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

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1.1 Covered Benefits - UnitedHealthcare Community Plan – Medicaid

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every calendar year beginning January 1st. ▪ Additional exams covered as necessary ages 20 and under.
Routine Exam Replacement	▪ Covered as twice per calendar year ages 20 and under if there is a prescription change or if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Frame	▪ 1 unit every calendar year beginning January 1st when documentation supports the following:
	  ▪ Eyeglasses are medically necessary,
	  ▪ Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
	  ▪ Eyeglasses meet eyeglass program specifications for frames and lenses.
	▪ Frame can be selected from the MARCH frame kit or provider's frame selection at no cost to the member.

Frame Replacement	▪ 2 units (2 pair) per calendar year as needed if lost, broken or damaged ages 20 and under. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st when documentation supports one of the following:
	  ▪ The prescription is at least 0.75 diopters for one eye or 0.75 diopters for each eye. The 0.75 diopter must be in either the sphere, the cylinder, or add power.
	  ▪ Lenses are covered for a prescription less of less than 0.75 diopter if medically necessary and are for the following reasons:
	    ▪ Visual acuity 20/40 or less
	    ▪ Needed as protective eye wear for persons with sight in only one eye
	    ▪ Plano lenses when there is a refractive error in only one eye
	    ▪ Required for school performance ages 20 and under
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ Hi index lenses are covered.
	  ▪ Polycarbonate lenses are covered for:
	    ▪ Ages 20 and under
	    ▪ Ages 21 and older when a medical condition warrants the need. Examples include:
	      ▪ Seizure disorder
	      ▪ Vision in only one eye
	  ▪ Plano lenses are covered when there is a refractive error in only one eye ages 21 and older.
	▪ **Lenses must be provided by the MARCH lab if using the MARCH frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 4 units (2 pairs) per calendar year if lost, broken, damaged, or for a prescription change ages 20 and under. ▪ 2 units (1 pair) per calendar year if lost, broken or damaged ages 21 and older. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

Benefit	Benefit Limitations/Criteria

Necessary Contact Lenses	▪ Covered, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.
	▪ **Contact lenses must be supplied by the provider.**

Necessary Contact Lens Replacement	▪ Covered if lost or damaged or for a prescription change ages 20 and under.
	▪ Covered if lost or damaged ages 21 and older.
	▪ One of the following medical necessity reasons must also be met.
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Eyewear After Cataract Surgery	▪ Covered for one year following cataract surgery ages 21 and older.
	  ▪ Once per eye, per lifetime. Additional pairs of glasses are covered within one year following cataract surgery, with documentation of medical necessity.
	  ▪ Eyewear must meet dispensing requirements and lens specifications
	  ▪ The expectation is that the annual benefit will be utilized, if available. If the annual benefit has been utilized and the post cataract glasses represent an additional pair of glasses within the benefit period, pre-authorization is required.
	  ▪ The following lens options are covered following cataract extraction when visually necessary and documented by the treating physician:
	    ▪ Tints (V2745)
	    ▪ Anti-reflective coating (V2750)
	    ▪ UV lenses (V2755)
	    ▪ Oversize lenses (V2780)
	  ▪ Aphakic without IOL: In addition to the post-surgical exam, aphakic patients who do not have an IOL are covered for the following lenses or combination of lenses when visually necessary:
	    ▪ Bifocal lenses in frames; or
	    ▪ Lenses in frames for distance vision and lenses in frames for near vision (two pairs of glasses); or
	    ▪ Conventional contact lenses for distance vision, eyeglasses for near vision to wear with contact lenses and eyeglasses to wear when the contact lenses have been removed.

Non-Covered Services	▪ Surgical eye care.

1.2 Covered Benefits - UnitedHealthcare Community Plan – Medicaid - Spenddown

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every calendar year beginning January 1st. ▪ **Exams in years 2, 3 and 4 are not subject to the spenddown.**
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Frame	▪ 1 unit every calendar year beginning January 1st when documentation supports the following:
	  ▪ Eyeglasses are medically necessary,
	  ▪ Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
	  ▪ Eyeglasses meet eyeglass program specifications for frames and lenses.
	▪ **Frames in years 2, 3 and 4 are not subject to the spenddown.**
	▪ Frame can be selected from the MARCH frame kit or provider's frame selection at no cost to the member.

Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st when documentation supports one of the following:
	  ▪ The prescription is at least 0.75 diopters for one eye or 0.75 diopters for each eye. The 0.75 diopter must be in either the sphere, the cylinder, or add power.
	  ▪ Lenses are covered for a prescription less of less than 0.75 diopter if medically necessary and are for the following reasons:
	    ▪ Visual acuity 20/40 or less
	    ▪ Needed as protective eye wear for persons with sight in only one eye
	    ▪ Plano lenses when there is a refractive error in only one eye
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ Hi index lenses are covered.
	  ▪ Polycarbonate lenses are covered when a medical condition warrants the need. Examples include:
	    ▪ Seizure disorder
	    ▪ Vision in only one eye
	  ▪ Plano lenses are covered when there is a refractive error in only one eye.
	▪ **Lenses in years 2, 3 and 4 are not subject to the spenddown.**
	▪ **Lenses must be provided by the MARCH lab if using the MARCH frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 2 units (1 pair) per calendar year if lost, broken or damaged. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

Benefit	Benefit Limitations/Criteria

Necessary Contact Lenses	▪ Covered, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.
	▪ **Contact lenses must be supplied by the provider.**

Necessary Contact Lens Replacement	▪ Covered if lost or damaged.
	▪ One of the following medical necessity reasons must also be met.
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Eyewear After Cataract Surgery	▪ Covered for one year following cataract surgery.
	  ▪ Once per eye, per lifetime. Additional pairs of glasses are covered within one year following cataract surgery, with documentation of medical necessity.
	  ▪ Eyewear must meet dispensing requirements and lens specifications
	  ▪ The expectation is that the annual benefit will be utilized, if available. If the annual benefit has been utilized and the post cataract glasses represent an additional pair of glasses within the benefit period, pre-authorization is required.
	  ▪ The following lens options are covered following cataract extraction when visually necessary and documented by the treating physician:
	    ▪ Tints (V2745)
	    ▪ Anti-reflective coating (V2750)
	    ▪ UV lenses (V2755)
	    ▪ Oversize lenses (V2780)
	  ▪ Aphakic without IOL: In addition to the post-surgical exam, aphakic patients who do not have an IOL are covered for the following lenses or combination of lenses when visually necessary:
	    ▪ Bifocal lenses in frames; or
	    ▪ Lenses in frames for distance vision and lenses in frames for near vision (two pairs of glasses); or
	    ▪ Conventional contact lenses for distance vision, eyeglasses for near vision to wear with contact lenses and eyeglasses to wear when the contact lenses have been removed.

Non-Covered Services	▪ Surgical eye care.

1.3 Covered Benefits - UnitedHealthcare Community Plan – Foster Care

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every calendar year beginning January 1st. ▪ Additional exams covered as necessary.
Routine Exam Replacement	▪ Covered twice per calendar year if there is a prescription change or if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Frame	▪ 1 unit every calendar year beginning January 1st when documentation supports the following:
	  ▪ Eyeglasses are medically necessary,
	  ▪ Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
	  ▪ Eyeglasses meet eyeglass program specifications for frames and lenses.
	▪ Frame can be selected from the MARCH frame kit or provider's frame selection at no cost to the member.

Frame Replacement	▪ 2 units (2 pair) per calendar year as needed if lost, broken or damaged. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st when documentation supports one of the following:
	  ▪ The prescription is at least 0.75 diopters for one eye or 0.75 diopters for each eye. The 0.75 diopter must be in either the sphere, the cylinder, or add power.
	  ▪ Lenses are covered for a prescription less of less than 0.75 diopter if medically necessary and are for the following reasons:
	    ▪ Visual acuity 20/40 or less
	    ▪ Needed as protective eye wear for persons with sight in only one eye
	    ▪ Plano lenses when there is a refractive error in only one eye
	    ▪ Required for school performance ages 20 and under
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ Hi index lenses are covered.
	  ▪ Polycarbonate lenses are covered.
	  ▪ Plano lenses are covered when there is a refractive error in only one eye
	▪ **Lenses must be provided by the MARCH lab if using the MARCH frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 4 units (2 pairs) per calendar year if lost, broken, damaged, or for a prescription change. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

<table>
<tr><th>Benefit</th><th>Benefit Limitations/Criteria</th></tr>
<tr><td>Necessary Contact Lenses</td><td>Covered, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:
Monocular aphakia
Bullous keratopathy
Keratoconus
Corneal transplant
Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.
Contact lenses must be supplied by the provider.</td></tr>
<tr><td>Necessary Contact Lens Replacement</td><td>Covered if lost or damaged or for a prescription change.
One of the following medical necessity reasons must also be met.
Monocular aphakia
Bullous keratopathy
Keratoconus
Corneal transplant
Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.</td></tr>
<tr><td>Non-Covered Services</td><td>Surgical eye care.</td></tr>
</table>

1.4 Covered Benefits - UnitedHealthcare Community Plan – CHIP

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every calendar year beginning January 1st. ▪ Additional exams covered as necessary.
Routine Exam Replacement	▪ Covered as needed if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Frame	▪ 1 unit every calendar year beginning January 1st when documentation supports the following:
	  ▪ Eyeglasses are medically necessary,
	  ▪ Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
	  ▪ Eyeglasses meet eyeglass program specifications for frames and lenses.
	▪ Frame can be selected from the MARCH frame kit or provider's frame selection at no cost to the member.

