First Nations Health Authority
Health through wellness

FIRST NATIONS HEALTH AUTHORITY

HEALTH BENEFITS

INTERIM

VISION CARE FRAMEWORK

AND

BENEFIT LIST

Effective date: October 1, 2013

The Interim Vision Care Program Framework is a combination of Health Canada's Vision Care National Framework, Vision Care Benefit list and NIHB BC Regional Policies. No changes to policy or rates have been made only changes to reflect the new organization.

The Interim Vision Care Program Framework Is a temporary framework effective October 1, 2013 until a review and consultation has taken place.

The purpose of this document is to explain the overarching framework that guide the administration of vision care benefits under the Health Benefits Program of First Nations Health Authority. This policy framework is intended to provide stakeholders, providers, and clients with a broad overview of the parameters of the HBP policies as they relate specifically to the vision care benefit area.

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1.0 The Health Benefits Program (HBP) – Introduction

As of October 1, 2013 the First Nations Health Authority (FNHA) assumed responsibility for Non Insured Health Benefits (NIHB), previously managed through Health Canada, First Nations and Inuit Health Branch. Continuity of care is our top priority and little or nothing will change for providers at this time. Our goal is to improve the existing Health Benefits Program (HBP) for First Nations residing in BC.

The Health Benefits Program (HBP) provides a limited range of medically necessary health-related goods and services not provided through private insurance plans, provincial health, or social programs or other publicly funded programs to eligible registered First Nations who are residents of BC. The benefits provided under the HBP supplement private insurance or provincial health and social programs, such as physician and hospital care, and community health programs.

The FNHA is currently reviewing benefit areas and policies as well as seeking guidance from BC First Nations and providers on how best to improve the Health Benefits system. Working with professional associations, providers and First Nations Health Directors, the FNHA is compiling past feedback and collecting additional input on the existing Health Benefits program. This will assist in building and improving the FNHA Health Benefits programs for BC First Nations to improve health service delivery, and to shift the focus of health service delivery for First Nations residing in BC to wellness and prevention.

1.1 Framework Objectives

The HBP *Interim* Vision Care Policy defines the framework and guidelines under which the HBP will fund eligible registered First Nations people with access to vision goods and services. Vision Care services are funded in accordance with the mandate of the HBP, which includes providing Health Benefits that are appropriate to the needs of the clients and sustainable. The HBP *Interim* Vision Care Framework sets out a clear definition as to the eligibility of clients, the types of benefits to be provided, and criteria under which they will be funded.

The HBP *Interim* Vision Care Framework applies to the funding of vision care benefits by the BC First Nations Health Authority (FNHA) or by First Nations Band or organization, who, under a contribution agreement, have assumed responsibility for the administration and funding of vision care benefits to eligible clients.

2.0 Program Objectives and Principles

The objectives of the Health Benefits Program are to provide benefits to eligible BC First Nations in a manner that:

- is suitable to their unique health needs;
- helps eligible First Nations to reach an overall health status that is comparable to other Canadians;
- is cost effective; and
- will maintain and improve health, prevent disease and assist in detecting and managing illnesses, injuries, or disabilities.

The Health Benefits Program operates according to a number of guiding principles:

- All eligible First Nations who are normally residents of British Columbia, and not otherwise covered under a separate agreement with federal, provincial or territorial governments, are eligible for Health Benefits, regardless of income level.
- Benefits are based on the judgement of recognized medical professionals, consistent with the best practices of health services delivery and evidence-based standards of care.
- There is consistency of mandatory benefits, equitable access, and portability of benefits and services.
- The Program is to be managed in a sustainable and cost-effective manner.
- Management processes will involve transparency and joint review structures whenever agreed to with First Nations organizations.
- In cases where a benefit is covered under another health care plan, the Health Benefits Program will act to coordinate payment in order to help ensure that the other plan meets its obligations and the client is not denied service.

3.0 Vision Care Benefits List

3.1 Objective

The objective of the Health Benefits Program vision care benefit is to provide eligible clients with access to vision care benefits and services in a fair, equitable and cost-effective manner that will:

- contribute to improving the overall health status of First Nation clients, recognizing their individual health needs and the context of health service delivery; and
- provide coverage for a range of vision care benefits and services based on professional judgement, consistent with the current best practices of health services delivery and evidence-based standards of care.

3.2 Vision Care Benefit Prescribers

Vision care benefits must be prescribed by an HBP recognized prescriber. A vision care prescriber must be an Ophthalmologist or Optometrist who is licensed / certified, authorized, and in good standing with the provincial regulatory body in British Columbia.

3.3 Vision Care Benefit Providers

Vision care benefits must be provided by an HBP recognized provider. A vision care provider must be an Optometrist or Optician who is licensed / certified, authorized, and in good standing with the regulatory body of the province of British Columbia.

3.4 Vision Care Coverage

There is a limited range of vision care benefits.

