Minnesota Specific Information

This document contains information specific to the State of Minnesota. 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 January 1, 2024.

- UnitedHealthcare Community Plan MinnesotaCare (Medicaid) copay updated effective 01/01/2024.
- UnitedHealthcare Community Plan Medical Assistance (Medicaid) copay updated effective 01/01/2024.
- UnitedHealthcare Community Plan Senior Care Plus (MSC+) (Medicaid) copay updated effective 01/01/2024.
- UnitedHealthcare Community Plan Special Needs BasicCare (SNBC) Integrated Dual (Medicaid) copay updated effective 01/01/2024.
- UnitedHealthcare Community Plan Special Needs BasicCare (SNBC) Non-Integrated Dual (Medicaid) copay updated effective 01/01/2024.

1.2 Covered Benefits – UnitedHealthcare Community Plan MinnesotaCare (Medicaid)

Benefit Plan(s): UD-MN-MCA, UD-MN-AI, UD-MN-MC25

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. ▪ A $28 copay may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay.
Frame	▪ 1 unit every 24 months. ▪ A $10 copay for a complete pair of glasses may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay. ▪ **Frame must be selected from the March frame kit.**
Deluxe Frame	▪ 1 unit every 24 months ages 20 and under or 21 and older with cognitive disabilities or seizure disorders. ▪ A $10 copay for a complete pair of glasses may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay. ▪ **Frame must be selected from the March frame kit. To identify the deluxe frame, please bill with V2025.**

Frame Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses
	  ▪ The original pair is lost, broken or irreparably damaged
	▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record.
	▪ A $10copay for a complete pair of glasses may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay.
	▪ **Frame must be selected from the March frame kit.**

Lenses	▪ 2 units every 24 months.
	▪ A $10 copay for a complete pair of glasses may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay.
	▪ Single, bifocal and trifocal lenses are covered.
	▪ For initial glasses, there is a correction of 0.50 diopters or greater in either sphere or cylinder power in either eye,
	▪ The following lenses are covered:
	  ▪ Plastic or polycarbonate lenses
	  ▪ Tinted or polarized lenses
	  ▪ High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
	  ▪ Double segs (FT25, FT28), plastic or glass
	  ▪ Fresnel prism, Slab off prism
	▪ Photochromatic (transition) lenses are covered when one of the following criteria is met:
	  ▪ Albinism
	  ▪ Achromatopsia
	  ▪ Aniridia
	  ▪ Blue cone monochromatism

Benefit	Benefit Limitations/Criteria
	▪ Cystinosis ▪ Retinitis pigmentosa ▪ Any other condition for which such lenses are medically necessary. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Lens Replacement	▪ 2 units every 24 months when one of the following criteria is met: ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye ▪ There is a shift in axis of greater than 10 degrees in either eye ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary ▪ There is a change in the recipient's head size which warrants a new pair of glasses ▪ The recipient has had an allergic reaction to the previous pair of glasses ▪ The original pair is lost, broken or irreparably damaged ▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record. ▪ A $10 copay for a complete pair of glasses may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Necessary Contact Lenses	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Necessary Contact Lens Replacement	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Industrial or Sport Eyeglasses	▪ 1 pair every 24 months when they are the recipient's only pair and are necessary for vision correction. ▪ A $10 copay for a complete pair of glasses may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 596-2724 to determine if the member has a copay. ▪ **Frame must be selected from the March frame kit. To identify industrial or sport eyeglasses, please bill with S0516, S0506, S0508 or S0510.**
Repairs	▪ Covered as needed when the cost of the repair does not exceed the cost of new frame and lenses.
Non-Covered Services	▪ Surgical eye care.

* Dispensing is limited to once every 30 days.

