



Benefit Summary Brochure

Customer Service: **800-638-3120**

Provider Locator: **800-839-3242**

www.myuhcvision.com

2011- 2012 School year WTU

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.

Copays for in-network services

Exam	\$0.00
Materials	\$0.00

Benefit frequency

Comprehensive exam	Every 12 months
Spectacle lenses	Every 12 months
Frames	Every 12 months
Contact lenses in lieu of eye glasses	Every 12 months

Frame benefit

Private practice provider	\$130.00 retail frame allowance, retail or private
Retail chain provider	\$130.00 retail frame allowance, retail or private

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. For those who choose disposable lenses, up to 6 boxes are included when obtained from a network provider.

Covered in Full In-Network Benefits (after applicable copays)

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.

Comprehensive Exam

Lenses	Contact Lenses (in lieu of eyeglasses)
Standard Single Vision Lenses	Elective
Standard Bifocal Lenses	Necessary ¹
Standard Trifocal Lenses	
Standard Lenticular Lenses	

Frame

Lens Options

Standard scratch-resistant coating, tints, UV, photochromic (including Transitions), polycarbonate, basic & high-end progressive lenses, and standard anti-reflective coating

Out-of-network reimbursements (Network Copays do not apply)

Comprehensive Exam	Up to \$25.00
Lenses	
Single Vision Lenses	Up to \$25.00
Bifocal Lenses	Up to \$30.00
Trifocal Lenses	Up to \$70.00
Lenticular Lenses	Up to \$70.00
Frames	Up to \$15.00
Elective Contacts in Lieu of Eye Glasses	Up to \$70.00
Necessary Contacts in Lieu of Eye Glasses ¹	Up to \$100.00

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. Call 1-888-563-4497 or visit www.uhclasik.com for more information.

Additional Materials Discount Program

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.²

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Only Exam, Single Vision & Covered-in-Full Frames	\$275.00 ⁴	\$0.00	\$275.00
Employee + Family³ Exam, Single Vision & Covered-in-Full Frames	\$1,100.00	\$0.00	\$1,100.00

¹ 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.

² 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.

³ For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

⁴ 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 months, based on last date of service.
- Your \$150.00 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 \$120.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you choose disposable contacts, you may receive up to 6 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 anti-reflective coating may be available at a discount.
- **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.

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 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.

