VBA Professional Provider Manual

November 17, 2022

Contents

Introduction

Our Mission

The ability to see clearly is key to optimal living and quality of life for all people and extends beyond health to every person's ability to participate in and contribute to society.

VBA's mission is to improve the human experience by utilizing innovative models of service, delivery and advocacy to reduce barriers to high-quality eye care.

Improving the Human Experience

VBA vision and dental products offer members access to vision and dental care. Through vision care exams and dental cleanings, doctors can help members see clearly and smile with confidence.

A Personal Approach

Everyone gets a uniquely personal approach to vision and dental benefits with VBA's customized plans, personalized service and the latest products. Whether you're a member, administrator, provider or lab, working with VBA is a simple process. At VBA, you're our focus.

Since 1965, we've provided comprehensive vision coverage to corporations, municipalities, schools, health and welfare funds, hospitals and health maintenance organizations in Pennsylvania.

Our focus on personalized service has helped us build and maintain long-term relationships — like the one we still have with our first customer that joined us more than 50 years ago.

Coverage for Those Who Need It Most

The Pennsylvania Vision Foundation, an affiliate of VBA, was founded in 2007 to provide eye care, including vision care exams, prescription lenses and frames, to those in need. To date, the foundation has proudly assisted more than 7,000 uninsured Pennsylvanians.

Contact Us

Our customer care representatives are available to answer your questions Monday through Friday, 8:30 a.m. to 6:00 p.m. ET.

Mailing Address:
VBA
400 Lydia Street, Suite 300
Carnegie, PA 15106

Providers
Phone – 1-800-432-4966 x6
Fax – 412-885-5646
Email – providers@vbaplans.com

Members
Phone – 1-800-432-4966 or 412-881-4900 x5
Fax – 412-881-4898
Email – memberservices@vbaplans.com

To give our employees an opportunity to spend time with family, VBA will be closed on the following holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, the Friday after Thanksgiving and Christmas.

2023 Holiday Observations

Monday, January 2
Monday, May 29
Tuesday, July 4
Monday, September 4
Thursday, November 23
Friday, November 24
Monday, December 25

We will be open with abbreviated office hours from 8:30 a.m. to 12:30 p.m. on Friday, December 22 and Friday, December 29.

Distribution of Information

VBA contacts members and providers by mail, fax, email, phone or on its website.

About This Manual

The VBA Professional Provider Manual applies to services rendered to VBA enrollees by VBA Participating Providers. It's the provider's responsibility to read and understand the policies and procedures in this manual. This manual is confidential and should not be shared with third parties.

The VBA Professional Provider Manual supersedes any prior manual received from VBA. VBA reserves the right to revise these policies and procedures at its sole discretion. All applicable laws and regulations supersede the provisions of this manual.

VBA Participating Providers will be notified of revisions to the VBA Professional Provider Manual via its Provider Portal.

Adherence to the Provider Agreement

Providers are contractually obligated to adhere to and comply with all terms of the most recent Provider Agreement with VBA and this manual. New Provider Agreements supersede any prior agreement. Participating Providers must comply with all applicable federal and state requirements.

Nondiscrimination

VBA does not discriminate against any provider on the basis of race, color, national origin, gender, age, religion, marital status, health status or any other basis under applicable law.

Requirements

- All VBA Participating Providers must be full-service locations offering both vision care exams and materials.
- All locations must accept new patents. Indicate that your location(s) accept new patients on your CAQH application.
- All claims must be filed through VBA's Provider Portal. Paper claims are not accepted.
- You must offer non-urgent appointments with VBA members within 30 days of request.

Member Confidentiality

You must follow all applicable state and federal laws and regulations regarding member Protected Health Information (PHI), Personally Identifying Information (PII) and credit card data.

Becoming a VBA In-Network Provider

To become a network provider, you must first complete the Provider Application and Participating Provider Agreement and submit it with all requested documentation. Once received, VBA will review all materials to ensure the application is complete. If complete, you will begin the credentialing process with VBA. You must first be credentialed prior to rendering services to VBA members.

Credentialing Vendors

VBA uses the following companies during credentialing and recredentialing:

- The Council for Affordable Quality Healthcare (CAQH)

  https://proview.caqh.org/

  1-888-599-1771

- OneHealthPort (Washington Only)

  https://www.onehealthport.com/

  1-800-973-4797

- Verisys (CVO)

  https://verisys.com/

Credentialing

Credentialing takes approximately sixty (60) days. To streamline the process, please ensure your CAQH Profile is up to date, recently re-attested and the current professional liability certificate is uploaded and approved. Once the application is complete, a credentialing review will be initiated with Verisys, formerly Aperture Health.

Verisys is an independent credentials verification organization contracted by VBA to perform primary source verification. Please respond to any requests for additional information by Verisys as quickly as possible.

Once Verisys completes the review, your credentialing file will be reviewed by VBA. If accepted by VBA's Credentialing Committee, you will receive a VBA account number and will officially be part of VBA's Participating Provider Network to begin rendering services to VBA members.

Credentialing Committee

VBA's Credentialing Committee is responsible for determining which providers may become network providers. VBA maintains a Credentialing Committee comprised of three (3) voting members, including an optometrist, an officer of VBA, and a provider relations representative who review all provider applications. The decision is governed by a simple majority vote with each member of the Committee having one (1) vote.

The Committee is empowered to credential any licensed ophthalmologist (M.D.), osteopath (D.O.) and optometrist (O.D.) if they meet the following parameters, including any additional state and federal laws and regulations.

Credentialing Standards

All providers are credentialed according to the standards of the National Committee for Quality Assurance (NCQA) and in accordance with applicable state and federal laws.

All credentialing files that meet the credentialing criteria as clean may be reviewed and approved by a medical director per NCQA and applicable state and federal laws.

Credentials Application

The provider must complete, sign, and date VBA's credentials application to be considered for participation in VBA's Participating Provider Network.

If VBA elects not to include an applicant in its network, for reasons that do not require review of the application, VBA will provide written notice to the applicant of that determination within thirty (30) days after receipt of the application.

Credentials Application – Required Information
The credentials application includes but is not limited to the following information:

1. Most recent five (5) years of work history as a heath professional with an explanation of any gaps greater than six (6) months, if less than five (5) years, timeframe starts at initial licensure date.
2. Attestation to the ability to perform essential functions.
3. Attestation that the provider does not use illegal substances.
4. Attestation to any loss of license since initial licensure.
5. Attestation to any felony conviction.
6. Attestation of any loss or limitation of privileges or of disciplinary action.
7. Attestation of the correctness and completeness of the application.

