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

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1.1 Covered Benefits - Alameda Alliance for Health (Medi-Cal)

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 24 months.

Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when one of the following criterion is met:
	  ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.
	  ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
	▪ **To identify a replacement exam, please bill using modifier RA.**

Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every 2 yearswhen frame is within the provider's designated Medi-Cal selection. ▪ 1 unit, $75 allowance every 2 years ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when frame is outside of the provider's designated Medi-Cal selection. ▪ **To identify frames outside of the provider's designated Medi-Cal selection, please bill using modifier 75 in conjunction with procedure code V2020.**
Frame Replacement	▪ Covered as needed ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when frame is within the provider's designated Medi-Cal selection. ▪ 1 unit, $75 allowance every 2 years ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when frame is selected from outside of the provider's designated Medi-Cal selection. ▪ Replacement of frames within 2 years of initial coverage is limited to the same model whenever feasible. ▪ Replacement of frames within 2 years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. Frames that are deliberately destroyed, abused or discarded by members will not be replaced. ▪ Frame replacement may be covered for reasons other than loss, theft or destruction in circumstances beyond a member's control. Providers must obtain from the member (or guardian), a signed statement that explains the circumstances of the replacement and the reason the existing frame cannot be used. The signed statement must be retained in the member's file for at least three years. ▪ **To identify replacement frames outside of the provider's designated Medi-Cal selection the provider's designated Medi-Cal selection, please bill using modifier RA. To identify replacement frames outside of the provider's designated Medi-Cal selection, please bill using modifier RA and modifier 75.**

Benefit	Benefit Limitations/Criteria

Lens (Single, Bifocal, Trifocal)	▪ 2 units every 2 years.
	▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.**
	▪ Single vision lenses must meet at least one of the following prescription requirements:
	  ▪ Change in power of at least one meridian of either lens of 0.75 diopters or more
	  ▪ Astigmatic correction of either eye of 0.75 diopters or more
	  ▪ Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian
	  ▪ Total differential prismatic correction of 1.50 or more prism diopters in the horizontal meridian
	  ▪ Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
	▪ Multi-focal lenses must meet at least one of the following prescription requirements:
	  ▪ Add power of at least 0.75 diopters in the reading segment.
	  ▪ Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
	  ▪ Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for members who currently wear trifocals. Trifocal lenses for first-time wearers are not a benefit.

Polycarbonate Lens	▪ 2 units every 2 years ages 17 and under. ▪ 2 units every 2 years ages 18-20, beneficiaries residing in a skilled nursing facility or pregnant women if the member meets the following criteria: ▪ Visual impairment in one or both eyes. Visual impairment is defined as visual acuity with optimal correction equal to or poorer than 0.30 decimal notation or 20/60 Snellen, or equivalent at specified distances, or when either visual field is limited to ten degrees or less from the point of fixation in any direction. ▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.**

Lens Extras/Deluxe Lens	▪ 2 units every 2 years ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women.
	▪ If a member chooses extras or deluxe lenses that cannot be provided by the Prison Industry Authority (PIA) Lab, the member must sign the Non-Covered Services Fee Acceptance Form (Exhibit A in the Provider Reference Guide). The form should be kept in the member's chart.
	▪ Members will pay the providers usual and customary charge with the following discount amounts for the lenses:
	  ▪ Single vision lenses - Twenty dollars ($20.00)
	  ▪ Bifocal lenses - Thirty dollars ($30.00)
	  ▪ Trifocal lenses - Forty dollars ($40.00)

Lens Replacement	▪ Covered as needed ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when the following criteria are met.
	  ▪ The power is changed at least 0.50 diopters in any corresponding meridian.
	  ▪ The cylinder axis is changed 20 degrees or greater for cylinder power of 0.50 - 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 - 0.87 diopters, 10 degrees or greater for cylinder power of 1.00 - 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 - 0.37 diopters, as the sole reason for change, is not covered.
	  ▪ The prismatic differential correction is changed at least 0.75 prism diopters in the vertical meridian or at least 1.50 prism diopters in the horizontal meridian.
	  ▪ The previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety.
	  ▪ A different frame size or shape is necessary due to member growth, metal allergy or other justifiable medical reasons.
	▪ **To identify replacement lenses, please bill using modifier RA.**

