

# Michigan Specific Information

This document contains information specific to the State of Michigan. 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 October 17, 2025.

- Added references to clinical policies.

## 1.2 Covered Benefits – UnitedHealthcare Community Plan 20 and Under (Medicaid)

Benefit Plan(s): UDMIM-20

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> <li>1 service date every 2 years.</li> </ul>
Routine Exam Replacement	<ul style="list-style-type: none"> <li>Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> <li>The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.</li> <li>A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.</li> </ul> </li> </ul>
Diabetic Exam	<ul style="list-style-type: none"> <li>1 service date every year.</li> <li>One dilated retinal exam every year.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every year for members who: <ul style="list-style-type: none"> <li>Have no ocular complaints or prior history of glaucoma and who have diabetes</li> <li>Have a family history of glaucoma</li> </ul> </li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Vision Therapy	<ul style="list-style-type: none"> <li>Vision therapy is covered when medically necessary at a maximum of 12 visits every year. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>1 unit every 2 years.</li> <li><b>Frame must be selected from the March frame kit.</b></li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>2 units every year due to damage/loss.</li> <li>Replacement of a complete frame (front and temples) is a benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement.</li> <li><b>To identify replacement frames, please bill using modifier code RA.</b></li> </ul>
Frame Repair	<ul style="list-style-type: none"> <li>Frame repairs are covered (aligning temples, insertion of screws or adjusting frames).</li> </ul>
Initial Lens (Single, Bifocal, Trifocal, Polycarbonate)	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>0.50 diopters myopia</li> <li>0.50 diopters astigmatism</li> <li>0.75 diopters anisometropia</li> <li>0.75 diopters hyperopia</li> </ul> </li> <li>Initial lenses are considered to be the first pair of prescription lenses ever worn by a person regardless of how they were obtained.</li> <li>Polycarbonate lenses are covered.</li> <li>Photochromic, tinted and dyed lenses are covered when medically necessary. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> <li>The applicable diagnosis must be listed on the claim and noted in the member's chart.</li> <li><b>Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.</b></li> </ul>

Benefit	Benefit Limitations/Criteria
Lens Replacement	<ul style="list-style-type: none"> <li>4 units every year due to damage/loss.</li> <li>Covered as needed for all ages when the following criteria are met: <ul style="list-style-type: none"> <li>Must be a change in refractive error of 0.75 diopters or more in the meridian of the greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00 diopters or more. The lenses must also meet minimum dioptric criteria for initial lenses as specified above. The change need only be present in one eye.</li> </ul> </li> <li>Replacement of corrective lens(es), without frames, for one that is damaged or lost is a benefit if that lens(es) is covered and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or lost lens(es).</li> <li><b>To identify replacement lenses, please bill using modifier code RA.</b></li> </ul>
Single Vision Eyeglasses in Lieu of Multi-Focals	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>When the member has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.</li> <li>When the member's physical condition does not allow bifocal usage.</li> </ul> </li> <li>Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a benefit.</li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>2 units every year when the member presents with one of the following conditions, and visual performance is expected to be significantly improved with the application of a contact lens(es). <ul style="list-style-type: none"> <li>Aphakia (congenital or surgical)</li> <li>Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)</li> <li>Anisometropia or anisometropia (of 2.00 diopters or greater that results in aniseikonia)</li> <li>Congenital cataracts up to age six</li> <li>Other conditions which have no alternative treatment</li> </ul> </li> <li>Written verification of medical necessity must be placed in the member's chart as part of his or her medical record.</li> <li>The applicable diagnosis code must be listed on the claim and noted in the member's chart.</li> <li><b>Contact lenses must be supplied by the provider.</b></li> </ul>
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> <li>4 units every year.</li> <li><b>To identify replacement contact lenses, please bill using modifier code RA.</b></li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care.</li> </ul>