In addition, the provider must submit proof of the following:

a. Current, valid license in the state(s) in which covered services are provided to members.

b. Professional liability insurance of at least one million dollars ($1,000,000 USD) per occurrence and three million dollars ($3,000,000 USD) aggregate unless the amount required by the state in which the provider renders covered services to members provides for other limits, and further that such minimum amounts required shall automatically increase to equal amounts required by the law of the state in which provider renders said services.

   The above paragraph does not prohibit insurance amounts that are below the aforesaid minimums, so long as the lower amounts are permissible within, and in accordance with, the laws and regulations of the state in which provider renders covered services.

   Proof under this paragraph shall be in the form of a current certificate of insurance evidencing coverage in the amounts aforesaid, or otherwise so required, and provider shall keep such certificate current at all times while under participating provider contract with VBA.

VBA Notification – Incomplete Application
Within fifteen (15) days after receipt of an incomplete application, VBA shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures:

1. The notice to the applicant shall include a complete and detailed description of all the missing or incomplete information or documents that must be submitted in order for review of the application to continue; and
2. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant.

VBA Review & Decision – Provisional Credentialing
Credentialing Committee review and decisions will be completed within sixty (60) days from the receipt of a completed application. If VBA has not approved or denied the provider credentialing application within sixty (60) days of receipt of the completed application, upon receipt of a written request from the applicant and within five (5) business days of its receipt, VBA will issue a provisional (temporary) credential to the applicant if the applicant has a valid professional or occupational license to provide the health care services to which the credential would apply.

VBA shall not issue a provisional credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The provisional credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer.

Verification of Credentials
Primary Source Verification (PSV) for the provider credentials listed below will be outsourced to an NCQA accredited Credential Verification Organization (CVO). All primary source verifications are made and documented in accordance with NCQA Standards.

VBA considers and makes allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials. VBA will also allow time for the scheduling of a final decision by the Credentialing Committee.

PSV is performed to confirm the following credentials:

1. Current and valid license to practice, in each state where the practitioner is licensed and provides care to members.
2. If held, current and valid DEA and CDS certification, in each state where the practitioner is licensed and provides care to members, along with any other state-specific drug qualifications.
3. The highest level of completed training is verified for each practitioner type: Board Certification, residency or graduation from medical or professional school.
4. Proof of valid malpractice insurance with the current coverage dates and amount of coverage.
5. Disciplinary actions, including sanctions, restrictions and limitation on licensure in all states practitioner provides care to members via the National Practitioner Data Bank (NPDB).
6. Malpractice history verified to NPDB. Provider's credentials that reveal the provider has three (3) or more malpractice case settlements with the last five (5) years will be reviewed by the Credentialing Committee prior to approval/denial.

Correction of Information
Any information obtained during the credentialing process that varies substantially from the information provided on the application is communicated to the provider. The provider will be allotted two (2) weeks to submit the amended information to VBA's Credentialing Department. The corrected information must be provided in writing from the facility or department from which the original information was received (i.e., State License Board, education facility, etc.). VBA's Credentialing Department will document the receipt of the corrected information in the provider's credentials file. Once all information is complete, the Credentialing Department will review and compare all information to established standards and will compare the information on the application to the primary source data. The completed credentialing files will then be presented to the Credentialing Committee for review and deliberation.

Closed or Held Applications
If, by the sixtieth (60th) day after receipt of the application, VBA has not received all the information or verifications it requires from third parties, or date sensitive information has expired, VBA shall issue a written notification to the applicant closing the application and detailing the attempts to obtain the information or verification. If the application is held, VBA shall inform the applicant of the length of time the application will be pending. Such notifications shall include the name, address and phone number of the credentialing staff person who serves as a contact person for the applicant.

Committee Recommendations
Within sixty (60) days after receipt of a completed application and all supporting documents, the Credentialing Committee shall assess and verify the applicant's qualifications and notify the applicant of its decision. The Credentialing Committee will recommend one of the following actions:

1. The provider meets all requirements and is recommended for appointment.
2. The provider needs to provide additional information.
3. The provider is not recommended for appointment. Specific reasons for denial are described in writing. A letter of denial is sent to the provider.

When a provider joins a practice that is under contract with VBA, the effective date of the provider's participation in the VBA network shall be the date the Credentialing Committee approves the provider's credentialing application.

Confidentiality & Record-Keeping
VBA will at all times protect the confidentiality of patient health or medical record information and personal information as required by law. All information regarding the credentialing of providers will be collected and maintained in a confidential manner. Credentialing personnel will be informed of the responsibility to maintain the confidentiality of the information reviewed in the credentials process. All documents, reports, and communications will be filed in a secure area.

The minutes of the Credentialing Committee are confidential information not to be discussed with unauthorized personnel. VBA maintains centralized files, either paper or electronic, on each individual provider making application to affiliate with VBA. VBA maintains for at least seven (7) years, or as otherwise required by applicable law, all records, books, documents and other business records, as well as provider credentialing information including the credentialing plan, policies and procedures thereunder and credential files.

VBA's Credentialing Policy shall be made available to network providers and applicants upon written request.

Re-Credentialing
All providers are re-credentialed every three (3) years. No less than six (6) months prior to the three (3) years, the Credentialing Committee will examine all supporting documentation, credentialing reports, utilization reviews and audits, member complaints and satisfaction surveys to determine which providers will be re-credentialed. If all the above are approved by the Credentialing Committee, then the provider will be automatically renewed.

Providers may file a written appeal of any denial of renewal by the Credentialing Committee that is based upon issues of quality of care or service, except in cases where a member's health has been threatened. Denials of renewal based on quality-of-care considerations will be supported by documented records of noncompliance with specific VBA expectations and requirements for providers.

VBA will follow any applicable requirements for re-credentialing providers as set forth by State and Federal law.

VBA Denials and Appeals
VBA's Credentialing Committee shall have a means of informing a provider of the denial of an initial or reappointment application for membership in the VBA's network. The Credentialing Committee will coordinate an appeals process for providers wanting to appeal negative decisions made by the Committee.

Initial Denial Communication
The Credentialing Committee will notify the provider of the initial denial via certified mail.

