\* Special lens designs, materials, powers and frames may require additional cost.

**All scheduled materials charges to be paid by patient at time of service.**



**ATTACHMENT A  
ROSIN EYECARE**

<b>FEDERAL EMPLOYEES FEP BLUEVISION PREMIER PLAN</b>	
<b>SERVICES / MATERIALS</b>	<b>PAID BY DAVIS VISION</b>
<b>Spectacle Examination</b> <i>Includes Dilation, when professionally indicated</i>	\$50.00
<b>Frame*</b>	
Retail Credit	\$130.00
Reimbursement	\$74.10
<b>Spectacle Lenses</b>	
Single Vision	\$35.00
Bifocal	\$55.00
Trifocal	\$65.00
<b>Contact Lenses**</b>	
Retail Credit	\$130.00
Reimbursement	\$110.50
<b>Medically Necessary Contact Lenses</b> Prior approval necessary	Covered in Full
<b>SPECTACLE LENS OPTIONS</b>	<b>PAID BY PATIENT</b>
Plastic or glass single vision, bifocal or Trifocal lenses	Included
Glass, Plastic and glass grey #3 prescription lenses	Included
Over-size lenses	Included
Post-cataract lenses	Included
Fashion, sun and gradient tinted plastic lenses	Included
Scratch resistant coating on plastic lenses	
Single Vision	\$20.00
Multifocal	\$20.00
Ultraviolet coating	\$12.00
PGX® (sun sensitive) glass lenses	\$20.00
Blended invisible bifocals	\$20.00
Progressive addition lenses	
Standard Types	\$50.00
Premium Types	\$90.00
ARC (Anti-Reflective Coating)	
Standard	\$35.00
Premium	\$48.00
Ultra	\$60.00
Polycarbonate lenses***	\$30.00
Polarized	\$75.00
High index (thinner and lighter)	\$55.00
Transitions® Lenses	
Single Vision	\$65.00
Multifocal	\$65.00

\* Charges in excess of the patient credit should be collected from the patient.

**Patient is entitled to 20% off charges over \$130.00 for frames.**

\*\* Charges in excess of the patient credit should be collected from the patient.

**Patient is entitled to 15% off charges over \$130.00 for contact lenses.**

\*\*\* No copayment applicable for dependent children, monocular patients and patients with a prescription of +/-6.00 diopters or greater.

**All prices illustrated are inclusive of any applicable member copayments.**

**One (1) year warranty required on all plan-supplied eyeglasses.**

**ATTACHMENT A  
ROSIN EYECARE**

GENERAL ELECTRIC	
	PAID BY DAVIS VISION
<b>Spectacle Examination*</b>	
<i>* Includes Dilation, when professionally indicated</i>	\$45.00
<b>Frame</b>	
Retail Credit	\$120.00
<i>Reimbursement</i>	\$42.00
<b>Spectacle Lenses</b>	
<i>Single Vision</i>	\$35.00
<i>Bifocal</i>	\$55.00
<i>Trifocal</i>	\$65.00
<b>Contact Lenses</b>	
Allowance	
Single Vision	\$130.00
<i>Reimbursement</i>	\$110.50
Allowance	
Bifocal	\$175.00
<i>Reimbursement</i>	\$148.75
<b>Medically Necessary Contact Lenses**</b>	100% U&C
<i>** Prior approval necessary</i>	
SPECTACLE LENS OPTIONS	PAID BY PATIENT
Plastic or glass single vision, bifocal or trifocal lenses	Included
Tint Plastic Gradient	\$13.00
Tint Plastic Solid	\$12.00
Tint Glass	\$7.00
Tint Plastic Rose Colored	\$12.00
Tint Glass Rose Solid	\$7.00
Over-size lenses	
Single Vision	\$10.00
Multifocal	\$14.00
Post-cataract lenses	Included
Scratch resistant coating on plastic lenses	\$20.00
Ultraviolet coating	\$12.00
PGX® (sun sensitive) glass lenses	\$20.00
Blended invisible bifocals	\$23.00
Progressive addition lenses	
Standard Types	\$65.00
Premium Types	\$90.00
Anti-reflective coating	
Standard Types	\$35.00
Premium Types	\$48.00
Polycarbonate lenses***	\$25.00
Polarized	\$50.00
High Index/Hi-Lite	
Single Vision < 1.6 index	\$30.00
Single Vision >= 1.6 index	\$55.00
Multifocal < 1.6 index	\$40.00
Multifocal >= 1.6 index	\$55.00
Plastic photosensitive lenses	
Single Vision	\$45.00
Multifocal	\$65.00
Mirror Coating	\$18.00
Near Variable Focus Lenses (smart seg)	\$18.00
Low Power Aspheric Lenses	Included

Quadrifocal Lenses	\$120.00
Executive Multifocal	\$12.00
Double Segment Lenses	\$90.00
Blended Myodisc	\$30.00

\*\*\* No copayment applicable for dependent children, monocular patients, and patients with a prescription of +/- 6.00 diopters or greater.

**All prices illustrated are inclusive of any applicable member copayments.**

**One (1) year warranty required on all plan-supplied eyeglasses.**

**LAB:** RxO

**BILLING:** Central

**PLAN ID:** 1824522

# Superior Vision

- Use the **SUPERIOR VISION-ROSIN 1824522** for all materials (Contact Lenses, Eyewear) and eye exam

	PATIENT PAYS	PLAN PAYS
Exam	Check plan details for exam copay	\$50 (includes refraction), reduce if copay
CL Fit	<ul style="list-style-type: none"> <li>• Standard Fit: copay</li> <li>• Specialty Fit (up to \$40/\$50 allow): copay + overage above allowance</li> <li>• If Specialty Fit covered: Patient pays \$0</li> <li>• Non-elective or Medically Necessary Contact Lens Fit up to a</li> <li>• \$250 retail allowance **</li> </ul>	<ul style="list-style-type: none"> <li>• Standard Fit: \$33, reduced if copay</li> <li>• Specialty Fit (up to \$40/\$50 allow): \$33, reduce if copay</li> <li>• If Specialty Fit covered: \$60</li> <li>• Non-elective/Med Nec: \$200</li> </ul>
Frames	Patient pays amount over allowance, no additional discount.	50% of allowance. If 50% of U&C is less, we get the lower amount.
Lenses	<p>Check plan detail for out-of-pocket amounts for material and enhancements.</p> <p>Patient pays lens copay if present + upgrade amounts noted on plan summary/benefit sheet.</p> <p>Progressive – Tier 4: Patient pays retail less \$120 or \$165 allowance, no additional discounts.</p>	<p>SV: \$30   BF: \$45   TF: \$65   Lenticular: \$105</p> <p>Progressive – Standard: \$85</p> <p>Progressive – Tier 1: \$120</p> <p>Progressive – Tier 2: \$135</p> <p>Progressive – Tier 3: \$160</p> <p>Progressive – Tier 4: \$50</p> <ul style="list-style-type: none"> <li>• \$120 Allowance: \$70</li> <li>• \$165 Allowance: \$95</li> </ul>
Contact Lenses	<p>Elective CTL Allowance: Patient pays amount over allowance</p> <p>Non-elective or Medically Necessary Contact Lens **</p>	<p>Elective: 80% of allowance. If ordering less than allowance amount, it's 80% of price.</p> <p>Non-elective/Med Nec: \$220, pre-auth needed</p>

