

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

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1.1 Covered Benefits – Aetna Better Health FamilyCare A&B, LTC (Members ages 20 & under & 60 and older)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year.
Exam Replacement	<ul style="list-style-type: none"> ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> ▪ 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 diopter change AND criteria for replacement frame and lenses are met.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year when eyeglasses are lost, stolen or damaged and there is medical necessity, and/or ▪ 1 unit every year for individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file. ▪ Replacement frame must be selected from the MARCH frame kit. If existing lenses can not be inserted into the MARCH frame, new lenses may be obtained from the MARCH lab. ▪ To identify replacement frames, please bill using modifier code RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every year. ▪ Lenses are provided by the MARCH lab <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. ▪ UV filter lenses are covered when the following criteria is met: <ul style="list-style-type: none"> ▪ The member is aphakic, albino or has clinical evidence of macular degeneration ▪ Is taking medication(s) which makes the member more sensitive to UV light ▪ Allowance is not applicable ▪ High-Index lenses are covered when the member has a diopter reading of +/- 10.00. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Polycarbonate, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ 2 units every year when one of the following criteria is met: <ul style="list-style-type: none"> ▪ Eyeglasses are lost, stolen or damaged and there is medical necessity ▪ +/-0.50 diopter change in sphere and/or cylinder power or a change of 5 degrees or more in cylinder axis ▪ Individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file ▪ Fully covered provided there is a prescription change of at least +/-0.75 diopters in spherical and/or cylindrical power or change in axis of 8 degrees or more. ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA.

Benefit	Benefit Limitations/Criteria
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every year ages 20 and under. ▪ 2 units every year ages 21 and older when the following criteria is met: <ul style="list-style-type: none"> ▪ The member has a prescription of +/- 8.00 ▪ Permanently reduced vision in one eye less than 20/200 ▪ Facial deformity or disease that interferes with eyeglass fit ▪ A documented occupational hazard ▪ Amblyopia ▪ Allowance is not applicable.
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter. ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when the following criteria is met: <ul style="list-style-type: none"> ▪ A change of +/- 1.00 diopters in power ▪ A change of 0.50mm diopters in base curve ▪ A change of 0.30mm of optic zone ▪ A change of 0.75mm in peripheral curve radius ▪ A change of 0.30mm in peripheral curve width ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ 1 pair (frame and lenses) every year ages 20 and under in addition to standard frame and lenses. ▪ 1 pair (frame and lenses) every year ages 21 and older due to medical necessity in lieu of standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit OR a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical eye care. ▪ Surgical eye care. ▪ Low vision. ▪ Vision therapy. ▪ Except as otherwise indicated above, lens extras.

1.2 Covered Benefits – Aetna Better Health FamilyCare C (Members ages 20 and under)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ \$5 copay*, 1 service date every year.
Exam Replacement	<ul style="list-style-type: none"> ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> ▪ 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 diopter change AND criteria for replacement frame and lenses are met.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year when eyeglasses are lost, stolen or damaged and there is medical necessity, and/or ▪ 1 unit every year for individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file, and/or ▪ Replacement frame must be selected from the MARCH frame kit. If existing lenses can not be inserted into the MARCH frame, new lenses may be obtained from the MARCH lab. ▪ To identify replacement frames, please bill using modifier code RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every year. ▪ Lenses are provided by the MARCH lab <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. ▪ UV filter lenses are covered when the following criteria is met: <ul style="list-style-type: none"> ▪ The member is aphakic, albino or has clinical evidence of macular degeneration ▪ Is taking medication(s) which makes the member more sensitive to UV light ▪ Allowance is not applicable ▪ High-Index lenses are covered when the member has a diopter reading of +/- 10.00. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Polycarbonate, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ 2 units every year when one of the following criteria is met: <ul style="list-style-type: none"> ▪ Eyeglasses are lost, stolen or damaged and there is medical necessity ▪ +/-0.50 diopter change in sphere and/or cylinder power or a change of 5 degrees or more in cylinder axis ▪ Individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file ▪ Covered as needed provided there is a prescription change of at least +/-0.75 diopters in spherical and/or cylindrical power or change in axis of 8 degrees or more. ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every year. ▪ Allowance is not applicable.

