This document contains information specific to the State of Missouri. Please refer to the Provider Reference Guide for general information regarding plan administration.

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## 1.1 Covered Benefits - Missouri Care (Medicaid)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every 2 years ages 21 and older.<br>▪ 1 service date every year ages 20 and under or pregnant ages 21 and older. |
| Frame | ▪ 1 unit every 2 years ages 21 and older.<br>▪ 1 unit every year ages 20 and under or pregnant age 21 and older.<br>▪ **Frame must be selected from the MARCH frame kit.** |
| Frame Replacement | ▪ Fully covered ages 20 and under due to loss or damage.<br>▪ Frames that are deliberately destroyed, abused or discarded by members will not be replaced.<br>▪ **To identify replacement frames, please bill with modifier RA.** |
| Deluxe Frame | ▪ 10% discount, 1 unit $10 allowance every 2 years ages 21 and older.<br>▪ 10% discount, 1 unit $10 allowance every year ages 20 and under or pregnant age 21 and older.<br>▪ Members may waive the standard frame selection and opt for any frame shown at the provider's location. Members then receive the "Ten plus Ten" frame benefit. The member receives a courtesy 10% discount on the retail price and MARCH provides a ten dollar ($10.00) frame allowance. The member pays the reduced fee directly to the provider. The provider bills MARCH for the deluxe frame using the code V2025. |
| Deluxe Frame Replacement | ▪ 10% discount, $10 allowance ages 20 and under due to loss or damage.<br>▪ Frames that are deliberately destroyed, abused or discarded by members will not be replaced.<br>▪ **To identify replacement frames, please bill with modifier RA.** |
| Lens | ▪ 2 units every 2 years ages 21 and older.<br>▪ 2 units every year ages 20 and under or pregnant ages 21 and older.<br>▪ **Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**<br>▪ Prescription must be at least 0.75 diopters for one eye or .075 diopters for each eye.<br>▪ Prescription for lens/lenses less than 0.75 may be covered if member under age 21 requires glasses for a school performance, if a member's visual acuity is 20/40 or less, or if member has sight in one eye and therefore needs protective eyewear.<br>▪ Photochromatic tinting and rose I and II are covered if medically necessary.<br>▪ Progressive lenses are covered if the member currently wears progressive lenses and there is a diopter change of 0.50 in one or both eyes.<br>▪ Anti-reflective coating is covered if the member has a history of cataract surgery. 2 units every 2 years. |
| Lens Replacement | ▪ Fully covered for members ages 20 and under due to loss or damage.<br>▪ Fully covered for members ages 21 and over if there is a prescription change of at least 0.50 diopters for one eye or 0.50 diopters for each eye. If there is a 0.50 diopter change in one eye, MARCH will only replace the lens for the eye with the 0.50 diopter change, not both eyes. Lenses must be inserted into existing frame.<br>▪ **To identify replacement lenses, please bill with modifier RA.** |
| Necessary Contact Lenses | ▪ Fully covered ages 20 and under when the diagnosis is anisometropia of 4.00 diopters or greater in one eye, keratoconus or aphakia.<br>▪ Contact lenses **must** be supplied by the provider. |
| Polycarbonate Lens | ▪ 2 units every 2 years ages 21 and older.<br>▪ 2 units every year ages 20 and under or pregnant ages 21 and older.<br>▪ Polycarbonate lenses are covered for the following.<br>  ▪ Ages 20 and under and necessary for school.<br>  ▪ Protective eyewear for monocular participant.<br>  ▪ Member has a seizure disorder or other medical condition which warrants the need for special lens.<br>  ▪ Member has a high prescription at or over +3.00 or -4.00 diopters. |

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Non-Covered Services | ▪ Medical or surgical eye care. |

## 1.2 Covered Benefits – Missouri Care WellCare Value HMO (Medicare)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Eyewear | ▪ $350 allowance every calendar year.<br>▪ Allowance may be used toward up to two pairs of frame and lenses or contact lenses.<br>▪ In-house frame and lenses **MUST** be used. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”:<br>▪ Individuals with a family history of glaucoma<br>▪ Individuals with diabetes mellitus<br>▪ African-Americans ages 50 and older<br>▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Medical eye care.<br>▪ Surgical eye care |

