# Covered Services

## Exam Benefits

A Vision Care Exam ("Exam") with refraction is covered if the Member is eligible. When providing an Exam as part of Covered Services to a Member, the following tests and services must be performed:

- Evaluation of complete history of patient
- External examination of the eyes and adnexa, pupillary reflexes, cover test, ocular motility and convergence near point
- Internal examination of the eyes
- Objective and subjective refraction and visual acuity
- Muscle balance and fusion evaluation, near point tests
- Depth and color perception tests
- Tonometry

Additionally, dilation shall be performed as part of an Exam covered under the Plan without charge as indicated if the provider performs dilation as part of a vision care exam to its uninsured patients. Neither the Insurance Company nor its Members shall be liable for any charges associated with any of the services described in this paragraph. The Member must be informed of any charges for any additional non-covered examination procedures prior to service and as otherwise may be required by applicable state or federal law. Medical examinations (related to evaluation or treatment of a Member for certain injuries or medical conditions) shall not be submitted to the Insurance Company but shall be submitted through the Member's medical plan.

| Exam Including Dilation | |
|---|---|
| Diagnostic Code | Description |
| 92004 | Comprehensive Eye Exam |
| 92014 | Established Patient Comprehensive Eye Exam |

If an Exam or another related service is billed to the Member's medical plan, the same service cannot also be billed to the Insurance Company when performed on the same day.

## Digital Retinal Screening

Digital retinal screening may be designated as non-covered or fully-covered and will vary by group. The Insurance Company's Provider Portal (www.vbaplans.com) automatically determines and displays coverage/Member payment amounts upon order entry.

Coverage for digital retinal screening will only apply when performed as an enhancement to a screening of a normal eye for baseline detection purposes. Exception 1: When performed in connection with a clinical condition, retinal imaging is considered medically necessary, and claims for such treatment shall be submitted to the Member's medical plan instead of the Insurance Company. Exception 2: When completed with interpretation and report, it is considered fundus photography and shall not be covered by the Member's digital retinal screening benefit.

If fundus photography or another related service is billed to the Member's medical plan, the same service cannot also be billed to the Insurance Company when performed on the same day.

If a Member's Plan does not include a digital retinal screening benefit, the service is considered a private pay transaction. If your office doesn't offer digital retinal screening, you are exempt from providing this service and you are not required to purchase any new equipment for the provision of the same.

Approved devices include any nonmydriatic camera or imager that images at least the posterior pole and beyond.

Digital retinal screening does not replace dilation which is to be performed as part of a Member's Vision Care Exam when indicated.

For reimbursement, digital retinal screening must be performed and observed onsite.

| Retinal Screening | | |
|---|---|---|
| Diagnostic Code | Modifier | Description |
| 92250 | GY | Digital Retinal Screening |
| Z13.5 | | Encounter for screening for eye and ear disorders |

## Lens Benefits

Lens Benefits may be designated as non-covered, partially-covered or fully-covered and will vary by group. The Insurance Company's Provider Portal automatically determines and displays coverage/Member payment amounts upon order entry. The Insurance Company reserves the right to amend or modify the Retail Plan Rate and Limit Schedule, including, but not limited to, product additions, product deletions or product category reassignments. XYZ is not required to offer every brand or product.

All dispensed lenses shall include a one-year, one-time replacement (normal wear) scratch warranty from the laboratory. Replacements are at the discretion of the laboratory and/or manufacturer.

## Frame & Contact Lens Allowances

Plan information will be displayed on the Provider Portal while you are confirming eligibility and coverage. Allowances shall be applied to Covered Services and materials unless otherwise directed by the Member. If your Usual and Customary Fee exceeds the applicable allowance amount, the Member shall be responsible for payment of the difference. Members shall not be charged any additional fees or Copayments for the receipt or collection of frames or contact lenses.

### Frame Allowance

The Insurance Company reserves the right to audit all frame submissions. Frame cost must be provided to the Insurance Company upon submission of the Claim.

