V1380

Vision Benefit Summary
Powered by UnitedHealthcare Vision Network
Customer Service and Provider Locator: (800) 638-3120
myuhcvision.com

UnitedHealthcare Vision has been trusted for more than 50 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.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months

In-Network Services	
Copays	
Exam(s)	$10
Eyeglasses (lenses and frame) - includes basic single vision, lined bifocal, lined trifocal or lenticular lenses	$25
Contact lenses instead of Eyeglasses	$25
Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage[1]	
Frame Allowance	$130
Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.	
Standard Scratch Coating	$0
Scratch Warranty	$10
Tint	$14
UV Coating	$16
Photochromic	$67
Anti-Reflective Tier I	$30
Anti-Reflective Tier II	$50
Anti-Reflective Tier III	$75
Anti-Reflective Tier IV	$95
Roll and Polish Edges	$13
Progressive Tier I	$55
Progressive Tier II	$100
Progressive Tier III	$150
Progressive Tier IV	$200
Progressive Tier V	$250
High Index (<1.66)	$53
High Index (1.66-1.73)	$63
Polycarbonate for Adults	$33
Polycarbonate for Dependent Children	$0
Contact Lens Benefit[2] - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com.	
Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	$130
Necessary contact lenses[3]	Covered in full after copay (if applicable).

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Children's and Maternity Eye Care Benefit
Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam 60 days after the initial exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up To $40.00
Frames	Up To $45.00
Single Vision Lenses	Up To $40.00
Lined Bifocal and Progressive Lenses	Up To $60.00
Lined Trifocal Lenses	Up To $80.00
Lenticular Lenses	Up To $80.00
Elective Contacts instead of Eyeglasses[2]	Up To $130.00
Necessary Contacts instead of Eyeglasses[3]	Up To $210.00

Discounts

Laser vision
UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

Additional Material
At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Contact Lens
Order extra contact lenses at uhccontacts.com for 10% off.

Hearing Aids
As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

Blue Light Protection Discount
UnitedHealthcare Vision has collaborated with industry partners to provide members with discounts off the retail price on blue-light screen filters for their devices. Members can learn more and access discount information by visiting their plan website.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify discounts with your provider.
[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at all in-network providers.
[3]Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Formulary.
- Patient lens options are subject to change.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130, or electronically through the online submission form on the plan website. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

READ YOUR PLAN CAREFULLY - THIS BENEFIT SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this

plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

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