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Guide to vision care benefits

Effective date: April 28, 2022

Note to reader

Indigenous Service Canada's First Nations and Inuit Health Branch and the Assembly of First Nations have undertaken a Joint Review of the Non-Insured Health Benefits (NIHB) program, including the vision care benefit. The objectives of this collaborative process are to enhance client access to benefits, identify and address gaps in benefits, and improve service delivery to be more responsive to client needs. This guide to vision care benefits has been updated as an interim measure to clarify policy changes in some areas, and respond to preliminary issues identified through Joint Review discussions to date. Once the ongoing work on the Joint Review is completed, further revisions to this guide are anticipated.

This guide provides information on the Indigenous Services Canada NIHB and its policies relevant providers and clients.

Effective June 29, 2020, Express Scripts Canada will be providing claims processing services for the NIHB program's vision care benefit. Providers are encouraged to enrol and send their claims directly to Express Scripts Canada so that clients do not pay fees at the point of service. Please refer to the Vision Care Regional Fee Grids available on the Express Scripts Canada NIHB provider and client website. Providers will continue to obtain prior approval from the NIHB regional office in the province or territory where the service is provided.

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1.0 Introduction

1.1 Purpose of the guide

This guide provides information on Indigenous Services Canada's Non-Insured Health Benefits (NIHB) program vision care benefit. The purpose of this guide is to outline the terms and conditions, criteria, guidelines and policies under which the NIHB program's vision care benefit operates.

In this guide, you will find information regarding:

- eligible services
- frequency guidelines
- benefit coverage and exceptions
- payments and reimbursement

In the event that this guide does not address questions regarding general policies, processing of payment requests, or specific conditions, clients or vision care providers may contact their NIHB regional office (Appendix B). Further information can also be found in the Vision Care Claims Submission Kit available on the Express Scripts Canada NIHB provider and client website.

1.2 About the vision care benefit

The NIHB program's vision care benefit provides eligible clients (Appendix D) with coverage for eye examinations and corrective eyewear; this includes:

- eye examinations when they are not insured by the province or territory

- corrective eyewear (glasses, contact lenses) when prescribed by a vision care professional
- eyeglass repairs

The program provides eligible clients (Appendix D) coverage for eligible benefits when coverage is not available to the client under provincial, territorial or private health insurance (for example, in many provinces and territories, eye examinations may be an insured service for clients based on their age or with certain medical conditions). See also section 4.4 for coordination of benefits information with other plans.

1.3 Benefit criteria

Vision care benefits are covered in accordance with NIHB program policies. Eye examinations and eyewear must be provided by a licensed vision care professional in accordance with provincial or territorial legislation and regulations. Providers should obtain prior approval from the NIHB regional office in the province or territory where the service is provided (section 4.2).

Vision care benefits are eligible for coverage for registered First Nations and recognized Inuit when all the following criteria are met:

- the requested item or service is eligible (section 2.0 and 3.0)
- the prescription is valid (less than 2 years old)
- the item or service is prescribed and provided according to established professional standards and applicable provincial/territorial legislation and regulations
- prior approval has been requested from the NIHB regional office in the province or territory where the service is provided
- any provincial, territorial public or private health insurance plans or programs for which the client is eligible must be accessed first

2.0 Eye examination

2.1 Eligible services

Coverage for eye examination within the frequency guidelines (section 2.2) falls into three major categories: general examination, follow-up examination, and single tests.

Please refer to the Vision Care Regional Fee Grids available on the Express Scripts Canada NIHB provider and client website.

Providers are requested to submit claims directly to the NIHB program (through Express Scripts Canada) so that clients are not required to pay at the point of service. Clients may contact their regional office for assistance in locating a vision care provider who will bill the NIHB program directly, in accordance with regional fee grids, for services provided. In the event that no such providers are available locally, clients may call their regional office to request travel support to access a vision care provider who will bill the program directly.

Please note that providers will not be reimbursed for missed appointments fees.

Eye exams in Nunavut and the Northwest Territories are provided under arrangements managed by the territorial governments. The NIHB program does not enrol optometrists (through Express Scripts Canada) to provide these services in these territories.

General examination

The NIHB program covers the following tests as part of a general exam. Coverage for additional tests may be approved on an exception basis, based on medical need, and requires prior approval (section 2.1; single tests).

