Harvard Pilgrim Health Care

Pediatric Vision Coverage – New Hampshire

If your plan includes this benefit, dependents under the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. 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 below:

(A) Prescription Eyeglass Frames and Lenses

The Plan will reimburse you for the purchase of one pair of Standard or Basic prescription eyeglass frames and lenses up to the following amounts:

- The Plan will reimburse you for the first $100 you pay toward covered prescription eyeglass frames and lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Standard or Basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses. Coverage is excluded for lenses larger than 55mm and upgrades such as tints. Coverage is also excluded for deluxe and designer eyeglass frames.

(B) Prescription Contact Lenses

The Plan will reimburse you for the purchase of your first order of prescription contact lenses up to the following amounts:

- The Plan will reimburse you for the first $100 you pay toward your first order of covered prescription contact lenses. Thereafter, the plan will reimburse you 50% of your remaining covered charges. Reimbursement for disposable contact lenses is limited to a 6 month supply.

Your plan also includes additional restrictions so you should also check your plan for specifics on what types of glasses and contacts are covered and any limitations that might apply. Not every plan includes coverage for pediatric vision hardware, so it's important that you check your benefit documents to ensure your plan includes this coverage BEFORE you purchase glasses or contacts.

How to Receive Reimbursement for the Pediatric Vision Care Benefit

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, you must follow these simple steps:

1. Complete a Pediatric Vision Benefit member reimbursement form. You can obtain this form by visiting our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **(888) 333-4742** to request a form. For TTY service, please call 711. Each Member must use a separate Pediatric Vision Benefit member reimbursement form.
2. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
3. Mail the original form, together with the bill and proof of payment to:

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

We will reimburse you for your payment of covered eyeglasses or contact lenses as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 6-8 weeks to receive your reimbursement.

Where to Call With Questions

If you have any questions about your Pediatric Vision Coverage, please contact Member Services at the number on your ID card. If you are deaf or hard-of-hearing, call **(800) 637-8257** for TTY service.

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Pediatric Vision Benefit Member Reimbursement Form

Instructions

1. Please use this benefit member reimbursement form to request reimbursement for the Pediatric Vision 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. Forms must be completed for each member seeking Pediatric Vision 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.

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		
	Scratch resistant coating, per lens	V2760	1	11		
	Progressive Lens, per lens	V2781	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 • 1-888-333-4742

Special Conditions

For certain medical conditions, such as Keratoconus, post-retinal detachment surgery or post-cataract surgery, eyewear benefits may be available. 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 Vision benefit 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 Vision benefit member reimbursement form to request reimbursement for the balance due under your Pediatric Vision 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 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