**ATTACHMENT 5**
**Illinois Fee Schedule**

<b>Exam, Contact Lens Fit/Exam and Contacts</b>	<b>Provider Reimbursement</b>	<b>Special Notes</b>
Comprehensive/Intermediate Eye Exam (includes refraction component 92015)	\$50	Covered in full to member.
Standard Contact Lens Fit (For an existing contact lens user who wears disposable, daily wear or extended wear. Includes 2 follow up visits within 3 months.)	\$33	Covered in full to member.
Specialty Contact Lens Fit up to a \$40 retail allowance (For a new contact lens wearer and/or a patient who wears toric, gas permeable or multi-focal lenses. Includes 2 follow up visits within 3 months.)	\$33	Covered up to the allowance. Member responsible for any amount over the \$40 allowance. Use modifier 22.
Specialty Contact Lens Fit up to a \$50 retail allowance (For a new contact lens wearer and/or a patient who wears toric, gas permeable or multi-focal lenses. Includes 2 follow up visits within 3 months.)	\$33	Covered up to the allowance. Member responsible for any amount over the \$50 allowance. Use modifier 22.
Specialty Contact Lens Fit (For a new contact lens wearer and/or a patient who wears toric, gas permeable or multi-focal lenses. Includes 2 follow up visits within 3 months.)	\$60	Covered in full to member. Use modifier 22.
Elective Contact Lens Allowance	80%	Lesser of 80% of billed or 80% of retail allowance.
Non-elective or Medically Necessary Contact Lens	\$220	Pre-authorization needed.
Non-elective or Medically Necessary Contact Lens Fit up to a \$250 retail allowance	\$200	Pre-authorization needed.
Retinal Imaging – covered in full	\$39	Routine screening

<b>Base Lenses</b> (uncoated glass or plastic lenses)	<b>Provider Reimbursement (per pair)</b>	<b>Special Notes</b>
Single Vision Lens	\$30	Covered in full to member.
Bifocal Lens	\$45	Covered in full to member.
Trifocal Lens	\$65	Covered in full to member.
Lenticular	\$105	Covered in full to member.

<b>Progressive Lenses</b>	<b>Provider Reimbursement (per pair)</b>	<b>Special Notes</b>
Progressive - when it is non-covered under plan design	\$65	Member pays the difference between retail trifocal and retail progressive.
Standard Progressive	\$85	Covered in full. Use modifier L1.
Premium Progressive Tier 1*	\$120	Covered in full. Use modifier T1.
Premium Progressive Tier 2*	\$135	Covered in full. Use modifier T2.
Premium Progressive Tier 3*	\$160	Covered in full. Use modifier T3.
Premium Progressive Tier 4* - \$120 retail allowance	\$70	Use modifier T4. Member responsible for any amount over the \$120 retail allowance.
\$120 Progressive Allowance	\$70	Member pays any amount over the allowance.
\$165 Progressive Allowance	\$95	Member pays any amount over the allowance.

\*Refer to the current Superior Vision Progressive Lens Chart. Note, the listing is subject to change.

**ATTACHMENT 5**
**Illinois Fee Schedule**

<b>Frames</b> (member pays any amount over allowance)	<b>Provider Reimbursement</b>	<b>Special Notes</b>
Frame Retail Allowance	50%	Lesser of 50% of billed or 50% of frame allowance.

<b>Specialty Lens Options **</b>	<b>Provider Reimbursement (per pair)</b>	<b>Special Notes</b>
Factory Scratch Coat (single sided only)	\$0	Covered in full to member.
Polycarbonate Single Vision Lens	\$25	Covered in full to member.
Polycarbonate Multifocal Vision Lens	\$25	Covered in full to member.
\$80 Photochromic Allowance	\$57	Member pays any amount over allowance.
Photochromic covered in full	\$57	Covered in full to member.
UV	\$8	Covered in full to member.
Standard Anti Reflective	\$38	Member is responsible for the difference between the standard AR and the brand name AR.
Tints solid or gradient (plastic or glass)	\$10	Covered in full to member.
\$60 High Index Allowance	\$38	Member pays any amount over allowance.

**\*\*Amount paid for lens add-ons or upgrades are in addition to base lens reimbursement.**

1. Network Providers agree that fees billed for covered Persons shall in no event be greater than the Network Provider's usual and customary charges for the services rendered.
2. Check member's plan for benefit coverage.
3. Benefits shall be paid only according to the applicable Plan as determined by Payor. If there is any discrepancy between the terms of the Plan or the terms of the Payor Agreement and this Fee Schedule, the terms of the Plan or the Payor Agreement, as applicable, shall control over this Fee Schedule.

# Superior Vision Progressive Lens Chart



For progressive lenses not listed on the chart below, select the tier most similar to the lens.  
This includes private label or house brands.