- 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
- confrontation visual fields

- direct ophthalmoscopy
- analysis and diagnosis of findings

Follow-up examination

A follow-up examination is the repetition of one or more tests from the general examination which are needed to assess the condition or progression of the client's oculo-visual condition. Coverage may be approved on an exception basis, based on medical need (for example: findings from general exams, chronic health conditions), and requires prior approval. Details of the client's medical condition and the specific test(s) to be repeated must be provided in writing by the prescriber.

Single tests

Clients may be eligible for single eye tests when their ocular or visual condition requires the use of specific additional tests. Coverage may be approved on an exception basis, based on medical need, and requires prior approval. The request must include in writing the client's vision diagnosis and any other pertinent medical conditions, the current results from the general or follow up eye exam including the client's vision prescription, and any other medical justification supporting the need for the single test. For example, for specialized tests for glaucoma, prescribers must include eye pressure readings.

Single tests include:

- assessment of visual fields, using visual field analyzer
- colour blindness test
- examination of the peripheral retina under pupil dilation
- gonioscopy of the angle
- 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

- electroretinogram measurement or visually evoked potentials
- trial contact lens and assessment of ocular reaction for clients who meet the criteria for exception contact lenses (section 3.4.3)
- Cycloplegic refraction test (for children aged 7 years and under without strabismus and children aged 12 years and under with strabismus)

Coverage for single tests not listed above will be reviewed on a case-by-case basis, based on medical need (as above), and requires prior approval.

All single tests must include recommendations to the patient and, if necessary, a prescription for treatment.

Clients with diagnosed medical conditions affecting the eye

Clients with diagnosed medical conditions affecting the eye, such as diabetes, glaucoma, cataract, age-related macular degeneration, may be eligible for a general examination and additional single tests every year (note that this is covered as an insured service in several provinces).

2.2 Eye examination frequency guidelines

<table>
<tr><th>Eye examination</th><th>Frequency guidelines</th></tr>
<tr><td>General exam</td><td>under 18 years old — once per calendar year
18 years old or over — once every two calendar years
clients with diagnosed medical conditions affecting the eye — once per calendar year</td></tr>
<tr><td>Follow-up exam</td><td rowspan="2">reviewed case-by-case</td></tr>
<tr><td>Single test</td></tr>
<tr><td colspan="2">Clients are encouraged to have an eye examination BEFORE they get eyewear to be sure that it meets their current needs.</td></tr>
</table>

3.0 Corrective eyewear

3.1 Eligible services

To be eligible for eyewear within the frequency guidelines (section 3.2), the client must obtain a prescription from a licensed vision care professional qualified to do so under applicable provincial or territorial legislation and regulations. The prescription must correct for one or more of the following conditions:

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

The client's prescription must meet at least one of the following criteria:

- in at least one eye, require spherical and/or cylindrical correction of at least 0.50 diopter, and/or for presbyopia, have an add power of at least 0.75 diopter
- require prismatic correction totalling at least 1.00 prism diopter vertically or at least 2.00 prism diopters horizontally

3.2 Corrective eyewear frequency guidelines

Coverage for corrective eyewear (glasses, contact lenses) is provided as follows:

Age group	Frequency
Clients under 18 years	once per calendar year

Age group	Frequency
Clients 18 years or over	once every two calendar years
Clients are encouraged to have an eye examination BEFORE they get eyewear to be sure that it meets their current needs.	

Frequency of coverage is calculated by calendar year only, not months and days. For example, for a two-year frequency, a client who received coverage for new eyewear at any time in 2019 will be eligible again starting on January 1, 2021, unless the client qualifies for early replacement per section 3.4.6.

3.3 Eyewear coverage amounts

The NIHB program provides clients with 2 types of coverage amounts for prescriptions: **standard** and **high index**. The coverage amount for which the client is eligible is determined by the client's eye examination and resulting prescription and may be used towards the purchase of any type of prescription eyewear (glasses or contact lenses).

A coverage amount includes all costs, including tints and coatings, dispensing fees, frames, lenses and fittings. No other coverage will be provided except as described in section 3.4 (Exceptions). Please refer to the Vision Care Regional Fee Grids available on the Express Scripts Canada NIHB provider and client website.