3.4.1 Eye And Vision Examinations

3.4.1.1 General Eye and Vision Examination (Full, Major, Routine)

General eye and vision examinations are benefits under the Health Benefits Program (HBP) when performed by an ophthalmologist or an optometrist where registered First Nations clients are not

covered by provincial, territorial, private, or other federal health care plans. Clients are eligible for general examination once every two years and usually includes the following:

- case history
- external examination of the eye
- assessment of visual acuity
- profile of ocular motility
- objective and subjective measurement of refraction
- assessment of binocular coordination
- assessment of amplitude of accommodation, when required
- biomicroscopy and assessment of pupillary reflexes
- tonometry (if clinically indicated)
- confrontation visual fields
- direct ophthalmoscopy
- posterior segment examination with pupil dilation, when clinically indicated
- analysis and diagnosis of findings
- recommendations to the patient and, if necessary, prescription for treatment

3.4.1.2 Specific Examination

Clients may be eligible for coverage under the HBP when a severe abnormality in their ocular or visual condition (e.g. retinal detachment or tear) requires a thorough assessment using specific tests. This condition will have been detected at the general examination. Specific examinations will be performed by an ophthalmologist or an optometrist who must be able to attest to, in writing, the oculo-visual condition justifying this examination.

Specific examinations include at least one of the following tests:

- assessment of visual fields, using visual field analyzer

- colour blindness vision test
- examination of the peripheral retina under pupil dilation
- gonioscopy of the angle (when indicated)
- study of oculomotor imbalance
- study of contrast sensitivity function over at least six spatial frequencies
- measurement of aniseikonia using an eikonometer or afocal magnifying lenses
- precise assessment of visual impairment and trial of optical aids
- assessment of corneal topography using a computerized video-keratoscope
- trial contact lens and assessment of ocular reaction for eligible clients
- electroretinogram measurement or visually evoked potentials

3.4.1.3 Follow-Up Examination (Control, Minor)

Clients may be eligible for a follow-up examination depending on their ocular or visual condition. The examination will be performed by an ophthalmologist or an optometrist who must be able to attest to, in writing, the oculo-visual condition justifying the examination. These examinations will be evaluated on a case-by-case basis.

The follow-up examination must include all of the following:

- case history;
- the repetition of one or more tests from the general examination in order to assess the condition or progression of the oculo-visual condition;
- diagnosis; and
- recommendations to the patient and, if necessary, a prescription for treatment.

3.4.1.4 Frequency Guidelines

Eye and Vision Examinations	Frequency Guidelines
Eye/vision exam, General (Full, Major, Routine) Clients with diabetes who are treated by means of tablets, injections, or diagnosed with retinal detachment or tear	Under 18 years old - 1 per 12 months 18 years old or over - 1 per 24 months Since the last date of service 1 per 12 months Since the last date of service
Eye/vision exam, Follow-up (Control, Minor exam)	Reviewed on a case-by-case basis
Eye/vision exam, Specific examination	

***Please note that frequency guidelines only apply when eligible FNHA clients are not already covered by a provincial, territorial, private or other federal health care plans.**

3.4.2 Glasses

Glasses are comprised of one frame and two lenses.

3.4.2.1 Lenses (ophthalmic)

Description
A plastic lens accompanied of a scratch resistant coating with a manufacturer's warranty of at least one (1) year, unless other agreements were negotiated with regional offices, will be provided on each lens sold to clients.

3.4.2.2 Eligibility Criteria for Lenses

To be eligible for lenses within the frequency guidelines, the client must obtain a written prescription from an ophthalmologist or an optometrist. The lenses must correct at least one of the following oculo-visual conditions in at least one eye:

- refractive error (myopia, hypermetropia and/or astigmatism);
- presbyopia;
- oculo-motor imbalance.

AND

the client's oculo-visual condition requires one of the following in at least one eye:

- spherical or cylindrical correction of at least 0.50 diopter;
- prismatic correction totaling at least 1.00 prism diopter vertically or at least 2.00 prism diopters horizontally (prismatic correction may be achieved in the form of a surfaced prism, a Fresnel prism or a compensatory prism for near vision);
- add power must be equal to or greater than 0.75 diopter for presbyopia.

3.4.2.3 Frequency Guidelines

Criteria for Lens (ophthalmic)	Frequency Guidelines
Unifocal (far distance or near vision) Aspheric Bifocal High Index	Under 18 years old - 1 per 12 months 18 years old or over - 1 per 24 months Since the last date of service
Polycarbonate lenses - for monocular clients *or* those who with the best possible correction have far vision acuity in the weaker eye which is equal to or less than 6/60 (20/200)	Reviewed on a case-by-case basis

3.4.2.4 Early Replacement Guidelines

If a replacement lens is required outside of the regular frequency guidelines, the HBP will provide coverage when a prescription from an ophthalmologist or an optometrist demonstrates one of the following changes in one or both eyes:

- a negative or positive change of at least 0.50 diopter over the sphere, cylinder or addition and the new power meets the eligibility criteria for ophthalmic lenses;

- a change in axis greater than 15 degrees for cylinder power up to 2.00 diopters or greater than 10 degrees for a cylindrical power greater than 2.00 diopters;

- a change of at least 1.00 prism diopter vertically or at least 2.00 prism diopters horizontally and the new prism power meets the eligibility criteria for ophthalmic lenses.