If eligible, the Member is to receive, without additional charge, any frame up to the Member's retail frame allowance. In the event that the retail price of the frame selected exceeds the Member's retail frame allowance, the maximum frame overage charge to the Member shall be calculated by subtracting the difference between the Member's applicable retail frame allowance and the actual retail price of the frame.

The actual retail price of the frame shall not exceed the wholesale cost of the frame as indicated by Frames Data® multiplied by a factor of 2.5. In the event a frame is not included in the most current Frames Data® publication, the retail cost of the frame utilized to calculate any frame overage charge shall not exceed 2.5 times the actual wholesale cost of the frame from its supplier.

| Frames | |
|---|---|
| Code | Procedure |
| V2020 | Frame |
| V2025 | Deluxe Frame |

**Insurance Company Reimbursement:**
The lesser of: (1) the wholesale cost of the frame as indicated by Frames Data® (or the actual wholesale cost of the frame if not available through Frames Data®); or (2) the retail frame allowance indicated by the Insurance Company's System divided by a factor of 2.5.

### Member Supplied Frames or Lenses

Neither XYZ nor the Insurance Company shall be liable for loss or damage to frames and/or lenses supplied by the Member. Should damage occur to the Member's existing frame, it shall be the Member's responsibility to select another frame at the Member's own expense.

Any fees XYZ charges for adding lenses to Member Supplied Frames shall be considered non-covered, private pay transactions.

### Elective Contact Lens Allowance

Elective Contact Lens Fitting includes a maximum of two (2) follow-up visits within ninety (90) days of the initial fitting. All subsequent follow-up visits are the sole responsibility of the Member and shall be considered non-covered, private pay transactions.

| Elective Contact Lenses | | |
|---|---|---|
| Code | Modifier | Procedure |
| V2500-V2503, V2510-V2513, V2520-V2523, V2430-V2531, V2599 | | Contact Lens Materials |
| 92310 | | Standard Contact Lens Fit and Follow-Up |
| 92310 | PF | Premium Contact Lens Fit and Follow-Up |

**Total Allowance Plan**
If eligible, the Member can elect to receive credit towards the purchase of contact lenses in the amount indicated by the Insurance Company's Provider Portal. The total allowance is applied to the cost of the Exam, fit, lenses and evaluation. If contacts are not dispensed, the Insurance Company will only reimburse for the Exam. Claims may not be submitted for contact lens fittings unless contact lenses are dispensed. Submission of a Claim for an Exam shall reduce the Member's contact lens Benefit by the amount of the Insurance Company's Reimbursement.

**Exam Plus Plan/Exam Plus + Plan**
If eligible, the Member is entitled to receive an Exam and a separate allowance in the amount indicated by the Insurance Company's Provider Portal for contact lens fittings and materials only. After completion of the Exam, the contact lens fitting fee is to be charged directly to the Member at the lesser of (1) 85% of your Usual and Customary Fee; or (2) $50.00 at the time of the visit.

**Insurance Company Reimbursement:**
For contact lens materials: The amount indicated by the Insurance Company's system.

## Medical Contacts

Some Plans offer Benefits for medically necessary contacts due to eye disease and injury. If specific criteria are met, the patient is entitled to receive an Exam followed by medical contact fittings and medical contacts as necessary. Prior approval and authorization must be received from the Insurance Company before any Optical Products are purchased and/or Optical Services are rendered in connection with this Benefit. Medical Contact Lens Fitting includes a maximum of two (2) follow-up visits within ninety (90) days of the initial fitting.

## Professional Fees

Vision Care Exam Fee (including refraction and tonometry): $50

Contact Lens Fitting Fee: The lesser of (1) the applicable U&C Fee or (2) $50.00

Digital Retinal Screening: Usual and Customary Fee up to a maximum of $39

Medical Contact Fitting and Material Fee (exclusive of $50 Exam Fee): Not to exceed $400 without prior approval from the Insurance Company.