TIER	PROGRESSIVE STYLE
STANDARD	ADAPTAR • ESSILOR COMPUTER • ESSILOR INTERVIEW/ NATURAL • NAVIGATOR • NAVIGATOR SHORT • FREEDOM 5 • FREEDOM FIT • FREEDOM ID • OVATION • SHOREVIEW • SHOREVIEW MINI • AMPLITUDE • AMPLITUDE MINI • GP • HOYALUX TACT • NAVIGATOR • NAVIGATOR SHORT • UNIQUE SOFTWARE • FIRST PAL • RELAX • STANDARD PROGRESSIVE • OUTLOOK • IMAGE • IMAGE SHORT CORRIDOR • SYNCHRONY ACCESS • SYNCHRONY EASY M • ACCESS • AO COMPACT • INSTINCTIVE • SOLA MAX • GRADAL RD • SYNCHRONY EASY VIEW • ZEISS BUSINESS • KIRKLAND SIGNATURE • SEIKO AF • SEIKO AF MINI • SHAMIR OFFICE
PREMIUM TIER 1	ADAPTAR DIGITAL • ADAPTAR DIGITAL SHORT • NATURAL DIGITAL • OVATION DIGITAL • SMALL FIT DIGITAL • SMALL FIT • EOS WRAP • XPLORER • AMPLITUDE BKS • AMPLITUDE BKS MINI • AMPLITUDE IQ • AMPLITUDE IQ MINI • GP WIDE • TACT BKS • CONCISE • NAVIGATOR FBS • NAVIGATOR FSHORT FBS • PRECISE • PRECISE SHORT • ELEMENT • ATTITUDE • PROCEED II • PROCEED III • NOVEL • NOVELLA • IMAGE WRAP • EOS • SYNCHRONY • SYNCHRONY EASY S • MVP • PREMIUM PROGRESSIVE • RAY BAN ROX • SHORT FIT • EOS • FUSION I • FUSION II • PROCEED II • PROCEED III • AO EASY • MVP
PREMIUM TIER 2	IDEAL • IDEAL SHORT • VARILUX COMFORT 2 • VARILUX COMFORT 2 SHORT • VARILUX COMFORT DRX • VARILUX COMFORT DRX SHORT • NIKON PRESIO I DIGITAL • SUMMIT CD • SUMMIT ECP • EVERYDAY • PRECISE PB • KODAK PRECISE PB SHORT • OFFICE • SPECTRUM • PC WIDE COMPUTER • SUCCEED • SUCCEED WS • TRUCLEAR • DST CUSTOM PLUS • NARRATIVE • EVERYWHERE • SYNCHRONY EASY VIEW S HD • ZEISS PROGRESSIVE CHOICE • ZEISS DIGITAL • ZEISS DIGITAL WRAP • SYNCHRONY EASY VIEW HD • SYNCHRONY EASY VIEW M HD • SYNCHRONY EASY VIEW S HD • GT2
PREMIUM TIER 3	DEFINITY • DEFINITY SHORT • IDEAL ADVANCED • IDEAL ADVANCED WRAP • VARILUX COMFORT W2+ • VARILUX COMFORT W2+ FIT • VARILUX ELLIPSE • VARILUX PANAMIC • NIKON DIGI LIFE • VARILUX PHYSIO • VARILUX PHYSIO SHORT • VARILUX PHYSIO DRX • VARILUX PHYSIO DRX SHORT • VARILUX STYLISTIC WRAP • DST CUSTOM PLUS HD • DST CUSTOM PLUS HD SUN WRAP • TRUCLEAR SD • ARRAY FIXED • ARRAY VL • SUMMIT ECP IQ • SUMMIT CD IQ • ULTIMATE • UNIVERSAL • CONCISE DIGITAL • PRECISE DIGITAL • PRECISE DIGITAL SHORT • UNIQUE SPECTRUM + • HD WORKSPACE • AUTOGRAPH II ATTITUDE WRAP • AUTOGRAPH II FIXED • AUTOGRAPH II OFFICE • AUTOGRAPH II VARIABLE • SHAMIR COMPUTER • SHAMIR GOLF PROGRESSIVE • INTOUCH • SUPERNAL • SURMOUNT • SUPERCEDE II / EVERYWHERE + • SPORTS WRAP PAL • VISION EASE OFFICE, COMPUTER • GT2 3D • GT2 3D SHORT • SOLA ONE HD • ZEISS CHOICE PLUS • ZEISS OFFILENS • CONCISE DIGITAL
PREMIUM TIER 4	All Other Premium Progressives

September 2017

- Use the **SPECTERA-ROSIN 1824521** for all materials (Contact Lenses, Eyewear) and eye exam
- Formulary CL orders need to be in Ciao! Optical as Specialty Rx to avoid an actual order. Order to be placed with Spectera and the claim by billing team. Billers will always ship to patient's address in their profile (alt. addresses will not be known).

	PATIENT PAYS	PLAN PAYS	
Exam (92004, 92014, 92015)	Check plan details for exam copay	92004: \$55 92014: \$49 92002: \$40 92012: \$35 92015: \$8	
CL Fit (92071, 92310, 92317, S0592)	<ul style="list-style-type: none"> <li>• Non-covered lenses, patient pays full U&amp;C of fit.</li> <li>• Covered lenses, patient pays copays (could be \$0).</li> </ul>	<ul style="list-style-type: none"> <li>• Non-covered lenses, plan pays is \$0.</li> <li>• Covered lenses, we get \$30 for fit. Reduce if copay.</li> </ul>	
Frames (V2020, V2025)	Patient pays amount over allowance, no additional discount.	71% of allowance amount	
Lenses	<p>Check plan detail for out-of-pocket amounts for material and enhancements.</p> <p>Patient pays lens copay if present + upgrade amounts noted on plan summary/benefit sheet.</p>	SV: \$35   BF: \$55   TF: \$60 Progressive – Tier I: \$125 Progressive – Tier II: \$164 Progressive – Tier III: \$190 Progressive – Tier IV: \$250 Progressive – Tier V: \$285	Photo: \$58.50 Poly: \$25.50 High Index: \$47 AR – Tier I: \$29 AR – Tier II: \$34 AR – Tier III: \$68 AR – Tier IV: \$82
Contact Lenses	<ul style="list-style-type: none"> <li>• Non-covered lens, patient pays overage above allowance, no additional discount.</li> <li>• Covered lenses are covered up to the amount listed on benefit sheet. Patient pays for copay if present.</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Covered, plan pays is 82% of allowance amount.</li> <li>• Non-Covered, plan pays is 82% of allowance amount.</li> </ul>	



# Spectera Formulary Contact Lenses

For Spectera Formulary Contact Lenses: Designate 1 person to manages these (manager)

- **Sell in Ciao! Optical**
- **Use Specialty Contact Lens Rx Type – this is a free-form Rx option – note brand in Note Section**
- **On the Order Screen – enter in price and QTY (# of boxes) into STORE STOCK. This will ensure it doesn't go to Premium Vision.**
- **Order will be placed with claim –WILL SHIP TO PATIENT**
- **If additional lenses need to be ordered outside of covered lenses, place a 2<sup>nd</sup> unique order and leverage Premium Vision (patient will pay).**

Fee Schedule

PROFESSIONAL SERVICES			
CODE RANGE	MODIFIER	DESCRIPTION	REIMBURSEMENT AMOUNT
EYE EXAMINATIONS			
92002		Medical exam and evaluation; intermediate, new patient	\$40.00
92004		Medical exam and evaluation; comprehensive, new patient	\$55.00
92012		Medical exam and evaluation; intermediate, established patient	\$35.00
92014		Medical exam and evaluation; comprehensive, established patient	\$49.00
S0620		Routine ophthalmological examination including refraction; new patient	\$47.00
S0621		Routine ophthalmological examination including refraction; established patient	\$46.00
92015		Refraction determination	\$8.00
S9986		Retinal screening photography	\$39.00
CONTACT LENS FITTING & FOLLOW UP			
92071, 92310-92317, S0592		Contact Lens Fitting and Evaluation - Elective	\$30.00 if covered in full by the Enrollee’s Vision Plan
92071, 92310-92317, S0592	ND	Contact Lens Fitting and Evaluation - Elective	Lesser of 80% Customary Charge or 80% of the Allowance
92071, 92310-92317, S0592	XC	Contact Lens Fitting and Evaluation – Necessary	Lesser of 80% of Customary Charge or \$500.00

