Navigating Insurance Coverage

Certain eye diseases may require lifelong monitoring and treatment. You may need to work with both your health care provider and insurance company to ensure your care does not result in undue financial burden. Here are some tips on how to effectively talk with your insurance company.

Medicare covers **22.4 million women** ages 65+[7]

Medicaid covers **25 million women** ages 19 to 64[8]

Employer-sponsored insurance covers **59 million women** ages 19 to 64[9]

Talking with Your Insurance Company

Know the details of your insurance policies.

Coverage for eye care can sometimes be confusing, as many individuals have **both vision and medical insurance.**

- Appointments with an optometrist or ophthalmologist for a routine eye exam or prescription lens renewal often fall under vision insurance coverage.
- Appointments with an optometrist or ophthalmologist to assess or treat eye disease will likely be covered by medical insurance.

For those enrolled in Medicare, routine eye exams for eye glasses or contact lenses are often not covered. Some Medicare Advantage Plan (Part C) offer extra benefits that original Medicare doesn't cover - like vision, hearing, or dental. Contact 1-800-MEDICARE or go to www.medicare.gov for more information.

Request a copy of your insurance policies that explain:

- Services covered
- Referral processes to see various health care professionals
- Prior authorization processes to receive services or medications
- Premium payment amounts
- Policy expiration date

Understand the financial aspects of your policy.
Insurance plans rarely cover 100% of health care costs, requiring patients to pay the outstanding portion. The primary out-of-pocket costs are:

- Deductible — a preset amount you must pay before insurance kicks in
- Coinsurance — an amount (often a percentage) you must pay for services after a deductible has been reached
- Copayment — a preset, flat fee you must pay for services after a deductible has been reached

Be aware of special coverage requirements.
Some insurance companies have prior authorization requirements that must be met before they will cover a specific medication, treatment, or procedure.

Plans may require an eye specialist to evaluate you before you can receive certain medications. Sometimes, an insurance company may require that certain medications are tried and 'failed' first before allowing the patient access to their clinician's preferred treatment method. This is called step therapy. Talk with your eye doctor to determine if required treatment is subject to step therapy, as a delay in treatment may result in further progression of your condition or affect your vision or long-term health.

Step therapy - or "fail first" - is a policy implemented by an insurance company that requires a patient to try and "fail" a lower-cost treatment before the treatment that a clinician originally prescribed or recommended. This policy may delay necessary treatment or further progress disease state.

In most cases, your doctor's office will be responsible for submitting the prior authorization. Work with office staff to ensure the necessary forms are completed accurately and submitted quickly. For additional help navigating the process, you can request the support of a case manager at your insurance company. This is typically a free resource provided by the insurance company. You may also be able to find help through patient advocate or patient navigator programs and support organizations. See the **Resources and Support Groups** section of the SWHR Guide to Women's Eye Health for additional information.

Patient navigators, also referred to as patient advocates, are people who help guide patients through the health care system. Patient navigators may be able to offer a wide variety of services, including setting up doctor's appointments, communicating with insurance, and providing social support while individuals navigate complex medical conditions and care.

Filing Claims & Appeals

If your insurance company denies your claim for your eye care, you have the right to appeal the decision.

Insurers are required to tell you how you can dispute their decisions and have them reviewed by a third party. **If you decide to appeal, it is important to take action immediately**. Carefully review your insurance policy to understand what it covers and outline your argument for why your insurer should honor your appeal.

Your insurance company must notify you why your claim was denied in writing and within specified timeframes, based on the circumstance. Typically, these timeframes are:

- **15 days** for prior authorization of a treatment
- **30 days** for medical services already received
- **72 hours** for urgent care cases

Additional Resources

- Employer – If you receive health insurance coverage through your employer, contact the human resources department. They may have dedicated case managers who can assist with your appeal or connect you with potential state-run external review processes.
- State – Many states offer administrative help with difficult claims. If you need help filing an internal appeal or external review, contact your state's Consumer Assistance Program. States also offer free health benefits counseling services for Medicare beneficiaries and their families or caregivers, such as State Health Insurance Assistance Program (SHIP).
- Federal – Contact the U.S. Department of Labor Employee Benefits Security Administration for more information about employer-sponsored benefits.