NATIONAL VISION ADMINISTRATORS

PROCEDURE MANUAL

Benefits/Eligibility | **File Claims** | **Plan Sheets (member benefits)** | **Obtain Authorizations**

PROVIDER PROCEDURE MANUAL

Table of Contents

Bylaws and Rules or Regulations (incorporated herein by reference and available upon written request)

IMPORTANT ADDRESS AND TELEPHONE NUMBERS

Customer Service/Provider Services
National Vision Administrators, L.L.C.
P.O. Box 2187
Clifton, NJ 07015
888-682-2020

E-mail address for Provider Services Department: providers@e-nva.com
(Use for change of address, telephone number, to add associate, or to report inaccurate information)

E-mail address for Prior Approvals (PA): priorapprovals@e-nva.com
(Use to request PA for Medical Necessity with form attached)

E-mail address for Service Issues: nva_customerservice@e-nva.com
(Use to report service issues for yourself or on behalf of a patient)

Customer Service/Member Services – NVA
National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015
888-672-7723, TTY: 711

Credentialing
National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015
Attn: Credentialing Department
credentialing@e-nva.com

Paper - vision claims should be sent to:
NVA - Claims
P.O. Box 2187
Clifton, NJ 07015

Fraud Hotline
888-328-0421

ELIGIBILITY AND VERIFICATION AUTHORIZATIONS

Most but not all Sponsors will issue an Identification Card to Eligible Members. Identification cards are **not** proof of eligibility for services. Participating Provider must contact NVA to verify eligibility in accordance with the Participating Provider Agreement and *receive an authorization number to provide services to Eligible Members.*

Participating Provider shall obtain eligibility confirmation and authorization numbers through one of the following methods:

NVA Website - WWW.E-NVA.COM:

By going to the NVA website (www.e-nva.com), you can verify member eligibility and obtain authorizations by following this process.

Simply go to the "search for subscriber" option and choose the specific member that you will be servicing. From there, you can go to the "eligibility details" page, which will allow you to select currently eligible services that the member can receive. Once you have submitted these services for authorization, you will be then sent to a confirmation page that will give you an authorization number to be used when submitting claims.

Should you have any issues navigating the NVA website, please contact us during normal business hours, so that we may assist you (please see contact info below).

24/7 – Toll free, Interactive Voice Response System (IVR) – 888-682-2020

NVA maintains an automated system to handle inquiries more efficiently. The IVR system has been designed to allow providers access to eligibility information, payment information and to obtain authorization numbers.

To utilize the IVR System simply call 1-888-682-2020 and follow the voice instructions. Please note that the Provider must use his or her NVA Pin Number to access the information. Your Provider Pin Number is the six-digit number on the label that is provided to you by NVA.

Should you have a problem using the IVR system during regular business hours, NVA maintains a 24/7 Provider Services Help Desk to assist you in verifying patient eligibility for services.

NVA Provider Services Help Desk (available 24/7/365): 1-888- 682-2020

CLAIMS SUBMISSION

Participating Provider must submit all claims for Vision Care Services to NVA via one of the following methods: Electronic Submission

Claims may be submitted electronically by visiting the NVA website **www.e-nva.com** and directly filing claims on-line. Using the web expedites payment through faster transmission and processing times. It is the fastest method for processing claims.

www.e-nva.com will edit your claim submission for you to be sure that completed claims are submitted and help to avoid delay in processing and payment. All claims should be checked for accuracy before submitting to NVA for processing. Claims without sufficient information to process will be returned to you.

To avoid duplication, claims that are submitted electronically should not be mailed, and mailed claims should not be submitted electronically. NVA will only process one claim per patient visit.

To submit claims electronically via the website at www.e-nva.com

1. Visit the NVA website at www.e-nva.com and register as a participating provider if you are a first-time user. To register you will need your Tax ID number and suffix code and an email address. Your Provider suffix code is the four-digit number that will be provided to you by NVA. Follow the onscreen directions to complete your registration. If you are already registered, login.
2. Once you login, you can select 'Submit Claims with Authorization' from the menu at the left of the screen.
3. Select the authorization number you are submitting claims, or;
4. Once you have chosen the authorization number, you can select 'Enter Claim' and complete the online Vision Claim Form according to the services provided. Submit once the Vision Claim Form is completely filled out.

Paper Claims Submission: If you cannot submit claims over the Internet, you may submit claims on an NVA issued Claim for Vision Care Expense form or on a CMS approved 1500 Form. The form must be filled out completely and legibly. In order to be processed the completed claim form must include but will not be limited to the following information:

a) Participating Provider Number;
b) Sponsor Plan Number (Optional);
c) Eligible Member Identification Number; and
d) Authorization Number received from NVA

All claims should be checked for accuracy before submitting to NVA for processing. Claims without sufficient information to process will be returned to you.

All paper submissions shall be mailed to the following address:

NVA
P.O. Box 2187
Clifton, New Jersey 07015-2187

Timely Filing: Any and all claims shall be submitted within forty-five (45) days from the date of performing the service(s).

Referrals: Referrals are not necessary for routine vision services.

Pre-authorization: Charges for vision services that are not expressly indicated in the Sponsor Plan Description that may be eligible for reimbursement in the sponsor's plan require preauthorization by NVA prior to rendering of the services and submitting the claim for processing. Participating Provider should call the NVA Call Center at 1-888-682-2020 to verify coverage and to obtain preauthorization for Vision Care Services diagnosed at the time of the initial eye exam. NVA shall verify eligibility for services being requested and will provide an authorization number to Participating Provider. This preauthorization number is unique to the service being requested and is not the same number received from NVA under the process to verify eligibility described in section Eligibility Verification and Authorizations. For additional information See Section 4, Services Requiring Prior Authorization.

Claims Appeals: If payment for services is denied in whole or in part, you may appeal the decision by requesting a review in writing. All claim reviews are handled in accordance with the NVA Appeal and Grievance Policies and Procedures, defined herein. All appeals must be submitted in writing and within ninety (90) days from the date of denial or as set forth by the specific state law requirements for the state where the services were rendered. See Section 6, Appeal and Grievance Process.

Missing Claims: If a Participating Provider submitted a claim, but the claim does not appear on the Participating Provider's check statement or Explanation of Benefits within forty-five (45) days from the date of Claims Submission, Participating Provider shall submit a copy of the Claim Submission with a written explanation identifying the date of submission.

Corrected Claim Submission: If an original claim was filed erroneously or included incorrect information, please resubmit a paper claim on a new Claim Form that includes the notation "CORRECTED CLAIM" in the upper right-hand corner of the Claim Form. Please mail the claim to:

NVA Claims Department
PO Box 2187
Clifton , New Jersey 07015

Please include a written explanation of the corrections and a copy of the originally filed claim. Any Corrected Claims shall be submitted within ninety (90) days from the date of performing the associated service(s).