MATERIALS			
CODE RANGE	MODIFIER	DESCRIPTION	REIMBURSEMENT AMOUNT
FRAMES			
S0516		Safety frame	71% of Customary Charge
V2020, V2025		Frame	71% of Customary Charge
OPHTHALMIC LENSES/PER PAIR			
V2100-V2115, V2118, V2121, V2199		Single Vision Lens – Plastic	\$35.00
V2200-V2215, V2218-V2221, V2299		Bifocal Vision Lens – Plastic	\$55.00
V2300-V2315, V2318-V2321, V2399		Trifocal Vision Lens – Plastic	\$60.00
V2781	P1	Tier I Progressive Ophthalmic Lens	\$125.00
V2781	P2	Tier II Progressive Ophthalmic Lens	\$164.00
V2781	P3	Tier III Progressive Ophthalmic Lens	\$190.00
V2781	P4	Tier IV Progressive Ophthalmic Lens	\$250.00
V2781	P5	Tier V Progressive Ophthalmic Lens	\$285.00
OPHTHALMIC LENS OPTIONS/PER PAIR			
V2744		Photochromic	\$58.50
V2745		Tint (not including Photochromic)	\$11.50
V2750	R1	Tier I Anti-reflective coating	\$29.00
V2750	R2	Tier II Anti-reflective coating	\$34.00
V2750	R3	Tier III Anti-reflective coating	\$68.00
V2750	R4	Tier IV Anti-reflective coating	\$82.00
V2755		UV coating	\$14.00
V2760		Standard scratch coating	Included
V2782, V2783		High Index 1.54-1.73 plastic	\$47.00
V2783	HI	High Index ≥ 1.74 plastic	70% of Customary Charge
V2784, S0580		Polycarbonate	\$25.50
V2799	PP	Roll and Polish	\$8.50
V2799	SW	Scratch warranty	\$10.00

MATERIALS			
ALL OTHER OPHTHALMIC LENS OPTIONS		70% of Customary Charge	
CONTACT LENSES			
CODE RANGE	MODIFIER	DESCRIPTION	REIMBURSEMENT AMOUNT
V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599	CD CM	Contact Lenses - Formulary, Elective	82% of Customary Charge, or \$50.00 per box for Daily or Bi-weekly Replacements, or \$70.00 per box for Monthly Replacements
V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599	ND	Contact Lenses – Non-Formulary, Elective	82% of Customary Charge
V2500-V2503, V2510-V2513, V2520-V2523, V2599	XC	Contact Lenses - Necessary	Lesser of 80% of Customary Charge or \$1,500.00

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# Ambetter of Illinois

LAB: RxO  
BILLING: Central  
PLAN ID:

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014)	Copay \$0	\$65
Refraction (92015)		\$20
CL Fit (92071, 92310, 92317, S0592)	Standard CLs fitting is covered in full.  Specialty CLs fit:: fitting is covered up to \$50. Member is responsible for any amount exceeding \$50.	\$35
Frames (V2020, V2025)	<ul style="list-style-type: none"> <li>Members are responsible for any amount over \$130 allowance. Copay may apply.</li> </ul>	<ul style="list-style-type: none"> <li>\$41.40 / \$78.00</li> </ul>
Dispensing Services 92340, 92341	<ul style="list-style-type: none"> <li>N/A</li> </ul>	\$20
Lenses  SV: V2100 Bifocal: V2200 Trifocal: V2300 Poly: V2784 AR – Standard: V2750	Scratch resistant lenses, in CR-39 or polycarbonate materials with standard anti-reflective coating are covered in full. <ul style="list-style-type: none"> <li>Single</li> <li>Bifocal</li> <li>Trifocal</li> </ul>	<ul style="list-style-type: none"> <li>SV: \$16.90</li> <li>BF: \$26.90</li> <li>TF: \$37.90</li> <li>Poly: \$7.00</li> <li>AR: \$30.00</li> </ul>
Contact Lenses	Members are responsible for any amount over \$130 allowance, in lieu of eyeglasses. Copay may apply.	\$104

# WellCare - Illinois

LAB: RxO

BILLING: Central

PLAN ID:

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014)	Copay \$0	\$40 / \$45
Refraction (92015)		\$10 / \$15
CL Fit (92071, 92310, 92317, S0592)	<ul style="list-style-type: none"> <li>Members are responsible for any amount over allowance.</li> </ul>	Based on allowance: \$100 allowance \$300 allowance \$400 allowance \$500 allowance
Frames & Lenses (V2020, V2025)	<ul style="list-style-type: none"> <li>Members are responsible for any amount over allowance.</li> <li><i>*Members must sign "Non-covered Services Liability Acknowledgement"</i></li> </ul>	70% of U&C  Based on allowance: \$100 allowance \$300 allowance \$400 allowance \$500 allowance
Dispensing Services 92340, 92341	N/A	\$18.05 / \$21.06
Contact Lenses	Members are responsible for any amount over allowance.	
Disclaimer	<b><i>Member's allowance is every calendar year. This allowance may be used towards the purchase of glasses (including lens add-ons or upgrades) and/or the purchase of contact lenses (including disposables and fitting fee)</i></b>	

# HC & Family Medicaid (IDPA, Medicaid)

**LAB:** Classic

**BILLING:** Central

**PLAN ID:** 1824527

- Use **HC & FAMILY MEDICAID-ROSIN 1824527**
- Copays must be subtracted from Plan Pays
- **Whenever purchasing glasses, select ADD ON SERVICE 92340 (SV) or 92341 (BF) Glasses Fitting Fee under EXAM path in Ciao.**

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014, 92015)	Varies Per Plan	<b>92004:</b> \$46.45 <b>92014:</b> \$44.45 <b>92015:</b> \$17.96
CL Fit	Patient Responsible	\$0
Frames & Lenses	\$0	Dispensing Fee: \$29.28 (SV&BF)
Contact Lenses		N/A

# March Vision

**LAB:** Classic Optical

**BILLING:** Central

**PLAN ID:** 1824528

- Use **MARCH** One exam per calendar year, unlimited eyewear if replacing due to loss or breakage
- Covers single CL Fit
- Copays must be subtracted from Plan Pays
- Benefit allowances listed on Authorizations
- **Whenever purchasing glasses, select ADD ON SERVICE 92340 Glasses Fitting Fee under EXAM path in Ciao- plan pays full \$130.**

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014, 92015)	Varies Per Plan	<b>92004:</b> \$45.20 <b>92014:</b> \$43.25 <b>92015:</b> \$17.95 <b>92002:</b> \$26.81 <b>92012:</b> \$22.67
CL Fit (one per 2 years)	Covered. No stipulation, all fits are covered. CLs fit is a separate benefit, not bundled with CLs supply.	Standard: \$36.10 Premium: \$50
Frames & Lenses	<ul style="list-style-type: none"><li>• Varies Per Plan</li><li>• See benefit see for coverage details.</li></ul>	
Contact Lenses	Members are responsible for any amount over \$80 allowance, in lieu of eyeglasses. \$80	Members are responsible for any amount over \$80 allowance, in lieu of eyeglasses. \$80



### 1.3 Medicaid Reimbursement Procedures – Aetna Better Health (Medicaid)

The Medicaid frame benefit affords members the opportunity to select a frame from the March frame kit **OR** members may choose to use a set retail allowance toward the cost of any frame in the provider's selection. The retail allowance is \$100.

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts.

#### March Frame Kit and March Lab

Providers must bill the current and appropriate service code for the fitting of spectacles. Reimbursement for the fitting of spectacles will be at the lesser amount of billed charges or the provider's rate.

