

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

# **Benefit Plan Year 2024**

UnitedHealthcare Vision has been trusted for more than 50 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.

Employee + Spouse   Sal 48   Employee + Childrom   Sal 29   Employee + Childrom   Sal 29   Employee + Childrom   Sal 20   Employee + Family   Sal 40   Expedies selected of Expediesses   Sal 40   Examigi   Sal 40   Examigi   Sal 40   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Contact lenses instead of Expediesses   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Contact lenses instead of Expediesses   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 40   Expediesses (Brease and frame)   Sal 20   Examigi   Sal 20   Exami	Rates(Monthly)	Exam with Materials		
Employee + Child(ren) \$13.36  Employee + Child(ren) \$10.36  Benefit Frequency  Comprehensive Exam(s) Once every 12 months  Eyedissa Lenses Once every 12 months  Eyedissa Lenses Once every 12 months  Connect Lenses instead of Eyedissass  Coneact Lenses instead of Eyedissass  Tin-Network Services  Copays  Exam(s) \$20.00  Eyedissase (lenses and frame) \$20.00  Eyedissase (lenses (lenses) \$		\$4.48		
Employee + Child(rem) \$10.36 Employee + Family \$14.50 Employee + Family \$14.50  Comprehensive Exam(s) Once every 12 months  Control Lenses instead of Eyeglasses Once every 12 months  Frames Conce every 12 months  In-Network Services  Copays  Exam(s) \$2.00  Evantis \$2.000  Contact Lenses instead of Eyeglasses \$2.000  Contact Lenses Extension Extensio		\$8.29		
Employee + Family  Benefit Frequency  Comprehensive Exam(s)  Comprehensive Exam(s)  Conce every 12 months  Eyeglass Lenses  Once every 12 months  Contact Lenses instead of Eyeglasses  Once every 12 months  Tenses  Contact Lenses instead of Eyeglasses  None every 12 months  Tenses  Contact Lenses instead of Eyeglasses  Exam(s)  Exam(s)  Exam(s)  Exam(s)  Eyeglasses (lenses and frame)  S 20.00  Eyeglasses (lenses and frame)  S 20.00  Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage!  Provate Provider  Fractic Provider  S 130.00 retail frame allowance  Retail Chain Provider  A 130.00 retail frame allowance  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cast with your provider prior to purchase.  Standard Scrittch Coating  S 14.  UV Coating  S 14.  UV Coating  S 14.  S 15.  S 14.  S 15.				
Comprehensive Exam(s) Eyeglass Lenses Once every 12 months Once every 12 months Once every 24 months Once every 24 months Once every 24 months  Trames Once every 24 months  Exam(c) Eyeglasses (lenses and frame) S 20.00  Contact Lenses instead of Eyeglasses S 20.00  Eyeglasses (lenses and frame) S 20.00  Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage' Private Practice Provider Retail Chain		\$14.50		
Eyeglass Lenses Once every 12 months Once overy 22 months Once overy 12 months  In-Network Services  Copays  Exam(e) Eyeglasses (lenses and frame) Services  Copays  Eyeglasses (lenses and frame) Services  Contact Lenses instead of Eyeglasses Frame Benefit - for frame sharefit - for frame that exceed the allowance, an additional 30% discount may be applied to the overage' Private Practice Provider Frame Benefit - for frame that exceed the allowance, an additional 30% discount may be applied to the overage' Private Practice Provider Retail Chain Provider Lens Options - this list highlights the discounted cost on our most popular lens potions. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating Soratch Warranty S10  Stratch Warranty S10  Stratch Warranty S10  Anti-Reflective Tier II S30  Anti-Reflective Tier II S30  Anti-Reflective Tier II S50  Anti-Reflective Tier II S50  Anti-Reflective Tier II S55  Progressive Tier II S55  Progressive Tier II S50  Anti-Reflective Tier II S50  Frogressive Tier II S50	Benefit Frequency			
Eyeglass Lenses Once every 12 months Once overy 22 months Once overy 12 months  In-Network Services  Copays  Exam(e) Eyeglasses (lenses and frame) Services  Copays  Eyeglasses (lenses and frame) Services  Contact Lenses instead of Eyeglasses Frame Benefit - for frame sharefit - for frame that exceed the allowance, an additional 30% discount may be applied to the overage' Private Practice Provider Frame Benefit - for frame that exceed the allowance, an additional 30% discount may be applied to the overage' Private Practice Provider Retail Chain Provider Lens Options - this list highlights the discounted cost on our most popular lens potions. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating Soratch Warranty S10  Stratch Warranty S10  Stratch Warranty S10  Anti-Reflective Tier II S30  Anti-Reflective Tier II S30  Anti-Reflective Tier II S50  Anti-Reflective Tier II S50  Anti-Reflective Tier II S55  Progressive Tier II S55  Progressive Tier II S50  Anti-Reflective Tier II S50  Frogressive Tier II S50		Once every 12 months		