1.3 Covered Benefits – UnitedHealthcare Community Plan Medical Assistance (Medicaid)

Benefit Plan(s): UD-MN-MA, UD-MN-MAI, UD-MN-MACO

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. ▪
Frame	▪ 1 unit every 24 months. ▪ **Frame must be selected from the March frame kit.**
Deluxe Frame	▪ 1 unit every 24 months ages 20 and under or 21 and older with cognitive disabilities or seizure disorders. ▪ **Frame must be selected from the March frame kit. To identify the deluxe frame, please bill with V2025.**

Frame Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses
	  ▪ The original pair is lost, broken or irreparably damaged
	▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record.
	▪ **Frame must be selected from the March frame kit.**

Lenses	▪ 2 units every 24 months.
	▪ Single, bifocal and trifocal lenses are covered.
	▪ For initial glasses, there is a correction of 0.50 diopters or greater in either sphere or cylinder power in either eye,
	▪ The following lenses are covered:
	  ▪ Plastic or polycarbonate lenses
	  ▪ Tinted or polarized lenses
	  ▪ High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
	  ▪ Double segs (FT25, FT28), plastic or glass
	  ▪ Fresnel prism, Slab off prism
	▪ Photochromatic (transition) lenses are covered when one of the following criteria is met:
	  ▪ Albinism
	  ▪ Achromatopsia
	  ▪ Aniridia
	  ▪ Blue cone monochromatism
	  ▪ Cystinosis
	  ▪ Retinitis pigmentosa
	  ▪ Any other condition for which such lenses are medically necessary.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 2 units every 24 months when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses

Benefit	Benefit Limitations/Criteria
	▪ The recipient has had an allergic reaction to the previous pair of glasses ▪ The original pair is lost, broken or irreparably damaged ▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Necessary Contact Lenses	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Necessary Contact Lens Replacement	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Industrial or Sport Eyeglasses	▪ 1 pair every 24 months when they are the recipient's only pair and are necessary for vision correction. ▪ **Frame must be selected from the March frame kit. To identify industrial or sport eyeglasses, please bill with S0516, S0506, S0508 or S0510.**
Repairs	▪ Covered as needed when the cost of the repair does not exceed the cost of new frame and lenses.
Non-Covered Services	▪ Surgical eye care.

* Dispensing is limited to once every 30 days.

1.4 Covered Benefits – UnitedHealthcare Community Plan Senior Care Plus (MSC+) (Medicaid)

Benefit Plan(s): UD-MN-SC, UD-MN-SCAI, UD-MN-SC3

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. ▪
Frame	▪ 1 unit every 24 months. ▪ **Frame must be selected from the March frame kit.**
Deluxe Frame	▪ 1 unit every 24 months ages 20 and under or 21 and older with cognitive disabilities or seizure disorders. ▪ **Frame must be selected from the March frame kit. To identify the deluxe frame, please bill with V2025.**

Frame Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses
	  ▪ The original pair is lost, broken or irreparably damaged
	▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record.
	▪ **Frame must be selected from the March frame kit.**

Lenses	▪ 2 units every 24 months.
	▪ Single, bifocal and trifocal lenses are covered.
	▪ For initial glasses, there is a correction of 0.50 diopters or greater in either sphere or cylinder power in either eye,
	▪ The following lenses are covered:
	  ▪ Plastic or polycarbonate lenses
	  ▪ Tinted or polarized lenses
	  ▪ High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
	  ▪ Double segs (FT25, FT28), plastic or glass
	  ▪ Fresnel prism, Slab off prism
	▪ Photochromatic (transition) lenses are covered when one of the following criteria is met:
	  ▪ Albinism
	  ▪ Achromatopsia
	  ▪ Aniridia
	  ▪ Blue cone monochromatism
	  ▪ Cystinosis
	  ▪ Retinitis pigmentosa
	  ▪ Any other condition for which such lenses are medically necessary.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 2 units every 24 months when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses

Benefit	Benefit Limitations/Criteria
	▪ The original pair is lost, broken or irreparably damaged ▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Necessary Contact Lenses	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Necessary Contact Lens Replacement	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Industrial or Sport Eyeglasses	▪ 1 pair every 24 months when they are the recipient's only pair and are necessary for vision correction. ▪ **Frame must be selected from the March frame kit. To identify industrial or sport eyeglasses, please bill with S0516, S0506, S0508 or S0510.**
Repairs	▪ Covered as needed when the cost of the repair does not exceed the cost of new frame and lenses.
Non-Covered Services	▪ Surgical eye care.