Item	Criteria for approval
Standard coverage amount	• coverage for clients who require a correction whose minimum power in a meridian is under ±7.00 in both eyes, and who do not qualify for one of the other coverage amounts • client's prescription must address minimum requirements specified in section 3.1

Item	Criteria for approval
High index coverage amount	• coverage for clients who require a correction whose minimum power in a meridian is ±7.00 or more in at least one eye

For coverage of eyewear for clients with exceptional prescriptions or eye conditions, please see section 3.4 (Exceptions). Exceptions include:

- polycarbonate lenses
- tints and coatings
- exception contact lenses
- flex frames
- high prescription lenses
- early lens replacement due to change in prescription
- repairs or replacement due to breakage, damage or loss
- inability to adjust to multifocal eyewear

Providers are encouraged to submit claims directly to Express Scripts Canada. Any additional costs over the maximum eligible amounts are the responsibility of the client. Providers are asked to inform the client when the cost of the eyewear selected exceeds the coverage amount and/or which will require the client to pay the balance.

3.3.1 Residual amount

Any unused portion of a coverage amount, or residual amount, will remain available to clients until the end of the frequency period (section 3.2). The residual amount will be applied to any future eyewear purchases within the same frequency period. For example, if a client has a residual amount from their coverage amount, it will be applied when the client purchases another pair of glasses or requests a lens replacement. Please note that residual amounts cannot be applied to eye exams since they have a separate fee structure.

The program will keep track of the residual amount until the end of the frequency period. Clients can contact their NIHB regional office to find out their residual amount.

3.4 Exceptions and criteria for approval

For all exception items, a written prescription with medical justification by an ophthalmologist or optometrist is required.

To support the exception request, details of the client's medical condition must be provided in writing by the prescriber. Where relevant, an additional amount may be added on top of the coverage amount (section 3.3) for which a client qualifies.

3.4.1 Exception: Polycarbonate lenses

Coverage for polycarbonate lenses is eligible when the client meets the following criteria.

Item	Criteria for approval
Glasses with polycarbonate lenses	Coverage for clients in cases where the client has just one functional eye or for 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)

3.4.2 Exception: Tints and coatings

Any client may use their coverage amount towards the purchase of tints or coatings of their choice. However, those with medical justification may qualify for additional amounts to be added to the coverage amounts (section 3.3) for these items.

Item	Criteria for approval
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. Coverage is eligible 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	Coverage is eligible for the following conditions: • aphakia (without intra-ocular lens) • cataracts • retinal degeneration or dystrophy • prolonged usage of some drugs that cause photosensitivity • where tints are authorized (see above)

3.4.3 Exception: Contact lenses

In some cases, contact lenses may be the most appropriate way to correct vision for a client with certain prescriptions. Clients with one of the following conditions (in the table below) may qualify for additional coverage for both contact lenses and back-up glasses based on detailed medical justification or a prescription from an ophthalmologist or an optometrist.

Note that clients who do not demonstrate one of the conditions (in the table below) may choose to use their standard or high index coverage amount towards the fitting and purchase of contact lenses.

Item	Criteria for approval
Exception contact lenses	Coverage for exception contact lenses is eligible if the client has one or more of the following conditions: • astigmatism of at least 3.00 diopters in at least one eye in the glasses prescription • myopia or hypermetropia of at least 7.00 diopters in the spherical component in at least one eye 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 or territorial legislation • extended-wear contact lenses for clients with a neurological or arthritic condition which makes it difficult for them to physically handle contact lenses
Back-up glasses for exception contact lens wearers only	if a back-up pair of glasses is dispensed, the client qualifies for one Standard or High Index coverage amount based on their prescription (section 3.3) or exception coverage amount (section 3.4)

The exception contact lens coverage amount is to be applied towards the purchase of contact lenses. Additional coverage may be provided towards an annual progress examination (section 2.1, single tests) and the purchase of glasses to use as a back-up. The coverage amount specific to the back-up glasses is based on the prescription (section 3.3).

3.4.4 Exception: Flex frames

Where the client is young or has a medical condition (for example: Down syndrome, craniofacial disorders) that makes handling frames difficult, the client may be eligible for coverage of flex frames on top of the coverage amounts (section 3.3).