Appeals Hearing
The provider has the right to request a credentialing denial appeal hearing. In that event, the Credentialing Committee shall give the provider notice of the hearing. That notice shall also request provider's consent to disclose the specifics of his/her application as well as all credentialing documentation to be discussed at an appeal hearing conducted by the Credentialing Committee.

Credentialing Appeals Committee
The Chairman of the Credentialing Committee shall designate the Appeals Committee, which will be composed of two providers (one in the appealing provider's field of specialization) and a Committee member. No person on the Appeals Committee may be in direct economic competition with the appealing provider.

Credentialing Appeals Hearing
The provider has the right to be present at the hearing. The time, date and place of the hearing will be communicated to the provider via certified mail at least thirty (30) days in advance of the scheduled hearing.

The provider may have legal counsel present but must notify the Credentialing Committee of that intent at least ten (10) business days prior to the hearing. The Credentialing Appeals Committee may arrange for a court reporter to provide a transcript of the hearing. Copies of the reporter's transcript will be provided to the Appeals Committee and provider upon request.

A Credentialing Committee representative will submit evidence (oral or written) of the reason for denial. The provider may call, examine and cross-reference witnesses, and/or present evidence or information to explain or refute the cause of denial. The Appeals Committee has the right to rebut the provider's evidence and ask either the Credentialing Committee or the provider to clarify any statements or information presented during the hearing.

The Credentialing Committee and provider may make summary statements.

The Appeals Committee has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider. The rules of evidence applicable in a court of law do not apply. A party who objects to the presentation of any evidence must state the grounds for the objection; however, the Appeals Committee has the sole discretion to determine the evidence that will be admitted.

The Appeals Committee will deliberate without the provider present and will make its determination based on all the evidence presented and discussed. The decision of the Appeals Committee hearing shall be by majority vote of the members present and be final.

Written notice of the decision will be given to the provider and will include a written statement of the basis of the decision.

Reporting
When VBA terminates a contract based on a determination of fraud, VBA shall report the fraud, with the basis of the determination of fraud, to the appropriate administrative agencies.

When VBA terminates a contract based on a determination that the provider represents an imminent danger to the member or the public health, safety and welfare, VBA shall report the determination to the appropriate State licensing board.

When a final termination decision has been rendered, VBA shall report such corrective action to the appropriate parties, including the state licensing agency and/or the National Practitioner Data Bank (NPDB). The NPDB is a federal agency established pursuant to the Health Care Quality Improvement Act of 1986 that is the repository of information about final adverse actions against practitioners.

Managing Practice Information

VBA's Provider Relations Department can help you:

- Add or update a provider
- Term a provider
- Add or update a location
- Close a location
- Update your tax information

Please contact VBA if you have a change in ownership or Tax ID. In these cases, VBA requires your organization to apply for panel membership with the updated information.

Fill-In Doctors

A doctor who has a regular schedule of appointments at your location is considered a fill-in doctor but not a locum tenens doctor.

Locum Tenens

A locum tenens doctor may fill in for a doctor who is on leave but will be returning. The locum tenens doctor may fill in for a colleague for a total of sixty (60) consecutive days. Locum tenens physicians who do not have an independent relationship with VBA are outside the scope of VBA's credentialing per NCQA.

Promoting Your Practice

Make sure our members and your patients know you're a VBA In-Network Provider by using:

- **Window Clings:** Email us or call to request free window clings to use on your window or door.
- **VBA Logo:** You may add our logo to your website.

To request window clings or logo files, visit our Provider Resources page.

The VBA Provider Portal

Our Independent Provider Portal provides a user-friendly, web-based environment that allows you to:

- View member eligibility, authorizations and statements
- File claims and send to an in-network lab
- Stay up-to-date on VBA news by accessing notifications
- View the VBA Plan Rate and Limit Schedule (PRLS)

Access and use of this portal by and through any third-party software applications or services is strictly prohibited without the express written consent of VBA. VBA may suspend or terminate your access to these online services at any time, for any reason or for no reason at all. If you experience a disruption in service due to the unauthorized access or misuse of this portal, contact us.

See the User Access Agreement available through the VBA Provider Portal.

Mobile Units

A mobile facility/unit moves from place-to-place equipped to provide services and/or materials.

Mobile Facility: A large vehicle that has been converted, equipped and licensed to render vision care services. These vehicles travel to see and treat patients inside the vehicle.

VBA allows a Mobile Unit to participate in its network if it meets the following requirements:

- Operates its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients;
- Provides an address for the "Base of Operations";
- Provides vehicle information and geographic areas served;
- Increases access to otherwise underserved populations;
- Includes credentialed providers licensed in the state where services are provided; and
- A brick-and-mortar location that provides vision care exams to ensure continuity of care without additional cost to the member or VBA.

Network Terminations

Voluntary Terminations

You may request termination from VBA's network with sixty (60)-days advance notice by completing our Practice Update form.

Involuntary Terminations

VBA may involuntarily terminate you for reasons in your provider contract or the following additional reasons:

- Fraud, waste or abuse;
- False or misleading information on initial or subsequent applications, credentialing or recredentialing and/or contracting;
- Unprofessional or inappropriate conduct toward members;
- When deemed necessary to protect the health or welfare of members;
- Failure to complete recredentialing requirements.

In the event you are involuntarily terminated from VBA's Participating Provider Network, you will receive a written notice with any applicable appeals rights.

Responsibilities Upon Termination

- VBA will process all claims submitted before termination and within claims filing limits.
- You will notify patients who have VBA benefits that you are leaving the network and, if applicable, how they can locate a new in-network provider. You must inform members you are no longer participating in VBA's network before seeing them.
- You will pay all outstanding balances owed to VBA.

Telemedicine

Telemedicine refers to remote vision care exams. The provider determines if a vision care exam Is clinically appropriate to be provided remotely, subject to member consent. VBA may reimburse for synchronous and asynchronous vision care exams:

- The standard of care for eye, health and vision services must remain the same regardless of whether services are provided in person or remotely;
- Providers must ensure all PHI and PII is held in confidence;
- VBA must be made aware that the doctor is practicing telemedicine during the application process;
- Doctors must be licensed and credentialed in the state in which the patient receives; and
- The member must be present in a physical location.

General Information

Member ID Number

In most cases, a member's ID is the last four digits of the policyholder's Social Security Number (SSN).

Occasionally, the member ID may be a unique number assigned and provided to by the member's employer or the assigning Vision Foundation clinic.

Member ID Cards

Members do not need an ID card to make an appointment or visit an in-network provider. If a member would like a VBA Member ID Card, they can print one from the VBA Member Portal.