Benefit	Benefit Limitations/Criteria
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. ▪ Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when the following criteria is met: <ul style="list-style-type: none"> ▪ A change of +/- 1.00 diopters in power ▪ A change of 0.50mm diopters in base curve ▪ A change of 0.30mm of optic zone ▪ A change of 0.75mm in peripheral curve radius ▪ A change of 0.30mm in peripheral curve width ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ 1 pair (frame and lenses) every year in addition to standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical eye care. ▪ Surgical eye care. ▪ Low vision. ▪ Vision therapy. ▪ Except as otherwise indicated above, lens extras.

* Designated members are not subject to the \$5 copay. Please refer to the Patient Benefit Summary in eyeSynergy® or contact customer service at (888) 493-4070 to determine if the copay is applicable.

1.3 Covered Benefits – Aetna Better Health FamilyCare D (Members ages 20 and under)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ \$5 copay*, 1 service date every year.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every 2 years. ▪ Frame may be selected from the MARCH frame kit OR a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every 2 years. ▪ Lenses are provided by the MARCH lab OR a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. ▪ UV filter lenses are covered when the following criteria is met: <ul style="list-style-type: none"> ▪ The member is aphakic, albino or has clinical evidence of macular degeneration ▪ Is taking medication(s) which makes the member more sensitive to UV light ▪ Allowance is not applicable. ▪ High-Index lenses are covered when the member has a diopter reading of +/- 10.00. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ Covered as needed if medically necessary due to a vision change requiring a new prescription. ▪ Replacement lenses are not covered due to loss, theft or damage regardless of medical necessity. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every 2 years ages 20 and under. ▪ 2 units every 2 years ages 21 and older when the following criteria is met: <ul style="list-style-type: none"> ▪ The member has a prescription of +/- 8.00 ▪ Permanently reduced vision in one eye less than 20/200 ▪ Facial deformity or disease that interferes with eyeglass fit ▪ A documented occupational hazard ▪ Amblyopia ▪ Allowance is not applicable.
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.

Benefit	Benefit Limitations/Criteria
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ 1 pair (frame and lenses) every 2 years ages 20 and under in addition to standard frame and lenses. ▪ 1 pair (frame and lenses) every 2 years ages 21 and older due to medical necessity in lieu of standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical eye care. ▪ Surgical eye care. ▪ Low vision. ▪ Vision therapy. ▪ Except as otherwise indicated above, lens extras.

* Designated members are not subject to the \$5 copay. Please refer to the Patient Benefit Summary in eyeSynergy® or contact customer service at (888) 493-4070 to determine if the copay is applicable.

1.4 Covered Benefits - UnitedHealthcare Community Plan FamilyCare A&B (Members ages 20 & under & 60 and older)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Additional exams covered when medically necessary.
Exam Replacement	<ul style="list-style-type: none"> ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> ▪ 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 diopter change AND criteria for replacement frame and lenses are met.
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year when eyeglasses are lost, stolen or damaged and there is medical necessity, and/or ▪ 1 unit every year for individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file. ▪ Replacement frame must be selected from the MARCH frame kit. If existing lenses can not be inserted into the MARCH frame, new lenses may be obtained from the MARCH lab. ▪ To identify replacement frames, please bill using modifier code RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every year. ▪ Lenses are provided by the MARCH lab <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. ▪ UV filter lenses are covered when medically necessary. Allowance not applicable. ▪ High-Index lenses are covered when medically necessary. Allowance not applicable. ▪ Tinting is covered if medically necessary. Allowance not applicable. <ul style="list-style-type: none"> ▪ Rose 1 & 2, grey or brown plastic lenses are excluded. ▪ Special base curve is covered when medically necessary. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Polycarbonate, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ 2 units every year when one of the following criteria is met: <ul style="list-style-type: none"> ▪ Eyeglasses are lost, stolen or damaged and there is medical necessity ▪ +/-0.50 diopter change in sphere and/or cylinder power or a change of 5 degrees or more in cylinder axis ▪ Individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file ▪ Fully covered provided there is a prescription change of at least +/-0.75 diopters in spherical and/or cylindrical power or change in axis of 8 degrees or more. ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA.

