Kentucky Specific Information

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

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1.1 Notice of Updates

Notice of updates published June 1, 2025.

- Updated Eyewear for UnitedHealthcare Dual Complete Medicare plans effective 06/01/2025.

1.2 Covered Benefits – UnitedHealthcare Dual Complete® KY-S001 (Medicare) H1889-008

Benefit Plan(s): UDKYS-DCP

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	▪ $250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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 – UnitedHealthcare Dual Complete® KY-S002 (Medicare) H6595-004

Benefit Plan(s): UDKYS-DC3

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	▪ $250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year.. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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 – UnitedHealthcare Dual Complete® KY-V001 (Medicare) H6595-003

Benefit Plan(s): UDKYS-DC4

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	▪ $200 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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 – UnitedHealthcare Dual Complete® KY-S3 (Medicare) H1889-030

Benefit Plan(s): UDKYS-DC5

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	▪ $250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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

1.6 Covered Benefits – UnitedHealthcare Dual Complete® KY-S4 (Medicare) H6595-005

Benefit Plan(s): UDKYS-DC6

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	▪ $250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.

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

1.7 Covered Benefits – UnitedHealthcare Community Plan (Medicaid)

Benefit Plan(s): UDKYM-20, UDKYM-21, UDKYM-PG20, UDKYM-PG21

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Eyeglasses (Single, Bifocal and Multi-focal)	▪ 1 unit every calendar year when the recipient has a diagnosed visual condition that:
	  ▪ Requires the use of eyeglasses;
	  ▪ Is within one of the following categories:
	  ▪ Amblyopia;
	  ▪ Post surgical eye condition;
	  ▪ Diminished or subnormal vision; or
	  ▪ Other diagnosis which indicates the need for eyeglasses; and
	  ▪ Requires a prescription correction in the stronger lens no weaker than:
	  ▪ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
	  ▪ 0.50 diopter of vertical prism; or
	  ▪ A total of two (2) diopter of lateral prism.
	▪ Polycarbonate and scratch coating are covered.
	▪ Tinted lenses are covered when the prescription specifically indicates a diagnosis of photophobia.
	▪ Plano safety glasses are covered when medically indicated for the recipient.
	▪ The following is covered when medically necessary for:
	  ▪ Photochromics
	  ▪ Anti-reflective coating
	  ▪ Other lens options
	  ▪ Press-on prism

Eyeglass Replacements	▪ 1 pair every calendar year when:
	  ▪ The recipient's eyeglasses are broken or lost during the calendar year; or
	  ▪ The eyeglass prescription for the recipient is changed during the calendar year.
	▪ **To identify replacement materials, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for materials.**

Medically Necessary Contacts	▪ Contact lenses are covered in lieu of eyeglasses when a medical condition prevents the use of eyeglasses. ▪ **Annual Contact Lenses:** 1 contact lens per eye, per year. Please bill using modifier code(s) RT/LT to designate eye. ▪ **Monthly Contact Lenses:** Year supply of monthly contact lenses is two boxes of contacts per year, per eye. Please bill using modifier code U1, and RT/LT to designate eye. ▪ **Daily Contact Lenses:** Year supply of daily contacts is four boxes per eye, per year. Please bill using modifier code U2, and RT/LT to designate eye. ▪ **Bi-Weekly Contact Lenses:** Year supply of bi-weekly contacts is four boxes of contacts per eye, per year. Please bill using modifier code U3, and RT/LT to designate eye.

Benefit	Benefit Limitations/Criteria
Medically Necessary Replacement Contacts	▪ **Annual Contact Lenses:** One replacement lens per eye, per year. Please bill using modifier code(s) RT/LT to designate eye. ▪ **Monthly Contact Lenses:** One replacement box per eye, per year. Please bill using modifier code U1, RA, and RT/LT to designate eye. ▪ **Daily Contact Lenses:** One replacement box per eye, per year. Please bill using modifier code U2, RA, RT/LT to designate eye. ▪ **Bi-Weekly Contact Lenses:** One replacement box per eye, per year. Please bill using modifier code U3, RA and RT/LT to designate eye.