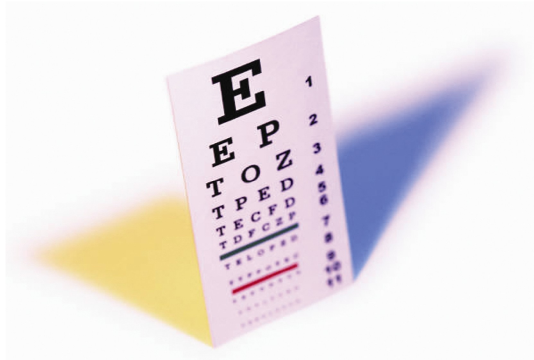
UnitedHealthcare Vision℠

Harford County Education Assoc.
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.

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

- Comprehensive Exam
- Lenses
  - Standard Single Vision
  - Standard Lined Bifocal
  - Standard Lined Trifocal
- Lens Options
  - Standard Scratch Resistant Coating
- Frame
- Contact Lenses (in lieu of eyeglasses)
  - Elective
  - Necessary^

Copays for in-network services

Comprehensive Exam	$	10.00
Materials	$	25.00

Benefit Frequency

Comprehensive Exam	12 months
Spectacle Lenses	12 months
Frames	24 months
Contact Lenses (in lieu of eye glasses)	12 months

Frame Benefit

Private Practice Provider- $50 wholesale allowance (approximate retail value of $120-$150)

Retail Chain Provider- $130 retail frame allowance

Network Contact Lens Benefit

Covered-in-full contact lenses in lieu of eyeglasses. The "covered-in-full" contact lens benefit at network providers includles fitting/evaluation, contacts, and two follow-up visits (after $25 copay). For those who choose disposable lenses, up to 4 boxes of "covered-in-full" contacts are included when obtained from a network provider. If a member chooses contacts outside of the "covered-in-full" selection, the $105 contact lens allowance will apply. When purchasing contacts that are outside of our "covered-in-full" selection, where the contact lens allowance applies, the materials copay does not apply.

Out of Network Reimbursement

Network Copays do not apply

Comprehensive Exam	$	40.00
Lenses		
Single Vision	$	40.00
Bifocal	$	60.00
Trifocal	$	80.00
Lenticular	$	80.00
Frames	$	45.00
Contact Lenses in lieu of eyeglasses		
Elective	$	105.00
Necessary ^	$	210.00

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.

UnitedHealthcare Vision℠
Vision Care Benefits

Copays	Exam	$	10.00
	Materials	$	25.00
Frequency	Exams		12 Months
	Lenses		12 Months
	Frames		24 Months
	Contacts		12 Months

(Contacts are in lieu of lenses and frames)

This card does not guarantee eligibility and benefits

Important to Remember:

• Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

• Your $105 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 $75 towards 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 4 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.

▪UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser correction providers. 1-877-28-SIGHT

• Standard Scratch-Resistant Coating is covered in full. Additional patient options that are not covered by the plan (such as Tints, UV Coating, Polycarbonate Lenses, Progressive Lenses) may be available at a discount.

• Out of Network Reimbursement: 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 Claims Department

PO Box 30978

Salt Lake City, UT 84130

Fax: (248) 733-6060

^ 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.

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 Specialty Benefits offers a broad array of specialty insurance products, UnitedHealthcare Vision is underwritten by United HealthCare Insurance Company or United HealthCare Insurance Company of New York.. UnitedHealthcare Specialty Benefits is a brand of UnitedHealth Group, a Fortune 21 company.

FOR MORE INFORMATION

Customer Service: 1.800.638.3120

Monday through Friday: 8:00 a.m. - 11:00 p.m. ET

Saturday: 9:00 a.m. - 6:30 p.m. ET

Provider Locator: 1.800.839.3242

TDD for the hearing impaired: 1.800.524.3157

Submit Out-of-Network Claims to:

UnitedHealthcare Vision Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

For more information about your UnitedHealthcare Vision plan, visit www.myuhcvision.com, or call Customer Service.