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

Benefit Plan(s): UDMIM-21

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> <li>1 service date every 2 years.</li> </ul>
Routine Exam Replacement	<ul style="list-style-type: none"> <li>Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> <li>The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.</li> <li>A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.</li> </ul> </li> </ul>
Diabetic Exam	<ul style="list-style-type: none"> <li>1 service date every year.</li> <li>One dilated retinal exam every year.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every year for members who: <ul style="list-style-type: none"> <li>Have no ocular complaints or prior history of glaucoma and who have diabetes</li> <li>Have a family history of glaucoma</li> <li>Are African-American age 50 or older</li> </ul> </li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Vision Therapy	<ul style="list-style-type: none"> <li>Vision therapy is covered when medically necessary at a maximum of 12 visits every year. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>1 unit every 2 years.</li> <li><b>Frame must be selected from the March frame kit.</b></li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>1 unit every year due to damage/loss.</li> <li>Replacement of a complete frame (front and temples) is a benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement.</li> <li><b>To identify replacement frames, please bill using modifier code RA.</b></li> </ul>
Frame Repair	<ul style="list-style-type: none"> <li>Frame repairs are covered (aligning temples, insertion of screws or adjusting frames).</li> </ul>
Initial Lens (Single, Bifocal, Trifocal, Polycarbonate)	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>0.50 diopters myopia</li> <li>0.50 diopters astigmatism</li> <li>0.75 diopters anisometropia</li> <li>0.75 diopters hyperopia</li> <li>0.50 diopters presbyopia ages 43 and older</li> </ul> </li> <li>Initial lenses are considered to be the first pair of prescription lenses ever worn by a person regardless of how they were obtained.</li> <li>Polycarbonate lenses are covered when diopter criteria are met and the lenses are inserted into a safety frame marked Z 87 or Z87-2.</li> <li>Photochromic, tinted and dyed lenses are covered when medically necessary. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> <li>The applicable diagnosis must be listed on the claim and noted in the member's chart.</li> <li><b>Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.</b></li> </ul>

Benefit	Benefit Limitations/Criteria
Lens Replacement	<ul style="list-style-type: none"> <li>2 units every year due to damage/loss.</li> <li>Covered as needed for all ages when the following criteria are met: <ul style="list-style-type: none"> <li>Must be a change in refractive error of 0.75 diopters or more in the meridian of the greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00 diopters or more. The lenses must also meet minimum dioptric criteria for initial lenses as specified above. The change need only be present in one eye.</li> </ul> </li> <li>Replacement of corrective lens(es), without frames, for one that is damaged or lost is a benefit if that lens(es) is covered and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or lost lens(es).</li> <li><b>To identify replacement lenses, please bill using modifier code RA.</b></li> </ul>
Single Vision Eyeglasses in Lieu of Multi-Focals	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>When the member has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.</li> <li>When the member's physical condition does not allow bifocal usage.</li> </ul> </li> <li>Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a benefit.</li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>2 units every year when the member presents with one of the following conditions, and visual performance is expected to be significantly improved with the application of a contact lens(es). <ul style="list-style-type: none"> <li>Aphakia (congenital or surgical)</li> <li>Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)</li> <li>Anisometropia or animetropia (of 2.00 diopters or greater that results in aniseikonia)</li> <li>Other conditions which have no alternative treatment</li> </ul> </li> <li>Written verification of medical necessity must be placed in the member's chart as part of his or her medical record.</li> <li>The applicable diagnosis code must be listed on the claim and noted in the member's chart.</li> <li><b>Contact lenses must be supplied by the provider.</b></li> </ul>
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> <li>2 units every year.</li> <li><b>To identify replacement contact lenses, please bill using modifier code RA.</b></li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care.</li> </ul>

#### 1.4 Covered Benefits – UnitedHealthcare Community Plan – Healthy Michigan Ages 19-20 (Medicaid)

Benefit Plan(s): UDMI-HM20

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> <li>1 service date every 2 years.</li> </ul>
Routine Exam Replacement	<ul style="list-style-type: none"> <li>Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> <li>The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.</li> <li>A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.</li> </ul> </li> </ul>
Diabetic Exam	<ul style="list-style-type: none"> <li>1 service date every year.</li> <li>One dilated retinal exam every year.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every year for members who: <ul style="list-style-type: none"> <li>Have no ocular complaints or prior history of glaucoma and who have diabetes</li> <li>Have a family history of glaucoma</li> </ul> </li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Vision Therapy	<ul style="list-style-type: none"> <li>Vision therapy is covered when medically necessary at a maximum of 12 visits every year. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>1 unit every 2 years.</li> <li><b>Frame must be selected from the March frame kit.</b></li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>2 units every year due to damage/loss.</li> <li>Replacement of a complete frame (front and temples) is a benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement.</li> <li><b>To identify replacement frames, please bill using modifier code RA.</b></li> </ul>
Frame Repair	<ul style="list-style-type: none"> <li>Frame repairs are covered (aligning temples, insertion of screws or adjusting frames).</li> </ul>
Initial Lens (Single, Bifocal, Trifocal, Polycarbonate)	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>0.50 diopters myopia</li> <li>0.50 diopters astigmatism</li> <li>0.75 diopters anisometropia</li> <li>0.75 diopters hyperopia</li> </ul> </li> <li>Initial lenses are considered to be the first pair of prescription lenses ever worn by a person regardless of how they were obtained.</li> <li>Polycarbonate lenses are covered.</li> <li>Photochromic, tinted and dyed lenses are covered when medically necessary. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> <li>The applicable diagnosis must be listed on the claim and noted in the member's chart.</li> <li><b>Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.</b></li> </ul>