Transmission   Tran		·		
In-Network Services	Frames	Once every 24 months		
Exam(s)   \$20.00	Contact Lenses instead of Eyeglasses	Once every 12 months		
Exam(s)   \$20.00	In-Net	work Services		
Exam(s) \$ 20.00  Eyeglasses (lenses and frame) \$ 20.00  Contact lenses instead of Eyeglasses \$ 20.00  Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage¹  Private Practice Provider \$ 130.00 retail frame allowance  Retail Chain Provider \$ 130.00 retail frame allowance  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating \$0  Scratch Warranty \$10  Trit \$14  UV Coating \$16  Photochronic \$67  Anti-Reflective Tier II \$50  Anti-Reflective Tier II \$50  Anti-Reflective Tier II \$50  Anti-Reflective Tier II \$55  Roll and Poish Edgas \$13  Progressive Tier II \$10  Progressive Tier IV \$200  Progressive Tier IV \$250  High Index (1.66-1.73) \$63  Progressive Tier IV \$250  Contact Lens Benefit* - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhovision.com.  Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lense opps is waived.  \$130.00				
Eyeglasses (lenses and frame) \$ 20.00 Contact lenses instead of Eyeglasses \$ 20.00 Contact lenses instead of Eyeglasses \$ 20.00 Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage¹ Private Practice Provider \$ 130.00 retail frame allowance Retail Chain Provider \$ 130.00 retail frame allowance  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating \$0 Scratch Warranty \$10 Vincotaing \$16 Vincotai		\$ 20.00		
Contact lenses instead of Eyeglasses  Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage'  Private Practice Provider  \$ 130.00 retail frame allowance  Retail Chain Provider  \$ 130.00 retail frame allowance  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating  \$ 10  Scratch Warranty  \$ 10  Trixt  \$ 14  UV Coating  \$ 16  Photochromic  Anti-Reflective Tier II  \$ 30  Anti-Reflective Tier II  \$ 550  Anti-Reflective Tier III  \$ 575  Anti-Reflective Tier IV  \$ 995  Roll and Polish Edges  \$ 13  Progressive Tier II  \$ 100  Progressive Tier IV  \$ 200  Progressive Tier IV  \$ 200  Progressive Tier IV  \$ 250  Progressive Tier IV  \$ 2500  Progre				
Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage' Private Practice Provider  Retail Chain Provider  Retail Chain Provider  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating  Scratch Warranty  \$10  Tint  UV Coating  \$16  Photochromic  \$67  Anti-Reflective Tier I  \$30  Anti-Reflective Tier III  \$75  Anti-Reflective Tier III  \$75  Anti-Reflective Tier III  \$55  Progressive Tier II  \$100  Progressive Tier III  \$150  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$300  Progressive Tier IV  \$300  Progressive Tier IV  \$300  Progressive Tier III  \$150  Progressive Tier III  \$150  Progressive Tier IV  \$200  Progressive Tier IV  \$300  Progressive Tier IV  \$400  Progressive Tier		· ·		
Private Practice Provider  Retail Chain Provider  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating  Socratch Warranty  S10  Stratch Warranty  S10  Wind Coating  Protochromic  Anti-Reflective Tier I  Anti-Reflective Tier II  Anti-Reflective Tier II  S50  Anti-Reflective Tier II  S75  Anti-Reflective Tier II  S75  Roll and Pollsh Edges  S13  Progressive Tier II  S55  Progressive Tier II  S10  Progressive Tier II  S10  Progressive Tier II  S55  Roll and Pollsh Edges  S13  Progressive Tier II  S10  Progressive Tier IV  S200  Progressive Tier IV  S200  Progressive Tier IV  S200  Progressive Tier IV  S250  High Index (1.66-1.73)  S63  Polycarbonate for Adults  Polycarbonate for Dependent Children  Contact Lens Benefit - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhovision.com.  Formulary Contact lenses An allowance is applied toward the purchase of contact lenses outside the formulary. A copy of the list can be found at myuhovision.com.  S130.00	· -	l ·		
Retail Chain Provider  Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating  \$0  Scratch Warranty  \$10  Tint  UV Coating  \$16  Photochromic  Anti-Reflective Tier II  \$30  Anti-Reflective Tier III  \$76  Anti-Reflective Tier III  \$76  Roll and Polish Edges  \$13  Progressive Tier II  \$100  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$250  High Index (-1.66)  #16] Index (-1.66)  #16] Index (-1.66)  #16] Index (-1.66)  #17] Index (-1.66)  #18] Index (-1.66)  #18] Index (-1.66)  #18] Index (-1.66)  #18] Index (-1.66)  #19] Index				
Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.  Standard Scratch Coating \$0 Scratch Warranty \$10 Tint \$14 UV Coating \$16 Photochromic \$67 Anti-Reflective Tier I \$30 Anti-Reflective Tier II \$50 Anti-Reflective Tier III \$50 Anti-Reflective Tier III \$75 Anti-Reflective Tier III \$75 Nord and Polish Edges \$13 Progressive Tier III \$100 Progressive Tier III \$100 Progressive Tier III \$100 Progressive Tier III \$100 Progressive Tier III \$150 Progressive Tier III \$150 Progressive Tier IV \$200 Progressive Tier IV \$200 Progressive Tier IV \$250 High Index (1.66-1.73) \$63 Polycarbonate for Adults \$33 Polycarbonate for Dependent Children \$0 Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact, up to 4 boxes are included when obtained from intwork provider.  If you choose disposable contacts, up to 4 boxes are included when obtained from intwork provider.  If you choose disposable contacts, up to 4 boxes are included when obtained from intwork provider.  If you choose disposable contacts, up to 4 boxes are included when obtained from intwork provider.  If you choose disposable contacts, up to 4 boxes are included when obtained from intwork provider.  If you choose disposable contacts, up to 4 boxes are included when obtained from intwork provider.  If you choose disposable contacts, up to 4 boxes are included when obtained from intwork provider.		· .		
Standard Scratch Coating \$0 Scratch Warranty \$10 Scratch Warranty \$10 Sind \$14 UV Coating \$16 Photochromic \$67 Anti-Reflective Tier I \$30 Anti-Reflective Tier II \$50 Anti-Reflective Tier II \$55 Anti-Reflective Tier III \$75 Anti-Reflective Tier III \$75 Roll and Polish Edges \$13 Progressive Tier II \$10 Sind Polish Edges \$13 Progressive Tier II \$10 Sind Polish Edges \$13 Sind Progressive Tier II \$10 Sind Polish Edges \$13 Sind Progressive Tier II \$10 Sind Polish Edges \$13 Sind Progressive Tier II \$10 Sind Polish Edges \$13 Sind Progressive Tier II \$10 Sind Polish Edges \$13 Sind Progressive Tier IV \$150 Sind Progressive Tier IV \$200 Sind Progressive Tier IV \$200 Sind Progressive Tier IV \$250 Si				
Scratch Warranty  State State Warranty  State Warranty  State State Warranty  State Warr				
Tint  UV Coating  Photochromic  \$67  Anti-Reflective Tier I  \$30  Anti-Reflective Tier II  \$50  Anti-Reflective Tier III  \$75  Anti-Reflective Tier IV  \$95  Roll and Polish Edges \$13  Progressive Tier I  \$100  Progressive Tier II  \$150  Progressive Tier III  \$150  Progressive Tier III  \$150  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$250  High Index (-1.66)  High Index (-1.66)  \$33  Polycarbonate for Adults  \$33  Polycarbonate for Dependent Children  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses  The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses  An allowance is applied toward the purchase of contact lenses outside the Formulary, he allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Standard Scratch Coating	\$0		
UV Coating Photochromic Sef7 Anti-Reflective Tier I Signor Anti-Reflective Tier II Seffective Tier III Seffective Tier III Seffective Tier IV Seffective Tier II Seffective Tier II Seffective Tier II Seffective Tier II Seffective Tier III Seffective Tier IV Seffect	Scratch Warranty			
Photochromic  Anti-Reflective Tier I  Anti-Reflective Tier II  \$50  Anti-Reflective Tier III  \$75  Anti-Reflective Tier IV  \$95  Roll and Polish Edges  \$13  Progressive Tier I  \$100  Progressive Tier II  \$100  Progressive Tier III  \$150  Progressive Tier III  \$150  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$200  Progressive Tier IV  \$250  High Index (<1.66)  \$53  High Index (<1.66)  \$33  Polycarbonate for Dependent Children  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lense copay is waived.	Tint	\$14		
Anti-Reflective Tier II \$30  Anti-Reflective Tier III \$55  Anti-Reflective Tier IV \$95  Roll and Polish Edges \$13  Progressive Tier I \$55  Progressive Tier II \$100  Progressive Tier III \$100  Progressive Tier III \$100  Progressive Tier III \$100  Progressive Tier IV \$200  Progressive Tier IV \$200  Progressive Tier IV \$250  High Index (<1.66) \$53  High Index (<1.66) \$53  High Index (<1.66) \$53  Polycarbonate for Adults \$33  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit* - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	UV Coating	\$16		
