City of Amarillo

UnitedHealthcare Vision®

Benefit Summary Brochure

Customer Service: **800-638-3120**
Provider Locator: **800-839-3242**
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[1] and the frame, or contact lenses in lieu of eye glasses.

Rates	
Employee	$7.11 Monthly
Employee + Spouse	$13.29 Monthly
Employee + Child(ren)	$13.49 Monthly
Employee + Family	$20.81 Monthly
Copays for in-network services	
Exam	$10.00
Materials	$25.00
Benefit frequency	
Comprehensive Exam	Every 12 months
Spectacle Lenses	Every 12 months
Frames	Every 24 months
Contact Lenses in Lieu of Eye Glasses	Every 12 months
Frame benefit	
Private Practice Provider	$130.00 wholesale frame allowance(approximate retail value of $312.00-$390.00)
Retail Chain Provider	$130.00 retail frame allowance
Lens options	
Standard scratch-resistant coating, Basic Progressive lenses, Polycarbonate lenses, UV, Tints -- covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit	
Covered-in-full elective contact lenses 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 6 boxes are included when obtained from a network provider. **All other elective contact lenses** A $150.00 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. **Necessary contact lenses**[3] Covered in full after applicable copay.	
Out-of-network reimbursements (Copays do not apply)	
Exam	$45.00
Frames	$50.00
Single Vision Lenses	$50.00
Bifocal Lenses	$60.00
Trifocal Lenses	$80.00
Lenticular Lenses	$80.00
Elective Contacts in Lieu of Eye Glasses[2]	$150.00
Necessary Contacts in Lieu of Eye Glasses[3]	$210.00
Laser vision benefit	
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 www.uhclasik.com.	

Sample Illustration of Savings				
Cost	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Annual Premium	$85.32	$159.48	$161.88	$249.72
Approx. Pre-Tax Savings (20%)[4]	$17.06	$31.90	$32.38	$49.94
Annual Tax-Adjusted Premium	$68.26	$127.58	$129.50	$199.78
Plus Copays	$35.00	$70.00	$105.00	$140.00
Total Cost to Employee	**$103.26**	**$197.58**	**$234.50**	**$339.78**

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan[5]	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Exam, Single Vision & Covered-in-Full Frames	$275.00	$103.26	$171.74
Employee + Spouse Exam, Single Vision & Covered-in-Full Frames	$550.00	$197.58	$352.42
Employee + Child(ren)[6] Exam, Single Vision & Covered-in-Full Frames	$825.00	$234.50	$590.50
Employee + Family[7] Exam, Single Vision & Covered-in-Full Frames	$1100.00	$339.78	$760.22

[1] On all orders processed through a company owned and contracted Lab network.

[2] The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

[3] 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.

[4] Actual tax savings will depend upon your individual tax bracket.

[5] Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by provider.

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

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

Important to Remember:

- Benefit frequency 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, 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.
- 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 how much of a reimbursement you can expect to receive before you purchase such contacts.
- **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. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.

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

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.

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