Benefit	Benefit Limitations/Criteria
Contact Lenses	▪ Covered as needed ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women for the following conditions: ▪ Aphakia ▪ Anisometropia with aniseikonia ▪ Corneal pathology or deformity (other than corneal astigmatism) ▪ Corneal transplants ▪ Keratoconus ▪ Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the member ▪ Chronic pathology or deformity of the nose, skin or ears which precludes the wearing of eyeglasses ▪ Note: Corneal astigmatism is not considered a deformity that justifies coverage of contact lenses ▪ Bandage contact lenses may be fitted only as prescribed as medically necessary by a physician or a Therapeutic Pharmaceutical Agent (TPA) certified optometrist. ▪ Contact lenses must be supplied by the provider.
Single Vision Eyeglasses in Lieu of Bifocals	▪ 2 units every 2 years. ▪ 2 pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists: ▪ There is evidence that the member cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern ▪ The member currently uses 2 pairs of such eyeglasses and does not use multifocal eyeglasses
Non-Covered Services	▪ Surgical eye care.

1.2 Covered Benefits – Imperial Health Plan – Senior Value San Francisco and Los Angeles Counties (Medicare)

Benefit	Benefit Limitations/Criteria
Routine Eye Exam	▪ 1 service date every calendar year. ▪ $15 copay.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $250 allowance, $15 copay every 2 calendar years. ▪ In-house frame and lenses **MUST** be used. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) or contact lenses after each cataract surgery with an intraocular lens. ▪ **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": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care.

1.3 Covered Benefits – Imperial Health Plan – Traditional San Francisco and Los Angeles Counties (Medicare)

Benefit	Benefit Limitations/Criteria
Routine Eye Exam	▪ 1 service date every calendar year. ▪ $15 copay.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $255 allowance, $15 copay every 2 calendar years. ▪ In-house frame and lenses **MUST** be used. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) or contact lenses after each cataract surgery with an intraocular lens. ▪ **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": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care.

1.4 Covered Benefits – Imperial Health Plan – Traditional Plus San Francisco and Los Angeles Counties (Medicare)

Benefit	Benefit Limitations/Criteria
Routine Eye 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	▪ $500 allowance every 2 calendar years. ▪ In-house frame and lenses **MUST** be used. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) or contact lenses after each cataract surgery with an intraocular lens. ▪ **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”:
	  ▪ Individuals with a family history of glaucoma
	  ▪ Individuals with diabetes mellitus
	  ▪ African-Americans ages 50 and older
	  ▪ Hispanic-Americans ages 65 and older

Non-Covered Services	▪ Surgical eye care.

1.5 Covered Benefits - Molina Healthcare of California (Medi-Cal)

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 service date every 24 months.

Exam Replacement	▪ Covered ages 20 and under in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met:
	  ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.
	  ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
	▪ **To identify a replacement exam, please bill using modifier RA.**

Diabetic Exam	▪ 1 service date every year with a diagnosis of diabetes.
Frame	▪ 1 unit every 2 years when frame is within the provider's designated Medi-Cal selection. ▪ 1 unit, $75 allowance every 2 years when frame is outside of the provider's designated Medi-Cal selection. ▪ **To identify frames outside of the provider's designated Medi-Cal selection the provider's selection, please bill using modifier 75 in conjunction with procedure code V2020.**
Frame Replacement	▪ Covered as needed ages 20 and under when frame is within the provider's designated Medi-Cal selection. ▪ 1 unit, $75 allowance every 2 years ages 20 and under when frame is selected from outside of the provider's designated Medi-Cal selection. ▪ Replacement of frames within 2 years of initial coverage is limited to the same model whenever feasible. ▪ Replacement of frames within 2 years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. Frames that are deliberately destroyed, abused or discarded by members will not be replaced. ▪ Frame replacement may be covered for reasons other than loss, theft or destruction in circumstances beyond a member's control. Providers must obtain from the member (or guardian); a signed statement that explains the circumstances of the replacement and the reason the existing frame cannot be used. The signed statement must be retained in the member's file for at least three years. ▪ **To identify replacement frames outside of the provider's designated Medi-Cal selection the provider's designated Medi-Cal selection, please bill using modifier RA. To identify replacement frames outside of the provider's designated Medi-Cal selection, please bill using modifier RA and modifier 75.**