Item	Criteria for approval
Flex frames	• infants and children 4 years and under • client has a medical condition that makes handling frames difficult

3.4.5 Exception: High prescription lenses

Where a client's prescription requires corrective lenses with a very high laboratory cost that cannot be managed within the corresponding coverage amount (section 3.3), additional coverage towards the cost of the lenses may be considered on an exception basis. A detailed breakdown of costs will be required to support consideration of these requests. Note that for glasses, the coverage for the frame will be according to the exception frame amount specified in the Vision Care Regional Fee Grids available on the Express Scripts Canada NIHB provider and client website. Note that as the coverage provided is for the **actual cost** of the lenses, there will be no residual amount.

Item	Criteria for approval
High prescription lenses	Coverage for high prescription lenses is eligible if the client meets one or more of the following criteria: • clients under 12 years old whose minimum power in a meridian is greater than 3.00 diopters of hyperopia or requiring bifocals for the management of strabismus • a correction whose minimum power in a meridian is greater than +9.00 diopters for hyperopia and -12.00 diopters for myopia in at least one eye • astigmatism greater than ±3.00 diopters in at least one eye

Item	Criteria for approval
	• anisometropia greater than 3.00 diopters between the two eyes

3.4.6 Exception: Early lens replacement due to change in prescription

If a client's prescription changes significantly and replacement lenses are required outside of the regular frequency guidelines, coverage for the replacement of contact lenses or eyeglass lenses (using existing frames) is eligible when the client's new prescription demonstrates one of the following criteria in at least one eye:

Item	Criteria for approval
Replacement of lenses for glasses	Coverage for replacement is eligible if the client meets one or more of the following criteria: • a change of at least 0.50 diopter over the sphere, cylinder or addition in at least one eye and the new power meets the eligibility criteria for eyewear (section 3.1) • a change in axis greater than 15 degrees for cylindrical power up to 2.00 diopters or greater than 10 degrees for a cylindrical power greater than 2.00 diopters in at least one eye • a change in prism of at least 1.00 prism diopter vertically or at least 2.00 prism diopters horizontally in at least one eye • applies to standard or high index coverage amount (section 3.3) or exception coverage amounts (section 3.4)
Replacement of contact lenses	• a change of at least 0.50 diopter over the sphere, cylinder or addition in at least one eye and the new power meets the eligibility criteria for eye wear (section 3.1)

Item	Criteria for approval
	• a change of cylinder axis of more than 10 degrees in at least one eye in a toric contact lens • applies to standard or high index coverage amount (section 3.3) or exception contact lenses (section 3.4.3)

When early lens replacement is required, because the client's vision is changing, the eye exam must have been done in the preceding three months to ensure the new eyewear meets the client's current needs.

3.4.7 Exception: Repairs or replacement due to breakage, damage or loss

All frames provided must be of a type that can be repaired and carry a replacement warranty against defective workmanship and materials for a minimum of 1 year from the date of issue. Any costs covered under warranty are not eligible for reimbursement by the program.

Coverage is provided on the condition that the repairs render the eyewear acceptable for wear and that repair costs does not exceed the prices in the Vision Care Regional Fee Grids available on the Express Scripts Canada NIHB provider and client website. Eyeglass repair kits for client use at home may be covered as a client reimbursement under minor repairs.

Coverage for replacement of eyewear in the event of breakage, damage or loss may also be considered with justification and supporting documentation of the incident that caused the need for replacement (such as an incident, insurance, medical or police report citing the incident). Replacements resulting from misuse or carelessness will not be considered for adults but may be considered on an exception basis for children.

Item	Criteria for approval
Repairs, minor	• includes repairs to frame, such as nose pads and hinges (prescription is NOT required) • includes eyeglass repair kits (of the type a client would purchase for use at home)

Item	Criteria for approval
Repairs, major	• includes repairs to frame, such as fronts and frame arms (prescription is NOT required) • includes replacement of one lens of the same prescription
Replacement of entire glasses or contact lenses in the event of breakage, damage or loss	• for clients 18 years and older, supporting documentation is required of the incident that caused it (such as an incident, insurance, medical or police report citing the incident) Supporting documentation is not required for clients under 18 years

Frequency guidelines: Repairs or replacement due to breakage, damage or loss

Item	Frequency
Minor repair	• under 18 years old — once per calendar year • 18 years old or over — once every two calendar years
Major repair	• under 18 years old — once per calendar year • 18 years old or over — once every two calendar years
Replacement of entire glasses or contact lenses	• under 18 years old — reviewed case-by-case • 18 years old or over — reviewed case-by-case; supporting documentation is required of the incident that caused it (such