Reimbursement shall be the lower of the Reasonable and Customary charges described by the Participating Provider and submitted through the Participating Provider's most recent credentialing application or the scheduled amount in the sponsor's Plan Description defined in Section 9, Sponsor Designated Plan Description.

In order to determine the status of your EFT Enrollment application, if applicable, please contact us at EFTNVA@e-nva.com.

SERVICES REQUIRING NVA's PRIOR AUTHORIZATION

After verification of the Eligible Member's Eligibility to receive Vision care Services benefits, Participating Provider shall review the Sponsor's Plan Description described in section 9 to determine if the services are Vision Care Services to be reimbursed by Sponsor or if the services require Prior Authorization or if the services are not considered benefits through the Sponsor's Plan Description.

In the event the Sponsor's Plan Description requires Prior Authorization for the service as defined above, the following shall apply:

Sponsor Plan Descriptions may include services that are not routinely covered as part of the Vision Care Services benefits. In order to obtain reimbursement for the Vision Care Services, Participating Provider shall submit via fax or mail the laboratory invoice to NVA for prior written approval to provide the Vision Care Services to an Eligible Member.

IMPORTANTPlease call NVA for a Prior Authorization Number **BEFORE** the claim is submitted. A copy of the laboratory invoice is REQUIRED with the claim form when it is submitted with a PRIOR AUTHORIZATION.

Medically Necessary Contact Lenses (MNCL)

There are some members plans that cover Medically Necessary contact lenses. All requests for MNCL must be reviewed and approved by an optometric consultant. An optometric consultant must follow the required process for review and approval based on the clients contracted benefits. The procedure to request prior approval is:

1. ECP's must request prior approval for Medically Necessary Contact Lenses in writing and include medical record documentation that supports the request. ECPs must also include a statement of fees that itemizes the fitting fee and cost of the lenses.

2. The optometric consultant will review the request and the medical records against the established criteria, to determine the presence of a qualifying condition. If approved, the amount to be paid will be based on the lesser of the billed amount or statement of fees from the ECP up to established Reasonable levels and coverage amounts.

3. For Plans that do not cover the fitting and follow up, the provider may bill the member their customary fee.

The NVA Peer Review Committee recommends that the Usual, Customary and Reasonable fees for medically necessary Hybrid (hard central lens surrounded by a soft carrier) and other specialty lens i.e. mini- scleral for the correction of keratoconus, be set at a total of $1400. The Provider will be paid up to $600 for fitting and follow-up (If a covered benefit) and up to $800 for the contact lenses.

Billing for Cosmetic Contact Lenses

NVA has been reviewing its benefits for contact lens fittings and follow up. In order to clarify the benefit, we recognize 3 types of fittings:

- **Standard Daily Wear (DW)**
  (*Re-useable or disposable, single vision spherical lenses, conventional hydrogel, silicone hydrogel lenses or PMMA 'hard lenses' for daily use only)*

- **Standard Extended Wear (EW)**
  (For continuous overnight wear from 2 to 30 days)

- **Specialty Fit (SF)**
  (Toric, Multifocal and Rigid Gas Permeable)

NVA has two methods of handling contact Lenses and contact Lens fitting benefits. Each type will require different coding with modifiers in order for the claims to process correctly. You will know the type of benefit the member has at the time you check eligibility.

Below are the coding guidelines you must use **effective January 1, 2018**. If the code with the appropriate modifier is not present on the claim it will reject, and you will be required to resubmit for payment.

Type 1: The contact lens fitting coverage is included in the contact lens allowance. For example, the member has $150 allowance toward contact lenses and the fitting and follow up. The codes to use to bill for the fitting are as follows (**no modifiers are needed)**:

- 92310
- 92311
- 92312

Type 2: The contact lens fitting and follow up are covered and paid in addition to the contact lens material allowance.

STANDARD DAILY WEAR (DW)	STANDARD EXTENDED WEAR	SPECIALTY FIT
92310 DW	92310 EW	92310 SF
92311 DW	92311 EW	92311 SF
92312 DW	92312 EW	92312 SF

We encourage you to use the provider portal on the NVA website to submit your claims. If you use the portal these codes will be presented to you automatically. By submitting your claims through the portal your payments will be processed more quickly.

Coordination of Benefits (COB)

When NVA is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. The payment made by the primary carrier must be indicated in the appropriate COB field, on a CMS 1500 Form. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, NVA will consider the claim paid in full and no further payment will be made on the claim. Examples of Coordination of Benefits may include no fault insurance carriers and worker's compensation claims. Only paper (CMS-1500) claim forms may be utilized to report a claim with COB information.

Filing Limits

Any claim received beyond the timely filing limit of 180 days will be denied for "untimely filing." unless the requirement in the State of services is longer. If a claim is denied for "untimely filing", the provider cannot bill the member. If NVA is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier. Claims that are initially denied for timely filing may be resubmitted within 60 additional days if it can be demonstrated that they could not have been submitted within the 180 days.

Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, NVA performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and provider identifying information. When potential problems are identified, your office may be contacted and asked to assist in resolving the problem. Please contact our Provider Services Department with any questions you may have regarding claim submission or your remittance.

Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

NVA has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIIPAA. One aspect of our compliance plan is to work cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, NVA has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate vision/medical, financial and administrative records related to covered services rendered by Provider in accordance with federal and state law.

- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.

- Neither NVA nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with NVA in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and NVA agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this Provider Manual reflect the most current coding standards (CPT-5 and HCPCS). Effective the date of this manual, NVA will require providers to submit all claims with the proper CPT-5 or HCPCS codes listed in this manual. In addition, all paper claims must be submitted on the current approved claim form. The current mandated ICD-10 diagnoses codes must be provided.

Note: Copies of NVA's HIPAA policies are available upon request by contacting NVA's Provider Services Department at, or via e-mail at providers@e-nva.com.

QUALITY IMPROVEMENT (QI) PROGRAM

NVA currently administers a Quality Improvement (QI) Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to ancillary services. The Quality Improvement program includes:

- Provider Credentialing and Re-credentialing.
- Member Satisfaction Surveys.
- Provider Satisfaction Surveys.
- Random Chart Audits.
- Member Complaint Monitoring and Trending.
- Peer Review Process.
- Site Reviews and Vision Record Reviews.
- Quality Indicator tracking (i.e., complaint rate, appointment waiting time, access to care, etc.).

A copy of NVA's QI Program is available, upon request, by contacting NVA's Provider Services Department at 888-682-2020 or via e-mail at providers@e-nva.com.