Member Information

VBA receives member name, address and date of birth from the employer.

- If a member's personal information is incorrect, they should contact their employer's benefits administrator or human resources department.
- Changes to a member's personal information can only be made by their employer or group's benefits administrator or human resources department.

Authorization

VBA's system uses Authorizations to give providers information regarding member coverage prior to an appointment and to give the provider adequate time to file claims. In some instances, authorizations may not be obtained through the provider portal (i.e., Medically Necessary Contact Lenses).

Date of Service must be within sixty (60) days of obtaining the authorization. Generally, authorizations expire sixty (60) days from the date it is obtained. The provider has an additional fourteen (14) days to file the claim after the authorization has expired. In some instances, the provider may request an authorization to be extended.

Security

Passwords

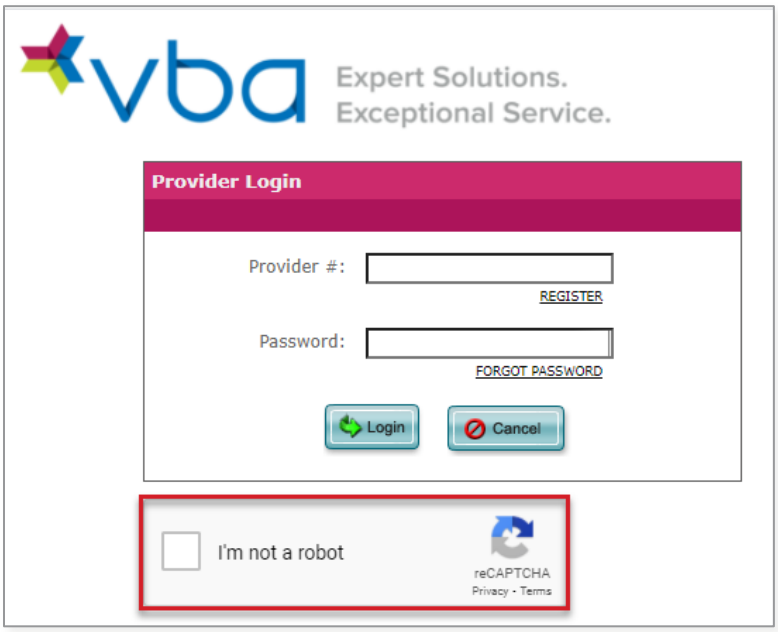
For providers requesting their current password, the provider must use the email password recovery option in the VBA Provider Portal.

Providers requesting a Password Reset will receive an email with the reset password. Reset passwords must be updated within 24 hours.

Access and use of the VBA Provider Portal is subject to the Terms and Conditions posted on the login screen, as may be amended from time to time and without advance notice to the user.

reCAPTCHA

VBA uses a reCAPTCHA to enhance the protection of your patients' PII and PHI through the provider portal.



reCAPTCHA protects websites from spam and abuse and is able to tell humans and bots apart. reCAPTCHA is easy for humans to solve, but hard for bots and other malicious software.

By adding reCAPTCHA, VBA can block malicious or unauthorized automated third-party software while continuing to allow human users to access the Portal with ease.

Interpretation and Translation Requirements

Reporting Spoken Languages

Report all languages spoken in your office, including American Sign Language, on your CAQH application, so we can include this information on our provider directory.

Interpreters

A health care provider cannot charge a deaf or hearing-impaired patient for part or all the costs of providing an auxiliary aid or service, either directly or through the patient's insurance carrier. 28 C.F.R. § 36.301 (c).

Claims and Payments

Member out-of-pocket fees and provider payments are available through the PRLS. The PRLS includes VBA's fee schedules and other important rules for providers to follow when administering VBA plans.

Each year, VBA releases an updated PRLS for all Independent Providers. One time per year, the PRLS is mailed to the provider's location, emailed to the provider and posted on the Provider Portal.

As lens manufacturers change their offerings throughout the year, VBA will release updates periodically. Those updates are emailed to the provider and posted on the Provider Portal.

In order to reduce administrative expenses, VBA may substitute electronic authorization and/or portal access for wet-ink or hard copies of signatures accepting changes to the PRLS. Any provider who does not wish to waive any signature rights under applicable law may (1) request a hard copy of any amendment to the PRLS for execution purposes; or (2) provide VBA with notice of their intent to terminate participation in the network.

Payment Schedule

VBA remits payments by the fifteenth (15th) of each month for claims completed the prior month. Claims are considered complete:

- Exam: the next business day after the exam is submitted to VBA
- Contact Lenses: the next business day after the contact lens order is submitted to VBA
- Frames and Lenses: the next business day after the lab completes the order

Payment Methods

VBA pays providers by paper check.

Chargebacks

When submitting an order through VBA's Laboratory Network, you are responsible for collecting the member out-of-pocket fees for non-covered and partially-covered lens options. To calculate the chargeback by product, locate the member out-of-pocket cost and doctor net on VBA's PRLS. The chargeback is equal to the member out-of-pocket – doctor net.

For example, if a Premium 4 Progressive Lens is partially-covered, the member out-of-pocket is $220. The doctor net is $80. The chargeback is $140. All chargebacks are used to pay for the lens at the selected in-network laboratory. VBA deducts the chargeback from the check each month. Therefore, chargebacks may result in a negative statement in lieu of a check.

Negative Statements

VBA contracts with an extensive network of ophthalmic laboratories. When using an in-network lab for VBA orders, VBA pays the lab bill on your behalf.

VBA is responsible for payment-in-full to the lab for fully-covered lens materials, options and treatments. The member is responsible for payment-in-full for non-covered lens materials, options and treatments.

When a member selects as partially-covered lens material, option or treatment, VBA and the member share responsibility for the lab cost.

When a member selects a non-covered lens material, option or treatment, you will collect the member out-of-pocket cost directly from the member at the time of purchase. The member out-of-pocket cost includes two components: doctor net and chargebacks.

Doctor net is the profit your office earns when selling non-covered and partially-covered lens materials, options and treatments. Doctor net can be found on the PRLS and is displayed when submitting an order through the VBA Provider Portal.

A chargeback is the amount collected from the member to pay the lab for non-covered lens materials, options and treatments. VBA subtracts the chargeback amount (negative balance) from your VBA payment to pay the lab.

Negative balances may result in a negative statement in lieu of a check. Negative statements occur most frequently for practices selling high end products and earning a higher doctor net.