The following example assumes a contracted rate of \$29.28 for the fitting of spectacles

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	\$ 40.00*	\$ 0.00
92340	Fitting of Spectacles**		\$ 30.00	\$ 29.28
<b>Total</b>			<b>\$ 70.00</b>	<b>\$ 29.28</b>

#### Retail Allowance - Frame

Providers must bill the current and appropriate service code(s) for frames with modifier code 75. Reimbursement for frames will be at the lesser amount of billed charges or the provider's contracted rate. The contracted rate is \$75.00.

The following example assumes a \$100.00 retail allowance for frames from the provider's selection.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses		\$ 80.00	\$ 0.00
V2020	Frame	75	\$ 125.00*	\$ 75.00
92340	Fitting of Spectacles**		\$ 40.00	\$ 0.00
<b>Total</b>			<b>\$ 245.00</b>	<b>\$ 75.00</b>

\*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$25.

\*\*Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

The following example assumes a \$100.00 retail allowance for eyeglasses from the provider's selection.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses		\$ 15.00	\$ 0.00
V2020	Frame	75	\$ 105.00*	\$ 75.00
92340	Fitting of Spectacles**		\$ 40.00	\$ 0.00
<b>Total</b>			<b>\$ 160.00</b>	<b>\$ 75.00</b>

\*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$5.

\*\*Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

**Retail Allowance – Contact Lenses**

Providers must bill the current and appropriate service code(s) for contact lenses. Reimbursement for contact lenses and contact lens fitting will be at the lesser amount of billed charges or the provider’s contracted rate. The contracted rate for contact lenses is \$80.00.

The following example assumes a \$80.00 retail allowance for contact lenses from the provider’s selection.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses		\$ 120.00*	\$ 80.00
92310	Contact Lens Fitting		\$ 40.00	\$ 15.20
<b>Total</b>			<b>\$ 160.00</b>	<b>\$ 95.20</b>

\*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$40.

# CLASSIC OPTICAL PROCESS

Ciao! Optical Plan Name	Ciao! Optical Plan ID	Type (Medical / Vision)	LAB
HC & FAMILY MEDICAID-ROSIN	1824527	Vision/Medicaid	Classic Optical
MARCH MEDICAID-ROSIN	1824528	Vision/Medicaid	Classic Optical

In Ciao! Optical, use the applicable UPC. These are priced at \$0 and indicate a frame kit selection for biller.

- UPC 20500001821955 MARCH VISION FRAME
- UPC 20500003011408 FAMILY HOME NETWORK FRAME KIT (For HC & Family, IDPA, Medicaid)
- The billing team will file the claim and a complete pair will be manufactured and sent back the ordering site.
- If non-formulary frame selected, billing team will send you a packing slip (similar to VSP) for you to send to Classic Optical.
  - In LPA, set to Rx Sun Authentics to bypass RxO.
- For these two UPCs, you WILL NOT COUNT this in inventory. The UPC above is just to sell in Ciao! Optical.

LAB ADDRESS FOR NON-FORMULARY:

Classic Optical  
3710 Belmont Ave  
Youngstown, OH 44505

# POINT COMFORT (Lincoln Park)

LAB: RxO

BILLING: Central

PLAN ID: 1824529

- Use **POINT COMFORT-ROSIN 1824529**
- Exception in Eclips. **This plan has a fee schedule in Eclips** (other routine payors discount to \$0).
- Staff will apply fee schedule and patient payment.
- Billers will file claim with the medical process.
  - Note this payor doesn't have a portal.

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014, 92015)	Varies Per Plan	<b>92004:</b> \$198.51 <b>92014:</b> \$168.25 <b>92015:</b> \$0
CL Fit (one per calendar year)	Patient Responsible	\$0
Frames & Lenses	Patient Responsible	\$0
Contact Lenses	Patient Responsible	\$0

# VSP HERITAGE MEDICAID

- Use **VSP HERITAGE MEDICAID-ROSIN 1824530**
- Copays must be subtracted from Plan Pays
- Benefit allowances listed on Authorizations

**LAB:** Expert

**BILLING:** Central

**PLAN ID:** 1824530

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014, 92015)	<ul style="list-style-type: none"><li>• Varies Per Plan</li></ul>	<b>92004:</b> \$40 <b>92014:</b> \$40 <b>92015:</b> \$10 <b>92002:</b> \$34.76 <b>92012:</b> \$30.62
CL Fit (one per calendar year)	<ul style="list-style-type: none"><li>• See fee schedule for CL fitting coverage</li></ul>	<ul style="list-style-type: none"><li>• See fee schedule for CL fitting coverage</li></ul>
Frames & Lenses	<ul style="list-style-type: none"><li>• Varies Per Plan</li></ul>	<b>V2020:</b> \$20 <b>V2025:</b> \$35 <b>SV:</b> \$6.38/\$10.21 <b>BF:</b> \$28.30 <b>Poly:</b> \$6.43 See fee schedule for additional benefits
Contact Lenses	<ul style="list-style-type: none"><li>• Medically necessary only</li></ul>	Prior Auth required.

## VSP ILLINOIS MEDICAID PLAN

### Professional Fee Schedule for Routine Services

Effective 4/1/2022

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.

#### Exam Services

92002	Intermediate exam, new patient	\$34.76
92004	Comprehensive exam, new patient	\$40.00
92012	Intermediate exam, established patient	\$30.62
92014	Comprehensive exam, established patient	\$40.00
92015	Determination of refractive state	\$10.00

#### Dispensing and Material Services

<b>Frame:</b>		
V2020	Frame (includes case)	\$20.00
V2025	Deluxe frame	\$35.00
	Service must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.	

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#### Dispensing:

92340	Fitting of spectacles, except for aphakia; monofocal	\$20.24
92341	Fitting of spectacles, except for aphakia; bifocal	\$28.14

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#### Single Vision Lenses, per lens:

V2100	Sphere, plano to $\pm 4.00d$	\$6.38
V2101	Sphere, $\pm 4.12$ to $\pm 7.00d$	\$6.38
V2102	Sphere, $\pm 7.12$ to $\pm 20.00d$	\$10.21
V2103	Spherocylinder, plano to $\pm 4.00d$ sphere, 0.12 to 2.00d cylinder	\$6.38
V2104	Spherocylinder, plano to $\pm 4.00d$ sphere, 2.12 to 4.00d cylinder	\$6.38
V2105	Spherocylinder, plano to $\pm 4.00d$ sphere, 4.25 to 6.00d cylinder	\$10.21
V2106	Spherocylinder, plano to $\pm 4.00d$ sphere, over 6.00d cylinder	\$10.21
V2107	Spherocylinder, $\pm 4.25$ to $\pm 7.00d$ sphere, 0.12 to 2.00d cylinder	\$6.38
V2108	Spherocylinder, $\pm 4.25$ to $\pm 7.00d$ sphere, 2.12 to 4.00d cylinder	\$6.38