***N.B.:** Outside of the replacement guidelines, consideration of replacements in the event of breakage, damage or loss, will require written justification and appropriate written proof (such as an incident, insurance, or police report). Replacements will not be provided as a result of misuse, carelessness or client negligence.

3.4.2.5 Eligibility Criteria for Specific Types of Lenses

Unifocal Lenses: Clients who need near or far distance vision correction may receive a unifocal lens, aspheric or non aspheric.

Aspheric Lenses: A plastic lens whose front side is aspheric may be provided to clients who require unifocal correction.

Bifocal Lenses: Clients who require both near and far vision correction can receive a single pair of glasses with bifocal lenses if the prescription meets the following criteria:

- a refractive error for far vision of at least 0.50 diopter on the sphere or cylinder; **and**
- an add power equal to or greater than 0.75 diopter.

If the client is not eligible for bifocal lenses, it is possible that he/she may be eligible for unifocal lenses if the prescription meets FNHA Program criteria.

Trial of bifocals*:* Clients should attempt full-time wear of bifocals for a period of three (3) months. If unsuccessful, the frames used to fit the bifocals should be used to make reading glasses. A separate pair of distance glasses may be dispensed to the client who meets the eligibility criteria for vision care.

The HBP Program may provide coverage for two (2) pairs of glasses (near and far distance), if there are contra-indications owing to a cervical or ocular mobility abnormality attested to by the optometrist or ophthalmologist.

High Index Lenses: Lenses made of a material with a refractive index ranging from 1.6 to 1.67 may be provided to clients who require, in at least one eye, a correction whose minimum power in a meridian is ±7.00. The refractive index is 1.6 for clients requiring one bifocal lens.

Polycarbonate Lenses: Polycarbonate lenses may only be authorized in cases where the client has just one functional eye or for those clients who, with the best possible correction, have far visual acuity in the weaker eye which is equal to or less than 6/60 (20/200).

3.4.3 Frames

3.4.3.1 Warranty and Repairs

All frames provided will be of a type that can be repaired and carry a replacement warranty against defective workmanship and material for a minimum of one (1) year from date of issue or as per a negotiated regional agreement. Costs for frames will be covered in accordance with the HBP regional payment schedule.

Repairs to frames (minor or major*) are a benefit after the usual and customary guarantees have expired and may be covered in accordance with the HBP Regional payment schedule on the condition that:

- The frame was covered by the HBP Program;
- The repairs render the frame acceptable for wear;
- Repair costs do not exceed the price of a new frame; and
- Only the most recently purchased vision item qualifies for repairs.

Please note: Repairs required as a result of misuse, carelessness or client negligence are not covered by the HBP Program.

*For a definition of minor and major repairs, please see the table on the following page.

3.4.3.2 Frequency Guidelines

Frames and Frame Repairs	Frequency Guidelines
Regular frames (general purpose issue)	Under 18 years old - 1 per 12 months 18 years old or over - 1 per 24 months Since the last date of service
Frame repairs, minor (includes repairs to nose pads, hinges - up to 20% of the cost of a new frame) **Prescription is NOT required**	
Frame repairs, major (includes repairs to frame fronts, frame arms and replacement of one lens of the same prescription - more than 20% of the cost of a new frame and less than the cost of a new frame) **Prescription is NOT required**	

3.4.3.3 Early Replacement Guidelines

Consideration of replacements in the event of breakage, damage or loss will require written justification and appropriate written proof (such as an incident, insurance, or

police report). Replacements will not be provided as a result of misuse, carelessness or client negligence.

3.5 Vision Care Benefit Exceptions

3.5.1 Exception Criteria For Approval

Items which are not on the HBP *Vision Care Benefit List* and are not exclusions under the HBP may be considered on an exception basis.

***N.B.:** Eligible FNHA clients can obtain ocular prosthesis, scleral shell and low vision aids under the Medical Supplies and Equipment benefit. For more information, please contact the HBP office.

For all exception items, a written prescription with proper medical justification by the ophthalmologist or optometrist is required as well as a completed HBP Prior Approval form.

Items that may be provided on an exception basis may include contact lenses, tints and coatings and, in applicable regions, general, specific and follow-up examinations.

3.5.2 Contact Lenses

Clients may be eligible for a pair of rigid gas permeable or soft lenses when detailed medical justification or a prescription from an ophthalmologist or an optometrist demonstrates one of the following:

- astigmatism of at least 3.00 diopters in the glasses prescription;
- myopia or hypermetropia of at least 7.00 spherical diopters in the glasses prescription;
- anisometropia or antimetropia of at least 2.00 diopters;
- corneal irregularities;
- optometrist-prescribed treatment of certain ocular pathologies, if authorized by provincial/territorial legislation.

Extended-wear contact lenses may be authorized on an exception basis, if the client is eligible and has a neurological or arthritic condition which makes it difficult for them to physically handle contact lenses.

Contact lens wearers may be eligible for one back-up pair of glasses in accordance with the conditions and rates set out in the HBP payment schedule for glasses.