Practices may elect to pay the negative balances in full each month. Any terminated practice must pay the negative balance in full immediately upon termination.

Medically Necessary Contact Lenses

Some plans offer benefits for medically necessary materials and services due to eye disease and injury to provide functional vision. Prior approval and authorization must be received before any Optical Products are purchased and/or Optical Services are rendered in connection with this benefit.

Medically Necessary materials and service include vision care service(s) and materials that are:

- In accordance with generally accepted standards of medical practice for the diagnosis or treatment of the patient's condition
- Clinically appropriate in terms of type, frequency, extent site, and duration
- Considered effective for the patient's illness, injury, or disease
- Not primarily for the convenience of the patient, physician or other provider
- Safe and effective;
- Not experimental or investigational
- Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the patient's illness, injury or disease.
- In lieu of eyeglasses and result in improved binocular function, including the avoidance of diplopia or suppression.

Medically Necessary Contact Lenses are only available for certain diagnoses. Some therapeutic services may be clinically appropriate but not medically necessary.

Choosing a diagnosis code only because it is on a patient's list of "covered" benefits constitutes fraud. Your diagnosis should always be based on sound clinical judgement.

Covered Benefits

Medically Necessary Contact Lens Benefits includes Contact Lens Evaluation/Fit, Follow Up and Materials. Members who qualify can use the benefit once per benefit period based on eligibility and can't exceed annual supply limits defined by the contact lens manufacturer replacement guidelines.

Medical Contact Lens Fitting includes a maximum of two (2) follow-up visits within ninety (90) days of the initial fitting.

Copayments do not apply to the contact less fitting/evaluation or materials.

Piggyback Lenses

Piggyback lenses may be covered for patients meeting the requirements of medically necessary contact lenses and who cannot tolerate RGP lenses resulting in the fitting of soft contact lenses and GP lenses in a piggyback fitting.

Spectacle Lenses Over Contact Lenses

Spectacle lenses may be covered for patients meeting the requirements of medically necessary contact lenses and require a prescription spectacle lens to meet functional visual needs. Plano lenses are not a covered benefit unless otherwise specified by the plan.

Spectacle lenses worn over contact lenses must be included at the time of the original submission of the Prior Authorization Form. Frames are a private pay transaction.

Requesting Prior Authorization

If the member's plan offers Medically Necessary Contact Lens Coverage, the member meets VBA's requirements for Medically Necessary Contact Lenses and the member is eligible for benefits on the date of service, you may submit a request for prior approval.

You must obtain prior authorization and approval from VBA prior to ordering and dispensing materials.

Step	Details
1. Getting Started	Confirm eligibility for Medically Necessary Contact Lenses by accessing the VBA Provider Portal or by contacting us. You must obtain an authorization for services and materials through the VBA Provider Portal.
2. What you'll need	To submit a request for prior approval, you will need to provide us with: • A completed VBA Medically Necessary Contact Lens Prior Authorization Form • A copy of the patient's medical records • The contact lens manufacturer's wholesale invoice or cost estimate
3. How to submit	After completing and signing the Medically Necessary Contact Lens Prior Authorization Form, mail or fax your request to: • VBA Utilization Management 400 Lydia Street, Suite 300 Carnegie, PA 15106 • 412-881-4898 (Facsimile)
4. Processing the request	We will return The Authorization Notification Form to the provider. The Authorization Notification Form includes approval, reimbursement amounts and authorization number or denial. Please allow up to 10 business days (after receipt of completed form) for VBA to review and process your prior authorization form.
5. Order Materials	Order and dispense materials after you receive the returned Authorization Notification Form.
6. Submit the Claim	After you receive approval and provide services and materials to the patient, submit the CMS-1500 form and a copy of the authorization approval to: • VBA Utilization Management 400 Lydia Street, Suite 300 Carnegie, PA 15106 • 412-881-4898 (Facsimile)

If a claim is filed without prior authorization and approval, VBA will reimburse up to the elective contact lens allowance. The provider may not balance bill for medically necessary contact lens materials and services reimbursed as elective contact lenses.

Exclusions

Corneal Refractive Therapy (CRT), orthokeratology (Ortho-K) and contact lenses for myopia management are not considered medically necessary. Patients may use their elective contact lens allowance towards the cost of CRT, Ortho-K or myopia management contact lenses.

There are no benefits for services or materials connected with the following:

- Plano lenses to change eye color cosmetically
- Artistically painted lenses
- Replacement of lost or damaged lenses
- Routine lens maintenance
- Refitting after the initial 90-day fitting period
- Solutions and other contact lens supplies
- Bandage contact lenses

Possible Reasons a Request is Delayed or Denied

It is important to make sure you submit all required information prior to ordering lenses. Please read and submit all required documents to VBA in one transmission.

Delayed

Medically Necessary Contact Lens Claims may be delayed if you do not submit the following:

- A completed VBA Medically Necessary Contact Lens Prior Authorization Form
- A copy of the patient's medical records
- The contact lens manufacturer's wholesale invoice or cost estimate

Denied

Medically Necessary Contact Lens Claims may be denied if:

- The patient is not eligible
- You did not receive authorization and approval prior to ordering materials
- Materials are not clinically appropriate in terms of type, frequency, extent site, and duration
- Materials are not considered effective for the patient's illness, injury, or disease
- Materials are primarily for the convenience of the patient, physician or other provider
- Treatment is experimental or investigational
- Treatment is more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the patient's illness, injury or disease

Payments for Special Services

Digital Retinal Screening

Digital retinal screening may be designated as non-covered or fully-covered and will vary by group. The VBA'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 VBA. 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 VBA 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.

Fully-Covered
Some plans include a fully-covered benefit for retinal imaging. It may be submitted with an exam. See VBA's PRLS for information about reimbursement.

Non-Covered
Some plans include a non-covered discount for retinal imaging. It may be submitted with an exam. See VBA's PRLS for information about Member Cost.

Low Vision Aids (LVAs)

All LVA claims are Out-of-Network (OON). LVA are only reimbursable if the group has elected a LVA allowance. The member will be required to pay the provider in full and submit an OON reimbursement form to VBA with a letter of medical necessity. The plan will reimburse the member up to the maximum allowable under the plan rules, once every 24 months unless another frequency is listed on the account.

Fee For Growth

VBA began phasing out the fee for growth in 2013 and was eliminated completely July 1, 2015. VBA has not withheld any funds since 2015 and has no intent to do so in the future.