V2109	Spherocylinder, $\pm 4.25$ to $\pm 7.00$ d sphere, 4.25 to 6.00d cylinder	\$10.21
V2110	Spherocylinder, $\pm 4.25$ to $\pm 7.00$ d sphere, over 6.00d cylinder	\$10.21
V2111	Spherocylinder, $\pm 7.25$ to $\pm 12.00$ d sphere, 0.25 to 2.25d cylinder	\$10.21
V2112	Spherocylinder, $\pm 7.25$ to $\pm 12.00$ d sphere, 2.25 to 4.00d cylinder	\$10.21
V2113	Spherocylinder, $\pm 7.25$ to $\pm 12.00$ d sphere, 4.25 to 6.00d cylinder	\$10.21
V2114	Spherocylinder, sphere over $\pm 12.00$ d	\$10.21
V2115	Lenticular, myodisc	\$19.00
V2121	Lenticular lens, single	\$19.00
V2199	Specialty single vision  Service must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*
<b>Bifocal Lenses, per lens:</b>		
V2200	Sphere, plano to $\pm 4.00$ d	\$12.43
V2201	Sphere, $\pm 4.12$ to $\pm 7.00$ d	\$12.43
V2202	Sphere, $\pm 7.12$ to $\pm 20.00$ d	\$17.20
V2203	Spherocylinder, plano to $\pm 4.00$ d sphere, 0.12 to 2.00d cylinder	\$12.43
V2204	Spherocylinder, plano to $\pm 4.00$ d sphere, 2.12 to 4.00d cylinder	\$12.43
V2205	Spherocylinder, plano to $\pm 4.00$ d sphere, 4.25 to 6.00d cylinder	\$17.20
V2206	Spherocylinder, plano to $\pm 4.00$ d sphere, over 6.00d cylinder	\$17.20
V2207	Spherocylinder, $\pm 4.25$ to $\pm 7.00$ d sphere, 0.12 to 2.00d cylinder	\$12.43
V2208	Spherocylinder, $\pm 4.25$ to $\pm 7.00$ d sphere, 2.12 to 4.00d cylinder	\$12.43
V2209	Spherocylinder, $\pm 4.25$ to $\pm 7.00$ d sphere, 4.25 to 6.00d cylinder	\$17.20
V2210	Spherocylinder, $\pm 4.25$ to $\pm 7.00$ d sphere, over 6.00d cylinder	\$17.20
V2211	Spherocylinder, $\pm 7.25$ to $\pm 12.00$ d sphere, 0.25 to 2.25d cylinder	\$17.20
V2212	Spherocylinder, $\pm 7.25$ to $\pm 12.00$ d sphere, 2.25 to 4.00d cylinder	\$17.20
V2213	Spherocylinder, $\pm 7.25$ to $\pm 12.00$ d sphere, 4.25 to 6.00d cylinder	\$17.20
V2214	Spherocylinder, sphere over $\pm 12.00$ d	\$17.20
V2215	Lenticular, myodisc	\$28.30
V2221	Lenticular lens, bifocal	\$28.30
V2299	Specialty bifocal  Service must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*
<b>Variable Asphericity Lenses, per lens:</b>		
V2410	Variable asphericity lens, single vision, full field, glass or plastic	\$14.50
V2430	Variable asphericity lens, bifocal, full field, glass or plastic	\$24.50

<b>Miscellaneous Covered Options and Services, per lens:</b>		
V2700	Balance lens	\$6.38
V2710	Slab off, glass or plastic	\$30.45
V2715	Prism	\$2.71
V2730	Special base curve, glass or plastic	\$13.03
V2756	Frame case included in the reimbursement for frame	\$0.00
V2784	Lens, polycarbonate or equal, any index	\$6.43
<b>Miscellaneous Covered Options and Services, per lens:</b>		
The below services must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.		
V2762	Polarization	\$29.97
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	\$32.37
V2797	Vision supply, accessory and/or service component of another HCPCS vision code	Submit invoice for pricing*
V2799	Miscellaneous vision service	Submit invoice for pricing*

## Repair Services

Repair and refitting codes cannot be billed with dispensing and/or material HCPCS codes (e.g., V2020) on the same date of service.		
92370	Repair and refitting spectacles; except for aphakia	\$4.63

## Visually Necessary Contact Lenses

<b>Visually Necessary Contact Lens Fitting and Dispensing</b>		
Service must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.		
92072	Fitting of contact lens for management of keratoconus, initial fitting	\$125.12
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	\$100.32
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	\$103.11
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	\$118.62
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal scleral lens	\$96.80



92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens, both eyes except for aphakia	\$84.69
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, one eye	\$78.17
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, both eyes	\$97.01
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	\$81.99

<b>Visually Necessary Contact Lenses:</b>		
Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	\$92.01
V2501	PMMA, toric or prism ballast	\$122.68
V2520	Hydrophilic, spherical	\$122.25
V2531	Scleral, gas permeable	\$544.58
V2599	Contact lens, other type	Submit invoice for pricing*

## 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. See <a href="#">VSP Illinois Medicaid Client Details</a> for requirements. Visual necessity must be documented in the patient's file.		
92354	Fitting of spectacle mounted low vision aid; single element system	\$12.50
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	\$19.60
V2600	Hand held low vision and other nonspectacle mounted aids	Submit invoice for pricing*

## Vision Therapy

Vision Therapy services must be billed with modifier KX. See <a href="#">VSP Illinois Medicaid Client Details</a> 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	\$60.86

92065	Orthoptic training; performed by a physician or other qualified health care professional	\$50.97
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\*Please refer to the Contacting VSP by Mail section in the VSP Manual.

- Use **NVA-ROSIN 1824519**
- One exam per calendar year
- Covers single CL Fit and one box per eye of contact lenses **in lieu of eyeglasses**
- Copays must be subtracted from Plan Pays
- Benefit allowances listed on Authorizations

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014, 92015)	Varies Per Plan	\$50
CL Fit (one per calendar year) (92071, 92310, 92317, S0592)	Copay OR Can be included in material allowance.	\$20
Frames	<ul style="list-style-type: none"><li>• Varies Per Plan</li><li>• Patient receives additional 20% over allowance amount.</li></ul>	Plan Varies \$51.75 \$58.50 \$67.50
Lenses	<ul style="list-style-type: none"><li>• Varies Per Plan</li></ul>	<b>SV:</b> Up to \$32 <b>BF:</b> Up to \$42 <b>TF:</b> Up to \$52
Contact Lenses	Difference between plan allowance and R&C price less 15% (conv) or 10% (disp)	Up to 75% of plan allowance

# UNUM - (FORMERLY ALWAYS VISION)

- Use **UNUM-ROSIN 1824523**
- One exam per calendar year
- Copays must be subtracted from Plan Pays
- Benefit allowances listed on Authorizations

