

**Vision Benefit Summary**

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

 Provider Locator: **800-839-3242**
[www.myuhcvision.com](http://www.myuhcvision.com)

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>Rates</b>	
Employee	\$5.77 Monthly
Employee + Spouse	\$10.73 Monthly
Employee + Child(ren)	\$13.41 Monthly
Employee + Family	\$18.75 Monthly
<b>Copays for in-network services</b>	
Exam	\$10.00
Materials	\$30.00
<b>Benefit frequency</b>	
Comprehensive Exam	Once every calendar year
Spectacle Lenses	Once every calendar year
Frames	Once every calendar year
Contact Lenses in Lieu of Eye Glasses	Once every calendar year
<b>Frame benefit</b>	
Private Practice and Retail Provider	\$130.00 retail frame allowance with additional 20% discount off amount that exceeds allowance
<b>Lens options and enhancements</b>	
<p><b>Covered in full lens options:</b> Standard scratch-resistant coating, Adult &amp; Child Polycarbonate lenses, and Gradient &amp; Solid Tints.</p> <p><b>Optional lens enhancements:</b> Standard Progressive \$70, Deluxe Progressive \$110, Premium Progressive \$150, Platinum Progressive \$250. Other optional lens upgrades at a discount 20% to 60%.</p>	
<b>Contact lens benefit</b>	
<p><b>Selection contact lenses - refer to our formulary contact list</b></p> <p>The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.</p> <p><b>All other elective contact lenses</b></p> <p>A \$130.00 allowance is applied toward the purchase of contact lenses outside the selection contact lenses (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our selection contacts formulary.</p> <p><b>Medically Necessary contact lenses</b> Covered in full after applicable copay.</p>	
<b>Out-of-network reimbursements up to (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>2</sup>	\$105.00
Necessary Contacts in Lieu of Eye Glasses <sup>3</sup>	\$210.00
<b>Laser vision benefit</b>	
<p>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 LasikPlus locations. For more information, call 1-888-563-4497 or visit us at <a href="http://www.uhclask.com">www.uhclask.com</a>.</p>	