Frame Replacement	▪ 2 units (2 pair) per calendar year as needed if lost or stolen. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st when documentation supports one of the following:
	  ▪ The prescription is at least 0.75 diopters for one eye or 0.75 diopters for each eye. The 0.75 diopter must be in either the sphere, the cylinder, or add power.
	  ▪ Lenses are covered for a prescription less of less than 0.75 diopter if medically necessary and are for the following reasons:
	    ▪ Visual acuity 20/40 or less
	    ▪ Needed as protective eye wear for persons with sight in only one eye
	    ▪ Plano lenses when there is a refractive error in only one eye
	    ▪ Required for school performance ages 20 and under
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ Hi index lenses are covered.
	  ▪ Polycarbonate lenses are covered.
	▪ **Lenses must be provided by the MARCH lab if using the MARCH frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 4 units (2 pairs) per calendar year if lost, broken, damaged, or for a prescription change. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

<table>
<tr><th>Benefit</th><th>Benefit Limitations/Criteria</th></tr>
<tr><td>Necessary Contact Lenses</td><td>

Covered, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:

Monocular aphakia
Bullous keratopathy
Keratoconus
Corneal transplant
Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Contact lenses must be supplied by the provider.
</td></tr>
<tr><td>Necessary Contact Lens Replacement</td><td>

Covered if lost or damaged or for a prescription change.
One of the following medical necessity reasons must also be met.

Monocular aphakia
Bullous keratopathy
Keratoconus
Corneal transplant
Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

</td></tr>
<tr><td>Non-Covered Services</td><td>

Surgical eye care.
</td></tr>
</table>

1.5 Spenddown

In some cases, the income of a family or individual exceeds the income standard to receive public assistance; however, their income is not sufficient to meet all medical expenses. The family group/individual must then incur a specified amount of medical expense before they are eligible for benefits. This process is referred to as spenddown. Spenddown is like an insurance deductible. It is the amount of medical costs for which a family or individual is responsible.

How to identify spenddown members

To identify spenddown beneficiaries, please refer to the Member Benefit Summary in eyeSynery®. You may also contact us at 844-506-2724.

How to determine the spenddown amount

Please login to the KMAP website at https://www.kmap-state-ks.us/provider/security/logon.asp and navigate to Eligibility to determine the unmet spenddown amount in real time.

Billing

The provider is responsible for collecting the appropriate spenddown amount from the member at the time of service. When billing, submit a claim for all services rendered and do not reduce billed charges by the spenddown amount. For example, if the Usual and Customary Charge for an eye exam is $100 and the member has a $50 spenddown, MARCH must be billed $100 for the eye exam.

Exceptions

The following value added benefits are **NOT** subject to the spenddown.

- Routine vision exams in years 2, 3 and 4.
- Frame and lenses in years 2, 3 and 4.

Example 1 – Member receives an eye exam, frame and lenses in years 1-4.

Service	Year 1 DOS 01/01/2017	Year 2 DOS 01/01/2018	Year 3 DOS 01/01/2019	Year 4 DOS 01/01/2020
Exam	✓	✗	✗	✗
Frame	✓	✗	✗	✗
Lenses	✓	✗	✗	✗

Example 2 – Member only receives an eye exam in year one, but receives an eye exam, frame and lenses in years 2, 3 and 4.

Service	Year 1 - Exam DOS 01/01/2017	Year 2 – Exam Year 1 – Frame/Lens DOS 01/01/2018	Year 3 – Exam Year 2 – Frame/Lens DOS 01/01/2019	Year 4 – Exam Year 3 – Frame/Lens DOS 01/01/2020
Exam	✓	✗	✗	✗
Frame	N/A	✓	✗	✗
Lenses	N/A	✓	✗	✗

Example 3 – Member receives an eye exam, frame and lenses in years 1, 2, 3 and 4 and replacement frame and lenses in year 1.

Service	**Year 1 DOS 01/01/2017**	**Year 1 DOS 06/30/2017**	**Year 2 DOS 01/01/2018**	**Year 3 DOS 01/01/2019**	**Year 4 DOS 01/01/2020**
Exam	✔	N/A	✖	✖	✖
Frame	✔	N/A	✖	✖	✖
Lenses	✔	N/A	✖	✖	✖
Replacements	N/A	✔	N/A	N/A	N/A

✔ = Spenddown **DOES** apply

✖ = Spenddown does **NOT** apply