## Dispensing Fees

For frame and spectacle lenses dispensed:

Frames: An amount no less than $5.00 and no more than $34.00 (as determined by the Insurance Company in its sole discretion)

Lenses: An amount no less than $7.00 and no more than $34.00 (as determined by the Insurance Company in its sole discretion)

Dispensing Reimbursements vary by Plan and are available on the Plan Coverage Sheet, which can be found on the Insurance Company's Provider Portal when pulling an authorization.

# Lens Option Reimbursements

All warranties of a material are subject to the policies and warranties held by XYZ. All lenses must have a one-year, one-time replacement (normal wear) front side scratch warranty.

## Fully-Covered Materials

Listed below are the maximum Insurance Company Reimbursements when a lens option is fully-covered by the Plan.

### Base Lens (Plastic CR-39, Edged)

| Base Lens | Single Vision | | | Multifocal | | |
|---|---|---|---|---|---|---|
| | CPT Code | Modifier | Reimbursement | CPT Code | Modifier | Reimbursement |
| Single Vision | V2100-V2114 | | $12.75 | | | |
| Bifocal - Flat Top 25 & 28 | | | | V2200-V2214 | | $20.50 |
| Bifocal - Flat Top 35 | | | | V2219 | | $26.95 |
| Bifocal - All other lined | | | | V2219 | EX | $25.95 |
| Blended Bifocal (add to FT 25/28) | | | | V2799 | BL | $40.00 |
| Trifocal - 7 X 25/28 | | | | V2300-V2314 | | $33.95 |
| Trifocal - 7 X 35 | | | | V2319 | | $45.95 |
| Trifocal - All other lined | | | | V2319 | EX | $52.95 |

### Base Lens (Glass, Edged)

| Base Lenses | Single Vision | | | Multifocal | | |
|---|---|---|---|---|---|---|
| | CPT Code | Modifier | Reimbursement | CPT Code | Modifier | Reimbursement |
| Single Vision | V2100-V2114 | GL | $15.25 | | | |
| Bifocal – Flat Top 25 & 28 | | | | V2200-V2214 | GL | $25.00 |
| Bifocal – Flat Top 35 | | | | V2219 | GL | $31.00 |
| Bifocal – Executive & All others (lined) | | | | V2219 | EX, GL | $29.00 |
| Blended Bifocal (add to FT 25/28) | | | | V2799 | BL | $40.00 |
| Trifocal - 7 X 25/28 | | | | V2300-V2314 | GL | $36.00 |
| Trifocal - 7 X 35 | | | | V2319 | GL | $52.00 |
| Trifocal - Executive & All others (lined) | | | | V2319 | EX, GL | $61.00 |

### Materials

| Materials | Single Vision | | | Multifocal | | |
|---|---|---|---|---|---|---|
| | CPT Code | Modifier | Reimbursement | CPT Code | Modifier | Reimbursement |
| Polycarbonate | V2784 | | $6.00 | V2784 | | $12.00 |
| Trivex | V2782 | TR | $28.00 | V2782 | TR | $35.00 |
| Hi index plastic - 1.60 | V2782 | | $28.00 | V2782 | | $35.00 |
| Plastic Aspheric & Atoric - 1.67 | V2783 | 67 | $48.00 | V2783 | 67 | $54.00 |
| Plastic Aspheric & Atoric - 1.70 | V2783 | 70 | $65.00 | V2783 | 70 | $82.00 |
| Plastic Aspheric & Atoric - 1.74 | V2783 | 74 | $70.00 | V2783 | 74 | $90.00 |
| High Index Glass | V2782 | GL | $25.00 | V2782 | GL | $45.00 |

### Digital Surfacing

| Digital Surfacing | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Digital/Free Form/HD Single Vision | V2100 -V2114, V2118 | DL | $28.00 |

### Progressive Lenses

| Progressive Lenses** | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Progressive Standard | V2781 | | $47.00 |
| Progressive Premium | V2781 | PP | $66.00 |
| Progressive HD/Digital | V2781 | DP | $100.00 |
| Glass Progressive (added to progressive charge) | | GL | $30.00 |

