



**Monthly Premium Deductions**

Employee	\$6.25
Employee + Spouse	\$11.32
Employee + Child(ren)	\$11.75
Employee + Family	\$18.11

**CHOICE AND ACCESS OF VISION CARE PROVIDERS**

UnitedHealthcare Vision offers its vision program through a national network including both private practice and retail optical providers. To access the provider locator service, please visit our website at [www.myuhcvision.com](http://www.myuhcvision.com), or call 1-800-839-3242, 24 hours a day, 7 days a week.

**Remember: You do not need a claim form or identification card to use this benefit.**

**In-network Services**

With UnitedHealthcare Vision, you are able to visit any provider you choose, but you maximize your savings when you visit a network provider.

**Copays for in-network services**

Comprehensive Exam	\$ 10.00
Materials	\$ 20.00

**Vision Benefit**

Exam once every	12 months
Lenses once every	12 months
Frames once every	24 months
Contacts* once every	12 months

*(in lieu of lenses & frames)Pair of Lenses (once every 12 months)	If prescribed, one pair of standard single vision or standard multi-focal lenses is covered-in-full
Lens Options	Standard scratch-resistant coating is covered-in-full. Lens options not covered by the plan, such as progressive lenses, polycarbonate lenses, high index, tints, UV and anti-reflective coating may be available at a discount
Frames (once every 24 months)	Receive a \$50 wholesale frame allowance applied toward the wholesale price of a frame at private practice providers, or a \$130 retail frame allowance at retail chain providers.
Contact Lenses in Lieu of Eyeglasses (once every 12 months)	<p>Covered –in-full elective contact lenses</p> <ul style="list-style-type: none"> <li>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 four boxes are included when obtained from a network provider.</li> </ul> <p>All other elective contact lenses</p> <ul style="list-style-type: none"> <li>A \$105.00 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.</li> </ul> <p>Necessary contact lenses</p> <ul style="list-style-type: none"> <li>Covered-in-full after applicable copay.</li> </ul>



**Out-of-Network Benefits**

If you choose an out-of-network provider, you will be reimbursed up to:

<b>Exam</b>	\$40.00
<b>Lenses</b>	
Single vision	\$40.00
Bifocal	\$60.00
Trifocal	\$80.00
Lenticular	\$80.00

<b>Frames</b>	\$45.00
<b>Contact Lenses in Lieu of Eyeglasses (lenses &amp; frame)</b>	
Elective	\$105.00*
Necessary**	\$210.00

\* Less any network fitting/evaluation fee.

\*\* 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 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 concerning the reimbursement that UnitedHealthcare Vision would make before you purchase such contacts.

If you visit an **out-of-network provider**, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

**UnitedHealthcare Vision  
 Claims Department  
 P.O. Box 30978,  
 Salt Lake City, UT 84130**

Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.