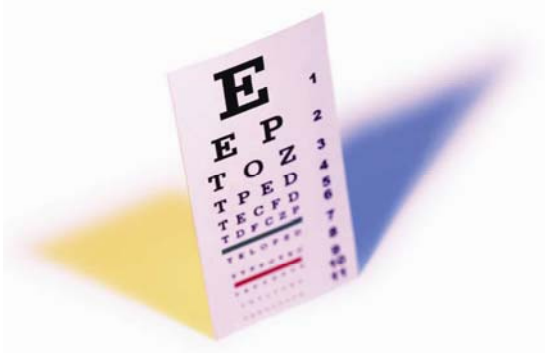


UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.



**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
- Frame
- Contact Lenses (in lieu of eyeglasses)
  - Elective
  - Necessary\*

**Copays for in-network services**

Comprehensive Exam	\$	10.00
Materials	\$	25.00

**Rates**

Employee Only	\$	7.38
Employee + Family	\$	17.72

**Benefit Frequency**

Comprehensive Exam	12 months
Spectacle Lenses	12 months
Frames	12 months
Contact Lenses (in lieu of eye glasses)	12 months

**Out of Network Reimbursement**

Network Copays do not apply

Comprehensive Exam	\$	40.00
<b>Lenses</b>		
Single Vision	\$	40.00
Bifocal	\$	60.00
Trifocal	\$	80.00
Lenticular	\$	80.00
Frames	\$	45.00
<b>Contact Lenses in lieu of eyeglasses</b>		
Elective	\$	125.00
Necessary*	\$	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.

**Frame Benefit**

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

Retail Chain Provider - \$130 retail frame allowance

**Network Contact Lens Benefit**

Covered-in-full 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 4 boxes are included when obtained from a network provider.

**Laser Vision Benefit**

United Healthcare 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

## SAMPLE ILLUSTRATION OF SAVINGS

Cost	Employee Only	Employee + Family**
Monthly Premium	\$7.38	\$17.72
Annual Premium	\$88.56	\$212.64
Approx. Pre-tax Savings (20%)***	\$17.71	\$42.53
Annual Tax-Adjusted Premium	\$70.85	\$170.11
Plus Copays	\$35.00	\$140.00
<b>Total Cost to Employee</b>	<b>\$105.85</b>	<b>\$310.11</b>

Exam and Materials Covered by UnitedHealthcare 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	\$105.85	<b>\$169.15</b>
<b>Employee + Family**</b>			
Exam, Single Vision, & Covered-in-full frames	\$1,100.00	\$310.11	<b>\$789.89</b>

\*\* 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 every 12 or 24 months (depending on the benefit frequency), based on last date of service.
- Your \$125 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 \$95 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 4 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.

- Lens Options such as progressive lenses, polycarbonate lenses, tints and 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 Attn. Claim Dept. P.O. Box 30978 Salt Lake City, UT 84130**

\* 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 reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

**Please note: Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations. If there are differences in this document and the Group Policy, the Group Policy is the governing document.**

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.

UnitedHealthcare Specialty Benefits offers a broad array of specialty insurance products, UnitedHealthcare Vision is underwritten by United HealthCare Insurance Company or United HealthCare Insurance Company of New York.. UnitedHealthcare Specialty Benefits is a brand of UnitedHealth Group, a Fortune 21 company.