FRAUD, WASTE, AND ABUSE (FWA)

Health care fraud costs taxpayers tens of billions of dollars every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. There are several stages to addressing fraudulent acts, including detection, prevention, investigation, and reporting. In this section, NVA provides information on how to help prevent participant and provider fraud by identifying the different types.

Many types of fraud, waste, and abuse have been identified, including:

- **Provider Fraud, Waste, and Abuse**:
  - Billing for services not rendered
  - Billing for services that were not medically necessary
  - Double billing
  - Unbundling services
  - Up coding services

Providers can prevent fraud, waste, and abuse by ensuring that services rendered are medically necessary, accurately documented in the medical records, and billed according to NVA guidelines.

- **Participant Fraud, Waste, and Abuse**:
  - Benefit sharing
  - Collusion
  - Drug trafficking
  - Forgery
  - Illicit drug seeking
  - Impersonation
  - Misinformation/misrepresentation
  - Subrogation/third-party liability fraud
  - Transportation fraud

One of the most important steps to help prevent participant fraud is as simple as reviewing the participant's ID card. NVA will not accept responsibility for the costs incurred by providers rendering services to a patient who is not a current NVA participant, even if that patient presents a NVA participant ID card. Providers should take measures to ensure the cardholder is the person named on the card and his or her participation in NVA is up to date by obtaining an authorization from NVA for the services.

Additionally, providers can assist in encouraging participants and their caregivers to protect their cards as they would a credit card or cash; carry their participant ID card at all times; and report any lost or stolen cards as soon as possible.

NVA encourages its participants, participants' representatives, and providers to immediately report any suspected instance of fraud, waste, and abuse. No individual who reports violations or suspected fraud, waste, or abuse will be retaliated against, and NVA will make every effort to maintain anonymity and confidentiality.

You can contact NVA's Fraud and Abuse Hotline at **888-328-0421.**

CREDENTIALING

NVA, in conjunction with the Plan, has the sole right to determine which Providers (O.D., M.D., and D.O) it shall accept and continue as Participating Providers. The purpose of NVA's credentialing program is to credential Eye Care Professionals (ECPs) through development of a credentialing standard for identifying competent ECPs who are eligible to participate in National Vision Administrators, L.L.C. (NVA) networks. The thorough review of each ECP's credentials is a critical part of NVA's overall service offering to its clients. NVA has established a set of rules for the gathering and review of ECP credentialing information that promotes a fair, impartial and stringent process.

Nothing in this Credentialing Plan limits NVA's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits NVA's right to permit restricted participation by a vision office or NVA's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan.

Initial and Re-Credentialing Applications

A complete application shall consist of the following:

- Completed and signed NVA Provider Agreement and a CAQH provider application.
- Copy of current state license.
- Copy of current DEA and/or CDS certification, if applicable.
- Proof of current professional liability.
- Evidence of Board Certification, if applicable.
- Signed W-9.
- NPI number, and Medicaid, Medicare and/or UPIN, as applicable.

Appeal of Credentialing Committee Recommendations

NVA maintains an appeal process for providers who received adverse network determinations during the recredentialing or on-going monitoring process. ECP initial appeals are initiated by written application for reconsideration to the Credentialing Committee within 30 calendar days of the ECPs receipt of the adverse decision. Failure to initiate the appeal in writing within 30 calendar days results in forfeiture of appeal rights. The Credentialing Committee reserves the right, in its sole discretion, to extend these time periods upon good cause shown.

Discipline of Providers

NVA believes in and works hard to maintain positive professional relations with our provider network. In rare instances, it may become necessary to discipline a provider up to and including termination from the program. NVA maintains the right to take such action under the terms of the Provider Agreement that all providers are required to sign prior to beginning participation.

Re-credentialing

After initial credentialing, NVA re-credentials ECPs at least every 36 months to verify compliance with the National Committee for Quality Assurance (NCQA) standard. The re-credentialing cycle is calculated from month/year to month/year. For example, a provider initially credentialed on 3/19/2019, must be re-credentialed no later than 3/31/2022.

Note: The aforementioned policies are available upon request by contacting NVA's Provider Services Department at 888-682-2020 or via e-mail at providers@e-nva.com.

STANDARDS OF CARE – ROUTINE CARE

Examination Standards

An intermediate or comprehensive eye examination shall include all of the following items and all findings shall be completely and legibly documented in the patient's record with quantitative/numerical findings where appropriate.

Current Status

1. Patient demographics (age/DOB, gender, race).
2. Personal and family medical and ocular history.
3. All current medications and medication allergies.
4. Patient's assessment of current vision status, use of eyeglasses or contact lenses.
5. Chief complaint/reason for visit.

Vision Assessment

1. Visual acuities in each eye at distance and near with or without correction.
2. Objective and subjective refraction at distance and near with the best corrected visual acuity at distance and near.
3. Gross and quantitative evaluation of color vision and the accommodative and binocular abilities of the patient.

Eye Health Assessment

1. Evaluation of external structures: lids, lashes, conjunctiva, gross visual fields, and pupil anatomy and responses (direct, indirect, accommodative, and afferent defects).
2 Bio-microscopic examination of the cornea, iris, lens, anterior chamber, anterior chamber angle estimation, and measurement of the intra-ocular pressure (specifying instrument and time).
3 Ophthalmoscopic examination of the internal eye structures including the vitreous, retina, blood vessels, optic nerve head (including C-D ratios), macula and peripheral retina.
4. Dilated/binocular indirect ophthalmoscopic, retinal examination should be performed when professionally indicated.

Disposition

1. List all diagnoses, prescriptions and treatment recommendations including, but not limited to:
    a. Refractive and eye health diagnoses
    b. Eyeglass and contact lens prescriptions
    c. Medications prescribed and/or treatment plans
    d. Patient education on their ocular status and any increased risk factors for any personal or family conditions.
    e. Recall/re-examination/referral recommendations
2. Doctor's signature and date

The Patient Record

A. Organization

The patient record must have areas for documentation of the following registration and administrative information:

a. Patient's first and last name.
b. Parent of guardian's name, if appropriate.
c. Date of Birth.
d. Gender.
e. Race.
f. Address.
g. Telephone number/numbers.
h. Emergency contact person and telephone number.
i. Primary care physician.
j. Medicaid ID Number or other identification number.

In addition to the patient registration information, the patient record must contain the examination data from all prior visits, all ancillary test results, consultation requests and reports, copies of all Prior Approval Requests and Non- Covered Services Agreements, and all eyewear and/or contact lens specifications.

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Each individual page of the patient record must contain the patient's name and/or identification number and the date the care recorded on that sheet was provided.

B. Content

For every routine examination, the patient examination record should contain all of the information including the recording of all of the detailed qualitative and quantitative information as described in the examination standards, 8.01, above.