**Aspheric charges are not permitted on progressive lenses.

## Photochromic and Polarized

| Photochromic and Polarized | Single Vision | | | Multifocal | | |
|---|---|---|---|---|---|---|
| | CPT Code | Modifier | Reimbursement | CPT Code | Modifier | Reimbursement |
| Photochromic / Transitions | V2744 | | $40.00 | V2744 | | $50.00 |
| Transitions XTRActive | V2744 | XA | $68.00 | V2744 | XA | $75.00 |
| Glass Photochromic (added to photochromic charge) | V2744 | GP | $9.00 | V2744 | GP | $14.00 |
| Polarized | V2762 | | $36.00 | V2762 | | $46.00 |

## Lens Treatments

| Dyes & Treatments | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Tints Solid or Gradient | V2745 | | $5.00 |
| UV 400 (do not bill on poly, photochromic, mid/high index) | V2755 | | $6.00 |
| Mirror Coating | V2761 | | $23.00 |

## Edging

| Edging | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Roll & Polish | V2799 | RP | $5.00 |

## Scratch Resistant Coating

| Scratch Resistant Coating | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Standard Scratch Coating (1-year warranty - 1 time replacement) | V2760 | | INCLUDED |
| Premium Scratch Coating (2-year warranty - 1 time replacement) | V2760 | PS | $18.00 |

## Anti-Reflective Coatings

| Anti-Reflective Coatings | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Standard A/R 1 | V2750 | | $27.00 |
| Standard A/R 2 | V2750 | 2Y | $33.00 |
| Premium A/R | V2750 | PA | $47.00 |
| Ultra A/R | V2750 | UA | $67.00 |
| A/R Bluelight* | V2750 | BL | $57.00 |

*A/R Bluelight is fully-covered if Premium A/R is fully-covered.

**Anti-Reflective Coating Categories**

The following chart indicates the applicable anti-reflective category, along with corresponding anti-reflective coating categories assigned to each of the specified products below. Insurance Company reserves the right to amend or modify this chart at any time, including, but not limited to, product additions, product deletions, or product category reassignments. For the dispensing of products not appearing in this chart, XYZ shall determine the applicable category for reimbursement by identifying the most equivalent product listed below and then utilizing the same category in which said equivalent product appears, subject to the Insurance Company's ultimate audit, discretion, review and approval. XYZ is not required to offer every brand or product listed below.

| Standard A/R 1 | | |
|---|---|---|
| Lab Choice | Hoya Premium with ViewProtect™ | SharpView+® |
| **Standard A/R 2** | | |
| Crizal® Easy™ | Hoya HiVision™ with ViewProtect™ | ZEISS SET |
| KODAK Clean&CleAR | | |
| **Premium A/R** | | |
| Crizal® Easy$^{Pro}$ | PermaVue XT | Shamir Glacier PLUS™ |
| Crizal® Rock™ | Hoya Recharge® | ZEISS DuraVision® Chrome UV |
| Crizal® SunShield UV™ | Hoya Super HiVision™ | ZEISS DuraVision® DriveSafe UV |
| Essilor® Anti-Fog AR | Hoya Super HiVision EX3™ | ZEISS DuraVision® Silver UV |
| Xperio UV™ | Seiko Super Resistant | ZEISS DuraVision® Sun UV |
| **Ultra A/R** | | |
| Crizal® Optifog® | Hoya Super HiVision EX3+ | Shamir Glacier PLUS™ Metaform™ |
| Crizal® Prevencia® | Hoya Super HiVision Meiryo EX4 | Shamir Glacier Sun™ |
| Crizal® Sapphire$_{TM}^{HR}$ | Shamir Glacier Expression™ | ZEISS DuraVision® Platinum UV |
| **A/R Bluelight** | | |
| Seiko Super Resistant Blue | ZEISS DuraVision® BlueProtect UV | |

## Partially-Covered Materials

Listed below are the maximum Member Charges and Insurance Company Reimbursements when a progressive lens is partially-covered by the Plan.