## 1.3 Covered Benefits – Missouri Care WellCare Access HMO D-SNP (Medicare)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Eyewear | ▪ $300 allowance every calendar year.<br>▪ Allowance may be used toward up to two pairs of frame and lenses or contact lenses.<br>▪ In-house frame and lenses **MUST** be used. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”:<br>▪ Individuals with a family history of glaucoma<br>▪ Individuals with diabetes mellitus<br>▪ African-Americans ages 50 and older<br>▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Medical eye care.<br>▪ Surgical eye care |

## 1.4 Covered Benefits – Missouri Care WellCare Liberty HMO D-SNP (Medicare)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Eyewear | ▪ $350 allowance every calendar year.<br>▪ Allowance may be used toward up to two pairs of frame and lenses or contact lenses.<br>▪ In-house frame and lenses **MUST** be used. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk":<br>  ▪ Individuals with a family history of glaucoma<br>  ▪ Individuals with diabetes mellitus<br>  ▪ African-Americans ages 50 and older<br>  ▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Medical eye care.<br>▪ Surgical eye care |

## 1.5 Covered Benefits – Missouri Care WellCare Dividend HMO (Medicare)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk":<br>  ▪ Individuals with a family history of glaucoma<br>  ▪ Individuals with diabetes mellitus<br>  ▪ African-Americans ages 50 and older<br>  ▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Routine eyewear.<br>▪ Medical eye care.<br>▪ Surgical eye care |

## 1.6 Covered Benefits – Missouri Care WellCare Premier PPO (Medicare)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Eyewear | ▪ $200 allowance every calendar year.<br>▪ Allowance may be used toward up to one pair of frame and lenses or contact lenses.<br>▪ In-house frame and lenses **MUST** be used. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk":<br>▪ Individuals with a family history of glaucoma<br>▪ Individuals with diabetes mellitus<br>▪ African-Americans ages 50 and older<br>▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Medical eye care.<br>▪ Surgical eye care |

## 1.7 Covered Benefits – Missouri Care WellCare Absolute PPO (Medicare)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Eyewear | ▪ $200 allowance every calendar year.<br>▪ Allowance may be used toward up to one pair of frame and lenses or contact lenses.<br>▪ In-house frame and lenses **MUST** be used. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk":<br>▪ Individuals with a family history of glaucoma<br>▪ Individuals with diabetes mellitus<br>▪ African-Americans ages 50 and older<br>▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Medical eye care.<br>▪ Surgical eye care |

## 1.8 Covered Benefits – UnitedHealthcare Community Plan – Ages 20 and Under and Foster Children (Medicaid)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every year. |
| Necessary Medical Services | ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. |
| Exam Replacement | ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met:<br>▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.<br>▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met. |
| Frame | ▪ 1 unit every 2 years.<br>▪ **Frame must be selected from the MARCH frame kit.** |
| Frame Replacement | Fully covered due to loss or damage.<br>▪ Frames that are deliberately destroyed, abused or discarded by members will not be replaced.<br>▪ **To identify replacement frames, please bill with modifier RA.** |
| Lens | ▪ 2 units every 2 years.<br>▪ **Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**<br>▪ Prescription must be at least 0.75 diopters for one eye or .075 diopters for each eye.<br>▪ Prescription for lens/lenses less than 0.75 may be covered if member under age 21 requires glasses for a school performance, if a member's visual acuity is 20/40 or less, or if member has sight in one eye and therefore needs protective eyewear.<br>▪ Photochromatic tinting and rose I and II are covered if medically necessary.<br>▪ Progressive lenses are covered if the member currently wears progressive lenses and there is a diopter change of 0.50 in one or both eyes.<br>▪ Anti-reflective coating is covered if the member has a history of cataract surgery. |
| Lens Replacement | ▪ Fully covered due to loss, damage or if there is a prescription change of at least 0.50 diopters for one eye or 0.50 diopters for each eye. If there is a 0.50 diopter change in one eye, MARCH will only replace the lens for the eye with the 0.50 diopter change, not both eyes. Lenses must be inserted into existing frame.<br>▪ **To identify replacement lenses, please bill with modifier RA.** |
| Necessary Contact Lenses | ▪ Fully covered when the diagnosis is anisometropia of 4.00 diopters or greater in one eye, keratoconus or aphakia.<br>▪ Contact lenses **must** be supplied by the provider. |
| Polycarbonate Lens | ▪ 2 units every 2 years when the following criteria is met.<br>▪ Necessary for school.<br>▪ Protective eyewear for monocular participant.<br>▪ Member has a seizure disorder or other medical condition which warrants the need for special lens.<br>▪ Member has a high prescription at or over +3.00 or -4.00 diopters. |
| Non-Covered Services | ▪ Surgical eye care. |

