Vision Care and Services

Policy Number: BIP192.M
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Instructions for Use

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- Corneal Hysteresis and Intraocular Pressure Measurement
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Federal/State Mandated Regulations

Oklahoma

2022 Oklahoma Statutes Title 36. Insurance Section 36-6060.9d: Prescription Eyedrop Refills

https://law.justia.com/codes/oklahoma/2022/title-36/section-36-6060-9d/

A. Any health benefit plan issued or renewed on or after November 1, 2017, that provides coverage for prescription eyedrops shall not deny coverage for a refill of a prescription if:
   1. For a 30 day supply, the amount of time has passed after which a patient should have used 70% of the dosage units of the drug according to a practitioner's instructions, or 21 days from:
      a. The original date the prescription was distributed to the insured, or
      b. The date the most recent refill was distributed to the insured;
   2. The prescribing practitioner indicates on the original prescription that additional quantities are needed;
   3. The refill requested by the insured does not exceed the number of additional quantities needed; and
   4. The prescription eye drops prescribed by the practitioner are a covered benefit under the policy or contract to the insured.

B. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes.

Texas

11.508: Basic Health Care Services and Mandatory Benefits Standards: Group, Individual and Conversion Agreements (Changed 08/01/2017)

Texas Administrative Code (state.tx.us)

(H) Preventive services, including:
   (v) Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction complying with established medical guidelines; and

Washington

WAC Section 284-43-5782: Pediatric Vision Services

https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5782

A health benefit plan must include "pediatric vision services" in its essential health benefits package. The designated base-benchmark plan for pediatric vision benefits consists of the benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* small group plan policy form, policy form number

WW0114CCONMSD, and certificate form number WW0114BPPO1SD, offered during the first quarter of 2014 (SERFF filing number RGWA-128968362).

(1) A health benefit plan must cover pediatric vision services as an embedded set of services.
(2) For the purpose of determining a plan's actuarial value, an issuer must classify as pediatric vision services the following vision services delivered to enrollees until at least the end of the month in which enrollees turn age nineteen:
    (a) Routine vision screening;
    (b) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;
    (c) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal or lenticular lenses;
    (d) One pair of frames every calendar year. An issuer may establish networks or tiers of frames within their plan design as long as there is a base set of frames to choose from available without cost-sharing;
    (e) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;
    (f) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:
        (i) One comprehensive low vision evaluation every five years;
        (ii) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and
        (iii) Follow-up care of four visits in any five-year period, with prior approval.
(3) The base-benchmark plan specifically excludes the following benefits. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing the plan's actuarial value for the pediatric vision services category:
    (a) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan; and
    (b) Ordering two pairs of glasses in lieu of bifocals.
(4) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.
(5) This section applies to health plans that have an effective date of January 1, 2017, or later.

State Market Plan Enhancements

Members may have supplemental coverage for frames and lenses. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) or contact the Customer Service Department to determine coverage eligibility.

Refer to the Pediatric Vision Care Services in the Combined Evidence of Coverage and Disclosure Form for additional pediatric vision benefits for members under the age of 19.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

- Eye examinations
    - Annual vision screening services to determine the possible need for vision correction that are performed in the primary care physician's office at the time of the member's routine health assessment. This screening may include use of a standard eye chart (Snellen chart) or its equivalent.
    - PCP may refer to an optometrist or ophthalmologist with a complaint or symptoms of an eye disease or injury
    - Routine refraction testing every 12 months to determine the need for corrective lenses (refractive error), including written prescription for eyeglass lenses
    - (**Note**: Members may have supplemental vision benefit coverage for frames and lenses. Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility).

- Annual retinal examination for members with diabetes.
- Routine screenings for glaucoma are limited to members who meet the medical criteria. Refer to the Medical Management Guideline titled Glaucoma Surgical Treatments.