Lens (Single, Bifocal, Trifocal)	▪ 2 units every 2 years.
	▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab when available. Please refer to Exhibit C in the Provider Reference Guide for lab information.**
	▪ Single vision lenses must meet at least one of the following prescription requirements:
	  ▪ Power in at least one meridian of either lens of 0.75 diopters or more
	  ▪ Astigmatic correction of either eye of 0.75 diopters or more
	  ▪ Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian
	  ▪ Total differential prismatic correction of 1.50 or more prism diopters in the horizontal meridian
	  ▪ Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
	▪ Multi-focal lenses must meet at least one of the following prescription requirements:
	  ▪ Must have an add power of at least 0.75 diopters in the reading segment.
	  ▪ Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
	▪ Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for members who currently wear trifocals. Trifocal lenses for first-time wearers are not a benefit.

Benefit	Benefit Limitations/Criteria
Polycarbonate Lens	▪ 2 units every 2 years ages 17 and under. ▪ 2 units every 2 years ages 18 – 20 if the member meets the following criteria: ▪ Visual impairment in one or both eyes. Visual impairment is defined as visual acuity with optimal correction equal to or poorer than 0.30 decimal notation or 20/60 Snellen, or equivalent at specified distances, or when either visual field is limited to ten degrees or less from the point of fixation in any direction. ▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab when available. Please refer to Exhibit C in the Provider Reference Guide for lab information.**

Lens Extras/Deluxe Lens	▪ 2 units every 2 years ages 20 and under.
	▪ If a member chooses extras or deluxe lenses that cannot be provided by the Prison Industry Authority (PIA) Lab, the member must sign the Non-Covered Services Fee Acceptance Form (Exhibit A in the Provider Reference Guide). The form should be kept in the member's chart.
	▪ Members will pay the providers usual and customary charge with the following discount amounts for the lenses:
	  ▪ Single vision lenses - Twenty dollars ($20.00)
	  ▪ Bifocal lenses - Thirty dollars ($30.00)
	  ▪ Trifocal lenses - Forty dollars ($40.00)

Lens Replacement	▪ Covered as needed ages 20 and under when the following criteria are met.
	  ▪ Change in power of at least 0.50 diopters in any corresponding meridian
	  ▪ Change in cylinder axis 20 degrees or greater for cylinder power of 0.50 - 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 - 0.87 diopters, 10 degrees or greater for cylinder power of 1.00 - 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 - 0.37 diopters, as the sole reason for change, is not covered.
	  ▪ Change in the prismatic differential correction of at least 0.75 prism diopters in the vertical meridian or at least 1.50 prism diopters in the horizontal meridian.
	  ▪ Previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety.
	  ▪ Different frame size or shape necessary due to member growth, metal allergy or other justifiable medical reasons.
	▪ **To identify replacement lenses, please bill using modifier RA.**

Contact Lenses	▪ Covered as needed ages 20 and under for the following conditions:
	  ▪ Aphakia
	  ▪ Anisometropia with aniseikonia
	  ▪ Corneal pathology or deformity (other than corneal astigmatism)
	  ▪ Corneal transplants
	  ▪ Keratoconus
	  ▪ Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the member
	  ▪ Chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses
	  ▪ Corneal astigmatism is not considered a deformity that justifies coverage of contact lenses
	▪ Bandage contact lenses may be fitted only as prescribed as medically necessary by a physician or a Therapeutic Pharmaceutical Agent (TPA) certified optometrist.
	▪ Contact lenses must be supplied by the provider.

Single Vision Eyeglasses in Lieu of Bifocals	▪ 2 units every 2 years ages 20 and under.
	▪ 2 pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists:
	  ▪ There is evidence that the member cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern
	  ▪ The member currently uses 2 pairs of such eyeglasses and does not use multifocal eyeglasses

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

1.6 Covered Benefits - Molina Healthcare of California (Medi-Cal) – Exempt Beneficiaries

Medi-Cal Beneficiaries in a Skilled Nursing Facility (SNF), Intermediate Care Facility-Developmentally Disabled (ICF/DD)
Medi-Cal Beneficiaries enrolled in the Program of All Inclusive Care for the Elderly (PACE)
Medi-Cal Ages 21 and Older who are Early & Periodic Screening, Diagnosis & Treatment (EPSDT) beneficiaries and treatment began before turning 21

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 service date every 24 months.

Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met:
	  ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.
	  ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
	▪ **To identify a replacement exam, please bill using modifier RA.**

Diabetic Exam	▪ 1 service date every year with a diagnosis of diabetes.
Frame	▪ 1 unit every 2 years when frame is within the provider's designated Medi-Cal selection. ▪ 1 unit, $75 allowance every 2 years when frame is outside of the provider's designated Medi-Cal selection. ▪ **To identify frames outside of the provider's designated Medi-Cal selection the provider's selection, please bill using modifier 75 in conjunction with procedure code V2020.**
Frame Replacement	▪ Covered as needed when frame is within the provider's designated Medi-Cal selection. ▪ 1 unit, $75 allowance every 2 years when frame is selected from outside of the provider's designated Medi-Cal selection. ▪ Replacement of frames within 2 years of initial coverage is limited to the same model whenever feasible. ▪ Replacement of frames within 2 years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. Frames that are deliberately destroyed, abused or discarded by members will not be replaced. ▪ Frame replacement may be covered for reasons other than loss, theft or destruction in circumstances beyond a member's control. Providers must obtain from the member (or guardian); a signed statement that explains the circumstances of the replacement and the reason the existing frame cannot be used. The signed statement must be retained in the member's file for at least three years. ▪ **To identify replacement frames outside of the provider's designated Medi-Cal selection the provider's designated Medi-Cal selection, please bill using modifier RA. To identify replacement frames outside of the provider's designated Medi-Cal selection, please bill using modifier RA and modifier 75.**

Lens (Single, Bifocal, Trifocal)	▪ 2 units every 2 years.
	▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab when available. Please refer to Exhibit C in the Provider Reference Guide for lab information.**
	▪ Single vision lenses must meet at least one of the following prescription requirements:
	  ▪ Power in at least one meridian of either lens of 0.75 diopters or more
	  ▪ Astigmatic correction of either eye of 0.75 diopters or more
	  ▪ Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian
	  ▪ Total differential prismatic correction of 1.50 or more prism diopters in the horizontal meridian
	  ▪ Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more
	▪ Multi-focal lenses must meet at least one of the following prescription requirements:
	  ▪ Must have an add power of at least 0.75 diopters in the reading segment.
	  ▪ Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.
	▪ Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for members who currently wear trifocals. Trifocal lenses for first-time wearers are not a benefit.

Benefit	Benefit Limitations/Criteria
Polycarbonate Lens	▪ 2 units every 2 years if the member meets the following criteria: ▪ Visual impairment in one or both eyes. Visual impairment is defined as visual acuity with optimal correction equal to or poorer than 0.30 decimal notation or 20/60 Snellen, or equivalent at specified distances, or when either visual field is limited to ten degrees or less from the point of fixation in any direction. ▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab when available. Please refer to Exhibit C in the Provider Reference Guide for lab information.**

Lens Extras/Deluxe Lens	▪ 2 units every 2 years.
	▪ If a member chooses extras or deluxe lenses that cannot be provided by the Prison Industry Authority (PIA) Lab, the member must sign the Non-Covered Services Fee Acceptance Form (Exhibit A in the Provider Reference Guide). The form should be kept in the member's chart.
	▪ Members will pay the providers usual and customary charge with the following discount amounts for the lenses:
	  ▪ Single vision lenses - Twenty dollars ($20.00)
	  ▪ Bifocal lenses - Thirty dollars ($30.00)
	  ▪ Trifocal lenses - Forty dollars ($40.00)

Lens Replacement	▪ Covered as needed when the following criteria are met.
	  ▪ Change in power of at least 0.50 diopters in any corresponding meridian
	  ▪ Change in cylinder axis 20 degrees or greater for cylinder power of 0.50 - 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 - 0.87 diopters, 10 degrees or greater for cylinder power of 1.00 - 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 - 0.37 diopters, as the sole reason for change, is not covered.
	  ▪ Change in the prismatic differential correction of at least 0.75 prism diopters in the vertical meridian or at least 1.50 prism diopters in the horizontal meridian.
	  ▪ Previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety.
	  ▪ Different frame size or shape necessary due to member growth, metal allergy or other justifiable medical reasons.
	▪ **To identify replacement lenses, please bill using modifier RA.**

Contact Lenses	▪ Covered as needed for the following conditions:
	  ▪ Aphakia
	  ▪ Anisometropia with aniseikonia
	  ▪ Corneal pathology or deformity (other than corneal astigmatism)
	  ▪ Corneal transplants
	  ▪ Keratoconus
	  ▪ Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the member
	  ▪ Chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses
	  ▪ Corneal astigmatism is not considered a deformity that justifies coverage of contact lenses
	▪ Bandage contact lenses may be fitted only as prescribed as medically necessary by a physician or a Therapeutic Pharmaceutical Agent (TPA) certified optometrist.
	▪ Contact lenses must be supplied by the provider.