Frequency Guidelines

Contact Lenses	
Regular soft Gas permeable	1 per 24 months or 12 pairs per year in the case of disposable lenses Since the last date of service
Extended wear, soft	

***Please note: Contact lens solution is an exclusion under HBP.**

3.5.3 Early Replacement Guidelines

If replacement contact lenses are required outside of the regular frequency guidelines, the HBP will provide coverage when the prescription from the ophthalmologist or optometrist demonstrates one of the following:

- A negative or positive change of at least 0.50 diopter over the sphere or cylinder *and* the new power meets the eligibility criteria for contact lenses.

- A change of cylinder axis of more than 10 degrees in a toric contact lens.

3.5.4 Tints and Coatings for Lenses

When requesting any tints or coatings for lenses, details of the client's medical condition must be provided in writing by the attending ophthalmologist or optometrist to support these types of requests.

Anti-Reflective Coating: Multi-layer anti-glare treatment may be authorized on lenses with a refractive index ranging from 1.6 to 1.67 on the condition that the client is eligible for high index lenses. This coating must be accompanied of a manufacturer's warranty of at least one (1) year, unless other agreements were negotiated with regional offices.

Tints: Tinted lenses must have an average transmission over the visible spectrum of 40 percent, as long as the tinted lenses provide total ultraviolet (UV) protection. Tints may be authorized for the following conditions:

- albinism;
- aniridia;

- certain chronic conditions of the anterior segment of the eye causing photophobia;
- prolonged usage of some drugs that cause photosensitivity.

Ultraviolet Protection Filter: Ultraviolet protection is the incorporation of a filter which blocks UV rays up to 400mm, without changing lens transmission over the visible spectrum. These filters may be authorized for the following conditions:

- aphakia (without intra ocular lens);
- cataracts;
- retinal degeneration or dystrophy;
- prolonged usage of some drugs that cause photosensitivity.

3.5.5 Frames

Frequency Guidelines

Criteria for Lens (ophthalmic)	Frequency Guidelines
Flex frames (only for those who are neurologically compromised)	
Second Frames (for clients who cannot wear bifocals)	
Oversized frames (56mm)	Reviewed on a case-by-case basis

For all exception benefit items, a written prescription with proper medical justification by the prescribing Ophthalmologist or Optometrist is required as well as a completed HBP Prior Approval (PA) form.

***Note:** Ocular prosthesis, scleral shell and low vision aids are available to eligible HBP clients under the Health Benefits Program Medical Supplies and Equipment Benefit. For more information, please contact the HBP office via the toll-free telephone number 1-800-317-7878 or they can be found on the First Nations Health Authority website at http://www.fnha.ca under the Health Benefits section.

3.6 Vision Care Benefit Exclusions

Exclusions are goods and services which will not be covered by the HBP under any circumstances and are not subject to the HBP appeal process. Exclusions include:

- Two pairs of glasses, except in the situations listed under "bifocal lenses"
- Vision care goods and services covered by the provincial/territorial insurance plan in the province/territory of residence of the client or any other third party
- Additional carrying cases for glasses or contact lenses (one is usually dispensed with the initial purchase)
- Bifocal contact lenses
- Cleaning kit
- Shampoo (e.g. "no more tears" type shampoo solution)
- A vision examination in the following cases: to obtain employment, a driver's license or to engage in sports activity
- A vision examination at the request of a third party (for example: completing a report or medical certificate)
- Any vision items for esthetic purposes
- Contact lens solution
- Industrial safety frames or lenses for sports or professional use
- Progressive or trifocal lenses
- Photochromic/photochromatic lenses
- Sunglasses with no prescription (please refer to the "Tints and Coatings for Lenses" section to verify when tints may be authorized for prescription glasses)
- Replacements as a result of misuse, carelessness or client negligence
- Implants (e.g. punctal occlusion procedure)
- Refractive laser surgery

- Treatments with investigational/experimental status
- Vision training

4.0 Accessing Vision Care Benefits – Prior Approval

Vision care benefits are available to eligible registered First Nations residing in BC when all of the following criteria are met:

- the requested item or service is on the HBP *Vision Care Benefit List*;
- the prescription is less than one year old;
- the vision care services/goods are provided according to established professional standards and applicable provincial/territorial laws; and
- any public or private health or provincial/territorial programs for which the client is eligible have been exhausted prior to accessing the Health Benefits Program.

If all the above criteria are met, the client obtains a prescription from an HBP recognized vision care prescriber and then submits the prescription to a Health Benefits Program recognized provider.

In order to ensure that reimbursement for goods and services are rendered, providers must obtain prior approval from the HBP regional office.

Clients are encouraged to:

- inform the prescriber and provider if they have coverage under any other plan;
- inform the prescriber and provider that they are eligible to receive benefits under the Health Benefits Program; and
- self-identify by providing their ten digit identification number (status registry number), Band name and family number, and personal health (care card) number.

Vision care benefits for eligible clients residing in British Columbia may be being administered on behalf of the Health Benefits Program through contribution agreements. Service providers need to contact the First Nation Band or organization to determine the client's eligibility for services.

4.1 Prior Approval – Invoice and Payment Process

In order to ensure reimbursement by HBP for goods and services rendered, providers must obtain prior approval from the HBP office. For some of the eligible clients, their vision care benefits are being administered by a BC First Nation Band or organization who, under a contribution agreement, have assumed responsibility for the administration and funding of vision care benefits.