Item	Criteria for approval
	as an incident, insurance, medical or police report citing the incident)

3.4.8 Exception: Inability to adjust to multifocal eyewear

Most clients who have more than one prescription can have these prescriptions fitted in one frame and find this most convenient for their everyday use. Clients who have not previously used multifocal eyewear, such as bifocals and progressives, should attempt full-time wear for a trial period of 3 months. If by the end of this trial period, the client remains unable to adjust to using multifocal eyewear, and provided that the client meets the prescription requirements outlined in section 3.1, the client may qualify for:

- one lens replacement coverage amount (fit new lenses using previously dispensed frame; section 3.4.6)
- a full coverage amount to fit the remaining qualifying prescription lenses (section 3.3 or 4.1) or exception coverage amount (section 3.4)
- the invoice must show that both of the above were provided to the client.

A client does not have to undergo a new trial period if they have already done so in the past, or if there are contra-indications owing to a cervical or ocular mobility abnormality attested to by the optometrist or ophthalmologist.

Multifocal eyewear	Criteria for approval
Second pair for client unable to adjust to multifocal eyewear after trial period	First time users only: • client has attempted to wear the multifocal glasses for at least 3 months

Multifocal eyewear	Criteria for approval
	• in addition to a second coverage amount, client may receive coverage towards the cost of the lens replacement, since the original frame can be reused for one pair • the invoice must show that both of these items were provided to the client
Two pairs for a client who has already tried and been unable to adjust to multifocal eyewear in the past	• client has undergone trial period in the past • client has contra-indications owing to a cervical or ocular mobility abnormality attested to by the optometrist or ophthalmologist • the invoice must show that both of these items were provided to the client

3.5 Ordering eyewear: A note to clients

Clients should be aware that eyewear is custom made. Once the optometrist or optician has made the eyewear, it cannot be used by anyone else. Clients are encouraged to make arrangements with the provider's office to pick up their eyewear when it is complete. A provider will generally hold eyewear for a **maximum** of four months from the time they were ready for pick up. Clients must sign the invoice to indicate they have picked up their eyewear. If a client must travel outside their community to have their new glasses fitted by the vision care provider, travel support may be available. Clients may contact their NIHB regional office for additional information.

Clients do not have to order their eyewear through the same vision care provider who does the exam. If clients choose to have eyewear made elsewhere (such as through a separate optician), they should tell their optometrist or optometric clinic right away, so that the program provides the prior approval to the correct providers.

The cost of eyewear varies greatly based on the choices made by the client. Clients should ask their provider to confirm the total cost of the eyewear selected **before** the client agrees to order the eyewear. The client is responsible for any cost over the amount covered by the NIHB program.

Clients have two options to seek payment for their exams or eyewear:

- direct billing through the provider: Clients are asked to contact their chosen vision care provider or NIHB regional office in advance to confirm that the provider is enrolled with NIHB, and will bill the NIHB program directly (through Express Scripts Canada) for the cost of the exam and/or eyewear up to the maximum eligible amount
- reimbursement to the client: A client may opt to pay the provider directly and seek reimbursement for eligible benefits (section 4.3) up to the maximum eligible amount

Maximum eligible amounts can be found in the Vision Care Regional Fee Grids available on the Express Scripts Canada NIHB provider and client website, or by calling the NIHB regional office.

3.6 Exclusions

Exclusions are goods and services which will not be covered by the NIHB program under any circumstances and are not subject to the NIHB program's appeal process.

Exclusions include:

- additional eye exams or costs over the coverage eligibility or frequency to obtain employment, a driver's license or to engage in sports activity, or at the request of a third party (for example, completing a report or medical certificate)
- eyeglass cleaning kit
- shampoo
- any vision items for aesthetic purposes (for example, non-prescription glasses or cosmetic contacts)
- contact lens solution
- replacements for adults as a result of misuse, carelessness or client negligence
- implants (for example, punctal occlusion procedure and intraocular lenses)
- refractive laser surgery
- treatments with investigational or experimental status
- vision therapy

- eyewear purchased online or outside Canada
- tele-optometry eye examinations

3.7 Items covered by other NIHB benefit areas

Eligible clients can obtain ocular prosthesis, scleral shell and low vision aids under the Medical Supplies and Equipment benefit. For more information, please contact your NIHB regional office.