### Progressive Lenses

| Progressive Lenses** | | | | | |
|---|---|---|---|---|---|
| | CPT Code | Modifier | Member Charges | VBA Reimbursement | Total Receivable (VBA Reimbursement + Member Charge) |
| Progressive Standard | V2781 | | $58.00 | $24.00 | $82.00 |
| Progressive Premium | V2781 | PP | $80.00 | $21.00 | $101.00 |
| Progressive HD/Digital | V2781 | DP | $120.00 | $20.00 | $140.00 |
| Glass Progressive (added to progressive charge) | | GL | $45.00 | - | $45.00 |

**Aspheric charges are not permitted on progressive lenses.

#### Progressive Non-Adapt Policy

If a Member cannot adapt to progressive lenses within sixty (60) days, XYZ shall remake the Rx in single vision or lined multifocal without additional charge to the Member.

#### Progressive Lens Categories

The following chart indicates the applicable Progressive Category assigned to each of the specified products below. Insurance Company reserves the right to amend or modify this chart at any time, including, but not limited to, product additions, product deletions, or product category reassignments. For the dispensing of products not appearing in this chart, XYZ shall determine the applicable category for reimbursement by identifying the most equivalent product listed below and then utilizing the same category in which said equivalent product appears, subject to the Insurance Company's ultimate audit, discretion, review and approval. XYZ is not required to offer every brand or product listed below.

| Standard Progressive | | |
|---|---|---|
| Lab House Brand | Essilor SmallFit® Digital | Shamir Element™ |
| Essilor Adaptar® | KODAK Easy Lens 14 | Shamir Element™ Short |
| Essilor Adaptar® Digital | KODAK Easy Lens 18 | Shamir Genesis HD |
| Essilor Adaptar® Short Digital | KODAK Precise PB | Shore Lens ShoreView™ |
| Essilor Ideal® | KODAK Precise Short PB | Shore Lens ShoreView Mini™ |
| Essilor Ideal® Short | Hoya Amplitude® BKS | Younger Optics Image® |
| Essilor Natural® | Hoya Amplitude® Mini BKS | ZEISS GT2 |
| Essilor Natural® Digital | Hoya GP Wide BKS | ZEISS GT2 Short |
| Essilor Ovation® | SA Navigator® | ZEISS Progressive Light $D^X$ |
| Essilor SmallFit® | SA Navigator Short® | ZEISS Progressive Light $H^X$ |
| **Premium Progressive** | | |
| Essilor Accolade® | Varilux® Comfort Max | IOT Everyday B |
| Essilor Accolade Freedom™ | Varilux Physio DRx™ | Shamir Attitude® III - Fashion |
| Essilor Ovation® Digital | Varilux Physio Short DRx™ | Shamir Attitude® III - Sport |
| KODAK Precise® Plus | Varilux® Stylistic® Wrap | Shamir Autograph II+® |
| KODAK Precise® Plus Short | Hoya Array 2 | Shamir Autograph III® |
| KODAK Unique™ | Hoya Summit® ecp BKS | Shamir InTouch™ |
| KODAK Unique DRO® | Hoya Summit® cd BKS | Shamir Spectrum+™ |
| Varilux Comfort® | IOT Endless Easy Fit | ZEISS Progressive Light $V^X$ |
| Varilux Comfort Short™ | IOT Endless Steady | ZEISS Progressive SmartLife Plus |
| Varilux Comfort DRx™ | IOT Essential Steady® | ZEISS Progressive SmartLife Pure |
| Varilux Comfort Short DRx™ | | |
| **HD/Digital Progressive Lens** | | |
| Varilux® Comfort Max Fit | Hoya iD LifeStyle® 3 Indoor, Outdoor, Urban | Shamir Driver Intelligence™ Moon |
| Varilux® Physio® W3+ | Hoya iD LifeStyle® 4 Indoor, Outdoor, Urban | Shamir Driver Intelligence™ Sun |
| Varilux® Physio® W3+ eyecode™ | Hoya MyStyle® 2 | ZEISS DriveSafe |
| Varilux® Physio® W3+ Fit | Hoya MyStyle® 2 Adventure, Detail, Modern, Stable | ZEISS DriveSafe Individual |
| Varilux® X 4D | Hoya MyStyle ® 3 Adventure, Expert, Detail, Modern, Tyro | ZEISS Progressive SmartLife Individual 3 |
| Varilux® X Design | IOT Camber Steady Plus | ZEISS Progressive SmartLife Individual 3 S/M/L |
| Varilux® X Design Fit | Shamir Autograph Intelligence™ | ZEISS Progressive SmartLife Superb |
| Varilux® XR Design | | |