* Dispensing is limited to once every 30 days.

1.5 Covered Benefits – UnitedHealthcare Community Plan MSHO Dual (Medicaid)**

Benefit Plan(s): UD-MN-D, UD-MN-DAI, UD-MN-D3

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every 24 months. ▪ **Frame must be selected from the March frame kit.**
Deluxe Frame	▪ 1 unit every 24 months ages 20 and under or 21 and older with cognitive disabilities or seizure disorders. ▪ **Frame must be selected from the March frame kit. To identify the deluxe frame, please bill with V2025.**

Frame Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses
	  ▪ The original pair is lost, broken or irreparably damaged
	▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record.
	▪ **Frame must be selected from the March frame kit.**

Lenses	▪ 2 units every 24 months.
	▪ Single, bifocal and trifocal lenses are covered.
	▪ For initial glasses, there is a correction of 0.50 diopters or greater in either sphere or cylinder power in either eye,
	▪ The following lenses are covered:
	  ▪ Plastic or polycarbonate lenses
	  ▪ Tinted or polarized lenses
	  ▪ High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
	  ▪ Double segs (FT25, FT28), plastic or glass
	  ▪ Fresnel prism, Slab off prism
	▪ Photochromatic (transition) lenses are covered when one of the following criteria is met:
	  ▪ Albinism
	  ▪ Achromatopsia
	  ▪ Aniridia
	  ▪ Blue cone monochromatism
	  ▪ Cystinosis
	  ▪ Retinitis pigmentosa
	  ▪ Any other condition for which such lenses are medically necessary.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 2 units every 24 months when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses

Benefit	Benefit Limitations/Criteria
	▪ The original pair is lost, broken or irreparably damaged ▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Necessary Contact Lenses	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Necessary Contact Lens Replacement	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Industrial or Sport Eyeglasses	▪ 1 pair every 24 months when they are the recipient's only pair and are necessary for vision correction. ▪ **Frame must be selected from the March frame kit. To identify industrial or sport eyeglasses, please bill with S0516, S0506, S0508 or S0510.**
Repairs	▪ Covered as needed when the cost of the repair does not exceed the cost of new frame and lenses.
Non-Covered Services	▪ Surgical eye care.

* Dispensing is limited to once every 30 days.

**UnitedHealthcare Community Plan MSHO Dual (Medicaid) members have additional coverage under UnitedHealthcare Dual Complete MSHO Dual (Medicare). See section 1.8 below for additional information.

1.6 Covered Benefits – UnitedHealthcare Community Special Needs BasicCare (SNBC) Integrated Dual (Medicaid)**

Benefit Plan(s): UD-MN-ID, UD-MN-IDAI, UD-MN-ID3

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. ▪
Frame	▪ 1 unit every 24 months. ▪ **Frame must be selected from the March frame kit.**
Deluxe Frame	▪ 1 unit every 24 months ages 20 and under or 21 and older with cognitive disabilities or seizure disorders. ▪ **Frame must be selected from the March frame kit. To identify the deluxe frame, please bill with V2025.**

Frame Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses
	  ▪ The original pair is lost, broken or irreparably damaged
	▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record.
	▪ **Frame must be selected from the March frame kit.**

Lenses	▪ 2 units every 24 months.
	▪ Single, bifocal and trifocal lenses are covered.
	▪ For initial glasses, there is a correction of 0.50 diopters or greater in either sphere or cylinder power in either eye,
	▪ The following lenses are covered:
	  ▪ Plastic or polycarbonate lenses
	  ▪ Tinted or polarized lenses
	  ▪ High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
	  ▪ Double segs (FT25, FT28), plastic or glass
	  ▪ Fresnel prism, Slab off prism
	▪ Photochromatic (transition) lenses are covered when one of the following criteria is met:
	  ▪ Albinism
	  ▪ Achromatopsia
	  ▪ Aniridia
	  ▪ Blue cone monochromatism
	  ▪ Cystinosis
	  ▪ Retinitis pigmentosa
	  ▪ Any other condition for which such lenses are medically necessary.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 2 units every 24 months when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses

Benefit	Benefit Limitations/Criteria
	▪ The original pair is lost, broken or irreparably damaged ▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Necessary Contact Lenses	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Necessary Contact Lens Replacement	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Industrial or Sport Eyeglasses	▪ 1 pair every 24 months when they are the recipient's only pair and are necessary for vision correction. ▪ **Frame must be selected from the March frame kit. To identify industrial or sport eyeglasses, please bill with S0516, S0506, S0508 or S0510.**
Repairs	▪ Covered as needed when the cost of the repair does not exceed the cost of new frame and lenses.
Non-Covered Services	▪ Surgical eye care.