If prior approval is granted, a prior approval number will be provided for billing purposes. Only then should the provider proceed with the fabrication/fitting/dispensing of the item. Professional/dispensing fees will be authorized in accordance with the relevant Health Benefits Program payment schedule. The prior approval will also ensure efficient processing of the claim.

If the client resides in a remote area, delivery charges (including mailing and registration) may be paid by the HBP office. Request for payment of delivery charges should be included in the request for prior approval with the supporting information.

Prescribers and providers should contact the HBP office for additional information on the prior approval process via the toll-free telephone number 1-800-317-7878 or they can be found on the First Nations Health Authority website at http://www.fnha.ca under the Health Benefits section.

4.2 Unclaimed glasses – Provider Reimbursement Process

A client has four (4) months **from the order date** to pick up their glasses. The provider should make a reasonable effort to encourage the client to pick up their glasses. These efforts should be documented in the client's file. In the event that the client does not pick up their glasses within four months, two options for the provider are proposed:

1) The provider will dismantle the glasses. The provider will invoice the Health Benefits Program only for the lenses and other parts of the glasses, which cannot be reused, as well as for any professional fees incurred for the provision of the lenses and other parts of the glasses, which cannot be reused. The frames should go back into the provider's inventory. No dispensing fee will be provided for the frames. The lenses should be sent to the HBP office. Instead of the client's signature, the provider will indicate that the client did not pick up the glasses within the four month time frame, and submit the signed invoice for payment to the HBP office. The HBP office will add a note in the client's file stating that the lenses will be held by the HBP office until the client claims them, or the frequency period* expires (whichever comes first). Should the client contact the HBP office for the lenses, the HBP office will make arrangements to have the lenses sent to an eligible provider to be fit into frames and provided to the client. At that time, HBP will reimburse the provider for the frames and dispensing fees for the client's glasses. Based on the original provider's professional opinion, if the glasses do not consist of any reusable parts, the second option should be employed.

2) The provider will mail the glasses to the HBP office. The HBP office will sign for the glasses on behalf of the client. The provider will submit an invoice and be reimbursed as per the fee schedule. The HBP office will add a note in the client's file stating that the glasses will be held by the HBP office until the client claims them, or the frequency period expires (whichever comes first). Should the client contact the HBP office for the glasses, the HBP office will make arrangements to have the glasses sent to the client. A note indicating the date that the glasses were mailed out will be put in the client's file. If the client does not contact the provider within the frequency period, the glasses will be sent to a charitable organization for their use.

It is important to note that the Health Benefits Program will not reimburse providers for any frames or lenses that are beyond the scope of HBP coverage.

*The frequency period refers to the date at which the client will be eligible for new vision care benefits. For more details on the frequency guidelines, please consult the *relevant sections in this document.*

4.3 Coordination of Benefits

Clients are required to access any other benefit programs for which they are eligible prior to accessing FNHA Health Benefits. When another benefit plan is available for a client, claims must be submitted to that plan or program first. Health Benefits will then coordinate payment with the other payer on eligible benefits.

Other providers may include Provincial social assistance clients' extended health plans, WorkSafeBC including the Crime Victim Assistance Program, Insurance Corporation of BC, employer-paid or private insurance plans.

The Coordination of Benefits Policy is the First Nations Health Authority Policy Number FNHB-13-001-001, and implemented as of October 1, 2013.

Appendix A Definitions

"Appeal Process" is a three level process which allows clients to appeal a decision when they have been denied a health benefit.

"AANDC" means Aboriginal Affairs and Northern Development Canada.

"BC" means British Columbia.

"**Client"** means a registered Indian according to the *Indian Act* and is a resident of the province of British Columbia and has an active BC Health Care card that is eligible to receive benefits under the HBP; can be referred as a community member.

"Exception" means goods, services and/or travel which are not defined benefits but which may be approved with appropriate justification.

"Exclusion" means goods, services and/or requested travel which will not be provided as benefits under the HBP under any circumstances and are not subject to the HBP appeal process.

"**First Nations Band or organization**" means a First Nations who is accountable for the provision of health benefits to eligible clients and who receives funds from BC First Nations Health Authority in accordance with the terms and conditions of a signed Contribution Agreement.

"FNHA" means the BC First Nations Health Authority.

"FNHA Eligibility List" is a multi-client database maintained by the Health Benefit Program, which lists clients who are eligible to receive health benefits through the BC First Nations Health Authority.

"HBP" means the Health Benefit Program of the BC First Nations Health Authority.

"PHN" means Personal Health Number. Each BC resident enrolled with the Medical Services Plan (MSP) is eligible for a BC Medical Services Card with a unique lifetime identifier for health care. The PHN remains the same, regardless of any changes to personal status.

"Vision care prescriber" is an Ophthalmologist or Optometrist who is licensed / certified, authorized, and in good standing with the provincial regulatory body in British Columbia.

"Vision care provider" is an Optometrist or Optician who is licensed / certified, authorized, and in good standing with the regulatory body of the province of British Columbia.

