

Vision Care and Services

Policy Number: BIP191.P
Effective Date: May 1, 2026

[Instructions for Use](#)

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Related Benefit Interpretation Policy
<ul style="list-style-type: none"> Preventive Care Services
Related Medical Policies
<ul style="list-style-type: none"> 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 Evidence of Coverage (EOC)/Schedule of Benefits (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.
 - Annual retinal examination for members with diabetes.
 - 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.
- 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.
- Cataracts are considered a medical condition and surgery for repair is covered.

For California Small Groups

- Corrective lenses and frames, contact lenses and contact lens fitting and measurements for the treatment of the following:
 - Keratoconus
 - Aphakia
 - Aniridia
 - As a corneal bandage
 - One pair after each cataract extraction
- FDA-approved hydrophilic contact lens used as moist corneal bandages for the treatment of acute or chronic corneal pathology. Note: Contact lenses must be obtained through the network medical group, not the member's supplemental vision benefit.
 - Conditions include, but are not limited to:
 - Anterior corneal dystrophy
 - Bullous keratopathy
 - Dry eyes
 - Corneal ectasis
 - Corneal edema
 - Corneal ulcers and erosion
 - Descemetocoele
 - Keratitis
 - Mooren's ulcer
 - Neurotrophic keratoconjunctivitis
- For members with aphakia who 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 – not the member's supplemental vision benefit.
 - (1) Prosthetic bifocal lenses in frames (prescription eyeglasses);
 - (2) Prosthetic lenses in frames for far vision (prescription eyeglasses) and lenses in frames for near vision (prescription eyeglasses); or
 - (3) When contact lenses for far vision are prescribed, coverage includes:
 - Contact lenses for far vision
 - Prosthetic lenses in frames (prescription eyeglasses) for near vision
 - Prosthetic lenses in frames (prescription eyeglasses) for far vision (for use 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.
- Routine screenings for glaucoma are limited to members who meet the medical criteria. Refer to the Medical Policy titled [Glaucoma Surgical Treatments](#).
- 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.
- Special contact lenses include:
 - Hard/rigid contact lenses for the treatment of keratoconus, aphakia, as a corneal bandage, and one pair after each cataract extraction
 - 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.)

Not Covered

- Additional frames, lenses or contact lens replacements **after** initial contact lens provided in connection with post cataract surgery with an IOL implant
- Contact lens cleaning solution and normal saline for contact lenses
- Eyeglasses and/or contact lenses for cosmetic purposes only
- Frames, lenses, and/or contact lenses unless the member has supplemental vision benefits or a medical diagnosis, as outlined in the *State Market Plan Enhancements* and *Covered Benefits* sections
- Hydrophilic contact lenses when used for non-diseased eyes with spherical ametropia, refractive astigmatism, and/or corneal astigmatism

- K-readings for fitting of non-medically necessary contact lenses and surgery for presbyopia, astigmatism, or myopia performed solely to improve refraction
Examples include but are not limited to radial keratotomy, keratomileusis (e.g., LASIK), and keratophakia
- Non-conventional or specialized IOL implants (e.g., presbyopia -correcting IOLs such as Crystalens™, AcrySof RESTOR™, ReZoom™)
- Ocular exercises, vision therapy rehabilitation, vision training, orthoptics, and any associated supplemental testing prescribed solely to improve visual acuity, reduce dependence on corrective lenses, or as otherwise noted in the *Covered Benefits* section
- Scratch resistant coating and progressive lenses
- Services or materials connected with contact lenses, plano glasses (nonprescription) glasses, low vision aids or two pairs of bifocals
- Sunglasses (e.g., cataract sunglasses)
- Services/materials provided by a non-network provider or provided by another vision or medical plan
- Surgical and laser procedures to correct or improve refractive error
- For California Large Groups only (Unless noted in the member's EOC or supplemental vision benefit):
 - Contact lenses or combination of lenses for members who with Aphakia who do not have an IOL, either because of surgery or congenital absence.
 - Corrective lenses and frames, contact lenses and contact lens fitting and measurements for the treatment of keratoconus, aphakia, aniridia, or corneal bandage.
 - FDA-approved hydrophilic contact lens used as moist corneal bandages for the treatment of acute or chronic corneal pathology.
- Routine screenings for glaucoma. Visual aids, except those included under the outpatient benefit for “diabetic self-management items”; electronic and nonelectronic magnification devices

Policy History/Revision Information

Date	Summary of Changes
05/01/2026	<p>Covered Benefits</p> <ul style="list-style-type: none"> • Revised list of covered benefits to reflect/include: <ul style="list-style-type: none"> ○ Eye exams <ul style="list-style-type: none"> ▪ 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 ▪ Annual retinal examination for members with diabetes ▪ Primary care physician (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 ▪ Members may have supplemental vision benefit coverage for frames and lenses ○ Refractive lenses <ul style="list-style-type: none"> ▪ 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 ○ Cataracts are considered a medical condition and surgery for repair is covered <p>For California Small Groups Only</p> <ul style="list-style-type: none"> ○ Added: <ul style="list-style-type: none"> ▪ Corrective lenses and frames, contact lenses, and contact lens fitting and measurements for the treatment of the following: <ul style="list-style-type: none"> – Keratoconus – Aphakia – Aniridia – As a corneal bandage – One pair after each cataract extraction ○ Added language to clarify: <ul style="list-style-type: none"> ▪ FDA-approved hydrophilic contact lens used as moist corneal bandages [are covered] for the treatment of acute or chronic corneal pathology; <i>conditions include but are not limited to [the listed conditions]</i>

Date	Summary of Changes
	<ul style="list-style-type: none"> ▪ <i>Special contact lenses include</i> hard/rigid contact lenses for the treatment of keratoconus, aphakia, as a corneal bandage, and one pair after each cataract extraction and contact lenses for the diagnosis of aniridia (missing iris) and aphakia (absence of the lens of the eye) <p>Not Covered</p> <ul style="list-style-type: none"> • Added language to indicate the following items/services are not covered for California Large Groups unless noted in the member’s Evidence of Coverage (EOC) or supplemental vision benefit: <ul style="list-style-type: none"> ○ Contact lenses or combination of lenses for members with aphakia who do not have an IOL, either because of surgery or congenital absence ○ Corrective lenses and frames, contact lenses, and contact lens fitting and measurements for the treatment of keratoconus, aphakia, aniridia, or corneal bandage ○ FDA-approved hydrophilic contact lens used as moist corneal bandages for the treatment of acute or chronic corneal pathology ○ Routine screenings for glaucoma <p>Supporting Information</p> <ul style="list-style-type: none"> • Archived previous policy version BIP191.O

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.