

## Nebraska Specific Information

This document contains information specific to the State of Nebraska. 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 Dual Complete® HMO-POS D-SNP (Medicare) H0169-003 benefits updated effective 01/01/2024.
- UnitedHealthcare Dual Complete® Plan 2 HMO-POS D-SNP (Medicare) H2802-053 benefits updated effective 01/01/2024.

### 1.2 Covered Benefits – UnitedHealthcare Dual Complete® Choice PPO D-SNP (Medicare) H0271-050

Plan ID(s): UDNE-DSNP4

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>1 service date every calendar year.</li> </ul>
Eyewear	<ul style="list-style-type: none"> <li>\$400 allowance every calendar year.</li> <li>Allowance may be used toward frames, lenses, lens extras and contact lenses.</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 following cataract surgery with an intraocular lens. Allowance does not apply.</li> <li><b>To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.</b></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>Medical eye care</li> <li>Surgical eye care</li> </ul>

### 1.3 Covered Benefits – UnitedHealthcare Dual Complete® HMO-POS D-SNP (Medicare) H0169-003

Plan ID(s): UDNE-DSNP2

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>1 service date every calendar year.</li> </ul>
Eyewear	<ul style="list-style-type: none"> <li>\$400 allowance every calendar year.</li> <li>Allowance may be used toward frames, lenses, lens extras and contact lenses.</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 following cataract surgery with an intraocular lens. Allowance does not apply.</li> <li><b>To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.</b></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>Medical eye care</li> <li>Surgical eye care</li> </ul>



#### 1.4 Covered Benefits – UnitedHealthcare Dual Complete® Plan 2 HMO-POS D-SNP (Medicare) H2802-053

Plan ID(s): UDNE-DSNP2

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"><li>1 service date every calendar year.</li></ul>
Eyewear	<ul style="list-style-type: none"><li>\$400 allowance every calendar year.</li><li>Allowance may be used toward frames, lenses, lens extras and contact lenses.</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 following cataract surgery with an intraocular lens. Allowance does not apply.</li><li><b>To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.</b></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>Medical eye care</li><li>Surgical eye care</li></ul>

#### 1.5 Covered Benefits – UnitedHealthcare Dual Complete® Select HMO-POS D-SNP (Medicare) H0169-006

Plan ID(s): UDNE-DSNP3

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"><li>1 service date every calendar year.</li></ul>
Eyewear	<ul style="list-style-type: none"><li>\$350 allowance every calendar year.</li><li>Allowance may be used toward frames, lenses, lens extras and contact lenses.</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 following cataract surgery with an intraocular lens. Allowance does not apply.</li><li><b>To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.</b></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>Medical eye care</li><li>Surgical eye care</li></ul>