The only doctors who were eligible and received Fee for Growth refunds were on the panel prior to 1983 (while the VBA was still VSP of Pennsylvania). Prior to 1983, the fees were guaranteed refundable, and thereafter became discretionary.

Vision Care Exam

Eye Exam Requirements

A vision care exam with refraction is covered if the member is eligible. When providing a vision care exam as part of covered services to a member, the following tests and services must be performed:

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

Additionally, dilation shall be performed as part of a vision care 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 VBA 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 VBA but shall be submitted through the member's medical plan.

Pupillary Distance Measurement & the Prescription

At the federal level, the Federal Trade Commission's (FTC) Eyeglass Rule includes prescription requirements. PD measurements are not required to be included in a prescription.

Alaska, Arizona, Kansas, Massachusetts and New Mexico have their own laws requiring PD measurements to be included in the prescription.

Second Opinions

Most groups cover one vision care exam per benefit period. On occasion, a member may contact VBA because they are having difficulty seeing out of the glasses they have ordered with the prescription from the exam rendered using the VBA vision care exam benefit at an in-network provider.

Prescription Dispute Program

VBA's Prescription Dispute Program is a courtesy offered to members on a one-time basis to receive an off-cycle vision care exam. To be eligible for the program, a member must have:

a. Contacted the dispensing provider,

b. Received one remake from the dispensing provider, and

c. Received their glasses no more than ninety (90) days prior.

It does not include additional remakes, frames or contact lenses. If the member chooses to purchase new frames or change lens options, it is considered a private pay transaction.

Off-Cycle Vision Care Exam
The member must receive an exam and submit the new prescription to VBA within thirty (30) days of approval for the Prescription Dispute Program. If a member receives an exam through VBA's Prescription Dispute Program, please provide the member with a copy of the new prescription to submit to VBA. Exam copayments do not apply.

VBA must review the prescription prior to ordering new lenses. Do not order lenses until you receive notification from VBA that lenses are approved.

Off-Cycle Lenses
Once approved, the member must order lenses with the new prescription within thirty (30) days of approval for off-cycle lenses through the Prescription Dispute Program. Through this program, the member is authorized to receive the same lens options as originally purchased. In some cases, you may not be able to order lenses from the same manufacturer. If that is the case, select a lens from the same category. For example, If the member previously ordered Varilux Comfort W2+, you may select a different Premium 2 Progressive Lens from VBA's PRLS.

Copayments and member out-of-pocket expenses do not apply.

When submitting the member's claim for payment using VBA's Provider Portal, you may be prompted to collect copayments or member out-of-pocket charges for the lenses or options listed above. Do not collect copayments or member out-of-pocket charges. VBA will process a billing adjustment so that your office will not incur the overages associated with the above lenses and options minus dispensing fees.

If the member does not order new lenses within thirty (30) calendar days, no further relief will be granted by VBA.

No refunds will be issued for the materials and services received from the original exam and eyeglass purchase. If the member chooses to purchase new frames, change lens options or order contact lenses, it is considered a private pay transaction.

Elective Contact Lenses

Contact Lens Fitting Fee
Contact lens fittings allow the provider to evaluate the member for potential risk factors that may cause eye conditions from improper contact lens fit. For first time wearers or wearers choosing a new lens, the provider may provide the member with training and education on how to properly care for and wear their new lenses.

Total Allowance Plan
If eligible, the member can elect to receive credit towards the purchase of contact lenses in the amount indicated by VBA's Provider Portal. The total allowance is applied to the cost of the vision care exam, fit, lenses and evaluation. If contacts are not dispensed, VBA will only reimburse for the vision care exam. Claims may not be submitted for contact lens fittings unless contact lenses are dispensed. Submission of a claim for a vision care exam shall reduce the member's contact lens benefit by the amount of VBA's Reimbursement.

Vision care exam copayments do not apply when a member utilizes a contact lens material benefit that is being filed concurrently with the vision care exam and contact lens fit.

Exam Plus Plan
If eligible, the member is entitled to receive a vision care exam and a separate allowance in the amount indicated by VBA's Provider Portal for contact lens fitting and materials only. After completion of the vision care exam, the contact lens fitting fee may be charged directly to the member at 85% of your Usual and Customary Fee at the time of the visit.

Exam Plus+ Plan

If eligible, the member is entitled to receive a vision care exam and a separate allowance for contact lens fitting and materials only. After completion of the vision care exam, the fitting levels and corresponding member fee limits are as follows:

Standard Fit
Standard Fit is for clear, soft, spherical daily wear contact lenses for single vision prescriptions of < 4 diopters. See VBA's PRLS for information about member cost.

Premium Fit
Premium Fit includes, but is not limited to, spherical daily wear contact lenses for single vision prescriptions > 4 diopters, all extended wear, toric, bifocal/ multifocal and new contact lens patients. See VBA's PRLS for information about member cost.

Follow-up Care, Training and Education

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

Contact Lens Prescription and Materials Dispensing Requirements

You must comply with the FTC Fairness to Contact Lens Consumers Act (15 USC §§ 7601-7610).

Eyeglass Frames and Lenses

Frame Requirements

Frames must meet ANSI Z80.5 Requirements For Ophthalmic Frames.

Members can apply their benefits to any frame available in your dispensary.

Safety Eyewear

Safety eyewear dispensed under the Safety Eyewear Plan must meet ANSI Z87.1 American National Standard for Occupational And Educational Personal Eye And Face Protection Devices.

Both the laboratory and the provider are responsible for ensuring that safety glasses meet ANSI and other applicable industry requirements.

If a member has a frame benefit, but does not have a Safety Eyewear Plan, they may use it to purchase safety glasses if they are eligible.

Scratch coating warranties apply to safety glass lenses manufactured at an in-network lab.

Sunglass Frames

If a member has a frame benefit, but does not have a standalone sunglass plan, they may use it to purchase sunglasses, if they are eligible.

Oakley, Maui Jim, Ray-Ban and Costa Frames
In most cases, these sunglass brands are excluded from insurance use. These are premium brands with premium lenses only offered through their own specialty labs that do not accept insurance. If the member's plan offers coverage for PLANO lenses and includes OON benefits, the member may be eligible for OON reimbursement for purchasing one of these premium sunglass brands.

In some instances, a provider's office may elect to allow a member with fully-covered PLANO lenses to use their in-network frame benefit when purchasing these premium sunglass brands.

Sports Goggles

If a member has a frame benefit, they may use it to purchase sports goggles, if they are eligible. This does not include custom Prescription ski lenses.