Benefit	Benefit Limitations/Criteria
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every year ages 20 and under. ▪ 2 units every year ages 21 and older when medically necessary. Allowance is not applicable.
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. ▪ Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter. ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when the following criteria is met: <ul style="list-style-type: none"> ▪ A change of +/- 0.50 diopters in power ▪ A change of 0.30mm of optic zone ▪ A change of 0.75mm in peripheral curve radius ▪ A change of 0.30mm in peripheral curve width ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ Covered as needed (frame and lenses) ages 20 and under in addition to standard frame and lenses. ▪ 1 pair (frame and lenses) every year ages 21 and older due to medical necessity in lieu of standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Single Vision Eyeglasses in Lieu of Multifocals	<ul style="list-style-type: none"> ▪ 2 pairs of eyeglasses in lieu of multifocals.
Repairs	<ul style="list-style-type: none"> ▪ Covered as needed. Repairs exceeding \$15 in charges require prior confirmation.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Surgical eye care. ▪ Except as otherwise indicated above, lens extras.

1.5 Covered Benefits - UnitedHealthcare Community Plan FamilyCare A (Members ages 21 to 59)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Additional exams covered when medically necessary.
Exam Replacement	<ul style="list-style-type: none"> ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> ▪ 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 diopter change AND criteria for replacement frame and lenses are met.
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every 2 years. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every 2 years when eyeglasses are lost, stolen or damaged and there is medical necessity, and/or ▪ 1 unit every year for individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file. ▪ Replacement frame must be selected from the MARCH frame kit. If existing lenses can not be inserted into the MARCH frame, new lenses may be obtained from the MARCH lab. ▪ To identify replacement frames, please bill using modifier code RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every 2 years. ▪ Lenses are provided by the MARCH lab <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. <ul style="list-style-type: none"> ▪ UV filter lenses are covered when medically necessary. Allowance not applicable. ▪ High-Index lenses are covered when medically necessary. Allowance not applicable. ▪ Tinting is covered if medically necessary. Allowance not applicable. <ul style="list-style-type: none"> ▪ Rose 1 & 2, grey or brown plastic lenses are excluded. ▪ Special base curve is covered when medically necessary. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Polycarbonate, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ 2 units 2 years when eyeglasses are lost, stolen or damaged and there is medical necessity. ▪ 2 units every year when one of the following criteria is met: <ul style="list-style-type: none"> ▪ +/-0.50 diopter change in sphere and/or cylinder power or a change of 5 degrees or more in cylinder axis ▪ Individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file ▪ Fully covered provided there is a prescription change of at least +/-0.75 diopters in spherical and/or cylindrical power or change in axis of 8 degrees or more. ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every 2 years when medically necessary.

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> ▪ Allowance is not applicable.
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. ▪ Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when the following criteria is met: <ul style="list-style-type: none"> ▪ A change of +/- 0.50 diopters in power ▪ A change of 0.30mm of optic zone ▪ A change of 0.75mm in peripheral curve radius ▪ A change of 0.30mm in peripheral curve width ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ 1 pair (frame and lenses) every 2 years due to medical necessity in lieu of standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Single Vision Eyeglasses in Lieu of Multifocals	<ul style="list-style-type: none"> ▪ 2 pairs of eyeglasses in lieu of multifocals.
Repairs	<ul style="list-style-type: none"> ▪ Covered as needed. Repairs exceeding \$15 in charges require prior confirmation.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Surgical eye care. ▪ Except as otherwise indicated above, lens extras.