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

Plan ID(s): UDNEM-20

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>▪ 1 exam every 12 months.</li> <li>▪ More frequent exams will be covered if medically necessary.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if glasses are lost, damaged or size change due to growth and it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>▪ 1 unit every 12 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.</li> </ul> </li> <li>▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.</li> </ul> </li> <li>▪ The following specifications apply to all frames:               <ul style="list-style-type: none"> <li>▪ Plastic and metal frames are covered; rimless frames are not covered.</li> <li>▪ Discontinued frames with new prescription lenses are not covered; and</li> <li>▪ Frame cases are covered with new eyeglasses.</li> </ul> </li> <li>▪ Frames are covered more frequently if necessary and appropriate.</li> <li>▪ <b>Frame must be selected from the March frame kit.</b></li> <li>▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.</li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if medically necessary and appropriate.</li> <li>▪ <b>To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.</b></li> </ul>
Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 12 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):                       <ul style="list-style-type: none"> <li>▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;</li> <li>▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or</li> <li>▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul> </li> <li>▪ The member's current lenses are no longer useable due to damage, breakage or loss.</li> </ul> </li> <li>▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.</li> <li>▪ Lenses are covered more frequently when medically necessary and appropriate.</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> <li>▪ <b>Lens Specifications:</b> <ul style="list-style-type: none"> <li>▪ The following specifications apply to all eyeglass lenses:</li> <li>▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ Lenses may be plastic or glass.</li> <li>▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.</li> <li>▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and</li> <li>▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.</li> </ul> <p><b>Special Lens Features:</b></p> <ul style="list-style-type: none"> <li>▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.</li> <li>▪ High index lenses are covered when there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Myodisc lenses are covered only if prescribed.</li> <li>▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.</li> <li>▪ Oversize lenses covered if:               <ul style="list-style-type: none"> <li>▪ Medically necessary - examples include:                   <ul style="list-style-type: none"> <li>▪ Narrow interpupillary distance</li> <li>▪ Unusual facial configuration</li> </ul> </li> <li>▪ The member purchases his/her own frame or uses previously purchased frame.</li> </ul> </li> <li>▪ Polycarbonate (standard and thin) lenses are covered.</li> <li>▪ Slab-off prism covered when there is at least 3.00 diopter of anisometropia in the vertical meridian.</li> <li>▪ Special base curve is covered for aniseikonia.</li> <li>▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple "photophobia" is not an acceptable diagnosis for coverage.</li> <li>▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.</li> <li>▪ Balance lenses are covered.</li> <li>▪ Press on fresnel prism lenses are covered.</li> <li>▪ Occluder lenses are covered.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if lost, damaged, size change due to growth or prescription change. If lenses are needed due to prescription change one of the following criteria must be met:               <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> <li>▪ <b>To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.</b></li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ Covered when medically necessary for the treatment of the following diseases or injury to the eye:               <ul style="list-style-type: none"> <li>▪ Keratoconus</li> <li>▪ Aphakia (excluding pseudophakia)</li> <li>▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.</li> <li>▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision.</li> <li>▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.</li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met:               <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul>
Repairs	<ul style="list-style-type: none"> <li>▪ Repair of damaged lenses and/or frames is covered.               <ul style="list-style-type: none"> <li>▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses.</li> <li>▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.</li> </ul> </li> </ul>
Services Not Covered by March	<ul style="list-style-type: none"> <li>▪ Medical eye care.</li> <li>▪ Surgical eye care.</li> </ul> <p>Contact UntiedHealthcare Community Plan for more information.</p>

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

Plan ID(s): UDNEM-21

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>▪ 1 exam every 24 months.</li> <li>▪ More frequent exams will be covered if medically necessary.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if glasses are lost, damaged and it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.</li> </ul> </li> <li>▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.</li> </ul> </li> <li>▪ The following specifications apply to all frames:               <ul style="list-style-type: none"> <li>▪ Plastic and metal frames are covered.</li> <li>▪ Discontinued frames with new prescription lenses are not covered.</li> <li>▪ Frame cases are covered with new eyeglasses.</li> </ul> </li> <li>▪ <b>Frame must be selected from the March frame kit.</b></li> <li>▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.</li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>▪ 1 unit every 12 months when frame is irreparable due to wear/damage, breakage or loss.</li> <li>▪ <b>To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.</b></li> </ul>
Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 24 months, to the day, when the following is present:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):                       <ul style="list-style-type: none"> <li>▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;</li> <li>▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or</li> <li>▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul> </li> <li>▪ The members current lenses are no longer useable due to damage, breakage or loss.</li> </ul> </li> <li>▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.</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> <li>▪ <b>Lens Specifications:</b> <ul style="list-style-type: none"> <li>▪ The following specifications apply to all eyeglass lenses:</li> <li>▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.</li> <li>▪ Lenses may be plastic or glass.</li> <li>▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must</li> </ul> </li> </ul>



