Frederick County Public Schools

2017 - 2018

UnitedHealthcare®

Vision Benefit Summary

Customer Service: **1-800-638-3120**
Provider Locator: **1-800-839-3242**
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, eyeglasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating, standard AR, standard, deluxe and premium progressive lenses

	Adults	Children under 19
Copays for in-network services		
Exam	$0.00	$0.00
Materials	$0.00	$0.00
Benefit frequency		
Comprehensive Exam	Once every 12 months	Once every 12 months
Spectacle Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months	Once every 12 months
Frame benefit		
$0 - $150	$150 retail frame allowance	100% coverage
$151 - $180	Not covered	$15 copay
$181 - $220	Not covered	$30 copay
$221 - $270	Not covered	$50 copay
$271+	Not covered	60% covered
Lens options		
Standard Scratch-resistant coating, Standard AR, Standard, Deluxe and Premium Progressives - covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)		

Contact lens benefit in lieu of glasses	**Adults**	**Children under 19**
Covered-in-full elective contact lenses[4] 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 4 boxes are included when obtained from a network provider. **All other elective contact lenses** Your $150.00 contact lens allowance applies to the purchase of contact lenses. Your material copay is waived when purchasing non-selection contacts. **Necessary contact lenses**[3] Covered in full after applicable copay.		**Medical Pediatric Selection Contacts (12 month supply)** 50% covered **Non-selection contacts** 50% covered **Necessary contact lenses** 100% covered

Out-of-network (Copays do not apply)	**Adults**	**Children under 19**
Exam	Reimbursed up to $45.00	80% covered
Frames	Reimbursed up to $30.00	$0 - $130 20% covered $131 - $160 20% covered $161 - $200 20% covered $201-$250 20% covered $251+ 10% covered
Single Vision Lenses	Reimbursed up to $42.00	80% covered
Bifocal Lenses	Reimbursed up to $67.00	80% covered
Trifocal Lenses	Reimbursed up to $90.00	80% covered
Lenticular Lenses	Reimbursed up to $157.00	80% covered
Elective Contacts in Lieu of Eyeglasses[2]	Reimbursed up to $105.00	50% covered
Necessary Contacts in Lieu of Eyeglasses[3]	Reimbursed up to $221.00	25% covered
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 more than 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.		

Important to Remember:

- Benefit frequency based on last date of service.
- For adults your $150.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- You can log on to our website to print your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- 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. Claim Dept., P.O. Box 30978, Salt Lake City, UT 84130.
- At a participating network provider you will receive 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 Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.
- The pediatric selection as well as the covered-in-full elective contact lens benefit does not apply at Costco, Walmart or Sam's Club locations. The allowance for all other elective contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

[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 such as keratoconus, anisometropia, 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 reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

[4] Covered-in-full elective contact lens benefit does not apply at Costco, Walmart or Sam's Club locations. The allowance for all other elective contact lenses will be applied toward the fitting/evaluation fee and purchase of all 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; Workers' 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, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their 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.13.TX 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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