Emergency and non-routine examination visits should contain all of the relevant clinical data and history to adequately describe the situation/condition at hand and support the diagnoses and treatments provided as appropriate for the situation.

C. Compliance

All entries in the record are legible and located consistently within the record.

Symbols and abbreviations used in the record must be uniform, easily understood and are commonly accepted within the profession.

The entire patient record should be maintained as a unit for at least the most recent seven (7) years or the time period required by the State Board of Registration, whichever is greater. For minors, records must be maintained until they reach majority (age 18), plus seven (7) years at minimum.

The patient record should be maintained in a format that will allow the doctor to make the entire record available to NVA for routine Quality Assurance review activities.

Electronic medical records (EMR) utilizing default settings must ensure that the defaults are appropriate for the specific patient or are modified to present an actual and accurate clinical picture.

NON-COVERED SERVICES AGREEMENT FORM

Recommended - Directions and Use

NVA has included the following non-covered services agreement form for use when members request services that are not covered under the plan certificate. Members may be billed for non-covered services in the event that they willingly elect to receive such non-covered services, understand the financial responsibility involved in receiving such services, and agree to be financially responsible for such services.

As a provider, you have agreed to hold covered members harmless for covered services, and you should make best efforts to minimize out-of-pocket expenses. In select circumstances, when the aforementioned requirements have been fulfilled, members may be financially responsible for non-covered services. The disclosure and agreement form has been provided as an option for securing member consent of financial responsibility. Examples of circumstances where members may be billed include:

- Non-Covered Frames
- Non-Covered Lens Types or Options
- Non-Covered Professional Services
- Cosmetic Contact Lenses (Member must acknowledge that cosmetic contact lenses are in lieu of eyeglasses for the current benefit period.)

Non-Covered Services Agreement

I,_____, being a patient of Dr. _____located at_____, do hereby acknowledge that it has been explained to me that a certain portion of my care will not be covered under the terms of my Benefit Coverage. The portion of care not covered is:

_____

_____.

I understand that acceptance of services or treatments not covered by NVA is voluntary and that I may refuse the service or treatments. I acknowledge that I have been told ***in advance of treatment*** what portion of my care I will have to self-pay for, and I agree to make financial arrangements with the aforementioned Provider to pay for these services myself.

_____

(Patient Name - Print)

_____

(Patient Name - Signature) Date

Member I.D. # _____

Plan Name _____

Members: If you feel you have not been offered alternatives that are within the benefit limits and/or allowance amount, or feel uncomfortable signing this agreement, please contact member services at the number listed below before signing.

Customer Service/Member Services 1- 888-682-2020

UTILIZATION REVIEW PROGRAM

NVA monitors and reviews the services and data received from Participating Providers to evaluate information regarding the demand, utilization trends and vision care needs for NVA clients. NVA's Utilization Review Program is designed to ensure quality and appropriate resource utilization and record reviews by NVA designated reviewers and auditors which will be completed in a timely manner. The information will be used for performance improvement activities and to develop and design programs to better meet the needs of the clients served by NVA.

On a regular basis, NVA will compile and analyze data received from Participating Providers in the NVA network. The claims and reimbursement data will be aggregated and analyzed for service trends.

Further, the medical record documentation to support the claims and reimbursement may be audited to validate and verify that the proper codes and reimbursement are being submitted by the Participating Providers.

In accordance with NVA policies for utilization review, NVA will evaluate the information to support the following goals:

1. Verify that the accuracy and validity of the Reasonable and Customary fees are equal to those submitted by the Participating Provider to NVA.

2. Verify that the records and Participating Provider's documentation supports the charges billed through the Claims Submission Process.

3. Verify that the procedure codes obtained through the Claims Submission Process is appropriate to the individual patient.

The Utilization Review Program will be used to improve the quality of services offered and to monitor accuracy in the services charged and payment practices.

APPEAL AND GRIEVANCE PROCESS

This process may be superseded by State law requirements and Participating Provider shall review his or her Participating Provider Agreement to determine if the Grievance process differs.

NVA shall process any and all claims in accordance with the applicable legal requirements and in accordance with the Sponsor Plan Descriptions. If a Participating Provider believes that a claim was denied or processed erroneously, the Participating Provider shall take the following steps in the order set forth below:

I. Request for Review:

1. Submit a written request to the department at the address listed below. The written request Shall include the following information:
   a. Copy of the original Claim.
   b. Written explanation of the objection to the NVA determination.
   c. Copy of the records for the Patient date of service.
   d. Detailed explanation of the amount of reimbursement that the ECP believes is due and owing.

2. The NVA Claims Department shall review the written request and the documentation and make a determination. The determination will be provided in writing to the participating provider.

II. Formal Appeal

1. If the Provider disagrees with the NVA determination the provider may request an appeal by submitting a written request to the NVA Vice President of Professional Services at the following address:

NVA Vice President of Professional Services
National Vision Administrators
1200 Route 46 West
Clifton, NJ 07013

The formal appeal request must be written and submitted within thirty (30) days of the receipt of the NVA Claims Department determination.

2. The Appeals Committee will review the requested Appeal, consider the Claims Submission Department determination, Sponsor Plan Description and make a determination. The determination shall be submitted in writing to the Participating provider within sixty (60) days.

III. Grievance Process:

1. If the Participating Provider disagrees with the Appeal Committees determination, Participating Provider may file a grievance. A Grievance is when the Claims Submission and Quality Assurance divisions have not been able to resolve the issue for the Participating Provider and the Participating Provider seeks a final determination regarding the matter.

2. The written request for a Grievance shall be submitted within ninety (90) days upon receipt of the Appeal Process determination.

3. Participating Provider shall submit the request in writing including any and all supporting documentation to the NVA Grievance Committee which shall have as a member at least one practicing Optometrist.

4. Grievance Committee shall consider all of the information relevant to the matter and the Participating Provider shall provide any materials or information requested by the Grievance Committee for consideration.

5. The Grievance Committee shall make a final determination and submit the determination in writing to the Participating Provider within ninety (90) days upon determination.

All appeals and grievances shall be monitored, aggregated and trended for performance improvement and quality assurance purposes.

QUALITY ASSURANCE PROGRAM

NVA maintains a comprehensive quality assurance program to assure efficient, timely and quality Vision Care Services and Administrative Services to both the Eligible Members and Sponsors. The Quality Assurance program coordinates activities throughout the NVA organization for continuous quality improvement. The Quality Assurance program encompasses multiple departments and committees to ensure proper aggregation and review of the organizational services, Eligible Member satisfaction, Sponsor satisfaction and improved quality vision care services for the community.