Single Vision Eyeglasses in Lieu of Bifocals	▪ 2 units every 2 years.
	▪ 2 pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists:
	  ▪ There is evidence that the member cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern
	  ▪ The member currently uses 2 pairs of such eyeglasses and does not use multifocal eyeglasses

Non-Covered Services	▪ Medical or surgical eye care.

1.7 Covered Benefits - Molina Healthcare of California – Complete Care (Medicare) Plan 001 and 003

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $350 allowance every 2 calendar years. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ 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 whether that includes insertion of an intraocular lens or not. Allowance does not apply. ▪ **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”: ▪ Individuals with a family history of glaucoma. ▪ Individuals with diabetes mellitus. ▪ African-Americans age 50 and older. ▪ Hispanic-Americans age 65 and older.
Non-Covered Services	▪ Medical or surgical eye care.

1.8 Covered Benefits - Molina Healthcare of California – MMP (Medicaid/Medicare)

Benefit	Benefit Limitations/Criteria
Routine Eye Exam	▪ 1 service date every calendar year.
Eyewear	▪ $100 allowance every 2 calendar years. ▪ In-house frame and lenses **MUST** be used. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) or contact lenses after each cataract surgery whether that includes insertion of an intraocular lens or not. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Medical or surgical eye care. ▪ Vision therapy. ▪ Low vision.

1.9 Covered Benefits – UnitedHealthcare Community Plan (Medi-Cal)

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 service date every 24 months.
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 ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when one of the following criterion is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met. ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met. ▪ **To identify a replacement exam, please bill using modifier RA.**
Frame	▪ 1 unit every 2 years when frame is within the provider's designated Medi-Cal selection.
Frame Replacement	▪ Covered as needed ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when frame is within the provider's designated Medi-Cal selection. ▪ Replacement of frames within 2 years of initial coverage is limited to the same model whenever feasible. ▪ Replacement of frames within 2 years is not covered if an existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken frame part. Frames that are deliberately destroyed, abused or discarded by members will not be replaced. ▪ Frame replacement may be covered for reasons other than loss, theft or destruction in circumstances beyond a member's control. Providers must obtain from the member (or guardian); a signed statement that explains the circumstances of the replacement and the reason the existing frame cannot be used. The signed statement must be retained in the member's file for at least three years.
Lens (Single, Bifocal, Trifocal)	▪ 2 units every 2 years. ▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab when available. Please refer to Exhibit C in the Provider Reference Guide for lab information.** ▪ Single vision lenses must meet at least one of the following prescription requirements: ▪ Power in at least one meridian of either lens of 0.75 diopters or more ▪ Astigmatic correction of either eye of 0.75 diopters or more ▪ Total differential prismatic correction of 0.75 or more prism diopters in the vertical meridian ▪ Total differential prismatic correction of 1.50 or more prism diopters in the horizontal meridian ▪ Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75 diopters or more ▪ Multi-focal lenses must meet at least one of the following prescription requirements: ▪ Must have an add power of at least 0.75 diopters in the reading segment. ▪ Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria. ▪ Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for members who currently wear trifocals. Trifocal lenses for first-time wearers are not a benefit.
Polycarbonate Lens	▪ 2 units every 2 years ages 17 and under. ▪ 2 units every 2 years ages 18-20, beneficiaries residing in a skilled nursing facility or pregnant women if the member meets the following criteria: ▪ Visual impairment in one or both eyes. Visual impairment is defined as visual acuity with optimal correction equal to or poorer than 0.30 decimal notation or 20/60 Snellen, or equivalent at specified distances, or when either visual field is limited to ten degrees or less from the point of fixation in any direction. ▪ **Lenses must be provided by the Prison Industry Authority (PIA) Lab when available. Please refer to Exhibit C in the Provider Reference Guide for lab information.**