Appendix B Client Eligibility

To be eligible to receive benefits under the First Nations Health Authority's Health Benefits Program, a person must be:

1) A registered Indian according to the Indian Act; or an infant up to one year old of an eligible parent;

2) A resident of British Columbia, as defined by the Medical Services Plan (having an active PHN),

3) Not funded or insured under any other benefit system or benefit plans provided by:
    a. Federal legislation, a federal policy or under agreements entered into by Canada and/or
    b. A First Nations Organization pursuant to self-government agreements, land claim agreements, contribution arrangements or internal policies or plans

The Client Eligibility Policy is the First Nations Health Authority Policy Number FNHB-13-002-001, and implemented as of October 1, 2013.

For more information, please refer to the FNHA Health Benefits Eligibility Framework at www.fnha.ca under the Health Benefits section, or contact the HBP office via the toll-free telephone number 1-800-317-7878.

Appendix C Fee Schedules

First Nations Health Authority
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HEALTH BENEFITS PROGRAM
Vision Care – Dispensing Fee Schedule for Optician

Fee Schedule for Optician Dispensing Fees

DISPENSING FEES - shall be paid an amount up to but not exceeding the following sums for services satisfactorily performed:

Frame Dispensing			
	Frame		$ 35.73
	Own Frame		$ 12.27
Lens Dispensing		1 lens	2 lens
	Unifocal	$ 16.38	$ 32.76
	Bifocal	$ 25.51	$ 50.23
	Aphakic	$ 55.69	$ 111.38
Contact Lenses - Initial Fitting			
	Hard or soft pair		$ 220.00
	Keratoconus Fitting		$ 270.00
Contact Lenses – Replacement			
	(i) Hard or soft - each		$ 25.00
	(ii) Hard or soft - pair		$ 50.00
Contact Lenses – Refit			
	(i) Hard or soft - each		$ 100.00
	(ii) Hard or soft - pair		$ 200.00
Eyeglass Case			$ 2.06

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HEALTH BENEFITS PROGRAM
Vision Care – Eye Examination and Dispensing Fee Schedule for Optometrist

Fee Schedule for Optometrist Examinations and Dispensing Fees

EYE EXAMINATIONS	$ 46.17

DISPENSING FEES - shall be paid an amount up to but not exceeding the following sums for services satisfactorily performed:

Frame Dispensing			
	Frame		$ 38.71
	Own Frame		$ 13.28
Lens Dispensing		1 lens	2 lens
	Unifocal	$ 17.75	$ 35.51
	Bifocal	$ 27.10	$ 54.92
	Aphakic	$ 55.69	$ 111.38
Contact Lenses - Initial Fitting			
	Hard or soft pair		$ 226.60
	Keratoconus Fitting		$ 270.00
Contact Lenses - Replacement			
(i)	Hard or soft - each		$ 25.75
(ii)	Hard or soft - pair		$ 51.50
Contact Lenses - Refit			
(i)	Hard or soft - each		$ 100.00
(ii)	Hard or soft - pair		$ 200.00
Eyeglass Case			$ 2.06

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HEALTH BENEFITS PROGRAM
Vision Care - Fee Schedule for Lenses

Fee Schedule for Lenses – Optician And Optometrist

Sphere	Cylinder	Single Vision	Executive/Ultex
Plano - 4.00		9.25	25.05
4.25 - 10.00		13.15	31.10
Plano - 4.00	0.25 - 4.00	12.60	35.25
4.25 - 10.00	0.25 - 4.00	20.15	40.55
For SPH - Over 10.00		add 11.95	add 11.95
For SPH - Over 15.00		add 18.00	add 18.00
For SPH - Over 18.00		add 22.80	add 22.80
For Cylinder Over 4.00D	add	5.80	5.80
For Cylinder Over 6.00D	add	11.95	11.95
For Uncut Deduct		1.50	6.50

BALANCE LENS 50% OF RX PRICE FOR POWER USED (Add-Ons (maximum allowed for both lenses)

OVER 57 EYE, OVERSIZE WILL BE CHARGED			
OVERSIZED	71mm: Add	3.60	6.20
	75mm: Glass	7.75	11.60
	80mm: Plastic	9.25	11.60
Prism	up to 3.50	4.10	4.10
	3.75 to 10.00	6.70	6.70
	Over 10.00	12.35	12.35
Monocular Clients Only		10.05	18.25
Hi-Index		15.00	15.00
Coating: Anti-reflective		25.00	25.00
Coating: Scratch coat		7.50	7.50
Coating - Hardex		7.50	7.50
Tints		10.00	10.00
Frames			41.20
Repair - Minor – maximum allowable		8.20	8.20
Repair - Major - less cost of a new frame		less than 41.20	Less than 41.20
Mail		5.00	5.00

NOTE: if the benefit item requested is not shown above, the provider needs to fax the request along with a written justification for consideration as an exception.

Appendix D Health Benefits Program Client Reimbursement

Service providers are encouraged to bill the Health Benefits Program directly so that clients do not face charges at the point of service when receiving health care goods or services.

When a client does pay directly for goods and services, he or she may seek reimbursement from the Health Benefits Program within one year from the date of service or date of purchase. In order to be reimbursed, the service or item must be an eligible benefit under the Health Benefits Program.

All requests for reimbursement of eligible benefits must include a completed HBP Client Reimbursement Form, original receipts, and a copy of the prescription.