**LAB:** RxO

**BILLING:** Central

**PLAN ID:** 1824523

	PATIENT PAYS	PLAN PAYS
Exam (92004, 92014, 92015)	<ul style="list-style-type: none"><li>• Copay Varies Per Plan</li></ul>	\$45 (Includes refraction and dilation)
CL Fit (one per calendar year)	<ul style="list-style-type: none"><li>• See plan benefit for allowance.</li><li>• Allowance includes fitting and materials.</li></ul>	<ul style="list-style-type: none"><li>• Fitting service: 80% of retail allowance</li></ul>
Frames & Lenses	<ul style="list-style-type: none"><li>• See plan benefit for allowance.</li></ul>	<b>V2020:</b> 55% of retail allowance <b>SV:</b> \$34 <b>BF:</b> \$50 <b>TF:</b> \$65
Contact Lenses	<ul style="list-style-type: none"><li>• See plan benefit for allowance.</li></ul>	<ul style="list-style-type: none"><li>• Conventional lenses: 80% of retail allowance</li><li>• Disposable lenses: 90% of retail allowance</li></ul>

Insured/Funded Plans <i>Plan pays this amount minus the Member co-pay.</i>		Additional Purchases <i>Member pays all.</i>
<b>Routine Exam</b> <i>(Includes dilation.)</i>	\$45	\$45 or 15% off not to exceed \$55
<b>Contact Lenses</b>		
<b>Plan Type I</b> — <i>(Allowance includes fitting service and materials.)</i>		
Conventional lenses*	80% of retail allowance	15% discount
Disposable lenses*	90% of retail allowance	5% discount
Fitting service — Standard or Specialty	80% of retail allowance	15% discount
<b>Plan Type II</b> — <i>(Includes separate co-pay and/or allowance for fitting services and materials.)</i>		
Standard, Specialty fit, and materials coverage varies by plan.		
Conventional contact lenses*	80% of retail allowance	15% discount
Disposable contact lenses*	90% of retail allowance	5% discount
Fitting service — Standard**	80% of UCR	15% discount
Fitting service — Specialty***	If <b>Specialty fit</b> is covered, plan pays 80% of retail allowance. Member pays balance over retail allowance, minus 20% discount.	15% discount
<b>Glasses</b>		
<b>Frames</b>		
Plan pays Member's choice of glasses or contacts, not both.	55% up to retail allowance. Member pays balance and receives 20% off retail on the difference.	35% discount
<b>Lenses</b>		
Single vision	\$34	\$40
Bifocal	\$50	\$60
Trifocal	\$65	\$70
Progressive	Varies by plan. See below.	See below.
Lenticular	Varies by plan.	
<b>Add-Ons and Upgrades</b> <i>(Charges are in addition to basic fee reimbursements listed above.)</i>		
<b>Progressives</b>		
Standard	Plan pays Progressive allowance for each plan (usually \$70-\$100). Member pays balance up to \$110. See "Sample Reimbursement Plan for Progressive Lenses." <b>Any upgrades are according to the "Add-Ons and Upgrades" schedule below.</b>	\$110
Premium	Plan pays Progressive allowance for each plan (usually \$70-\$100). Member pays balance up to \$170. See "Sample Reimbursement Plan for Progressive Lense." <b>Any upgrades are according to the "Add-Ons and Upgrades" schedule below.</b>	20% discount
Ultra	Plan pays Progressive allowance for each plan (usually \$70-\$100). Member pays balance and receives 20% off retail on the difference.	20% discount
<b>Materials</b> Unless the Plan pays for these items, the Member is responsible for the following amounts:		
Standard polycarbonate (SV and MF)	\$40	\$40
High index (SV) 1.56-1.60 1.66 and up	\$60 20% discount	\$60 20% discount
High index (MF) 1.56-1.60 1.66 and up	\$75 20% discount	\$75 20% discount
Polarized	\$75	\$75
Transitions®	\$75	\$75
<b>Coatings</b>		
UV	\$15	\$15
Solid tint	\$15	\$15
Gradient tint	\$15	\$15
Standard scratch resistance	\$15	\$15
Standard anti-reflective	\$45	\$45
Premium anti-reflective	\$70	20% discount
Ultra anti-reflective	20% discount	20% discount
Edge	\$15	\$15
<b>Other Products</b> <i>(may not be available at all locations)</i>		
Non-prescription sunglasses	20% discount	20% discount
Other ancillary products/solutions	20% discount	20% discount

Some frames and lens items may have manufacturer restrictions and cannot be discounted. These Items are excluded from the fee schedule. Discounts are taken from Usual and Customary. Plan does not pay sales tax.

I, the Provider, agree to the fee schedule listed herein and understand that my signature reflects my agreement to both the fully insured plan and additional purchases.

<div></div> <div>Tax Identification Number</div>	<div></div> <div>Phone Number</div>	<div></div> <div>Email Address</div>
<div></div> <div>Print Name</div>	<div></div> <div>Signature</div>	<div></div> <div>Date</div>



FIRST LOOK VISION NETWORK PROVIDER MANUAL SUPPLEMENT

General Note Regarding Progressive Lenses and Specialized Lens Coatings:

First Look Vision Network (First Look) recognizes and respects the relationship Eye Care Professionals (ECP) have with their patients. We also understand some patients have preconceived preferences relating to certain specialty lenses. The following progressive lens and anti-reflective coating guidance is intended to help ECPs and Members better manage these benefits without dictating how ECPs manage their lens preferences or patient relationships.

Progressive Lenses:

In order to honor Member requests, each ECP is requested to have available at least one Standard and Premium Progressive lens. While First Look’s suggested Progressive lens classifications are noted below for guidance purposes, First Look encourages ECPs to designate, based on their professional experience in consultation with their patient, any of these lenses, alternate lenses, or generic/private label alternatives as appropriate. Further, First Look requests ECPs, in conjunction with patient consultation, honor direct consumer requests for the lenses as listed below in their respective classifications.

The following are First Look’s classifications for Progressive lenses. The classifications apply to Standard CR-39 lenses. Incremental coatings and other options (e.g. higher index, polycarbonate, glass, transitions, etc.) are available to Members for the appropriate scheduled or discounted charge. Please note that generic and/or private label varieties of Standard and Premium Progressive lenses are acceptable alternatives to the branded lenses. These classifications are subject to periodic changes and apply to the purchase of insured/covered glasses.

Standard	Premium	Ultra
AO Compact, Navigator, Navigator Short, Adaptar, Hoyalux GP, SOLA - VIP, Outlook, and IMAGE.	AO Compact Ultra, AO Easy, Accolade, Ovation, Essilor Natural, SmallFit, Gradal Top, Gradal Brevity, Summit CD, Summit ECP, Hoyalux GP Wide, KODAK Concise, KODAK Precise, KODAK Precise Short, Paradigm, Genesis, Shamir Piccolo, SOLA Max, SOLA XL, SOLAOne, Varilux Comfort, Ellipse, Varilux Panamic, Freedom ID, and Gradal RD.	Any lenses not listed as Standard or Premium.

ANTI-REFLECTIVE COATINGS (ARC)

In order to honor Member requests, ECP will have available at least one Standard and one Premium ARC for First Look Members. While First Look’s suggested ARC classifications are noted below for guidance purposes, First Look allows ECPs to designate, based on their professional experience, any of these coatings, alternate coatings, or generic options as deemed appropriate. Further, First Look requests ECPs, in conjunction with patient consultation, honor direct consumer requests for the ARCs as listed below in their respective classifications. These classifications are subject to periodic changes.