Reading Glasses

Over-the-counter reading glasses are not covered. Reading glasses may be reimbursed if the lenses are manufactured by an in-network laboratory.

Frame Restrictions

Some frame manufacturers have restrictions on which frames can be discounted. It is up to you to be aware of restrictions on the frames you carry.

Frame Dispensing

The professional service of dispensing the frame to the patient may include frame adjustment, nose pad adjustment, alignment, and delivery to the patient.

VBA reimburses providers for frame dispensing fees if a frame is purchased using the patient's frame benefit. The VBA reimbursement includes the eyeglass case and any postage.

Lens Requirements

Standard Lenses

All standard lenses must include a minimum of a one (1) year one time replacement warranty from the laboratory. Replacements lenses are at the discretion of the laboratory and/or manufacturer.

ANSI Standards

All lenses must meet current ANSI standards.

Safety Eyewear Program Lens Requirements

All safety eyewear must meet current ANSI standards.

Sunglass Program Lens Requirements

All sunglasses must meet current ANSI standards.

Lens Dispensing

The professional service of dispensing lenses should follow manufacturer recommendations.

VBA reimburses providers for lens dispensing fees if lenes are purchased using the patient's frame benefit. The VBA reimbursement includes any postage.

Lens Sourcing

Ordering through a VBA In-Network Lab

Unless otherwise prohibited by law, you are required to use the VBA Laboratory Network to produce eyewear for members. Prior to submitting an order through a lab, you must have an account with that lab.

Ordering through an OON Lab

Contact VBA's provider relations department for each claim you would like to file using an OON lab. You must contact VBA prior to submitting the claim. If you elect to use an OON lab, you are responsible for remakes and warranties.

Progressive Lenses

See VBA's PRLS for more information on progressive lens categories.

Progressive Lenses and Aspheric Charges

Aspheric cannot be billed with progressives.

Anti-Reflective Treatments

See VBA's PRLS for more information on anti-reflective treatment categories.

Lens Options

UV Protection

When UV protection is already included in a premium product, do not collect the member out-of-pocket for or submit to VBA for reimbursement.

Sunglasses

Under most plans, sunglasses do require an Prescription, unless PLANO lenses are a covered option.

If the member does not have sunglass coverage under their plan, in lieu of getting dress glasses, they can add lens options such as tinting and polarization to their glasses to turn them into sunglasses.

PLANO

PLANO lenses are eyeglass lenses that provide no vision correction. To be considered a prescription lens, there must be an Prescription in one eye.

Fully-Covered

Some plans offer coverage for PLANO lenses. You may need to report a prescription in the VBA Provider Portal and include a note in both the lens and frame sections prior to submitting the claim that it is PLANO only.

You may only bill VBA for lenses customized and manufactured through a laboratory for the member.

Non-Covered

In most cases, plans do not offer coverage for PLANO lenses including frames with stock lenses. For in-network claims where a member purchases frames, a prescription lens must be purchased for the frame.

PLANO lenses are NOT a covered option for members whose plan does not include fully-covered PLANO lenses. VBA typically does not allow orders for Frame Only material purchases or reimbursement for OON claims for frames only.

For example, if a member is requesting to simply use their "frame" benefit toward eyeglass or sunglass frames at an optical store, they will not be able to use their insurance without purchasing prescription lenses.

If you receive prior approval from VBA for a member to purchase frames without ordering prescription lenses, the provider should remove the PLANO lenses from the frame prior to dispensing. Providers should notify the member that removal of lenses from the frame may void the manufacturer's warranty.

Stock Lenses

The provider cannot bill VBA for stock lenses. If a member has coverage for PLANO lenses, the provider does not need to remove the stock lenses from the frame.

Specialty Lenses

Biconcave

To order a biconcave lens, the provider must:

1. Obtain an authorization through the VBA Provider Portal.
2. Submit the lens order through the VBA Provider Portal order wizard to include all requested lens options, frame (if applicable) and exam (if applicable).

Prior to submitting the order, the provider must include a note in the Lens Notes section of the order wizard, saying "This order is for a Biconcave Lens. Please call (XXX) XXX-XXXX for more information.

Biconcave lens reimbursement is paid directly to the lab through an adjustment.

EnChroma Lenses

At this time, EnChroma lenses are not covered, and they cannot be ordered through our lab network.

Fresnel Prism

Fresnel Prisms are not covered and cannot be ordered through VBA or reimbursed through OON reimbursements.

Once a prescription lens is finalized that includes prism, a member may be covered for the lenses under their VBA plan.

Lenticular Lenses/Myopic Disk Lenses/Round 22 Bifocals

Lenticular lenses are used when very high lens powers are needed to reduce weight and thickness. Lenticular Lenses are available in a variety of lens materials

Lenticular Lenses are typically fully-covered items in group contracts. To order a Lenticular lens, the provider must:

1. Obtain an authorization through the VBA Provider Portal.
2. Submit the lens order through the VBA Provider Portal order wizard to include all requested lens options, frame (if applicable) and exam (if applicable).

Prior to submitting the order, the provider must include a note in the Lens Notes section of the order wizard, saying "This order is for a Lenticular/Myopic Disk/Round 22 Bifocal Lens. Please Call (XXX) XXX-XXXX for more information."

Lenticular Lenses, Myopic Disk Lenses and Round 22 Bifocals are paid directly to the lab through an adjustment.

Specialty Edging

Edging for Wrap Sunglasses is not covered. To order a specialty edging, the provider must:

1. Obtain an authorization through the VBA Provider Portal.
2. The provider must contact the lab to find out pricing prior to submitting the order.
3. Submit the lens order through the VBA Provider Portal order wizard to include all requested lens options, frame (if applicable) and vision care exam (if applicable).

Prior to submitting the order, the provider must include a note in the Lens Notes section of the order wizard saying "This order is for a Wrap Sunglass and requires a (Step, T or Advanced) Edging."

The lab will bill the provider directly for the specialty edging. The provider may charge the member out-of-pocket for the edging. It is considered a private pay transaction.

Claims

All claims must be submitted through VBA's Provider Portal unless the benefits need special processing.

Timely Filing

Once an authorization is issued by VBA's system, it is valid for sixty (60) days. All claims must be filed within 14 days of the authorization expiration date. If you do not file the claim in this time period, it will be denied, and you will not be able to collect money from the member.

VBA's Provider Relations Department can extend an authorization for you for up to 365 days from the date of service. Please contact us for more information.