- Refractive lenses
  - One pair of eyeglasses or contact lenses are covered after each cataract surgery, with the insertion of a conventional intraocular lens (IOL). Eyeglasses or contact lenses must be obtained through the participating/contracting medical group/provider rather than through the member's supplemental vision benefit.
  - For members who are aphakia and do not have an IOL, either because of surgery or congenital absence, the following lenses or combination of lenses are covered when determined to be medically necessary. Prosthetic lenses must be obtained through the participating/contracting medical group/provider rather than through the member's supplemental Vision benefit.
    1) Prosthetic bifocal lenses in frames (prescription eyeglasses);
    2) Prosthetic lenses in frames (prescription eyeglasses) for far vision and lenses in frames for near vision (prescription eyeglasses); or
    3) When contact lenses for far vision are prescribed, coverage includes: contact lenses and prosthetic lenses in frames (prescription eyeglasses) for near vision, and prosthetic lenses in frames (prescription eyeglasses) for when the contacts are removed (i.e., coverage for contacts for far vision, eyeglasses for near vision to be worn with the contacts, and eyeglasses for far vision for when the contacts are removed).

    Note: Prosthetic lenses (prescription eyeglasses) that have ultraviolet absorbing or reflecting properties may be covered in lieu of the regular (untinted) prosthetic lenses mentioned in 1), 2) and 3) above if it has been determined that such lenses are medically reasonable and necessary for the individual member.)

- FDA-approved hydrophilic contact lens used as moist corneal bandages are covered for the treatment of acute or chronic corneal pathology. Contact lenses must be obtained through the participating medical group/provider rather than through the member's supplemental vision benefit.
  - Bullous keratopathy
  - Dry eyes
  - Corneal ulcers and erosion
  - Keratitis
  - Corneal edema
  - Descemetocele
  - Corneal ectasis
  - Mooren's ulcer
  - Anterior corneal dystrophy
  - Neurotrophic keratoconjunctivitis
- Hard/rigid contact lenses for the treatment of keratoconus, aphakia, as a corneal bandage, and one pair after each cataract extraction.
- Cataracts are considered a medical condition and surgery for repair is covered.
- Contact lenses for the diagnosis of aniridia (missing iris)
- **Pediatric Vision**: Members may have benefits for additional pediatric vision care services. Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility.

Not Covered

- Sunglasses (e.g., cataract sunglasses)
- Eyeglgsses and/or contact lenses for cosmetic purposes only
- Services/materials connected with contact lenses, plano glasses (nonprescription), low vision aids or two pairs of bifocals
- Ocular exercises, vision therapy rehabilitation, vision training, orthoptics, and any associated supplemental testing when prescribed solely for the purpose of improving visual acuity, or to reduce dependence on corrective lenses or as described above in the *Covered Benefits* section.
- Services/materials provided by a nonparticipating provider or provided by another vision or medical plan
- Additional frames, lenses or contact lens replacements **after** initial contact lens provided in connection with post cataract surgery with IOL implant.
- Non-conventional/specialized IOL implants (e.g., presbyopia-correcting IOLs such as Crystalens™, AcrySof RESTOR™, ReZoom™)

- Frames, lenses and/or contact lenses unless member has supplemental vision benefits or the member has a medical diagnosis, as described above in the *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections.
- K-readings for fitting of non-medically necessary contact lenses, surgery for presbyopia, astigmatism and myopia only for the purpose of improving refraction
  Examples include, but are not limited to, radial keratotomy, keratomileusis (e.g., LASIK), and keratophakia.
- Contact lens cleaning solution and normal saline for contact lenses
- Scratch resistant coating and progressive lenses
- Hydrophilic contact lenses are not covered when used in the treatment of non-diseased eyes with spherical ametropia, refractive astigmatism and/or corneal astigmatism.
- Surgical and laser procedures to correct or improve refractive error
- Visual aids, except as specified under the outpatient benefit for "Diabetic Self-Management Items." Electronic and non-electronic magnification devices are not covered

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
06/01/2024	All	**Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP192.L
	Oklahoma	**Federal/State Mandated Regulation** • Revised language pertaining to *2022 Oklahoma Statutes Title 36 Insurance, Section 36-6060.9d*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.