Benefit	Benefit Limitations/Criteria
	<p>indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.</p> <ul style="list-style-type: none"> <li>▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and</li> <li>▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.</li> </ul> <p><b>Special Lens Features:</b></p> <ul style="list-style-type: none"> <li>▪ Glass or plastic single lenses are covered.</li> <li>▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.</li> <li>▪ High index lenses are covered where there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Myodisc lenses are covered only if prescribed.</li> <li>▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.</li> <li>▪ Oversize lenses covered if: <ul style="list-style-type: none"> <li>▪ Medically necessary - examples include: <ul style="list-style-type: none"> <li>▪ Narrow interpupillary distance</li> <li>▪ Unusual facial configuration</li> </ul> </li> <li>▪ The member purchases his/her own frame or uses previously purchased frame.</li> </ul> </li> <li>▪ Polycarbonate (standard) lenses are covered only if prescribed for members with significantly monocular vision (e.g. due to amblyopia, eye injury, eye disease, or other disorder).</li> <li>▪ Polycarbonate (thin) lenses are covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Slab-off prism covered when there is at least 3.00 diopters of anisometropia in the vertical meridian.</li> <li>▪ Special base curve is covered for aniseikonia.</li> <li>▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple "photophobia" is not an acceptable diagnosis for coverage. Photochromatic tints and sunglasses are not covered.</li> <li>▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.</li> <li>▪ Balance lenses are covered.</li> <li>▪ Press on fresnel prism lenses are covered.</li> <li>▪ Occluder lenses are covered.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 12 months if lost, damaged, or prescription change. If lenses are needed due to prescription change one of the following criteria must be met: <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> <li>▪ <b>To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.</b></li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ Covered when medically necessary for the treatment of the following diseases or injury to the eye: <ul style="list-style-type: none"> <li>▪ Keratoconus</li> <li>▪ Aphakia (excluding pseudophakia)</li> <li>▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction.</li> <li>▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision.</li> <li>▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.</li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul>
Repairs	<ul style="list-style-type: none"> <li>▪ Repair of damaged lenses and/or frames is covered. <ul style="list-style-type: none"> <li>▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses.</li> <li>▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.</li> </ul> </li> </ul>
Services Not Covered by March	<ul style="list-style-type: none"> <li>▪ Medical eye care.</li> <li>▪ Surgical eye care.</li> </ul> <p>Contact UnitedHealthcare Community Plan for more information.</p>

## 1.8 Covered Benefits – UnitedHealthcare Community Plan Heritage Health Adult Expansion Prime Ages 19 and 20 (Medicaid)

Plan ID(s): UDNEM-P19

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>▪ 1 exam every 12 months.</li> <li>▪ More frequent exams will be covered if medically necessary.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if glasses are lost, damaged or size change due to growth and it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.</li> </ul> </li> <li>▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.</li> </ul> </li> <li>▪ The following specifications apply to all frames:               <ul style="list-style-type: none"> <li>▪ Plastic and metal frames are covered; rimless frames are not covered.</li> <li>▪ Discontinued frames with new prescription lenses are not covered; and</li> <li>▪ Frame cases are covered with new eyeglasses.</li> </ul> </li> <li>▪ Frames are covered more frequently if necessary and appropriate.</li> <li>▪ <b>Frame must be selected from the March frame kit.</b></li> <li>▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.</li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if medically necessary and appropriate.</li> <li>▪ <b>To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.</b></li> </ul>
Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 24 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):                       <ul style="list-style-type: none"> <li>▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;</li> <li>▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or</li> <li>▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul> </li> <li>▪ The member's current lenses are no longer useable due to damage, breakage or loss.</li> </ul> </li> <li>▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.</li> <li>▪ Lenses are covered more frequently when medically necessary and appropriate.</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> <li>▪ <b>Lens Specifications:</b> <ul style="list-style-type: none"> <li>▪ The following specifications apply to all eyeglass lenses:</li> <li>▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ Lenses may be plastic or glass.</li> <li>▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.</li> <li>▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and</li> <li>▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.</li> </ul> <p><b>Special Lens Features:</b></p> <ul style="list-style-type: none"> <li>▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.</li> <li>▪ High index lenses are covered when there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Myodisc lenses are covered only if prescribed.</li> <li>▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.</li> <li>▪ Oversize lenses covered if:               <ul style="list-style-type: none"> <li>▪ Medically necessary - examples include:                   <ul style="list-style-type: none"> <li>▪ Narrow interpupillary distance</li> <li>▪ Unusual facial configuration</li> </ul> </li> <li>▪ The member purchases his/her own frame or uses previously purchased frame.</li> </ul> </li> <li>▪ Polycarbonate (standard and thin) lenses are covered.</li> <li>▪ Slab-off prism covered when there is at least 3.00 diopter of anisometropia in the vertical meridian.</li> <li>▪ Special base curve is covered for aniseikonia.</li> <li>▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple "photophobia" is not an acceptable diagnosis for coverage.</li> <li>▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.</li> <li>▪ Balance lenses are covered.</li> <li>▪ Press on fresnel prism lenses are covered.</li> <li>▪ Occluder lenses are covered.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if lost, damaged, size change due to growth or prescription change. If lenses are needed due to prescription change one of the following criteria must be met:               <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> <li>▪ <b>To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.</b></li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ Covered when medically necessary for the treatment of the following diseases or injury to the eye:               <ul style="list-style-type: none"> <li>▪ Keratoconus</li> <li>▪ Aphakia (excluding pseudophakia)</li> <li>▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.</li> <li>▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision.</li> <li>▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.</li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul>
Repairs	<ul style="list-style-type: none"> <li>▪ Repair of damaged lenses and/or frames is covered. <ul style="list-style-type: none"> <li>▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses.</li> <li>▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.</li> </ul> </li> </ul>
Services Not Covered by March	<ul style="list-style-type: none"> <li>▪ Medical eye care.</li> <li>▪ Surgical eye care.</li> </ul> <p>Contact UnitedHealthcare Community Plan for more information.</p>