The following are recommended classifications for Standard and Premium ARCs. Please note that generic and/or private label varieties are acceptable alternatives to the branded coatings.

Standard	Premium	Ultra
Reflection Free, and In-house/private label "standard" coatings.	Crizal, Hi Vision, and In-house/private label "premium" coatings.	Any coatings not listed as Standard or Premium.

CONTACT LENS FIT DEFINITION

\* In lieu of Eyeglass lenses and Frames.

\*\*The standard contact lens fitting service fee applies to new or existing contact lens users who wear spherical disposable, daily wear, or extended wear lenses only.

\*\*\*The specialty contact lens fitting service fee applies to new or existing contact lens users who wear toric, gas-permeable, mono-fit, or multi-focal lenses only. Member is responsible for any charges over the \$55 allowance after 20% discount.

# LENS CLASSIFICATION

ITEM	VCODE	EyeMed	VSP	UHC/Spectera	Versant (Superior/Davis)	VBA
Crizal Easy Pro	V2750 V2755 EM/VSP	Tier 2	Cat C + BS UV	Tier 3	Ultra	Prem AR 1
Crizal Sapphire HR	V2750 V2755 EM/VSP	Tier 3	Cat D + BS UV	Tier 4	Ultimate	Ultra
Crizal Previncia	V2750 V2755 EM/VSP	Tier 3	Cat D + BS UV	Tier 4	Ultimate	Ultra
Crizal Rock	V2750 V2755 EM/VSP	Tier 3	Cat D + BS UV	Tier 4	Ultimate	Prem AR 2
Premium AR	V2750 V2755 EM/VSP	Tier 2	Cat C	Tier 3	Ultra	Prem AR 1
Varilux Comfort Max Fit	V2781	Tier 3	Cat O + CM	Tier 3	Ultra	Cat D
Varilux X	V2781	Tier 4	Cat O	Tier 5	Ultimate	Cat D
Varilux X Fit	V2781 V2799 CM for VSP	Tier 4	Cat N + CM	Tier 5	Ultimate	Cat D
Premium Accolade	V2781	Tier 1	Cat K	Tier 2	Premium	Cat A
MVC - Ovation Digital	V2781	Standard	Cat K	Tier 1	Premium	Cat D
Lux Workspace PG 5' no Distance	V2781 V2799 for VSP	Tier 3	Near Variable Focus	Tier 1	N/A	Cat C
Computer PG* 11 mm above - full distance	V2781	N/A	N/A	N/A	Standard	N/A

\*Typically – Computer PGs are purchased as a secondary pair – leverage 40% Off Additional Pairs when applicable.

# LENS RETAIL PRICING

Code	Lens Materials	Price
	Plastic	\$ 75.00
V2784	Poly	\$ 45.00
V2783	High Index 1.67	\$ 120.00
V2783	High Index 1.74	\$ 195.00

	Lens Designs	Price
V2419	Aspheric	\$ -
	Digital	\$ 60.00
V2100- V2114	Single Vision	\$ 75.00
V2100- V2114	Single Vision Eyezen Start	\$ 150.00
V2100- V2114	Single Vision Eyezen 1 - 4	\$ 160.00
V2781	Varilux Comfort Max Fit	\$ 295.00
V2781	Varilux X Design	\$ 400.00
V2781	Varilux X Fit	\$ 450.00
V2781	Elite (Ideal Adv IV Fit) Sun Only	\$ 285.00
V2781	Premium PG Design (Accolade)	\$ 210.00
V2781	Standard PG Design (MVC = Ovation Digital)	\$ 165.00
	Workspace (5' no distance - similar to Shamir computer)	\$ 295.00
	Computer (11 mm above = full distance (Similar to Shamir Workspace)	\$ 295.00

	Add-on/Custom measurement	Price
	Polish	\$ 25.00
	Roll & Polish	\$ 40.00
	Rimless Drill (Only GA Poly Hi Index)	\$ 70.00
V2780	Oversize Frame	\$ 15.00
	Custom Measurements (VX X Fit & Comfort Max Fit)	\$ 10.00
	Technical Add On, (Eyezen 1-4 only)	\$ 10.00

Code	ARs	Price
V2750	Backside AR	\$ 50.00
V2750	Premium AR	\$ 85.00
V2750	Crizal SunShield	\$ 85.00
V2755	Backside UV (added to Crizal ARs below)	\$ 15.00
V2750	Crizal Easy Pro	110+15= \$ 125.00
V2750	Crizal Rock	150+15= \$ 165.00
V2750	Crizal Sapphire HR	170+15= \$ 185.00
V2750	Crizal Previncia	170+15= \$ 185.00

	Tints	Price
	Blue Light (Not Eyezen)	\$ 45.00
	Polarized	\$ 85.00
V2745	Solid tint	\$ 25.00
V2745	Gradient tint	\$ 30.00
V2761	Mirror	\$ 90.00
V2744	Transition GEN8	\$ 125.00
V2744	Transition Xtractive	\$ 150.00

VSP = High Luster Edge Polish

VSP = 61 eye size or greater



# REFERENCE - CODES

## EXAM CODES

92014, 92004	Comprehensive Exam
92012, 92002	Intermediate Exam
92015	Refraction

## VISION CODES

V2020	Frame	V2750	Anti-reflective Coating
V2025	Deluxe Frame	V2755	UV, per lens
V2100-V2199	SV Lens	V2760	Scratch Resistant Coating
V2200-V2299	Bifocal Lens	V2761	Mirror Coating
V2300-V2399	Trifocal Lens	V2762	Polarized Lens
V2700	Balance Lens	V2781	Progressive Lens
V2710	Slab Off Prism	V2782	Plastic Lens
V2715	Prism, per lens	V2783	High Index Lens
V2744	Tint, Photochromic	V2784	Polycarbonate Lens
V2745	Addition to lens, tint		

## HYPEROPIA

H52.00	Unspecified Eye
H52.01	Right Eye
H52.02	Left Eye
H52.03	Bilateral

## REGULAR ASTIGMATISM

H52.229	Unspecified Eye
H52.221	Right Eye
H52.222	Left Eye
H52.223	Bilateral

## MYOPIA

H52.10	Unspecified Eye
H52.11	Right Eye
H52.12	Left Eye
H52.13	Bilateral

## IRREGULAR ASTIGMATISM

H52.219	Unspecified Eye
H52.211	Right Eye
H52.212	Left Eye
H52.213	Bilateral

# Rosin Billing Info

## CEP:

- File Claim
- Post in Acuity Logic
- Handle patient collection and refunds as they do today

## Rosin:

### Medical:

- File Claim
- Post EOB in Eclips
- Post in SAP (will have to be taught and given access)
  - This varies from other TV clinics where Assignment Back Office posts in SAP

### Routine:

- File Claim
- Post in AS400 (will have to be taught and given access)
  - This varies from other TV clinics where Assignment Back Office posts in AS400

Patient Statements will be managed by billers (from Eclips).

Patient/Insurance Refunds will go through back-office process.