Objectives

- Continual development of the quality improvement processes throughout the organization.
- Ensuring collaboration and cooperation among NVA departmental managers on a regular basis.
- Analysis, review, and integration of national, state and client goals and initiatives.
- Provision of proactive and superior member and provider service to all customers.
- To provide providers, clients, and members with knowledge regarding their benefits.
- Continual development of our partnerships with participating providers.
- Continuing to achieve superior customer service.
- Providing and distributing the necessary resources, both human and technological, to support the quality improvement initiatives.
- Providing superior quality, cost-effective care within the plan guidelines using available financial resources.
- Reviewing methodologies to streamline the authorization process.
- Serving as the liaison with our clients to ensure compliance with all program requirements.
- To continue to adhere to existing HIPAA and other rules and guidelines and to monitor changes in the rules so that new policies and procedures can be developed.

NVA ORGANIZATIONAL LEADERSHIP

Compliance Committee of the Board of Directors

The Compliance Committee of the NVA Board has been established by the NVA Board of Directors to review all reports, findings and recommendations put forth by the NVA Compliance Committee through its representatives, the Chief Compliance Officer, Chair of the NVA Compliance Committee. The Board Compliance Committee meets quarterly.

Compliance Committee

The Compliance Committee is a standing committee that meets monthly and is charged with assisting NVA in adhering to its corporate commitment to abide by all state and federal regulations governing the legal and ethical conduct of our business. The Committee is chaired by the Chief Compliance Officer and includes the Chief Vision Officer, NVA Compliance Officer and other ad hoc members as necessary. The Compliance Committee creates the Annual Compliance Plan and oversees the Compliance Program. The committee reviews and approves Quality Assurance activities, and programs regarding Fraud, Waste, and Abuse, Compliance and Ethics, and HIPAA. The Quality Assurance Committee reports monthly to the Compliance Committee. The Compliance Committee reports quarterly to the Board Compliance Committee.

Quality Assurance/Utilization Management Committee

The Quality Assurance / Utilization Management (QA/UM) Committee is chaired by the NVA Compliance Officer and is comprised of the following additional members: Chief Vision Officer, SVP of Operations, VP Professional Services, a Vision Consultant and ad hoc members. The QA/UM Committee coordinates activities throughout all NVA departments for continuous quality improvement. The QA/UM committee meets monthly and is charged with carrying out NVA's Quality Assurance Program-including drafting and executing annual quality improvement work plans and all company policies. The Credentialing and Peer Review committees report to the QA Committee.

Peer Review Committee

The Peer Review Committee is a standing committee that meets monthly and on an ad hoc basis. The Committee is chaired by the Chief Vision Officer and is comprised of the VP of Professional Services, two additional Vision Consultants, the NVA Compliance Officer, and administrative staff. The Peer Review Committee reviews member complaints regarding quality of care issues, the results of quality reviews, issues identified through facility site reviews, standards of care, covered professional services, and other matters related to professional services. The Peer Review Committee is also responsible for reviewing any sanctions or licensing actions against any providers that may occur in the interim, prior to re-credentialing. The Peer Review Committee reports to the Quality Assurance Committee as noted above.

- Grievance, Appeals and Complaints Sub-Committee: reports to the Peer Review Committee. Consists of representatives of Account Management, Professional Services, Call Center, and Claims Department. Tasked with reviewing member and provider grievances, appeals and complaints and facilitating resolution of issues.

Credentialing Committee

The Credentialing Committee is a standing committee that meets monthly and is responsible for overseeing the NVA Credentialing Plan. The Committee is chaired by the Chief Vision Officer and is comprised of the VP of Professional Services, at least two additional Vision Consultants of appropriate specialties, the NVA Compliance Officer, and administrative staff. The Credentialing Committee reviews the initial applicants to be credentialed, all recredentialing files and any credentialing appeals.
The committee is also responsible for review and recommendation of policies and procedures.

PROVIDER ROLES AND RESPONSIBILITIES

Contracted providers and practitioners with NVA are obligated to comply with the following rules, regulations, and guidelines:

- Providers shall provide services that conform to accepted medical and surgical practice standards in the community as well as applicable standards. These standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, governmental or otherwise, from which providers and practitioners seek advice or guidance or to which they are subject for licensing and oversight.

- Providers must immediately notify NVA's Chief Vision Officer, in writing, of any of the following circumstances:
  - If their ability to carry out their professional responsibilities is restricted or impaired in any way
  - If their license to practice their respective profession is revoked, suspended, restricted, requires a practice monitor, or is limited in any way
  - If any adverse action is taken
  - If an investigation is initiated by any authorized local, state, or federal agency
  - If there are any new or pending malpractice actions
  - If there is any reduction, restriction, or denial of clinical privileges at any affiliated hospital

- Providers shall comply with all NVA administrative, participant referral, quality assurance, utilization management, reporting, and reimbursement protocols and procedures.

- Providers shall not differentiate or discriminate in the treatment of participants on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, health status, source of payment, or and any other category protected by law.

- Providers shall observe, protect, and promote the rights of participants.

- Providers shall cooperate and participate in all NVA peer review functions, including quality assurance, utilization review, administrative, and grievance procedures as established by NVA.

- Providers shall comply with all final determinations rendered by NVA peer review programs or external arbitrators for grievance procedures consistent with the terms and conditions of the provider's agreement with NVA.

- Providers shall notify NVA in writing of any change in office address, telephone number, or office hours. A minimum of thirty (30) calendar days advance notice is requested.

- Providers shall notify NVA at least ninety (90) calendar days in advance, in writing, of any decision to terminate their relationship with NVA or as required by the provider's agreement with NVA.

- Providers shall not under any circumstances, including non-payment by or insolvency of the Plan or NVA, bill, seek, or accept payment from Plan participants for covered services or benefits.

- Providers agree to maintain standards for the confidentiality of and documentation of participant medical/service records.

- Providers agree to retain medical/service records for 10 years after the last date of service or the length of time required by applicable law.
- Providers shall maintain appointment availability in accordance with federal and state requirements.
- Providers agree to continue care in progress during and after termination of a participant's enrollment in NVA for up to 60 days (so long as they maintain coverage under Medicare and/or Medicaid), or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the participant to another network provider.
- Providers must establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act (ADA).
- Providers shall notify NVA immediately in the event they cannot accept new patients.

Informed Consent

The provider must adhere to all federal and state requirements, including applicable requirements, for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent. Providers must additionally provide participants/representatives with complete information concerning their diagnosis, evaluation, treatment, and prognosis and grant them the opportunity to take part in decisions involving their health care.

Confidentiality

All Protected Health Information (PHI), as this term is defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 CFR § 164.501), related to services provided to participants shall be confidential pursuant to federal and state laws, rules, and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by federal or state laws, rules, and regulations.

Medical/Service records of all NVA participants shall be confidential and only be disclosed to and by the provider's staff in accordance with applicable laws and regulations.

