

WAC 284-43-5782 Pediatric vision services. A health benefit plan must include "pediatric vision services" in its essential health benefits package. The designated base-benchmark plan for pediatric vision benefits consists of the benefits and services covered by health care service contractor Regence BlueShield as the *Regence Direct Gold* small group plan policy form, policy form number WW0114CCONMSD, and certificate form number WW0114BPP01SD, offered during the first quarter of 2014 (SERFF filing number RGWA-128968362).

(1) A health benefit plan must cover pediatric vision services as an embedded set of services.

(2) For the purpose of determining a plan's actuarial value, an issuer must classify as pediatric vision services the following vision services delivered to enrollees until at least the end of the month in which enrollees turn age nineteen:

(a) Routine vision screening;

(b) A comprehensive eye exam for children, including dilation as professionally indicated and with refraction every calendar year;

(c) One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch resistant coating. Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular lenses;

(d) One pair of frames every calendar year. An issuer may establish networks or tiers of frames within their plan design as long as there is a base set of frames to choose from available without cost-sharing;

(e) Contact lenses covered once every calendar year in lieu of the lenses and frame benefits. Issuers must apply this limitation based on the manner in which the lenses must be dispensed. If disposable lenses are prescribed, a sufficient number and amount for one calendar year's equivalent must be covered. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be medically necessary, contact lenses must be covered in lieu of eyeglasses at a minimum for the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;

(f) Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:

(i) One comprehensive low vision evaluation every five years;

(ii) High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and

(iii) Follow-up care of four visits in any five-year period, with prior approval.

(3) The base-benchmark plan specifically excludes the following benefits. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing the plan's actuarial value for the pediatric vision services category:

(a) Visual therapy, which is otherwise covered under the medical/surgical benefits of the plan; and

(b) Ordering two pairs of glasses in lieu of bifocals.

(4) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human

Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(5) This section applies to health plans that have an effective date of January 1, 2017, or later.

[WSR 16-01-081, recodified as § 284-43-5782, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.21.241, 48.21.320, 48.44.460, 48.44.341, 48.46.291, 48.46.530, and 48.43.715. WSR 15-20-042 (Matter No. R 2015-02), § 284-43-8801, filed 9/29/15, effective 9/29/15.]