Montgomery County Gov't - VA

Benefit Plan Year 10/01/2016 - 09/30/2019

UnitedHealthcare

Vision Benefit Summary

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

myuhcvision.com

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.

In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eyeglasses.

Rates (Monthly)	Exam with Materials
Employee	$5.78
Employee + Spouse	$10.98
Employee + Child(ren)	$11.48
Employee + Family	$17.60
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Materials	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[2]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Standard Progessive Lenses,Mid Index < 1.60 - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider).	
Contact Lens Benefit[3]	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$125.00
Necessary contact lenses[4]	Covered in full after copay (if applicable).
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 Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[3]	Up to $125.00
Necessary Contacts in Lieu of Eyeglasses[4]	Up to $210.00

Discounts

Laser vision

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 standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.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.

Hearing Aids

As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

Sample Illustration of Savings

Cost	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly Premium	$5.78	$10.98	$11.48	$17.60
Annual Premium	$69.36	$131.76	$137.76	$211.20
Approx. Pre-Tax Savings (20%)[5]	$13.87	$26.35	$27.55	$42.24
Annual Tax-Adjusted Premium	$55.49	$105.41	$110.21	$168.96
Plus Copays	$10.00	$20.00	$30.00	$40.00
Total Cost to Employee	$65.49	$125.41	$140.21	$208.96

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan[6]	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Only Exam, Single Vision & Covered-in-Full Frame	$275.00	$65.49	$209.51
Employee + Spouse Exam, Single Vision & Covered-in-Full Frame	$550.00	$125.41	$424.59
Employee + Child(ren)[7] Exam, Single Vision & Covered-in-Full Frame	$825.00	$140.21	$684.79
Employee + Family[8] Exam, Single Vision & Covered-in-Full Frame	$1,100.00	$208.96	$891.04

[1] On all orders processed through a company owned and contracted lab network.
[2] 30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[3] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.
[4] 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 eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. 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.
[5] Actual tax savings will depend upon your individual tax bracket.
[6] Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail cost may vary by provider.
[7] For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.
[8] 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 selection.
- Your $125.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of non-selection contact lenses. For example, if your allowance is $125.00 and the fitting/evaluation fee is $35.00, you will have $90.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Evaluation and fitting fees may vary among providers and type of fitting required. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

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, 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.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
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 full fee 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. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. 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.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

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 or VPOL.13TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

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Vision Benefit Card

Montgomery County Gov't - VA

Copays

Exam(s)	$10.00
Materials	$0.00

To print a personalized ID card, please log on to our website and select 'Group/Plan' then select 'Print ID card' from the member benefits page.

UnitedHealthcare®

myuhcvision.com

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

TDD for Hearing Impaired: (877) 735-2929