You Can Help Protect Patient Confidentiality

Protecting privacy is an essential part of building a physician/patient relationship. You and your staff can help protect patient confidentiality by following these simple measures:

- Avoid discussing cases within earshot of other patients or visitors.
- If voices can be heard easily through exam room walls, consider adding soundproof panels or piping in soft music.
- Make sure computer screens that contain patient information are protected from general view.
- Be sure all patient care is provided out of sight from other patients (e.g., taking body weight, lab draws)
- Have an Office Confidentiality Policy for staff to read and keep in your office personnel files.

- Ask your patients and/or their authorized representatives to sign an Authorization to Release Information prior to releasing medical records to anyone.

- Have a protocol for sending confidential information via fax.

Office Wait Times

NVA participants with a previously scheduled appointment must not be made to wait longer than one (1) hour on a routine basis.

Cultural Competency

Cultural Competency is a process of developing and exercising proficiency in effectively communicating in a cross-cultural context. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word "competence" is used because it implies having the capacity to function effectively. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors including tailoring delivery to meet patients' social, cultural, and linguistic needs.

The term "culturally competent', as defined by the Developmental Disabilities Bill of Rights and Assistance Act of 2000 (DD Act), "means services, supports, or other assistance that is conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of individuals who are receiving the services, supports, or other assistance, and in a manner that has the greatest likelihood of ensuring their maximum participation in the program involved."

Cultural competency assists providers and participants to:

- Acknowledge the importance of culture and language
- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment. Some of the reasons that justify a provider's need for cultural competency include, but are not limited to:

- The perception that illness and disease and their causes vary by culture.
- The understanding that belief systems relating to health, healing, and wellness are very diverse.
- The recognition that an individual's cultural background influences help-seeking behaviors and attitudes toward health care providers.

- An acknowledgement that individual preferences affect traditional and non-traditional approaches to health care.

NVA strongly encourages providers to recognize cultural factors that shape personal and professional behavior and to accept that their own world views and those of the participant and/or his or her caregiver may differ while avoiding stereotyping and misapplication of scientific knowledge.

NVA staff will gladly assist providers who may have questions or require help in accessing needed resources such as language translation services.

Americans with Disabilities Act Requirements

The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 is a civil rights law that prohibits discrimination against individuals with disabilities in programs or activities that receive federal financial assistance, including Medicare and Medicaid. This legislation requires that medical providers offer individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable accommodations to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the essential nature of the services

NVA's policies and procedures are designed to promote compliance with the ADA. Providers are strongly encouraged to take actions to remove an existing barrier and/or to accommodate the needs of NVA participants, many of whom have some degree of physical disability. This action plan includes the following:

- Providing reasonable accommodations to individuals with hearing, vision, cognitive, and psychiatric disabilities
- Utilizing waiting room and exam room furniture that meets the needs of all participants, including those with physical and non-physical disabilities
- Utilizing clear signage and wayfinding throughout facilities
- Clearly marking handicap parking unless there is street-side parking
- Providing street-level access to provider offices
- Providing elevators or accessible ramps into facilities
- Providing wheelchair accessible entrances and restrooms
- Providing access to an examination room that accommodates a wheelchair
- Offering first and last appointment availability to accommodate special needs visits

All providers are strongly encouraged to complete the DOH ADA Attestation form that is included as Attachment A to this Provider Manual. If you should have further questions about ADA provisions and provider responsibilities, please contact Provider Services at 1-888-682-2020.

Policy of Non-Interference with Provider Advice to Participants

NVA will not prohibit or otherwise restrict providers from advising or advocating on behalf of participants about the following topics:

- The participant's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the participant and his or her authorized representative to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the participant and his or her authorized representative to refuse treatment and to express preferences about future treatment decisions.

Provider Termination

Termination without Cause: Either NVA or provider may request termination from the network by giving not less than 90 days prior written notice. It is understood that during any such ninety (90) day period the terms and conditions of the provider agreement shall remain in full force and effect.

Termination for Cause: NVA reserves the right to terminate this Agreement immediately by providing written notice to Participating Provider, in the event Participating Provider:

1. breaches a material term of this Agreement, including without limitation, the Representations and Warranties or Responsibilities defined herein; or
2. poses an imminent danger to Eligible Member or the public health, safety and welfare; or
3. ceases to maintain agreements with or engagement of Participating Providers; or
4. fails to satisfy the credentialing program requirements; or
5. ceases to perform adequate credentialing application and approval processing in a timely manner.

Termination of Participating Provider: NVA reserves the right to terminate a Participating Provider immediately by providing written notice to Participating Provider, through the Participating Organization or directly to Participating Provider in the event the Participating Provider:

1. breaches a material term of this Agreement, including without limitation, the Representations and Warranties or Responsibilities defined herein; or

a. Poses an imminent danger to Eligible Member or the public health, safety and welfare;
b. Is charged with a felony or a crime or moral turpitude;
c. fails to satisfy the credentialing program requirements; or
d. ceases participating in NVA network(s) through non-renewal of credentialing application or denial or approval for participation.

For Connecticut Providers Only

Please note, as per §38a-472f (g) (1) (A), Regulations of CT State Agencies, Sect. 38a-472f-2 (f) (6), and Regulations of CT State Agencies, Sect. 38a-472f-2 (l), the list of covered persons must be provided by the provider within 30 days of issuing or receiving a termination notice.

Credentialing and Re-Credentialing policies and requirements are available upon request by contacting NVA's Provider Services Department at 888-682-2020 or via e-mail at providers@e-nva.com.

For non-covered Lens options, provider is responsible for charging the member according to the fixed pricing table found on the members plan sheet

For the most up to date documents regarding Lens Options: See Progressive and AR Formularies at www.e-nva.com for corresponding Lens Brands. Equivalent Brands may be used

Patient pays the lower of providers U&C less 20%, or the NVA fixed price. Options excluded from the schedule are payable at the providers U&C less 20%

Lens Option	Fixed Fee	Lens Option	Fixed Fee
Polycarbonate SV	$25	Progressives – Tier 1	$50
Polycarbonate BI	$30	Progressives – Tier 2	$80
Polycarbonate TRI	$30	Progressives – Tier 3	$100
Transitions SV (Standard)	$65	Progressives – Tier 4	$120
Transitions BI (Standard)	$70	Progressives – Tier 5	$140
Transitions TRI (Standard)	$70	Progressives – Tier 6	$165
Glass Photogrey SV	$20	Progressives – Tier 7	$190
Glass Photogrey BI	$30	Progressives – Tier 8	20% discount
Glass Photogrey TRI	$30	Polarized	$75
Anti-Reflective Coatings – Tier 1	$40	High Index	$55
Anti-Reflective Coatings – Tier 2	$50	Blended Bifocals (Segment)	$30
Anti-Reflective Coatings – Tier 3	$65	Solid Tints	$10
Anti-Reflective Coatings – Tier 4	$80	Fashion Gradient Tint	$12
Anti-Reflective Coatings – Tier 5	20% discount	Blue Light Blocker (Standard)	$40
Scratch-Resistant Coating (Standard)	$10	Blue Light Blocker (Premium)	$60
UV Coatings	$12	Blue Light Blocker (Ultra)	$150