## 1.9 Covered Benefits – UnitedHealthcare Community Plan Heritage Health Adult Expansion Prime Ages 21 and Older (Medicaid)

Plan ID(s): UDNEM-P

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>▪ 1 exam every 24 months.</li> <li>▪ More frequent exams will be covered if medically necessary.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if glasses are lost, damaged and it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.</li> </ul> </li> <li>▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.</li> </ul> </li> <li>▪ The following specifications apply to all frames:               <ul style="list-style-type: none"> <li>▪ Plastic and metal frames are covered.</li> <li>▪ Discontinued frames with new prescription lenses are not covered.</li> <li>▪ Frame cases are covered with new eyeglasses.</li> </ul> </li> <li>▪ <b>Frame must be selected from the March frame kit.</b></li> <li>▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.</li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>▪ 1 unit every 12 months when frame is irreparable due to wear/damage, breakage or loss.</li> <li>▪ <b>To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.</b></li> </ul>
Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 24 months, to the day, when the following is present:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):                       <ul style="list-style-type: none"> <li>▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;</li> <li>▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or</li> <li>▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul> </li> <li>▪ The members current lenses are no longer useable due to damage, breakage or loss.</li> </ul> </li> <li>▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.</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> <li>▪ <b>Lens Specifications:</b> <ul style="list-style-type: none"> <li>▪ The following specifications apply to all eyeglass lenses:</li> <li>▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.</li> <li>▪ Lenses may be plastic or glass.</li> <li>▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<p>indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.</p> <ul style="list-style-type: none"> <li>▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and</li> <li>▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.</li> </ul> <p><b>Special Lens Features:</b></p> <ul style="list-style-type: none"> <li>▪ Glass or plastic single lenses are covered.</li> <li>▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.</li> <li>▪ High index lenses are covered where there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Myodisc lenses are covered only if prescribed.</li> <li>▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.</li> <li>▪ Oversize lenses covered if: <ul style="list-style-type: none"> <li>▪ Medically necessary - examples include: <ul style="list-style-type: none"> <li>▪ Narrow interpupillary distance</li> <li>▪ Unusual facial configuration</li> </ul> </li> <li>▪ The member purchases his/her own frame or uses previously purchased frame.</li> </ul> </li> <li>▪ Polycarbonate (standard) lenses are covered only if prescribed for members with significantly monocular vision (e.g. due to amblyopia, eye injury, eye disease, or other disorder).</li> <li>▪ Polycarbonate (thin) lenses are covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Slab-off prism covered when there is at least 3.00 diopters of anisometropia in the vertical meridian.</li> <li>▪ Special base curve is covered for aniseikonia.</li> <li>▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple "photophobia" is not an acceptable diagnosis for coverage. Photochromatic tints and sunglasses are not covered.</li> <li>▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.</li> <li>▪ Balance lenses are covered.</li> <li>▪ Press on fresnel prism lenses are covered.</li> <li>▪ Occluder lenses are covered.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 12 months if lost, damaged, or prescription change. If lenses are needed due to prescription change one of the following criteria must be met: <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> <li>▪ <b>To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.</b></li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ Covered when medically necessary for the treatment of the following diseases or injury to the eye: <ul style="list-style-type: none"> <li>▪ Keratoconus</li> <li>▪ Aphakia (excluding pseudophakia)</li> <li>▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction.</li> <li>▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision.</li> <li>▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.</li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: <ul style="list-style-type: none"> <li>▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.</li> <li>▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.</li> <li>▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> </ul>
Repairs	<ul style="list-style-type: none"> <li>▪ Repair of damaged lenses and/or frames is covered. <ul style="list-style-type: none"> <li>▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses.</li> <li>▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.</li> </ul> </li> </ul>
Services Not Covered by March	<ul style="list-style-type: none"> <li>▪ Medical eye care.</li> <li>▪ Surgical eye care.</li> </ul> <p>Contact UnitedHealthcare Community Plan for more information.</p>