Warranties, Guarantees, Exchanges and Returns

Lab and Manufacturer Warranties

All warranties that are offered on lenses or frames are done so through the VBA in-network, contracted lab or manufacturer. VBA is an insurance carrier and does not manufacture, produce or warrant any lenses, frames or other materials. Upon notice of a warranty claim, you are responsible for contacting the VBA in-network, contracted lab and/or manufacturer who produced the materials to make any arrangements to address the alleged defect or issue.

All warranties, remakes and cancellations are part of the VBA Lab Agreement and are offered by the in-network lab or manufacturer. If you use an OON lab, you are required to honor the same warranties and remakes.

Lab Remake

All lens remakes caused by a Participating Lab error will be completed at no charge to any party (including, but not limited to VBA, the ECP and the member). The Lab shall provide VBA with a description of the lab error and copy of the original invoice/ shipping slip. Incorrectly manufactured lenses shall be returned to the Participating Lab within two (2) months from the date the job is completed.

Lens Warranty Claims

While under warranty, replacement lenses will be completed at no charge. To initiate a Lens Warranty Claim, the Provider shall be required to return the damaged or defective lenses with a copy of the original invoice/ shipping slip as requested by the Participating Lab.

Non-adapts

For a period of sixty (60) calendar days from the original date of dispensing, Progressive and digital single vision lenses will be remade with a fitting change one time at no charge in the same design and material (or lesser priced design and material). If the member still cannot adapt after the no-charge replacement, the in-network lab will remake the Prescription into conventional lenses and bill the provider.

Varilux

Within 365 days of delivery, if the member is not satisfied with the progressive addition lenses, the in-network lab will remake the progressive addition lenses with a fitting change one time at no charge in the same progressive design and material (or lesser priced design or material). If the member still cannot adapt after the no-charge replacement, the lab will remake the Prescription into conventional lenses at full charge to the provider OR within 365 days of delivery, if the member is not satisfied or cannot adapt to the original progressive lenses and prefers to go directly from the original progressive Prescription to conventional lenses, the original progressive lenses will be credited and the conventional lenses will be billed to the ECP.

Scratch

All scratch resistant coated lenses shall be guaranteed by the lab or manufacturer for one year from date of order and will be replaced at no charge during that one year in the same prescription and original frame at no additional charge if damaged due to scratching. Lenses must be replaced in identical form. A maximum of one replacement per Prescription order is allowed. Front surface scratches through normal use will be covered; however, abuse of the lens, as determined at the discretion of the manufacturer, will not be covered.

Anti-Reflective

Anti-reflective coatings shall be warranted by the lab or manufacturer for one year, one time replacement in the same prescription and original frame at no additional charge. Lenses must be replaced in identical form.

Crizal

Lenses are manufacturer guaranteed for two years, two-time replacement. If a member is wearing lenses coated with Crizal, the in-network lab will stand behind these with a one hundred percent (100%) patient satisfaction guarantee. In the event a member is dissatisfied for any reason with the performance of his or her Crizal lenses, the lab will replace them with scratch resistant lenses, without AR, in the same prescription and original frame at no additional charge.

Lens Remake

First-time remakes for lenses shall be completed at no charge to the provider or member if the following criteria are met:

1. Notification and request submitted to the Participating Lab within two (2) months from the date the job is completed. The provider must return the lenses and a copy of the original invoice/shipping slip to the Lab with the remake request.
2. Not a frame change alone except in extreme circumstances where a new frame needs to be selected to accommodate progressive lens Prescription, prism or other Prescription need.
3. Only the first remake is eligible for no-cost completion. Subsequent remake requests on the same job shall be billed to the provider and be considered a private pay transaction.

Requests due solely to upgrade requests, and/or lost, broken or damaged lens are not eligible to be remade. Eligible remakes shall also require at least one of the following:

- Power changes (not including changes resulting in Plano lenses)
- Axis changes
- Segment height/segment style changes due to no adaptation (i.e., FT28 to Executive)
- Change in lens style (i.e., TF to BF, BF to SV, or any other base lens change, PAL to non-PAL lens style)
- Errors in transcription
- Change in materials (i.e., glass to plastic, plastic to poly, plastic to high index plastic or glass, etc.)
- Changes in base curves
- Lenses within ANSI standards but rejected by ECP

Frame changes

A request involving a frame change shall not be eligible for a no-cost remake under this policy if it is due to ECP's error or the member's dissatisfaction with the style, shape, size or fit of the frame. In such an event, the ECP will be required to submit the remake request and ship the new frame to the lab and will be billed in full for completion of the same.

Cancellations

The manufacturing process is considered initiated as soon as the lab order has been accepted by the lab through the VBA Lab Portal. At the lab's sole discretion, a cancellation of a lab order in manufacturing may result in the lab order being billed to the provider.

Protection Plans

Plans do not offer coverage for protection plans, additional product warranties, replacement plans or club memberships. You are welcome to offer members the option to purchase an extended protection plan through your office. You must notify the member that the extended protection plan is a private pay transaction.

Return Policies

If you have a specific return policy that will not impact a member's benefits or eligibility, share the policy with the member at the time of dispensing.

Issues with Lenses and/or Frames

VBA does not allow returns and/or refunds. If a member is experiencing an issue and requests a return and refund for materials purchased using their benefits, contact VBA prior to refunding their money.

Group Requirements

GR # 099 – VBA

The members of this group are VBA employees and their dependents. Employees and dependents are eligible for one vision care exam and two material benefits per year. Utilization of the second benefit per year by dependents requires a manual authorization request through VBA's Provider Relations Department. Members may select PLANO lenses. Additional terms, conditions and restrictions apply. Contact VBA's Provider Relations Department for more information.

GR # 115 – Delaware Technical & Community College

The members of this group use the last four digits of their state ID instead of the last four digits of their SSN.

GR# 638 - Industries of the Blind Inc.

If an employee is blind in one or both eyes, the employee may purchase PLANO, polycarbonate lenses as a fully-covered option. This group has elected to offer this option to employees only to protect the employees' eyes.

Providers should contact the Provider Relations team to obtain prior approval from the Benefit Relations Supervisor. Once approved, the provider will submit the claim as usual, but not collect any OOP for polycarbonate. After the claim is processed, Provider Relations will process a manual billing adjustment.

Change Summary

The Change Summary log below will be used to document revisions that are made after the initial publication of this manual.

Version	Date	Change Description