1.6 Covered Benefits - UnitedHealthcare Community Plan FamilyCare C (Members ages 20 and under)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ \$5 copay, 1 service date every year. ▪ Additional exams covered when medically necessary. \$5 copay applies.
Exam Replacement	<ul style="list-style-type: none"> ▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: <ul style="list-style-type: none"> ▪ 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 diopter change AND criteria for replacement frame and lenses are met.
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year when eyeglasses are lost, stolen or damaged and there is medical necessity, and/or ▪ 1 unit every year for individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file, and/or ▪ Replacement frame must be selected from the MARCH frame kit. If existing lenses can not be inserted into the MARCH frame, new lenses may be obtained from the MARCH lab. ▪ To identify replacement frames, please bill using modifier code RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every year. ▪ Lenses are provided by the MARCH lab <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. <ul style="list-style-type: none"> ▪ UV filter lenses are covered when medically necessary. Allowance not applicable. ▪ High-Index lenses are covered when medically necessary. Allowance not applicable. ▪ Tinting is covered if medically necessary. Allowance not applicable. <ul style="list-style-type: none"> ▪ Rose 1 & 2, grey or brown plastic lenses are excluded. ▪ Special base curve is covered when medically necessary. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Polycarbonate, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ 2 units every year when one of the following criteria is met: <ul style="list-style-type: none"> ▪ Eyeglasses are lost, stolen or damaged and there is medical necessity ▪ +/-0.50 diopter change in sphere and/or cylinder power or a change of 5 degrees or more in cylinder axis ▪ Individuals with developmental disabilities. Provider must place a written supporting statement, diagnosis related information and a copy of the developmental disabilities report in the member's file ▪ Covered as needed provided there is a prescription change of at least +/-0.75 diopters in spherical and/or cylindrical power or change in axis of 8 degrees or more. ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA.

Benefit	Benefit Limitations/Criteria
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every year. ▪ Allowance is not applicable.
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. ▪ Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when the following criteria is met: <ul style="list-style-type: none"> ▪ A change of +/- 0.50 diopters in power ▪ A change of 0.30mm of optic zone ▪ A change of 0.75mm in peripheral curve radius ▪ A change of 0.30mm in peripheral curve width ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ Covered as needed (frame and lenses) in addition to standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Single Vision Eyeglasses in Lieu of Multifocals	<ul style="list-style-type: none"> ▪ 2 pairs of eyeglasses in lieu of multifocals.
Repairs	<ul style="list-style-type: none"> ▪ Covered as needed. Repairs exceeding \$15 in charges require prior confirmation.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Surgical eye care. ▪ Except as otherwise indicated above, lens extras.

1.7 Covered Benefits - UnitedHealthcare Community Plan FamilyCare D (All age groups)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ \$5 copay*, 1 service date every year. ▪ Additional exams covered when medically necessary. \$5 copay* applies.
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every 2 years. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units every 2 years. ▪ Lenses are provided by the MARCH lab <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. If frames are selected from the MARCH frame kit, lenses must be provided by the MARCH lab. If frames are selected from the provider's selection using the \$100 retail allowance, lenses must be supplied by the provider. Please refer to Exhibit D in the Provider Reference Guide for MARCH lab information. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for lenses. ▪ UV filter lenses are covered when medically necessary. Allowance not applicable. ▪ High-Index lenses are covered when medically necessary. Allowance not applicable. ▪ Tinting is covered if medically necessary. Allowance not applicable. <ul style="list-style-type: none"> ▪ Rose 1 & 2, grey or brown plastic lenses are excluded. ▪ Special base curve is covered when medically necessary. Allowance not applicable.
Lens Replacement (Single, Bifocal, Trifocal, Protective Sports Eyewear)	<ul style="list-style-type: none"> ▪ Covered as needed if medically necessary due to a vision change requiring a new prescription. ▪ Replacement lenses are not covered due to loss, theft or damage regardless of medical necessity. ▪ Replacement lenses must be obtained from the MARCH lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the MARCH lab for lens insertion. ▪ To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units every 2 years ages 20 and under. ▪ 2 units every 2 years ages 21 and older when medically necessary. Allowance is not applicable.
Contact Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance in lieu of eyeglasses every 2 years. ▪ To identify contact lenses provided using the allowance, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. ▪ Contact lenses must be supplied by the provider. ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.