## Non-Covered Materials

Listed below are the maximum charges to Members when a lens option is not covered, in whole or in part, by the Plan.

### Materials

| Materials | Single Vision | | | Multifocal | | |
|---|---|---|---|---|---|---|
| | CPT Code | Modifier | Member Cost | CPT Code | Modifier | Member Cost |
| Polycarbonate | V2784 | | $19.00 | V2784 | | $30.00 |
| Trivex | V2782 | TR | $50.00 | V2782 | TR | $60.00 |
| Hi Index Plastic - 1.60 | V2782 | | $50.00 | V2782 | | $60.00 |
| Plastic Aspheric & Atoric - 1.67 | V2783 | 67 | $78.00 | V2783 | 67 | $93.00 |
| Plastic Aspheric & Atoric - 1.70 | V2783 | 70 | $100.00 | V2783 | 70 | $130.00 |
| Plastic Aspheric & Atoric - 1.74 | V2783 | 74 | $110.00 | V2783 | 74 | $150.00 |
| High Index Glass | V2782 | GL | $36.00 | V2782 | GL | $70.00 |

### Digital Surfacing

| Digital Surfacing | | | |
|---|---|---|---|
| | CPT Code | Modifier | Member Cost |
| Digital/Free Form/HD Single Vision | V2100 -V2114, V2118 | DL | $48.00 |

### Photochromic and Polarized

| Photochromic and Polarized | Single Vision | | | Multifocal | | |
|---|---|---|---|---|---|---|
| | CPT Code | Modifier | Member Cost | CPT Code | Modifier | Member Cost |
| Photochromic / Transitions® | V2744 | | $60.00 | V2744 | | $70.00 |
| Transitions XTRActive | V2744 | XA | $93.00 | V2744 | XA | $100.00 |
| Glass Photochromic (added to photochromic charge) | V2744 | GP | $18.00 | V2744 | GP | $28.00 |
| Polarized | V2762 | | $56.00 | V2762 | | $66.00 |

### Lens Treatments

| Tint and Coating | | | |
|---|---|---|---|
| | CPT Code | Modifier | Member Cost |
| Tints Solid or Gradient | V2745 | | $10.00 |
| UV 400 (do not bill on poly, photochromic, mid/hi index) | V2755 | | $12.00 |
| Mirror Coating | V2761 | | $35.00 |

### Edging

| Edging | | | |
|---|---|---|---|
| | CPT Code | Modifier | Reimbursement |
| Roll & Polish | V2799 | RP | $10.00 |

### Scratch Resistant Coating

| Scratch Resistant Coating | | | |
|---|---|---|---|
| | CPT Code | Modifier | Member Cost |
| Premium Scratch Coating (2-year warranty - 1 time replacement) | V2760 | PS | $30.00 |

### Anti-Reflective Coatings

| Anti-Reflective Coatings | | | |
|---|---|---|---|
| | CPT Code | Modifier | Member Cost |
| Standard A/R 1 | V2750 | | $40.00 |
| Standard A/R 2 | V2750 | 2Y | $49.00 |
| Premium A/R | V2750 | PA | $69.00 |
| Ultra A/R | V2750 | UA | $99.00 |
| A/R Bluelight* | V2750 | BL | $85.00 |

*A/R Bluelight is fully-covered if Premium A/R is fully-covered.