Certain medications used to treat conditions such as Macular Degeneration may be covered under the Pharmacy benefit. For more information, vision care providers or clients may contact the Drug Exception Centre at 1-800-580-0950.

4.0 Prior approval and payment

4.1 Delivery and shipping policy

The provider should notify the client that they have four months from the time the eyewear is ready for pick up and document their attempts to contact the client in the client's file. In the event that the client does not pick up their eyewear, please refer to Appendix A on Unclaimed eyewear for more information.

In specific circumstances, where the client and provider are not in the same city and are in agreement to ship an item to the client, the provider may request payment for shipping costs (including registered mail) in addition to the client's coverage amount. Request for approval of shipping costs should be included in the request for prior approval.

4.2 Prior approval

Prior approvals are required for all requests and are valid until the end of client's frequency period.

Providers are encouraged to check with the NIHB program to ensure the client has met the frequency guidelines for an eye exam or eyewear (if not, the claim cannot be paid). Providers should obtain prior approval from the NIHB regional office in the province/territory where the service is provided. The regional office will provide a prior approval number for the purpose of billing the claim, which can include the eye exam, the eyewear, or both. Prior approval also ensures that the provider and the client are aware of the amount of coverage that is available, and can select eyewear accordingly. Providers should contact the NIHB regional office for additional information on the prior approval process.

Clients are encouraged to:

- contact their NIHB regional office to find out their eligible coverage amount
- inform the provider if they have coverage under any other plan
- inform the provider that they are eligible to receive benefits under the NIHB program
- provide their client identification number
- ask about the total cost of their eyewear and if there will be a balance owing to be paid on pickup

4.3 Payments: Provider claims and client reimbursements

All claims for reimbursement of eligible goods and services must be received within one year from the date of service. In order to be reimbursed, the service or item must be an eligible benefit, and the client must have been eligible at the time the service or item was provided.

Processing of payments, including provider claims and clients reimbursements, for the NIHB program vision care benefit are done through Express Scripts Canada.

All providers are required to complete a NIHB Vision Care Provider Enrolment Package available on the Express Scripts Canada NIHB provider and client website. The Vision Care Provider Enrolment Package contains the following forms: A mandatory Vision Care Billing Agreement, an optional Alternate Mailing Address/Communication Form and Direct Deposit Form. Should Express Scripts Canada not receive completed and signed enrolment documents, your claims will not be processed.

After signing a Vision Care Billing Agreement with the Express Scripts Canada for the NIHB program, providers are advised to read and retain a copy of the Vision Care Claims Submission Kit. This kit outlines provider accountability and obligations when submitting claims for payment. The Vision Care Claims Submission Kit is available on the Express Scripts Canada NIHB provider and client website.

Providers are encouraged to send their claims directly to Express Scripts Canada so that clients do not pay fees at the point of service. For some clients, balance billing and charging up front for services are barriers to accessing vision care services.

For requests for client reimbursement, clients must include a completed NIHB Client Reimbursement Form, found on the Express Scripts Canada NIHB provider and client website, original receipts and a copy of the optical prescription. If the client has coverage through a private plan (section 4.4), the client must also include an explanation of benefits (EOB) form from the other plan and a copy of the original receipt (the primary insurer requires the original receipt). For more information, please refer to the NIHB Client Reimbursement section available on the Express Scripts Canada NIHB provider and client website.

4.4 Coordination of benefits

Clients are required to access any public or private health or provincial/territorial programs for which they are eligible prior to submitting their claim to the NIHB program through Express Scripts Canada. For example, eye examinations may be an insured service under the provincial or territorial health plan based on a client's age or medical condition (in this case, the exam is not a benefit to the client under NIHB). Providers should be aware when a client qualifies for an eye exam under the provincial or territorial health plan.

It is the responsibility of the client to inform the provider if they have coverage through a private plan, such as a group plan. When claiming expenses, having coverage under more than one plan allows clients to use both plans. When an NIHB-eligible client is covered by another plan, claims must be submitted to the other plan first. The other plan will provide an explanation of benefits (EOB) form that must be sent with the claim to Express Scripts Canada.

Clients may use their full NIHB coverage to pay any remaining balance after the other plan has paid. If a client has other insurance, the client's NIHB eligibility is not reduced. Any balance remaining after another plan has paid may be claimed, up to the client's full NIHB eligible amount. If the client has a residual amount, it will be applied to any future eyewear purchases within the same frequency period. See section 3.3.1 on residual amounts.

