

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.



### Covered in Full (after applicable copays)

#### In-Network Benefits:

Comprehensive Exam

Lenses

Standard Single Vision

Standard Lined Bifocal

Standard Lined Trifocal

Lens Options

Standard Scratch Resistant Coating, tints, UV coating, polycarbonate and basic progressive lenses

Frame

Contact Lenses (in lieu of eyeglasses)

Elective

Necessary<sup>^</sup>

### Copays for in-network services

Comprehensive Exam	\$	10.00
Materials	\$	25.00

### Rates

Employee Only	\$	6.39
Employee + Spouse	\$	13.58
Employee + Child(ren)	\$	10.49
Employee + Family	\$	18.70

### Benefit Frequency

Comprehensive Exam	once every plan year
Spectacle Lenses	once every plan year
Frames	once every other plan year
Contact Lenses (in lieu of eye glasses)	once every plan year

### Frame Benefit

Private Practice Provider- \$50 wholesale allowance  
(approximate retail value of \$120-\$150)

Retail Chain Provider- \$130 retail frame allowance

### In-Network Contact Lens Benefit

Contact lenses in lieu of eyeglasses.

The covered-in-full contact lens benefit at network providers includes fitting/evaluation, contacts, and two follow-up visits (after \$25 copay). For those who choose disposable lenses, up to 6 boxes are included when obtained from a network provider. If you select contact lenses outside UnitedHealthcare Vision's covered-in-full contacts you will receive a \$150 allowance towards the fitting/evaluation and purchase of contacts (materials copay does not apply).

### Out of Network Reimbursement

Network Copays do not apply

Comprehensive Exam	\$	45.00
Lenses		
Single Vision	\$	50.00
Bifocal	\$	60.00
Trifocal	\$	80.00
Lenticular	\$	80.00
Frames	\$	50.00
Contact Lenses in lieu of eyeglasses		
Elective	\$	150.00
Necessary <sup>^</sup>	\$	210.00

You do not need to submit a claim for In-Network benefits. However, you must submit a claim to UnitedHealthcare Vision for benefit reimbursement for Out-of-Network services.

## UnitedHealthcare Vision<sup>SM</sup>

### Vision Care Benefits

Copays Exam	\$	10.00
Materials	\$	25.00
Frequency Exams	once every plan year	
Lenses	once every plan year	
Frames	once every other plan year	
Contacts	once every plan year	
<i>(Contacts are in lieu of lenses and frames)</i>		

**This card does not guarantee eligibility and benefits**

## SAMPLE ILLUSTRATION OF SAVINGS

Cost	Employee Only	Employee + Spouse	Employee + Child(ren)*	Employee + Family**
Monthly Premium	\$6.39	\$13.58	\$10.49	\$18.70
Annual Premium	\$76.68	\$162.96	\$125.88	\$224.40
Approx. Pre-tax Savings (20%)***	\$15.34	\$32.59	\$25.18	\$44.88
Annual Tax-Adjusted Premium	\$61.34	\$130.37	\$100.70	\$179.52
Plus Copays	\$35.00	\$70.00	\$105.00	\$140.00
<b>Total Cost to Employee</b>	<b>\$96.34</b>	<b>\$200.37</b>	<b>\$205.70</b>	<b>\$319.52</b>

Exam and Materials Covered by UnitedHealthcare Vision's Vision Plan	Estimated Cost Without a Vision Plan****	Less Employee Cost	Total Savings with UnitedHealthcare Vision
<b>Employee Only</b> Exam, Single Vision, & Covered-in-full frames	\$275.00	\$96.34	<b>\$178.66</b>
<b>Employee + Spouse</b> Exam, Single Vision, & Covered-in-full frames	\$550.00	\$200.37	<b>\$349.63</b>
<b>Employee + Child(ren)*</b> Exam, Single Vision, & Covered-in-full frames	\$825.00	\$205.70	<b>\$619.30</b>
<b>Employee + Family**</b> Exam, Single Vision, & Covered-in-full frames	\$1,100.00	\$319.52	<b>\$780.48</b>

\* For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

\*\* For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

\*\*\* Actual tax savings will depend upon your individual tax bracket.

\*\*\*\* Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail costs may vary by provider.

### Important to Remember:

- Benefits available once every plan year or every other plan year (depending on the benefit frequency).
- Your \$150 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$120 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you choose disposable contacts, you may receive up to 6 boxes of disposable contacts (depending on prescription). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
- UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser correction providers. 1-877-28-SIGHT
- If not covered- Lens Options such as anti-reflective coating may be available at a discount.
- Out of Network Reimbursement: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address:

**UnitedHealthcare Vision, Inc. Attn. Claim Dept. P.O. Box 30978 Salt Lake City, UT 84130**

^ Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

#### FOR MORE INFORMATION

**Customer Service:** 1.800.638.3120

*Monday through Friday: 8:00 a.m. - 11:00 p.m. ET*

*Saturday: 9:00 a.m. - 6:30 p.m. ET*

**Provider Locator:** 1.800.839.3242

**TDD for the hearing impaired: 1.800.524.3157**

**Submit Out-of-Network Claims to:**

**UnitedHealthcare Vision Claims Department**

**P.O. Box 30978**

**Salt Lake City, UT 84130**

For more information about your UnitedHealthcare Vision plan, visit  
[www.myuhcvision.com](http://www.myuhcvision.com), or call Customer Service.

#### Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.