UnitedHealthcare Vision Benefit Summary Plan 170

Benefits at a **Network Provider**

When you visit a network provider and receive these covered services….

Vision Exam	You will pay a $10 copay at the time of service.
Materials	You will pay a $25 copay at the time of service. The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses.
Pair of Lenses (for spectacles) ▪ Standard single vision ▪ Standard lined bifocal ▪ Standard lined trifocal ▪ Standard lenticular	Options, such as progressive lenses, polycarbonate lenses, tints, UV and anti-reflective coating, may be available at a discount. Standard scratch-resistant coating covered-in-full.
Frames	You will receive a $130 retail frame allowance towards the purchase of any frame at an in-network provider. Additionally, for materials cost that exceed the frame allowance; you may receive an additional 30% discount, available only at participating providers.
Contact Lenses[*] ▪ Covered-in-full elective contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for the most popular brands on the market. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UnitedHealthcare Vision's covered-in-full contact lenses may vary by provider.
▪ All other elective contacts	A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the UnitedHealthcare Vision's covered-in-full contacts (materials copay does not apply). Toric, gas permeable and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
▪ Necessary contact lenses[**]	Covered-in-full (after applicable copay)
Frequencies	Exam – Once every 12 months Lenses – Once every 12 months Frames – Once every 12 months

[*] *Contact lenses are in lieu of spectacle lenses and a frame.*

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

Benefits at a **Non-Network Provider**

When you visit a non-network provider, you will be reimbursed up to the non-network maximums:

Service	Amount	Service	Amount
Exam	Up to $40	Lenticular Lenses	Up to $80
Single Vision Lenses	Up to $40	Frames	Up to $45
Bifocal Lenses	Up to $60	Elective Contacts	Up to $105
Trifocal Lenses	Up to $80	Necessary Contacts**	Up to $210

Network Provider - Copays and non-covered patient options are paid to provider by program participant.

Non-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare Vision reimburses the customer for services rendered up to the maximum allowance. All receipts must be submitted at the same time. Copays do not apply to non-network benefits.

Important to Remember:

Network

• Always identify yourself as a UnitedHealthcare Vision customer when making your appointment. This will assist your provider in obtaining a claim authorization before your visit.

• Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Vision selection.

• Your contact lens allowance is applied to the fitting/evaluation fees, as well as the purchase of non-covered contact lenses. For example, if your allowance is $105 and the fitting fee and evaluation is $35, you will have $70 toward the purchase of non-covered contact lenses. Evaluation and fitting fees may vary among providers and type of fitting required.

• Patient options, such as UV coating, progressive lenses, etc., are not covered-in-full, but may be available at a discount.

Non-Network Claims

• Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Network and Non-Network Benefits

• Benefits are available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

• Benefits for contact lenses are in lieu of spectacle lenses and frames.

Choice and Access of Vision Care Providers

UnitedHealthcare Vision offers its vision program through a national network including both private practice and retail chain providers.

To access the Provider Locator service, visit our Web site at www.myuhcspecialtybenefits.com (then select vision) or call 1-800-839-3242, 24 hours a day, seven days a week.

Retain this UnitedHealthcare Vision Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

Customer Service is available toll-free at 1-800-638-3120 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.

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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, which 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 and cosmetic extras.

UnitedHealthcare Vision® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, 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 and associated COC form number VCOC.INT.06.TX.

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