Progressive Program Categories and Modifiers

Effective Date: November 19,2019

FOR BILLING PURPOSES YOU MUST USE THE "T" MODIFIER WITH CODE V2781 TO ENSURE CORRECT PAYMENT

Progressive Name	8-Tier Program Modifier	3 Tier Program Category Modifier	
House Brands	T1	Standard	T1
Essilor Accolade	T1	Standard	T1
Essilor Adaptar	T1	Standard	T1
Essilor Adaptar Digital	T1	Standard	T1
Essilor Adaptar Digital Short	T1	Standard	T1
Essilor Ideal / short	T1	Standard	T1
Essilor Natural	T1	Standard	T1
Essilor Ovation	T1	Standard	T1
Essilor Super No line	T1	Standard	T1
Hoya Amplitude BKS	T1	Standard	T1
Hoya Amplitude BKS mini	T1	Standard	T1
Hoya Amplitutde /mini	T1	Standard	T1
Hoya Summit CD	T1	Standard	T1
Hoya Summit ECP	T1	Standard	T1
HoyaLux Tact Computer	T1	Standard	T1
Kbco iRx - Polarized	T1	Standard	T1
Kodak Concise	T1	Standard	T1
Kodak Softwear	T1	Standard	T1
Shamir Computer	T1	Standard	T1
Shoreview / MVP	T1	Standard	T1
Shoreview Mini/Mini Wrap	T1	Standard	T1
Signet Armolite Direc Tek	T1	Standard	T1
Signet Armolite Navigator/ Short	T1	Standard	T1
Sola Access	T1	Standard	T1
Sola Max	T1	Standard	T1
Sola VIP	T1	Standard	T1
Vision Ease Illumina	T1	Standard	T1
Vision Ease Outlook	T1	Standard	T1
Younger Image / Wrap	T1	Standard	T1
Zeiss Business	T1	Standard	T1
Other brands equivalent to products in Tier 1	T1	Standard	T1
Essilor Acolade Freedom	T2	Standard	T2
Essilor Ideal Advanced / Wrap/ Short	T2	Standard	T2
Essilor Natural Digital	T2	Standard	T2
Essilor Ovation Digital	T2	Standard	T2
Essilor Small Fit	T2	Standard	T2
Essilor Small Fit Digital	T2	Standard	T2
Hoya Amplitude IQ	T2	Standard	T2
Hoya Amplitude IQ mini	T2	Standard	T2
Hoya GP Wide	T2	Standard	T2
Kbco Eos polarized	T2	Standard	T2

Progressive Program Categories and Modifiers

Effective Date: November 19,2019

FOR BILLING PURPOSES YOU MUST USE THE "T" MODIFIER WITH CODE V2781 TO ENSURE CORRECT PAYMENT

Progressive Name	8-Tier Program Modifier	3 Tier Program Category Modifier	
Kbco Fusion-polarized	T2	Standard	T2
Kbco Xplorer-polarized	T2	Standard	T2
Kodak Precise /Short	T2	Standard	T2
Kodak Precise Digital / Short	T2	Standard	T2
Kodak Precise PB	T2	Standard	T2
Kodak Precise PB Short	T2	Standard	T2
Nikon Presio I Digital	T2	Standard	T2
Seiko Proceed II	T2	Standard	T2
Seiko Proceed III	T2	Standard	T2
Shamir Element / Short	T2	Standard	T2
Shamir Genesis	T2	Standard	T2
synchrony Easy Adapt	T2	Standard	T2
synchrony Easy S	T2	Standard	T2
synchrony Easy View	T2	Standard	T2
synchrony Easy M	T2	Standard	T2
Younger Adage	T2	Standard	T2
Zeiss Gradal Top	T2	Standard	T2
Zeiss GT2	T2	Standard	T2
Zeiss GT2 Short	T2	Standard	T2
Other brands equivalent to products in Tier 2	T2	Standard	T2
Direc Tek / Short	T3	Premium	T3
Essilor Definity 2 /Short	T3	Premium	T3
Hoya Array VL	T3	Premium	T3
Hoya Tact BKS	T3	Premium	T3
Kodak Concise Digital	T3	Premium	T3
Kodak Unique	T3	Premium	T3
Shamir Work Space	T3	Premium	T3
Shamir Golf Progressive	T3	Premium	T3
Shamir Intouch	T3	Premium	T3
Shamir Piocolo-glass only	T3	Premium	T3
Shamir Spectrum	T3	Premium	T3
Shamir Spectrum +	T3	Premium	T3
Varilux Comfort DRx / Short	T3	Premium	T3
Varilux Comfort 2 / Short	T3	Premium	T3
Vision Ease Novel / Novella	T3	Premium	T3
Zeiss Choice	T3	Premium	T3
Zeiss Synchrony Easy Adapt HD	T3	Premium	T3
Zeiss Synchrony Easy M	T3	Premium	T3
Zeiss Synchrony Easy S	T3	Premium	T3
Zeiss Synchrony Easy View	T3	Premium	T3
Zeiss Synchrony Easy View HD	T3	Premium	T3

