UnitedHealthcare®

Vision Benefit Summary

www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan V1077

	NETWORK	NON-NETWORK
Comprehensive Vision Exam	$10 Copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$25 Copay[1]	See below
Frequencies - Based on last date of service	Exam Once every 12 months Lenses Once every 12 months Frames Once every 24 months	

COVERED SERVICES	NETWORK	NON-NETWORK
Pair of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay[1] Includes standard scratch-resistant coating	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay [1])	Up to $45
Contact Lenses[2]		
• Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting our website www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay [1])	Up to $125
• Non-selection contacts You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $125 (material copay is waived)	Up to $125
• Necessary contact lenses[4]	Covered in full after applicable copay[1]	Up to $210

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

[4] 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 eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneals/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

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Important to Remember:

Network

- Always identify yourself as a UnitedHealthcare 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 selection.
- Your contact lens allowance is applied to the fitting/evaluation fees, as well as the purchase of non-covered selection contact lenses. For example, if your allowance is $125 and the fitting fee and evaluation is $35, you will have $90 toward the purchase of non-selection contact lenses. Evaluation and fitting fees may vary among providers and type of fitting required. Your material copay is waived when purchasing non-selection contacts.
- Patient options, such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

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, visit our Web site at www.myuhcvision.com or call 1-800-839-3242, 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 www.myuhcvision.com.

Retain this UnitedHealthcare vision benefit summary which 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.

Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Non-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to non-network benefits. All receipts must be submitted at the same time. Written proof of loss should be given to the Company within 90 days after the date of the loss. 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.

Additional Materials Benefit

UnitedHealthcare offers an additional Materials Discount Program. At a participating network provider you will receive 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. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

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.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

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.TX and associated COC form number VCOC.INT.06.TX.