## 1.9 Covered Benefits – UnitedHealthcare Community Plan – 21 and Older (Medicaid)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every 2 years. |
| Necessary Medical Services | ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. |
| Exam Replacement | ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met:<br>▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement lenses are met.<br>▪ A replacement exam is necessary to determine a vision change AND criteria for lenses are met. |
| Frame | ▪ 1 unit every 2 years.<br>▪ **Frame must be selected from the MARCH frame kit.** |
| Lens | ▪ 2 units every 2 years.<br>▪ **Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**<br>▪ Prescription must be at least 0.75 diopters for one eye or .075 diopters for each eye.<br>▪ Prescription for lens/lenses less than 0.75 may be covered if a member's visual acuity is 20/40 or less or if member has sight in one eye and therefore needs protective eyewear.<br>▪ Photochromatic tinting and rose I and II are covered if medically necessary.<br>▪ Progressive lenses are covered if the member currently wears progressive lenses and there is a diopter change of 0.50 in one or both eyes.<br>▪ Anti-reflective coating is covered if the member has a history of cataract surgery. |
| Lens Replacement | ▪ Fully covered if there is a prescription change of at least 0.50 diopters for one eye or 0.50 diopters for each eye. If there is a 0.50 diopter change in one eye, MARCH will only replace the lens for the eye with the 0.50 diopter change, not both eyes. Lenses must be inserted into existing frame.<br>▪ **To identify replacement lenses, please bill with modifier RA.** |
| Polycarbonate Lens | ▪ 2 units every 2 years when the following criteria is met.<br>▪ Protective eyewear for monocular participant.<br>▪ Member has a seizure disorder or other medical condition which warrants the need for special lens.<br>▪ Member has a high prescription at or over +3.00 or -4.00 diopters. |
| Non-Covered Services | ▪ Surgical eye care. |

## 1.10 Covered Benefits – UnitedHealthcare Community Plan – Pregnant 21 and Older (Medicaid)

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every year. |
| Necessary Medical Services | ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. |
| Exam Replacement | ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met:<br>▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement lenses are met.<br>▪ A replacement exam is necessary to determine a vision change AND criteria for lenses are met. |
| Frame | ▪ 1 unit every 2 years.<br>▪ **Frame must be selected from the MARCH frame kit.** |
| Lens | ▪ 2 units every 2 years.<br>▪ **Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**<br>▪ Prescription must be at least 0.75 diopters for one eye or .075 diopters for each eye.<br>▪ Prescription for lens/lenses less than 0.75 may be covered if a member's visual acuity is 20/40 or less or if member has sight in one eye and therefore needs protective eyewear.<br>▪ Photochromatic tinting and rose I and II are covered if medically necessary.<br>▪ Progressive lenses are covered if the member currently wears progressive lenses and there is a diopter change of 0.50 in one or both eyes.<br>▪ Anti-reflective coating is covered if the member has a history of cataract surgery. |
| Lens Replacement | ▪ Fully covered if there is a prescription change of at least 0.50 diopters for one eye or 0.50 diopters for each eye. If there is a 0.50 diopter change in one eye, MARCH will only replace the lens for the eye with the 0.50 diopter change, not both eyes. Lenses must be inserted into existing frame.<br>▪ **To identify replacement lenses, please bill with modifier RA.** |
| Polycarbonate Lens | ▪ 2 units every 2 years when the following criteria is met.<br>▪ Protective eyewear for monocular participant.<br>▪ Member has a seizure disorder or other medical condition which warrants the need for special lens.<br>▪ Member has a high prescription at or over +3.00 or -4.00 diopters. |
| Non-Covered Services | ▪ Surgical eye care. |

## 1.11 Covered Benefits – UnitedHealthcare Dual Complete® HMO D-SNP (Medicare) H0169-002

| Benefit | Benefit Limitations/Criteria |
|---|---|
| Exam | ▪ 1 service date every calendar year. |
| Necessary Medical Services | ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. |
| Eyewear | ▪ $400 allowance every calendar year.<br>▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.<br>▪ In-house frame and lenses **MUST** be used. |
| Eyewear After Cataract Surgery | ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply.<br>▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.** |
| Glaucoma Screening | ▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”:<br>  ▪ Individuals with a family history of glaucoma<br>  ▪ Individuals with diabetes mellitus<br>  ▪ African-Americans ages 50 and older<br>  ▪ Hispanic-Americans ages 65 and older |
| Non-Covered Services | ▪ Surgical eye care |