Additional information on the Health Benefits Program client reimbursement process can be or found on First Nations Health Authority website at http://www.fnha.ca under the Health Benefits section or clients can contact the HBP office via the toll-free telephone number 1-800-317-7878.

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FNHA CLIENT REIMBURSEMENT REQUEST FORM

Information you need to include with your completed client reimbursement form can be found on the next page of this form. **Please note** that all FNHA policies and requirements for coverage apply. **All requests for reimbursement of eligible benefits must be made within one year from the date of service.**

It is important to submit ALL related documents or there will be a delay in processing your claim. Please keep copies for your files.

Under the First Nations Health Authority (FNHA), eligibility for the FNHA Health Benefits program extends to include all First Nations people that are resident of British Columbia and have a status number (excluding persons who receive health benefits by way of a First Nations organization pursuant to self-government agreements with Canada).

• Residency in BC is defined as having an active BC Care Card and living in BC.

• Non-resident First Nations using health services in BC will continue to be covered by Health Canada through the Alberta NIHB Regional office.

Part 1 – Client Information (client receiving the service)

Surname:	First and Middle Names:
Address: Apt.:	Identification Number:
City: Province/Territory:	Telephone number: ( )
Postal Code:	Date of Birth: / / (YYYY/MM/DD) PHN:
Are you covered for any of these expenses under any other health plan(s)/program(s)? **No** ❑ **Yes** ❑ **If yes**, please attach a copy of a detailed statement or explanation of benefits form from all other plan(s)/program(s).	

Part 2 – Parent, Guardian or Person to whom payment should be made

Please provide the name and address of the person to whom payment should be made if different from client receiving the service. If client is under one year of age and not registered, please provide parent or guardian information. The person must also be over the provincial/territorial legal age.

Surname:	First and Middle Names:
Address: Apt.:	Identification Number (if applicable):
City: Province/Territory:	Telephone number: ( ) -
Postal Code:	Date of Birth: / / (YYYY/MM/DD) PHN:
Relationship to Treated Client:	

Part 3 – Details of Claim

Instructions on what information is needed to be included with the completed client reimbursement form are listed on the next page. Fill in the total of **all** receipts for each category.

List Benefit Items Requested: (Prescription drugs, Medical Supplies & Equipment, Vision and Eye Care, Medical Transportation or Dental/Orthodontic Benefits)	**Cost**
TOTAL AMOUNT CLAIMED:	

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HEALTH BENEFITS PROGRAM
Vision Care - Fee Schedule for Lenses

Part 4 – Authorization and Signature (Mandatory)

I authorize the release of any records that are relevant to the processing and payment of all claims held by the service provider to FNHA, its agents or contractors, or any appropriate Health Professional licensing or Regulatory Body for the purpose of administrative audit. I declare the information to be true and accurate and does not contain a claim for any benefit or service previously paid for by Health Canada and/or FNHA or by any other plan(s)/program(s) that is noted in the statement or explanation of benefits. By signing below, I also authorize FNHA to collect information from my medical provider for services provided to me and paid for by the Health Benefits Program.

Client, Parent, Guardian or Person having a legally recognized authority **Date:** / / (YYYY/MM/DD)

Print Name: **Signature:**

Forms that are not signed will be returned to the client for signature.

Privacy statement
FNHA is committed to protecting your privacy and safeguarding the personal information in its possession. When a request to provide coverage for benefits is received, the FNHA Health Benefits Program collects, uses, discloses and retains your personal information in accordance with the applicable privacy laws and policies. Further details of the FNHA Health Benefits Program can be found on the website www.FNHA.ca

INFORMATION YOU NEED TO INCLUDE WITH YOUR COMPLETED CLIENT REIMBURSEMENT FORM

- Original receipt(s) for proof of payment. Credit card/Debit (Interac) slips are not acceptable forms for proof of payment.
- If applicable, submit your detailed statement or explanation of benefits form from all other health plan(s)/program(s). Note: Original receipts are not required when submitting the detailed statement or explanation of benefits form as the primary insurer requires them. In such cases, a copy of the original receipt is acceptable.
- A copy of your prescription (MS&E, Vision Care)
- Dental or Orthodontic Services a Dental Claim Form and Client Reimbursement Request Form.
- Medical Transportation – confirmation of attendance signed by physician/health facility

MAILING INSTRUCTIONS

For all reimbursements (other than Orthodontics), please mail your completed form(s) and receipt(s) to the FNHA Health Benefits Office at the following address:

First Nations Health Authority
Health Benefits
757 West Hastings Street, Suite 540
Vancouver, British Columbia V6C 1A1
Telephone (toll-free): 1-800-317-7878
Dental (toll-free): 1-888-321-5003

FOR ORTHODONTIC SERVICES - Please mail your completed orthodontic forms and receipt(s) to the Orthodontic Review Centre.

