Harvard Pilgrim Health Care

Pediatric VisionCare – Massachusetts

If your plan includes this benefit, the benefit details and exclusions will be listed on your Schedule of Benefits. Dependents under the age of 19 are eligible for coverage of (A) prescription eyeglasses or (B) contact lenses; (C) medically necessary contact lenses; and (D) low vision aids, as described below.

(A) Prescription Eyeglass Frames and Lenses

One pair of Standard or Basic prescription eyeglass frames and lenses. Standard or Basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses.

(B) Prescription Contact Lenses

Your first order of prescription contact lenses. Reimbursement for disposable contact lenses is limited to a 6 month supply.

Each dependent under the age of 19 is eligible for coverage every 12 months for either (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described above.

(C) Medically Necessary Contact Lenses

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

(D) Low Vision Services

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. Covered low vision services include Medically Necessary visual aids such as high-power eyeglasses, magnifiers and telescopes.

Reimbursement for the covered items listed above will be as follows:

- The Plan will reimburse you for the first $50 you pay toward (A) prescription eyeglasses or (B) contact lenses; (C) medically necessary contact lenses; and (D) low vision aids. Thereafter, the Plan will reimburse you 50% of your remaining covered charges.

This is a summary of the Pediatric VisionCare benefit, please see your Benefit Handbook and Schedule of Benefits for coverage details and any limitations that apply to your Plan. Not all plans include this coverage, it's important that you check your benefit documents BEFORE you purchase glasses or contacts.

How to Receive Reimbursement for the Pediatric VisionCare Benefit

To receive reimbursement for: (A) prescription eyeglasses or (B) contact lenses; (C) medically necessary contact lenses; or (D) low vision aids that you have paid for, complete the Pediatric VisionCare member reimbursement form, below.

The Plan will reimburse you for your payment of covered items as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 30 days to receive your reimbursement.

Where to Call With Questions

If you have any questions about your Pediatric VisionCare benefit, please contact Member Services at **(888) 333-4742**. For TTY service, call **711**.

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Pediatric VisionCare Member Reimbursement Form

Instructions

1. Please use this member reimbursement form to request reimbursement for the Pediatric VisionCare benefit only. For other eyewear coverage that may be available due to a medical condition (post-cataract or retinal detachment surgery or Keratoconus), please refer to "Special Conditions" on the other side of this form.
2. Please read and complete this form. Separate forms must be completed for each member seeking Pediatric VisionCare benefits.
3. Attach proof of payment and an itemized bill from the provider which includes the date of service, description of services provided, provider's tax ID number and amount paid.
4. Mail the original form, together with the bill and proof of payment to:

   HPHC Claims
   P.O. Box 699183, Quincy, MA 02269-9183

Exclusions: Any service or supply purchased from the internet is not covered (with the exception of contact lenses).

Member Information

Subscriber Name: First _____ Middle Initial _____ Last _____

Address _____ City _____ State _____ Zip _____

Patient's Name: First _____ Middle Initial _____ Last _____

Patient's Identification No. (from ID card)_____ Date of Birth _____ Sex (m/f) _____

Claim Information

Check (√) item that applies	Description of Services	Procedure No.	No. of Services	Place of Service	Date(s) of Services Rendered	Amount Billed
	eyeglass frames or lenses	92390	1	11		
	contact lenses	92310	1	11		
	hand held low visual aid	V2600	1	11		
	Single lens spectacle mounted low vision aid	V2610	1	11		
	Telescopic, other compound lens system	V2615	1	11		
	Lens, polycarbonate or equal any index per lens	V2784	1	11		

Diagnosis

ICD-10 Z01.00-Z01.01 routine vision correction ❑ yes ❑ no
If no, please see other side for "special conditions" section

TOTAL DUE MEMBER $

Provider Information

Name of Provider _____

Address _____ City _____ State _____ Zip _____

Mail to: HPHC Claims • P.O. Box 699183 • Quincy, MA 02269-9183 • (888) 333-4742

Special Conditions

For certain medical conditions, such as Keratoconus, post-retinal detachment surgery or post-cataract surgery, eyewear benefits may also be available under your medical coverage. Please refer to your Member Handbook for details. If you have a claim for eyeglasses or contact lenses for special conditions that are covered under the medical benefit please do the following:

1. Have your optical provider complete a standard claim form and submit the claim for processing. Do not use the Pediatric VisionCare member reimbursement form to request initial payment for eyewear obtained due to these conditions.
2. If there is a remaining balance due to the provider after Harvard Pilgrim pays the claim, use this Pediatric VisionCare member reimbursement form to request reimbursement for the balance due under your Pediatric VisionCare benefit (up to the benefit limit). Attach a copy of the itemized bill from your optical provider that includes:
    - original dollar amount of services provided;
    - the appropriate diagnostic code(s):
        - Post-cataract surgery ICD-10 H26.40, H26.411-H26.419, H26.491-H26.499, H26.8, H26.9, Z96.1
        - Post-retinal detachment surgery ICD-10 H52.31, Z98.41-Z98.49
        - Keratoconus ICD-10 H18.601-H18.609, H18.611-H18.619, H18.621-H18.629
    - amount of Harvard Pilgrim payment;
    - amount you still owe to provider after Harvard Pilgrim payment.

Assignment of Benefits

PAYMENT WILL BE MADE DIRECTLY TO YOU, IF YOU SIGN BELOW.

I authorize reimbursement of benefits to myself for the services described above or as indicated on the enclosed bill.
I understand that I am financially responsible to the provider for charges in excess of the Plan's schedule or charges not covered by my benefit plan.

Subscriber's Signature _____ Date _____

I hereby apply for benefits and certify that the above information is complete, true and correct. To all physicians and other medical professionals, hospitals, and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide the Plan and any benefit plan administrators from consumer reporting agencies, attorneys and independent claim administrators acting on the Plan's behalf, with information concerning medical care, advice, treatment or supplies to the Patient, and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that the duration of the authorization is the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

CLAIM CANNOT BE PROCESSED WITHOUT SUBSCRIBER'S SIGNATURE

_____ _____

Subscriber's Signature Date Patient's Signature Date