Anti-Reflective Tier III \$50  Anti-Reflective Tier IV \$95  Roll and Polish Edges \$13  Progressive Tier I \$55  Progressive Tier III \$100  Progressive Tier III \$100  Progressive Tier III \$100  Progressive Tier IV \$200  Progressive Tier IV \$200  Progressive Tier IV \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit <sup>2</sup> - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Photochromic	\$67		
Anti-Reflective Tier III \$75  Anti-Reflective Tier IV \$95  Roll and Polish Edges \$13  Progressive Tier I \$55  Progressive Tier II \$100  Progressive Tier III \$150  Progressive Tier III \$150  Progressive Tier IV \$200  Progressive Tier IV \$220  Progressive Tier IV \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit <sup>2</sup> - Formulary contact lenses refer to contact lenses available on our formulary contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Anti-Reflective Tier I	\$30		
Anti-Reflective Tier IV \$95  Roll and Polish Edges \$13  Progressive Tier I \$55  Progressive Tier II \$100  Progressive Tier III \$150  Progressive Tier III \$150  Progressive Tier IV \$200  Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Anti-Reflective Tier II	\$50		
Roll and Polish Edges  Progressive Tier I  Progressive Tier II  \$100  Progressive Tier IIII  \$150  Progressive Tier IV  \$200  Progressive Tier IV  \$220  Progressive Tier V  \$250  High Index (<1.66)  \$53  High Index (1.66-1.73)  \$63  Polycarbonate for Adults  \$33  Polycarbonate for Dependent Children  Contact Lens Benefit <sup>2</sup> - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses  The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses  An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Anti-Reflective Tier III	\$75		
Progressive Tier II \$55  Progressive Tier III \$100  Progressive Tier IV \$150  Progressive Tier IV \$200  Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$50  Contact Lens Benefit <sup>2</sup> - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary contact lenses  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lense copay is waived.	Anti-Reflective Tier IV	\$95		
Progressive Tier II \$100  Progressive Tier III \$150  Progressive Tier IV \$200  Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lense copay is waived.	Roll and Polish Edges	\$13		
Progressive Tier III \$150  Progressive Tier IV \$200  Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Progressive Tier I	\$55		
Progressive Tier IV \$200  Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.  \$130.00	Progressive Tier II	\$100		
Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	Progressive Tier III	\$150		
Progressive Tier V \$250  High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lense copay is waived.	Progressive Tier IV	\$200		
High Index (<1.66) \$53  High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lense copay is waived.	Progressive Tier V	\$250		
High Index (1.66-1.73) \$63  Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.	-	\$53		
Polycarbonate for Adults \$33  Polycarbonate for Dependent Children \$0  Contact Lens Benefit² - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.  \$33  Formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor formulary contact lenses not on this list are referred to as Nor fo				
Contact Lens Benefit <sup>2</sup> - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.  If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.  \$130.00				
Contact Lens Benefit <sup>2</sup> - Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Nor Formulary. A copy of the list can be found at myuhcvision.com.  Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.  If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.  \$130.00		<u> </u>		
The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.  Non-Formulary contact lenses  An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.		able on our formulary contact list. Contact lenses not on this list are referred to as Non-		
An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting and evaluation. Contact lens copay is waived.  \$130.00	The fitting/evaluation fees, contact lenses, and up to two follow-up visits are	If you choose disposable contacts, up to 4 boxes are included when obtained from an innetwork provider.		
	An allowance is applied toward the purchase of contact lenses outside the Formulary. The allowance is for materials. No portion will be applied to the fitting	\$130.00		
Necessary contact lenses³ Covered in full after copay (if applicable).	Necessary contact lenses³	Covered in full after copay (if applicable).		