Orthodontic Review Centre
Non-Insured Health Benefits
First Nations and Inuit Health Branch
Health Canada
55 Metcalfe Street, 5th Floor
Postal Locator 4005A
Ottawa, Ontario K1A 0K9
Telephone: 1-866-227-0943

Appendix E Privacy

The Health Benefits Program of the First Nations Health Authority is committed to protecting clients' privacy and safeguarding the personal information in its possession. When a benefit request or appeal is received, the Health Benefits Program collects, uses, discloses, and retains an individual's personal information according to British Columbia's Personal Information Protection Act. The information collected is limited to only that which is required for the Health Benefits Program to administer and verify benefits.

If you have questions about privacy, you can contact the toll-free Privacy Line at 1-844-364-7748, or local line at 604-693-6844. You can also email us at privacy@fnha.ca

FNHA Privacy Office
First Nations Health Authority
320 – 757 West Hastings Street
Vancouver, BC V6C 1A1

Appendix F Appeal Process

When coverage for a benefit through the Health Benefits Program has been denied, the recipient or parent / guardian of the recipient, has the right to appeal the decision. Appeals must be submitted in writing and can be initiated by the client, legal guardian, or interpreter. There are three levels of appeal available. At each stage, the appeal must be accompanied by supporting information from the provider or prescriber to justify the exceptional need.

At each level of appeal, the information will be reviewed by an independent appeal structure that will provide recommendations to the program based on the client's needs, availability of alternatives, and HBP guidelines. At all levels of the appeal process, the client will be provided with a written explanation of the decision made.

The Benefit Appeals Policy is the First Nations Health Authority Policy Number FNHB-13-009-001, and implemented as of October 1, 2013.

Additional information on the Health Benefits Program appeals process can be found on the First Nations Health Authority website at http://www.fnha.ca under the Health Benefits section, or by contacting the HBP office via the toll-free telephone number 1-800-317-7878.

Appendix G HBP Provider Audit Program

Audit activities are conducted as part of the Health Benefits Program's need to comply with the terms and conditions of the Program, the HBP Benefit Framework and/or the HBP Provider Guides provided to providers, along with other relevant documents.

The objectives of the HBP Provider Audit Program are to:

- prevent and detect inappropriate billing practices;
- detect billing irregularities;
- validate active licensure of registered providers;
- ensure that services paid for were received by eligible Health Benefits Program clients; and
- ensure that providers have retained appropriate documentation to support submitted claims.

Audit activities are administrative in nature and based on accepted industry practices. Claims not meeting the billing requirements of the Health Benefits Program are subject to audit recovery. For additional information, please contacting the HBP office via the toll-free telephone number 1-800-317-7878.

Appendix H Vision Care Prior Approval Form – Eye Examination

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HEALTH BENEFITS PROGRAM
Vision Care Prior Approval Form – Eye Examination

Toll Free Line: 1-800-317-7878
Toll Free Fax: 1-888-299-9222

PROVIDER INFORMATION:	**PROVIDER NUMBER:** _____ **TELEPHONE NUMBER:** _____ **FAX NUMBER:** _____ **PROVIDER SIGNATURE**: _____

CLIENT INFORMATION: (MUST BE COMPLETED – INCOMPLETE FORMS WILL BE RETURNED)

NAME OF CLIENT: _____

ADDRESS: _____

CLIENT PHONE NUMBER: _____

10 DIGIT STATUS NUMBER: _____ DOB:_____

PERSONAL HEALTH CARE NUMBER (PHN): _____

DATE OF CLIENT'S LAST EXAMINATION:

REASON FOR EXAMINATION:

First Nation Health Authority reserves the right to deny coverage and/or audit the client's provider.

Once approved a separate Approval/Denial form will be faxed directly to the provider.

Appendix I Vision Care Prior Approval Form – Eye Wear

First Nations Health Authority
Health through wellness

HEALTH BENEFITS PROGRAM
Vision Care Prior Approval Form – Eye Wear

Toll Free Line: 1-800-317-7878
Toll Free Fax: 1-888-299-9222

PROVIDER INFORMATION:	**PROVIDER NUMBER:** _____ **TELEPHONE NUMBER:** _____ **FAX NUMBER:** _____

CLIENT INFORMATION: (MUST BE COMPLETED – INCOMPLETE FORMS WILL BE RETURNED)

NAME OF CLIENT: _____

ADDRESS: _____

10 DIGIT STATUS NUMBER: _____ DOB:_____

PERSONAL HEALTH CARE NUMBER (PHN): _____

DOES THE CLIENT HAVE ALTERNATIVE COVERAGE:_____

Name of Prescriber: (Optometrist/Ophthalmologist) **COPY OF THE PRESCRIPTION MUST BE ATTACHED**	**DATE OF EXAMINATION**:

OPTICAL INFORMATION (SUBMIT COPY OF PRESCRIPTION)

Prescription:	**Sphere**	**Cyl**	**Axis**	**Prism**	**Base**	**Add**
Right						
Left						

EYEWEAR REQUESTED

Description	**Cost**	**Description**	**Cost**	**Dispensing**	**Cost**
Frames		High Index		Lenses	
Lens Lab Cost		Contact Lenses		Frames	
Anti Reflective/Tint		Case		Mail	
S/R - Hardex		Repairs		Other	
			GRAND TOTAL		

First Nation Health Authority reserves the right to deny coverage and/or audit the client's provider. Once approved a separate Approval/Denial form will be faxed directly to the provider.