Benefit	Benefit Limitations/Criteria
Lens Replacement	<ul style="list-style-type: none"> <li>4 units every year due to damage/loss.</li> <li>Covered as needed for all ages when the following criteria are met: <ul style="list-style-type: none"> <li>Must be a change in refractive error of 0.75 diopters or more in the meridian of the greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00 diopters or more. The lenses must also meet minimum dioptric criteria for initial lenses as specified above. The change need only be present in one eye.</li> </ul> </li> <li>Replacement of corrective lens(es), without frames, for one that is damaged or lost is a benefit if that lens(es) is covered and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or lost lens(es).</li> <li><b>To identify replacement lenses, please bill using modifier code RA.</b></li> </ul>
Single Vision Eyeglasses in Lieu of Multi-Focals	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>When the member has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.</li> <li>When the member's physical condition does not allow bifocal usage.</li> </ul> </li> <li>Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a benefit.</li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>2 units every year when the member presents with one of the following conditions, and visual performance is expected to be significantly improved with the application of a contact lens(es). <ul style="list-style-type: none"> <li>Aphakia (congenital or surgical)</li> <li>Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)</li> <li>Anisometropia or animetropia (of 2.00 diopters or greater that results in aniseikonia)</li> <li>Congenital cataracts up to age six</li> <li>Other conditions which have no alternative treatment</li> </ul> </li> <li>Written verification of medical necessity must be placed in the member's chart as part of his or her medical record.</li> <li>The applicable diagnosis code must be listed on the claim and noted in the member's chart.</li> <li><b>Contact lenses must be supplied by the provider.</b></li> </ul>
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> <li>4 units every year.</li> <li><b>To identify replacement contact lenses, please bill using modifier code RA.</b></li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care.</li> </ul>



## 1.5 Covered Benefits – UnitedHealthcare Community Plan – Healthy Michigan Ages 21-64 (Medicaid)

Benefit Plan(s): UDMI-HM21

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> <li>1 service date every 2 years.</li> </ul>
Routine Exam Replacement	<ul style="list-style-type: none"> <li>Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> <li>The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met.</li> <li>A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.</li> </ul> </li> </ul>
Diabetic Exam	<ul style="list-style-type: none"> <li>1 service date every year.</li> <li>One dilated retinal exam every year.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every year for members who: <ul style="list-style-type: none"> <li>Have no ocular complaints or prior history of glaucoma and who have diabetes</li> <li>Have a family history of glaucoma</li> <li>Are African-American age 50 or older -</li> </ul> </li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Vision Therapy	<ul style="list-style-type: none"> <li>Vision therapy is covered when medically necessary at a maximum of 12 visits every year. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>1 unit every 2 years.</li> <li><b>Frame must be selected from the March frame kit.</b></li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>1 unit every year due to damage/loss.</li> <li>Replacement of a complete frame (front and temples) is a benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement.</li> <li><b>To identify replacement frames, please bill using modifier code RA.</b></li> </ul>
Frame Repair	<ul style="list-style-type: none"> <li>Frame repairs are covered (aligning temples, insertion of screws or adjusting frames).</li> </ul>
Initial Lens (Single, Bifocal, Trifocal, Polycarbonate)	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>0.50 diopters myopia</li> <li>0.50 diopters astigmatism</li> <li>0.75 diopters anisometropia</li> <li>0.75 diopters hyperopia</li> <li>0.50 diopters presbyopia ages 43 and older</li> </ul> </li> <li>Initial lenses are considered to be the first pair of prescription lenses ever worn by a person regardless of how they were obtained.</li> <li>Polycarbonate lenses are covered when diopter criteria are met and the lenses are inserted into a safety frame marked Z 87 or Z87-2.</li> <li>Photochromic, tinted and dyed lenses are covered when medically necessary. Please see link for medical necessity criteria: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> <li>The applicable diagnosis must be listed on the claim and noted in the member's chart.</li> <li><b>Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.</b></li> </ul>