* Dispensing is limited to once every 30 days.

** UnitedHealthcare Community Plan Special Needs BasicCare (SNBC) Integrated Dual (Medicaid) members have additional coverage under UnitedHealthcare Dual Complete Special Needs BasicCare (SNBC) Integrated Dual (Medicare). See section 1.9 below for additional information.

1.7 Covered Benefits – UnitedHealthcare Community Plan Special Needs BasicCare (SNBC) Non-Integrated (Medicaid)

Benefit Plan(s): UD-MN-NI, UD-MN-NIAI, UD-MN-NI3

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed when medically necessary.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. ▪
Frame	▪ 1 unit every 24 months. ▪ **Frame must be selected from the March frame kit.**
Deluxe Frame	▪ 1 unit every 24 months ages 20 and under or 21 and older with cognitive disabilities or seizure disorders. ▪ **Frame must be selected from the March frame kit. To identify the deluxe frame, please bill with V2025.**

Frame Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses
	  ▪ The original pair is lost, broken or irreparably damaged
	▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record.
	▪ **Frame must be selected from the March frame kit.**

Lenses	▪ 2 units every 24 months.
	▪ Single, bifocal and trifocal lenses are covered.
	▪ For initial glasses, there is a correction of 0.50 diopters or greater in either sphere or cylinder power in either eye,
	▪ The following lenses are covered:
	  ▪ Plastic or polycarbonate lenses
	  ▪ Tinted or polarized lenses
	  ▪ High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater
	  ▪ Double segs (FT25, FT28), plastic or glass
	  ▪ Fresnel prism, Slab off prism
	▪ Photochromatic (transition) lenses are covered when one of the following criteria is met:
	  ▪ Albinism
	  ▪ Achromatopsia
	  ▪ Aniridia
	  ▪ Blue cone monochromatism
	  ▪ Cystinosis
	  ▪ Retinitis pigmentosa
	  ▪ Any other condition for which such lenses are medically necessary.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 2 units every 24 months when one of the following criteria is met:
	  ▪ There is a change in correction of 0.50 diopters or greater in either sphere or cylinder power in either eye
	  ▪ There is a shift in axis of greater than 10 degrees in either eye
	  ▪ A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary
	  ▪ There is a change in the recipient's head size which warrants a new pair of glasses
	  ▪ The recipient has had an allergic reaction to the previous pair of glasses

Benefit	Benefit Limitations/Criteria
	▪ The original pair is lost, broken or irreparably damaged ▪ Documentation of medical necessity for the above situations must be kept in the recipient's medical record. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Necessary Contact Lenses	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Necessary Contact Lens Replacement	▪ Covered as needed in lieu of eyeglasses when medically necessary. ▪ Disposable contact lenses; S0500; 1-month supply, up to 30 per eye per dispensing* ▪ PMMA, gas permeable, gas impermeable contact lens; V2500-V2513, V2530-V2599; 2 units (1 per eye) per dispensing* ▪ Hydrophilic contact lens; V2520-V2523; 2 units (1 per eye) per dispensing*
Industrial or Sport Eyeglasses	▪ 1 pair every 24 months when they are the recipient's only pair and are necessary for vision correction. ▪ **Frame must be selected from the March frame kit. To identify industrial or sport eyeglasses, please bill with S0516, S0506, S0508 or S0510.**
Repairs	▪ Covered as needed when the cost of the repair does not exceed the cost of new frame and lenses.
Non-Covered Services	▪ Surgical eye care.

* Dispensing is limited to once every 30 days.