Benefit	Benefit Limitations/Criteria
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units every 2 years when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> ▪ Unilateral aphakia ▪ Keratoconus when vision with eyeglasses is less than 20/40 ▪ Corneal transplant when vision with eyeglasses is less than 20/40 ▪ Anisometropia that is greater than or equal to 4.00 diopter ▪ Contact lenses must be supplied by the provider. ▪ Allowance is not applicable.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when medically necessary. ▪ Initial lens criteria must be met in order to be eligible for replacement. ▪ To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.
Protective Sports Eyewear	<ul style="list-style-type: none"> ▪ Covered as needed (frame and lenses) ages 20 and under in addition to standard frame and lenses. ▪ 1 pair (frame and lenses) every 2 years ages 21 and older due to medical necessity in lieu of standard frame and lenses. ▪ Frame may be selected from the MARCH frame kit <u>OR</u> a \$100 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify frames within the provider's selection, please bill using modifier code SF and 75 in conjunction with the current and appropriate HCPCS code for frames.
Single Vision Eyeglasses in Lieu of Multifocals	<ul style="list-style-type: none"> ▪ 2 pairs of eyeglasses in lieu of multifocals.
Repairs	<ul style="list-style-type: none"> ▪ Covered as needed. Repairs exceeding \$15 in charges require prior confirmation.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Surgical eye care. ▪ Except as otherwise indicated above, lens extras.

* Designated members are not subject to the \$5 copay. Please refer to the Patient Benefit Summary in eyeSynergy® or contact customer service at (888) 493-4070 to determine if the copay is applicable.

1.8 Covered Benefits - UnitedHealthcare Dual Complete® ONE HMO D-SNP (Medicare) H3113-005

Benefit	Benefit Limitations/Criteria
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery that includes insertion of an intraocular lens. ▪ To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.
Glaucoma Screening	<ul style="list-style-type: none"> ▪ 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"> ▪ 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	<ul style="list-style-type: none"> ▪ Routine exam or eyewear.* ▪ Surgical eye care

*UnitedHealthcare Dual Complete® ONE HMO D-SNP (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families A&B (Medicaid) plan. Please refer to section [1.4](#) above for additional covered benefit information.

1.9 Medicaid Reimbursement Procedures

The Medicaid benefit affords members the opportunity to:

- Select eyeglasses from the MARCH frame kit and lab, OR
- Select eyeglasses from the provider’s selection and in-house lab using a \$100 retail allowance, OR
- Select contact lenses from the provider’s selection in lieu of eyeglasses using a \$100 retail allowance.

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts.

MARCH Frame Kit and MARCH Lab

Providers must bill the current and appropriate service code for the fitting of spectacles. Reimbursement for the fitting of spectacles will be at the lesser amount of billed charges or the provider’s contracted rate. Frame and lens codes are not reimbursable and should not be billed as materials are provided by the MARCH lab.

The following example assumes a contracted rate of \$20.00 for the fitting of monofocal spectacles.

Service Code	Description	Modifier	Billed Charges	Paid Amount
92340	Fitting of Spectacles		\$ 50.00	\$ 20.00
Total			\$ 50.00	\$ 20.00

Retail Allowance - Eyeglasses

Providers must bill the current and appropriate service code(s) for frame and lenses with modifier code 75. Reimbursement will be at the lesser amount of billed charges or the following rates:

- Frame - \$20.00
- Single Vision Lenses (V2100-V2121) - \$10.50 per lens.
- Bifocal Lenses (V2200-V2221) - \$13.00 per lens.
- Trifocal Lenses (V2300-V2321) - \$15.50 per lens.
- UV Lenses (V2755) - \$10.00 per lens.

The following example assumes a \$100 retail allowance for eyeglasses from the provider’s selection/in-house lab.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	\$ 60.00*	\$ 20.00
V2100	Lenses	75	\$ 50.00*	\$ 21.00
V2755	UV Lenses**	75	\$ 100.00	\$ 20.00
92340	Fitting of Spectacles***		\$ 40.00	\$ 0.00
Total			\$ 250.00	\$ 61.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$10.

**Allowance is not applicable to medically necessary lens options.

***Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

Retail Allowance – Contact Lenses

Providers must bill the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. Reimbursement will be at billed charges up to \$100.

The following example assumes a \$100 retail allowance for contact lenses and a billed amount less than \$100.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	\$ 50.00	\$ 50.00
92310	Contact Lens Fitting	75	\$ 25.00	\$ 25.00
Total			\$ 75.00	\$ 75.00

The following example assumes a \$100 retail allowance for contact lenses and a billed amount greater than \$100.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	\$ 150.00	\$ 100.00
92310	Contact Lens Fitting	75	\$ 25.00	\$ 0.00
Total			\$ 175.00*	\$ 100.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$75.

For billing and calculation of the **Medicare** allowance, please refer to Section 3 in the [Provider Reference Guide](#).