Vision Care and Services

Policy Number: BIP191.O
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➲ Instructions for Use

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Related Benefit Interpretation Policy

- Preventive Care Services

Related Medical Policies

- Preventive Care Services
- Visual Information Processing Evaluation and Orthoptic and Vision Therapy

Federal/State Mandated Regulations

None

State Market Plan Enhancements

Members may have supplemental coverage for frames and lenses. Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility.

For California Small Groups

Refer to the Pediatric Vision Care Services Addendum in the *Combined Evidence of Coverage and Disclosure Form* for additional pediatric vision benefits for members who are covered until at least the end of the month in which member turns 19 years of age.

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 Exams
  - 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 a written prescription for eyeglass lenses.
    Note: members may have supplemental vision benefit coverage for frames and lenses.
  - Annual retinal examination for members with diabetes.
  - Routine screenings for glaucoma are limited to members who meet the medical criteria. Refer to the Medical Policy 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 network medical group rather than through the member's supplemental vision benefit.
  - For members who have 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 network medical group-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 (un-tinted) 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 network medical group 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) and aphakia (absence of the lens of the eye) (Refer to member's EOC for specific coverage limitations.)

For California Small Groups

- Special contact lenses for aniridia are limited to two medically necessary contact lenses per eye in any 12-month period (including fitting and dispensing) to treat aniridia or missing iris, whether provided by the plan during the current or a previous 12-month contract period.
- Special contact lenses for aphakia are limited to six medically necessary contact lenses per eye per calendar year (including fitting and dispensing) to treat aphakia or absence of the crystalline lens of the eye for members through age 9, whether provided by the plan under the current or a previous contract in the same calendar year.

Not Covered

- Sunglasses (e.g., cataract sunglasses)
- Eyeglasses 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 non-network 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 *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 shown under the outpatient benefit for “diabetic self-management items”; electronic and nonelectronic magnification devices are not covered

Policy History/Revision Information

Date	Summary of Changes
05/01/2025	• Routine review; no change to coverage guidelines • Archived previous policy version BIP191.N

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.