

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

Table of Contents

1.1 Covered Benefits - Anthem Blue Cross and Blue Shield - BadgerCare Plus Standard Plan (Medicaid)2

1.2 Covered Benefits - Anthem Blue Cross and Blue Shield - Supplemental Security Income (SSI) (Medicaid) 3

1.3 Covered Benefits - Care Wisconsin (Medicare).....4

1.4 Covered Benefits - Molina Healthcare of Wisconsin - Complete Care (Medicare)5

1.5 Covered Benefits - UnitedHealthcare Community Plan - Standard Plan (Medicaid) 6

1.6 Covered Benefits - UnitedHealthcare Community Plan - Supplemental Security Income (SSI) (Medicaid)7

1.7 Covered Benefits - UnitedHealthcare Dual Complete® LP HMO D-SNP (Medicare) H5253-024 8

1.8 Covered Benefits - UnitedHealthcare Dual Complete® LP1 HMO D-SNP (Medicare) H3794-0028

1.9 Accessibility..... 9

1.10 State Mandated Contract Provisions9

1.1 Covered Benefits - Anthem Blue Cross and Blue Shield – BadgerCare Plus Standard Plan (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame must be selected from the MARCH frame kit.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement frames, please bill with modifier RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Lenses must be provided by the MARCH contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement lenses, please bill with modifier RA.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year ages 20 and under. ▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met: <ul style="list-style-type: none"> ▪ The member has a +/- 8.00 ▪ Permanently reduced vision in one eye less than 20/200 ▪ A facial deformity or disease that interferes with eyeglass fit ▪ A documented occupational hazard
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses: <ul style="list-style-type: none"> ▪ Aphakia ▪ Keratoconus ▪ Contact lenses MUST be supplied by the provider.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement contact lenses, please bill with modifier RA.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.2 Covered Benefits - Anthem Blue Cross and Blue Shield – Supplemental Security Income (SSI) (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame must be selected from the MARCH frame kit.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement frames, please bill with modifier RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Lenses must be provided by the MARCH contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement lenses, please bill with modifier RA.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year ages 20 and under. ▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met: <ul style="list-style-type: none"> ▪ The member has a +/- 8.00 ▪ Permanently reduced vision in one eye less than 20/200 ▪ A facial deformity or disease that interferes with eyeglass fit ▪ A documented occupational hazard
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses: <ul style="list-style-type: none"> ▪ Aphakia ▪ Keratoconus ▪ Contact lenses MUST be supplied by the provider.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement contact lenses, please bill with modifier RA.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.3 Covered Benefits – Care Wisconsin (Medicare)

Benefit	Benefit Limitations/Criteria
Eyewear	<ul style="list-style-type: none"> ▪ \$150 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses MUST be used.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Exams ▪ Medical eye care ▪ Surgical eye care

1.4 Covered Benefits - Molina Healthcare of Wisconsin – Complete Care (Medicare) Plan 001

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every calendar year.
Eyewear	<ul style="list-style-type: none"> ▪ \$300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses MUST be used.
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ 20% coinsurance applies to select members. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (855) 516-2724 to determine if the member has a coinsurance. ▪ To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical or surgical eye care.

1.5 Covered Benefits - UnitedHealthcare Community Plan - Standard Plan (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame must be selected from the MARCH frame kit.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement frames, please bill with modifier RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Lenses must be provided by the MARCH contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement lenses, please bill with modifier RA.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year ages 20 and under. ▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met: <ul style="list-style-type: none"> ▪ The member has a +/- 8.00 ▪ Permanently reduced vision in one eye less than 20/200 ▪ A facial deformity or disease that interferes with eyeglass fit ▪ A documented occupational hazard
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses: <ul style="list-style-type: none"> ▪ Aphakia ▪ Keratoconus ▪ Contact lenses MUST be supplied by the provider.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement contact lenses, please bill with modifier RA.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.6 Covered Benefits - UnitedHealthcare Community Plan - Supplemental Security Income (SSI) (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Frame must be selected from the MARCH frame kit.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement frames, please bill with modifier RA.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Lenses must be provided by the MARCH contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement lenses, please bill with modifier RA.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year ages 20 and under. ▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met: <ul style="list-style-type: none"> ▪ The member has a +/- 8.00 ▪ Permanently reduced vision in one eye less than 20/200 ▪ A facial deformity or disease that interferes with eyeglass fit ▪ A documented occupational hazard
Necessary Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses: <ul style="list-style-type: none"> ▪ Aphakia ▪ Keratoconus ▪ Contact lenses MUST be supplied by the provider.
Necessary Contact Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ To identify replacement contact lenses, please bill with modifier RA.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.7 Covered Benefits - UnitedHealthcare Dual Complete® LP HMO D-SNP (Medicare) H5253-024

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every calendar year.
Eyewear	<ul style="list-style-type: none"> ▪ \$200 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses MUST be used.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical or surgical eye care.

1.8 Covered Benefits - UnitedHealthcare Dual Complete® LP 1 HMO D-SNP (Medicare) H3794-002

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> ▪ 1 service date every calendar year.
Eyewear	<ul style="list-style-type: none"> ▪ \$200 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses MUST be used.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical or surgical eye care.

1.9 Accessibility

All providers participating in Wisconsin must provide accessible programs, facilities and reasonable accommodations to service participants/customers with disabilities in compliance with Section 504 of the Rehabilitation Act of 1973, Title II of the American With Disabilities Act of 1990 as amended (ADA) and as it applies to local governments and municipalities, Title III of the ADA or Wisconsin Civil Rights Statute Chapter 106.52 Public Places of Accommodations or Amusement, and DWD Chapter 221.1.

1.10 State Mandated Contract Provisions

Please click [here](#) to access state mandated contract provisions.