Vision Care

Applies to: All plans

Vision Care

Vision care is designed to cover a member's preventive and routine visual needs, such as glaucoma testing for those at high risk, routine eye exams for both preventive and diagnostic purposes, and eyewear for corrective purposes.

Original Medicare

Original Medicare covers glaucoma tests once every 12 months for people who are at high risk. The beneficiary is at high risk if they have diabetes, a family history of glaucoma, are African American and 50 years of age or older or are Hispanic and age 65 or older. An eye doctor who is legally authorized by the state must perform the test.

Original Medicare also covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.
Original Medicare does not cover routine eye exams.

Premera Blue Cross Medicare Advantage HMO Plans Enhanced Benefit

Premera Blue Cross Medicare Advantage HMO plans are Medicare Advantage plans, which provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Premera Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Since Original Medicare does not cover routine vision care and supplemental eyewear, the scope of the benefit, reimbursement methodology, maximum allowed payment amounts, and member cost sharing are determined by Premera Blue Cross.

Eye Exams

A routine eye exam is a complete assessment by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing, and other tests necessary to determine overall visual health. One routine eye exam is covered per calendar year. Here are the copays for the plans:

1. HMO - $20 copay
2. Classic (HMO) - $0 copay
3. Total Health (HMO) - $0 copay

Eyewear

Members can get their eyewear anywhere that Medicare is accepted. Members may be reimbursed up to their plan maximum for medically necessary eyewear, fitting, and extras such as tinting. Specialty eyewear such as sunglasses and specialty glasses may be covered only with a prescription. Coverage for routine supplemental eyewear is provided to members under HMO, Classic (HMO), Total Health (HMO).

- One eyeglass frame and lenses are covered in a calendar year.
- Elective* contact lenses in lieu of lenses and frame, or medically necessary contact lenses, renewed in a calendar year.
- Medically necessary** contact lenses in lieu of lenses and frame, or elective contact lenses, renewed in a calendar year.

*Elective—prescribed by an ophthalmologist or optometrist but does not meet the criteria of 'medically necessary'.
** Medically necessary—must meet the criteria of 'medically necessary'.

Plan Name	Annual Allowance
HMO	$150
Classic (HMO)	$250
Total Health (HMO)	$200

Conditions for Payment

The table below specifies conditions for routine vision exam and supplemental eyewear in an outpatient setting.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Outpatient
Frequency	Once per calendar year
CPT/HCPCS codes	92002, 92004, 92012, 92014, 92015, 92081-92083, 92235, 92310-92317, 92325, 92326,92340-92342, 92352-92355, 92370, 92499, S0500, S0504, S0506, S0508, S0512, S0514, S0516, S0518, S0580, S0581, S0590, S0592, S0595, S9999, V2020, V2025, V2100-V2115, V2118, V2121, V2199-V2215, V2218-V2221, V2299-V2315 V2318-V2321, V2399, V2410, V2430, V2499-V2503, V2510- V2513, V2520-V2523, V2530-V2531, V2599- V2600, V2610, V2700, V2702, V2710, V2715, V2718, V2730, V2744, V2745, V2750, V2755, V2760-V2762, V2770, V2780-V2784, V2786, V2797, V2799
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

Note: Members are responsible for all charges that exceed the annual allowance for the items listed above that are ordered and delivered by either in-network or out-of-network providers.

Member Cost Sharing

- Premera Blue Cross Medicare Advantage HMO providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat dollar copayment, a percentage coinsurance, or a deductible. Providers can only collect the appropriate Premera Blue Cross Medicare Advantage HMO cost sharing amounts from the member.

- If the member elects to receive a non-covered service, he or she is responsible for the entire charge associated with the non-covered service.
- Cost share amounts incurred by the member under this benefit do not count toward the combined maximum out-of-pocket or to the deductible as listed in the Evidence of Coverage document.
- To verify member eligibility, benefits, and cost share, go to the Premera Blue Cross Medicare Advantage HMO secure website at premera.com/wa/provider/medicare-advantage/. Click on Sign in to tools and resources.

Billing Instructions for Providers

1. Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim form.
2. Use the Premera Blue Cross Medicare Advantage HMO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Use electronic billing.
6. Submit claims to your local BCBS plan.

Member Reimbursement

Reimbursement forms are available on the Medicare Advantage member website, https://medicareadvantage.premera.com/

To be reimbursed for covered services members must submit a completed reimbursement request form along with the following information to the address below:

- Copy of prescription
- Copy of receipt(s) for eye wear

Premera Blue Cross Medicare Advantage Plans
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