Benefit	Benefit Limitations/Criteria
Lens Replacement	▪ Covered as needed ages 20 and under, beneficiaries residing in a skilled nursing facility or pregnant women when the following criteria are met. ▪ Change in power of at least 0.50 diopters in any corresponding meridian ▪ Change in cylinder axis 20 degrees or greater for cylinder power of 0.50 - 0.62 diopters, 15 degrees or greater for cylinder power of 0.75 - 0.87 diopters, 10 degrees or greater for cylinder power of 1.00 - 1.87 diopters, or 5 degrees or greater for cylinder power of 2.00 diopters or greater. Change in axis of cylinder power of 0.12 - 0.37 diopters, as the sole reason for change, is not covered. ▪ Change in the prismatic differential correction of at least 0.75 prism diopters in the vertical meridian or at least 1.50 prism diopters in the horizontal meridian. ▪ Previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety. ▪ Different frame size or shape necessary due to member growth, metal allergy or other justifiable medical reasons. ▪ **To identify replacement lenses, please bill using modifier RA.**
Contact Lenses	▪ Covered as needed for the following conditions: ▪ Aphakia ▪ Anisometropia with aniseikonia ▪ Corneal pathology or deformity (other than corneal astigmatism) ▪ Corneal transplants ▪ Keratoconus ▪ Conditions in which eyeglasses are contraindicated and/or contacts lenses provide significant improvement in visual acuity and better functional vision for the member ▪ Chronic pathology or deformity of the nose, skin or ears precludes the wearing of eyeglasses ▪ Corneal astigmatism is not considered a deformity that justifies coverage of contact lenses ▪ Bandage contact lenses may be fitted only as prescribed as medically necessary by a physician or a Therapeutic Pharmaceutical Agent (TPA) certified optometrist. ▪ Contact lenses must be supplied by the provider.
Single Vision Eyeglasses in Lieu of Bifocals	▪ 2 units every 2 years. ▪ 2 pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists: ▪ There is evidence that the member cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern ▪ The member currently uses 2 pairs of such eyeglasses and does not use multifocal eyeglasses
Non-Covered Services	▪ Surgical eye care.

1.10 Molina Healthcare of California MMP Reimbursement Procedures

The MMP benefit includes a $100 retail allowance toward the cost of frame and lenses including lens extras or contact lenses. Providers should bill the current and appropriate HCPCS codes for frames, lenses, and/or contact lenses along with the usual and customary charges for those codes. Reimbursement will be the lesser of billed charges or the contracted rate of $75. The allowance does not apply to routine eye exams. Routine eye exams are paid separately.

Frames and Lenses

The allowance for frames and lenses will be applied in the following order:

1. Basic lens codes (V2100-V2399)
2. Frame codes (V2020, V2025)
3. Any remaining allowance will be applied to lens upgrades such as tinting, scratch coating, polycarbonate lenses, etc.

The following example assumes a $100.00 allowance, a contracted rate of $75 and a billed amount more than the allowance.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 50.00	$ 25.00
V2100	Lens	$ 50.00	$ 50.00
V2745	Tint	$ 35.00	$ 0.00
92340	Fitting	$ 25.00	$ 0.00
Total		**$ 160.00***	**$ 75.00**

*Member is responsible for charges exceeding their $100 benefit allowance. In this example, the member is responsible for $60.

The following example assumes a $100 allowance, a contracted rate of $75 and a billed amount less than the allowance.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 35.00	$ 35.00
V2100	Lens	$ 25.00	$ 25.00
Total		**$ 60.00**	**$ 60.00**

Contact Lenses

The allowance for contact lenses will be applied to the purchase of contact lenses. Dispensing/fitting fees are not reimbursable. Following is an example of how the allowance is applied to contact lenses. The billed charges and paid amounts listed are for illustrative purposes only.

The following example assumes a $100 allowance, a contracted rate of $75 and a billed amount more than the allowance.

Service Code	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 100.00	$ 75.00
92310	Fitting	$ 50.00	$ 0.00
Total		**$ 150.00***	**$ 75.00**

*Member is responsible for charges exceeding their $100 benefit allowance. In this example, the member is responsible for $50.

The following example assumes a $100 allowance, a contracted rate of $75 and a billed amount less than the allowance.

Service Code	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 50.00	$ 50.00
92310	Fitting	$ 20.00	$ 0.00
Total		**$ 70.00**	**$ 50.00**