Benefit	Benefit Limitations/Criteria
Lens Replacement	<ul style="list-style-type: none"> <li>2 units every year due to damage/loss.</li> <li>Covered as needed for all ages when the following criteria are met: <ul style="list-style-type: none"> <li>Must be a change in refractive error of 0.75 diopters or more in the meridian of the greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00 diopters or more. The lenses must also meet minimum dioptric criteria for initial lenses as specified above. The change need only be present in one eye.</li> </ul> </li> <li>Replacement of corrective lens(es), without frames, for one that is damaged or lost is a benefit if that lens(es) is covered and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or lost lens(es).</li> <li><b>To identify replacement lenses, please bill using modifier code RA.</b></li> </ul>
Single Vision Eyeglasses in Lieu of Multi-Focals	<ul style="list-style-type: none"> <li>2 units every 2 years when one of the following criterion is met: <ul style="list-style-type: none"> <li>When the member has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.</li> <li>When the member's physical condition does not allow bifocal usage.</li> </ul> </li> <li>Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a benefit.</li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>2 units every year when the member presents with one of the following conditions, and visual performance is expected to be significantly improved with the application of a contact lens(es). <ul style="list-style-type: none"> <li>Aphakia (congenital or surgical)</li> <li>Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)</li> <li>Anisometropia or animetropia (of 2.00 diopters or greater that results in aniseikonia)</li> <li>Other conditions which have no alternative treatment</li> </ul> </li> <li>Written verification of medical necessity must be placed in the member's chart as part of his or her medical record.</li> <li>The applicable diagnosis code must be listed on the claim and noted in the member's chart.</li> <li><b>Contact lenses must be supplied by the provider.</b></li> </ul>
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> <li>2 units every year.</li> <li><b>To identify replacement contact lenses, please bill using modifier code RA.</b></li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care.</li> </ul>

## 1.6 Covered Benefits – UnitedHealthcare Dual Complete® MI-S002 (Medicare) H2247-001

Benefit Plan(s): UDMI-DSNP

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>1 service date every calendar year.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Eyewear	<ul style="list-style-type: none"> <li>\$250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year.</li> <li>In-house frame and lenses <b>MUST</b> be used.</li> </ul>
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> <li>One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery.</li> <li>Allowance does not apply and may not be used towards extras. Any add on items will be denied.</li> <li>Policy can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: <ul style="list-style-type: none"> <li>Individuals with a family history of glaucoma</li> <li>Individuals with diabetes mellitus</li> <li>African-Americans ages 50 and older</li> <li>Hispanic-Americans ages 65 and older</li> </ul> </li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care</li> </ul>

## 1.7 Covered Benefits – UnitedHealthcare Dual Complete® MI-V001 (Medicare) H2247-003

Benefit Plan(s): UDMI-DSNP3

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>1 service date every calendar year.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide</a> (www.marchvisioncare.com).</li> </ul>
Eyewear	<ul style="list-style-type: none"> <li>\$200 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year.</li> <li>In-house frame and lenses <b>MUST</b> be used.</li> </ul>
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> <li>One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery.</li> <li>Allowance does not apply and may not be used towards extras. Any add on items will be denied.</li> <li>Policy can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide</a> (www.marchvisioncare.com).</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: <ul style="list-style-type: none"> <li>Individuals with a family history of glaucoma</li> <li>Individuals with diabetes mellitus</li> <li>African-Americans ages 50 and older</li> <li>Hispanic-Americans ages 65 and older</li> </ul> </li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care</li> </ul>

## 1.8 Covered Benefits – UnitedHealthcare Dual Complete® MI-S001 (Medicare) H2001-039)

Benefit Plan(s): UDMI-DSNP4

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>1 service date every calendar year.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Eyewear	<ul style="list-style-type: none"> <li>\$200 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year.</li> <li>In-house frame and lenses <b>MUST</b> be used.</li> </ul>
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> <li>One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery.</li> <li>Allowance does not apply and may not be used towards extras. Any add on items will be denied.</li> <li>Policy can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: <ul style="list-style-type: none"> <li>Individuals with a family history of glaucoma</li> <li>Individuals with diabetes mellitus</li> <li>African-Americans ages 50 and older</li> <li>Hispanic-Americans ages 65 and older</li> </ul> </li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care</li> </ul>

## 1.9 Covered Benefits – UnitedHealthcare Dual Complete® MI-S3 (Medicare) H2247-004

Benefit Plan(s): UDMI-DSNP5

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>1 service date every calendar year.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Medical services covered when medically necessary and performed by an optometrist with the scope of licensure.</li> <li>Individual medical policies can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Eyewear	<ul style="list-style-type: none"> <li>\$250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year.</li> <li>In-house frame and lenses <b>MUST</b> be used.</li> </ul>
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> <li>One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery.</li> <li>Allowance does not apply and may not be used towards extras. Any add on items will be denied.</li> <li>Policy can be found at the following link: <a href="http://www.marchvisioncare.com">Provider Reference Guide (www.marchvisioncare.com)</a>.</li> </ul>
Glaucoma Screening	<ul style="list-style-type: none"> <li>1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: <ul style="list-style-type: none"> <li>Individuals with a family history of glaucoma</li> <li>Individuals with diabetes mellitus</li> <li>African-Americans ages 50 and older</li> <li>Hispanic-Americans ages 65 and older</li> </ul> </li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care</li> </ul>