

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.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating<sup>1</sup> and the frame, or contact lenses in lieu of eye glasses.

<b>Copays for in-network services</b>	
Exam	\$ 0.00
Materials	\$ 0.00
<b>Benefit frequency</b>	
Comprehensive Exam	Every calendar year
Spectacle Lenses	Every calendar year
Frames	Every calendar year
Contact Lenses in Lieu of Eye Glasses	Every calendar year
<b>Frame benefit</b>	
Private Practice Provider	\$150.00 retail frame allowance
Retail Chain Provider	\$150.00 retail frame allowance
<b>Lens options</b>	
Standard scratch-resistant coating, standard basic and high-end progressive lenses, standard polycarbonate lenses, standard anti-reflective coating, UV, tints, photochromic, Transitions®, edge coating — covered in full from a network provider. (Discount varies by provider.)	
<b>Contact lens benefit</b>	
<p><b>Covered-in-full elective contact lenses</b> The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full. If you choose disposable contacts, up to 8 boxes are included when obtained from a network provider.</p> <p><b>All other elective contact lenses</b> A \$200.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.</p> <p><b>Necessary contact lenses<sup>2</sup></b> Covered in full after applicable copay.</p>	
<b>Additional materials discount</b>	
UnitedHealthcare Vision now 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. <sup>3</sup>	
<b>Out-of-network reimbursements (Copays do not apply)</b>	
Exam	\$40.00
Frames	\$45.00
Single Vision Lenses	\$40.00
Bifocal Lenses	\$60.00
Trifocal Lenses	\$80.00
Lenticular Lenses	\$80.00
Elective Contacts in Lieu of Eye Glasses <sup>4</sup>	\$200.00
Necessary Contacts in Lieu of Eye Glasses <sup>2</sup>	\$210.00
<b>Laser vision benefit</b>	
UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik <i>Plus</i> locations. For more information, call 1-888-563-4497 or visit us at www.uhclasic.com.	

**Important to Remember:**

- Benefit frequency based on a calendar year.
- Your \$200.00 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 \$30.00, you will have \$170.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- Medically 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 how much of a reimbursement you can expect to receive before you purchase such contacts.
- **Out-of-Network Reimbursement, when applicable:** 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, Attn. Claim Dept., P.O. Box 30978, Salt Lake City, UT 84130. Fax: 248.733.6060

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

<sup>1</sup> On all orders processed through a company owned and contracted Lab network.

<sup>2</sup> 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.

<sup>3</sup> Once all of your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision 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.

<sup>4</sup> The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company 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.

**Vision Benefit Card**

**UnitedHealthcare Vision®**

**Trinity Health High Plan**

Exam	once every calendar year
Lenses	once every calendar year
Frames	once every calendar year
Contacts*	once every calendar year
*(in lieu of lenses & frames)	

Exam Copay	\$0.00
Materials Copay	\$0.00

**To print a personalized ID card, please logon to our website and select 'Print ID card' from the member benefits page.**

# UnitedHealthcare Vision®

[www.myuhcvision.com](http://www.myuhcvision.com)

Customer Service: 1-800-638-3120

TDD for Hearing Impaired: 1-800-524-3157

Provider Locator: 1-800-839-3242