Progressive Program Categories and Modifiers

Effective Date: November 19,2019

FOR BILLING PURPOSES YOU MUST USE THE "T" MODIFIER WITH CODE V2781 TO ENSURE CORRECT PAYMENT

Progressive Name	8-Tier Program Modifier	3 Tier Program Category Modifier	
Zeiss Synchrony Easy View M HD	T3	Premium	T3
Zeiss Synchrony Easy View S HD	T3	Premium	T3
Zeiss Synchrony Easy Wear	T3	Premium	T3
Zeiss Synchrony Easy Wear HD	T3	Premium	T3
Zeiss Synchrony PAL Starter HD	T3	Premium	T3
Zeisss Offilens	T3	Premium	T3
Other brands equivalent to products in Tier 3	T3	Premium	T3
New Varilux Comfort W2+	T4	Premium	T4
Shamir Genesis - Glass	T4	Premium	T4
Varilux Comfort Enhanced / Short	T4	Premium	T4
Varilux Ellipse	T4	Premium	T4
Varilux Physio / Short	T4	Premium	T4
Varilux Physio DRx/Short	T4	Premium	T4
Kodak Unique HD	T4	Premium	T4
Varilux Physio Enhanced Eyecode	T4	Premium	T4
Essilor Definity 3 / Short	T4	Premium	T4
Hoya Array Fixed	T4	Premium	T4
Hoya Summit CD IQ	T4	Premium	T4
Hoya Summit ECP IQ	T4	Premium	T4
Shamir Autograph II Attitude Wrap	T4	Premium	T4
Shamir Autograph II Office	T4	Premium	T4
Shamir Autograph II Variable	T4	Premium	T4
Shamir Autograph II Variable / Fixed	T4	Premium	T4
Shamir Autograph III/ Variable / Fixed	T4	Premium	T4
Varilux Comfort Enhanced Fit	T4	Premium	T4
Varilux Stylistic Wrap	T4	Premium	T4
Zeiss Synchrony Ult HD	T4	Premium	T4
Zeiss Choice Plus	T4	Premium	T4
Zeiss GT2 3D	T4	Premium	T4
Zeiss GT2 3D Short	T4	Premium	T4
Zeiss Synchrony HD	T4	Premium	T4
Zeiss Synchrony Performance HD	T4	Premium	T4
Zeiss Synchrony Work & Go HD	T4	Premium	T4
Zeiss Synchrony Work & Office	T4	Premium	T4
Zeiss Synchrony Work & Read	T4	Premium	T4
Zesiss Digital	T4	Premium	T4
Other brands equivalent to products in Tier 4	T4	Premium	T4
New Varilux Comfort W2+ Fit	T5	Ultra	T5
Varilux Comfort W2+ Eyecode	T5	Ultra	T5
Varilux Ipseo IV	T5	Ultra	T5
Varilux Physio Enhanced	T5	Ultra	T5

Progressive Program Categories and Modifiers

Vision Benefits. Smarter.

Effective Date: November 19,2019

FOR BILLING PURPOSES YOU MUST USE THE "T" MODIFIER WITH CODE V2781 TO ENSURE CORRECT PAYMENT

Progressive Name	8-Tier Program Modifier	3 Tier Program Category Modifier	
Varilux Physio Enhanced India	T5	Ultra	T5
Varilux S Design	T5	Ultra	T5
Varilux S Design short	T5	Ultra	T5
Varilux Ipseo IV Eyecode	T5	Ultra	T5
Other brands equivalent to products in Tier 5	T5	Ultra	T5
Varilux Physio W3+ Fit	T6	Ultra	T6
Varilux Physio W3+ Eyecode	T6	Ultra	T6
Varilux Physio W3+	T6	Ultra	T6
Varilux S Fit	T6	Ultra	T6
Varilux X	T6	Ultra	T6
Other brands equivalent to products in Tier 6	T6	Ultra	T6
Varilux Physio Enhanced Azio	T7	Ultra	T7
Varilux Physio Enhanced Fit	T7	Ultra	T7
Varilux S 4D	T7	Ultra	T7
Varilux X Fit	T7	Ultra	T7
Other brands equivalent to products in Tier 7	T7	Ultra	T7
All other progressive lens not included above or equivalent	T8	Ultra	T8

This information is subject to change. For more information log into www.e-nva.com.

Proprietary and Confidential

Anti-Reflective Coating (AR) Brands and Modifiers
Categories and Modifiers

Anti Reflective Coating Brands	5-Category Program Modifer	3-Category Program Category/ Modifer	
Clear Sight	T 1	Standard	T 1
Essilor Reflection Free	T 1	Standard	T 1
Essilor Sharpview	T 1	Standard	T 1
Essilor Sharpview +	T 1	Standard	T 1
Other brands equivalent to products in this Tier	T 1	Standard	T 1
Crizal EZ UV	T 2	Premium	T 2
Essilor RF Endura	T 2	Premium	T 2
Hoya Hi Vision AR	T 2	Premium	T 2
Komodo AR	T 2	Premium	T 2
Xperio	T 2	Premium	T 2
Zeiss Carat Advantage or Carat Gold Advantage	T 2	Premium	T 2
Zeiss DuraVision Silver	T 2	Premium	T 2
Other brands equivalent to products in this Tier	T 2	Premium	T 2
Crizal Alize UV	T 3	Premium	T 3
Crizal Sunshield UV	T 3	Premium	T 3
Essilor RF Endura EZ	T 3	Premium	T 3
Hoya Hi Vision AR w/View Protect	T 3	Premium	T 3
Hoya Recharge	T 3	Premium	T 3
Komodo VES AR	T 3	Premium	T 3
Teflon Elite	T 3	Premium	T 3
Zeiss Allure	T 3	Premium	T 3
Zeiss Allure Plus	T 3	Premium	T 3
Zeiss DuraVision Platinum	T 3	Premium	T 3
Zeiss Pure Coat	T 3	Premium	T 3
Other brands equivalent to products in this Tier	T 3	Premium	T 3
ClearSight Claris AR	T 4	Ultra *	T 4
Crizal Avance UV	T 4	Ultra *	T 4
Crizal Prevencia	T 4	Ultra *	T 4
Crizal Sapphire 360 UV	T 4	Ultra *	T 4
Crizal Sapphire UV	T 4	Ultra *	T 4
Crizal Sunshield Mirrors UV	T 4	Ultra *	T 4
Crizal UV with Optifog	T 4	Ultra *	T 4

Hoya Super Hi Vision	T 4	Ultra *	T 4
Kodak Clear+	T 4	Ultra *	T 4
Komodo Extreme	T 4	Ultra *	T 4
Teflon Easy Care Package	T 4	Ultra *	T 4
Zeiss Dura Vision Blue Protect	T 4	Ultra *	T 4
Zeiss Pure Coat Plus	T 4	Ultra *	T 4
other brands equivalent to products in this Tier	T 4	Ultra *	T 4
Hoya Clean N Clear	T 5	Ultra *	T 5
Sola Teflon	T 5	Ultra *	T 5
all other brands not included above, or equivalent	T 5	Ultra *	T 5
* the lessor of the Fixed Pricing, or the Provider's U and C less 20%			

Effective January 1, 2020. This information is subject to change. For more information log into www.e-nva.com.

NVA BLUE BLOCKER LENS FORMULARY JULY 2018

STANDARD 20 % off of U&C up to a maximum of $40	PREMIUM 20% off of U&C up to a maximum of $60	ULTRA 20% off of U&C up to a maximum of $150
Generic Blue Blocker	Bluetech Ultra (indoor/outdoor)	Zeiss Dura Vision Blue Protect
Vision-Ease Clear Blue Filter	Bluetech Classic (indoor)	Hoya Recharge EX3
Essential Blue	Bluetech Max (outdoor)	Shamir Blue Zero
	Kodak Total Blue	Seiko Super- Resistant -Blu