## Children's and Maternity Eye Care Benefit

Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam 60 days after the initial exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

Out-of-Network Reimbursements (Copays do not apply)				
Exam(s)	Up To \$40.00			
Frames	Up To \$45.00			
Single Vision Lenses	Up To \$40.00			
Lined Bifocal and Progressive Lenses	Up To \$60.00			
Lined Trifocal Lenses	Up To \$80.00			
Lenticular Lenses	Up To \$80.00			
Elective Contacts instead of Eyeglasses <sup>2</sup>	Up To \$130.00			
Necessary Contacts instead of Eyeglasses³	Up To \$210.00			

# **Discounts**

#### Laser vision

UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at \$945 per eye for Traditional LASIK and \$1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com

### **Additional Material**

At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

#### **Contact Lens**

Order extra contact lenses at uhccontacts.com for 10% off.

### **Hearing Aids**

As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

UnitedHealthcare Vision has collaborated with Eyesafe® to provide members with a 20% discount off the retail price on blue-light screen filters for their devices. Members can receive the discount by visiting myuhcvision.com and clicking on the Eyesafe link.

Sample Illustration of Savings						
Cost	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family		
Monthly Premium	\$4.48	\$8.29	\$10.36	\$14.50		
Annual Premium	\$53.76	\$99.48	\$124.32	\$174.00		
Approx. Pre-Tax Savings (20%)⁴	\$10.75	\$19.90	\$24.86	\$34.80		
Annual Tax-Adjusted Premium	\$43.01	\$79.58	\$99.46	\$139.20		
Plus Copays	\$40.00	\$80.00	\$120.00	\$160.00		
Total Cost to Employee	\$83.01	\$159.58	\$219.46	\$299.20		

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan⁵	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Only Exam, Single Vision & Covered-in-Full Frames	\$275.00	\$83.01	\$191.99
Employee + Spouse Exam, Single Vision & Covered-in-Full Frames	\$550.00	\$159.58	\$390.42
Employee + Child(ren) <sup>6</sup> Exam, Single Vision & Covered-in-Full Frames	\$825.00	\$219.46	\$605.54
Employee + Family <sup>7</sup> Exam, Single Vision & Covered-in-Full Frames	\$1,100.00	\$299.20	\$800.80

<sup>&#</sup>x27;30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify discounts with your provider.

<sup>&</sup>lt;sup>2</sup>Contact lenses are instead of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at all in-network providers

Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

<sup>&</sup>lt;sup>4</sup>Actual tax savings will depend upon your individual tax bracket.

<sup>5</sup>Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail cost may vary by provider.

For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

<sup>&</sup>lt;sup>7</sup>For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

### Important to Remember:

#### In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- · Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Formulary.
- · Patient lens options are subject to change.

# **Choice and Access of Vision Care Providers**

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision com

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

READ YOUR PLAN CAREFULLY - THIS BENEFIT SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, 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.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

11/23 © 2023 United HealthCare Services, Inc. AEUA-LZCZ0 V1432 40718757-2-1-1-R-S 1/1/2022 1/1/2022-12/31/2024 NCA-03C (v5.5)

United Healthcare

Vision Benefit Card

**Rockwell Automation** 

Copays

Exam(s) \$20.00 Eyeglasses \$20.00 Contacts \$20.00

Powered by UnitedHealthcare Vision Network



myuhcvision.com

Customer Service & Provider Locator: (800) 638-3120 TDD for Hearing Impaired: (877) 735-2929