Where a client is no longer eligible for coverage from another payer, the client or provider can contact the NIHB regional office to update the file.

Appendices

A. Unclaimed eyewear

A client has 4 months to pick up their eyewear from the time the eyewear was ready for pick up. Clients must sign the invoice to indicate they have picked up their eyewear. The provider must document their efforts to communicate with the client, in the client's file. In the event that the client does not pick up their eyewear, the client's coverage amount will be reduced by the cost of unclaimed eyewear, up to the coverage amount. After the four-month period, the provider has 2 options to obtain payment:

1. Where the client has ordered glasses, the provider will dismantle the glasses and invoice the NIHB program only for the lenses and other parts of the glasses which cannot be reused. The frames should go back into the provider's inventory. The lenses must be sent to the regional office. Before the provider can submit a claim to Express Scripts Canada, the provider must contact the regional office to amend the prior approval to unclaimed eyewear. 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 from Express Scripts Canada. The regional office will add a note in the client's file stating that the lenses will be held by the regional office until the client claims them, or the frequency period expires (section 3.2), whichever comes first. Should the client contact the regional office for the lenses, the regional 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, the NIHB program (via Express Scripts Canada) will reimburse the provider for the frame for the client's glasses.

   Based on the provider's professional opinion, if the eyewear does not consist of any reusable parts, the second option should be used.

2. The provider must contact the regional office to amend the prior approval to unclaimed eyewear and mail the glasses or contact lenses to the regional office. The regional office will sign for the eyewear on behalf of the client. The provider will submit an invoice to Express Scripts Canada and be reimbursed for the amount approved. The regional office will add a note in the client's file stating that the eyewear will be held by the regional office until the client claims them, or the frequency period expires (whichever comes first). Should the client contact the regional office for the eyewear, the regional office will make arrangements to have the eyewear sent to the client or a provider of the client's choice. A note indicating the date that the eyewear was mailed out will be put in the client's file. If the client does not contact the provider within the frequency period, where possible, the eyewear will be sent to a charitable organization for their use.

It is important to note that the NIHB program will not reimburse providers for any costs for eyewear above the approved amount. For additional information, please contact the NIHB regional office in your province or territory.

B. Contact information: NIHB regional offices

For additional information, please contact the NIHB regional office in your province or territory.

C. Privacy statement

Indigenous Services Canada's NIHB program has a responsibility to protect personal information under its control in accordance with the *Privacy Act* and its related Treasury Board privacy policy and directives and is responsible for ensuring the personal information collected is limited to that which is necessary to administer the program.

For more information, please contact Indigenous Services Canada's Access to Information and Privacy Coordinator at 819-997-8277 or aadnc.atiprequest-aiprpdemande.aandc@canada.ca. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

D. Client eligibility

To be eligible for NIHB program benefits, a client must be a Canadian resident and have one of the following statuses:

- a First Nations person who is registered under the *Indian Act* (commonly referred to as a "status Indian")

  OR

- an Inuk, recognized by one of the following Inuit Land Claim organizations — Nunavut Tunngavik Incorporated, Inuvialuit Regional Corporation, Makivik Corporation. For an Inuk residing outside of their land claim settlement area, a letter of recognition from one of the Inuit land claim organizations and a birth certificate are required

  OR

- an infant, less than 18 months of age, whose parent is an eligible client

  AND

- currently registered or eligible for registration, under a provincial or territorial health insurance plan
- not otherwise covered under a separate agreement (for example, a self-government agreement such as the Nisga'a and Nunatsiavut agreements) with federal, provincial or territorial governments

Refer to the NIHB client eligibility page or contact the NIHB regional office for information.

E. Appeal process

A denial of benefit can be appealed by the client or the provider on behalf of the client. For the provider to send in an appeal, an authorization letter signed by the client is required. Please note that the items identified as exclusions cannot be appealed. Refer to the NHIB appeal procedures or contact the NIHB regional office for information.

F. Provider claims verification program

Verification activities are conducted as part of the NIHB program's need to comply with accountability requirements for the use of public funds and to ensure provider compliance with the terms and conditions of the program as outlined in this guide, the Claims Submission Kit, Provider Agreement and other relevant documents. The program reserves the right to withhold any future payments to providers pending receipt of monies determined to be paid in error.

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