Anglican Church in
North America

UnitedHealthcare®

Vision Benefit Summary

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.

If you choose the Exam Only Benefit, you will receive a comprehensive vision exam benefit. If you choose the Exam and Materials Benefit, 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.

Copays for in-network services	**Exam Only Benefit**	**Exam and Materials Benefit**
Exam	$10.00	$10.00
Materials	N/A	$25.00
Benefit frequency		
Comprehensive Exam	Once every 12 months	Once every 12 months
Spectacle Lenses	N/A	Once every 12 months
Frames	N/A	Once every 24 months
Contact Lenses in Lieu of Eye Glasses	N/A	Once every 12 months
Frame benefit		
Private Practice Provider	N/A	$130.00
Retail Chain Provider	N/A	$130.00
Lens options		
The Exam and Materials Benefit includes coverage for standard scratch-resistant coating lenses covered in full. (Discount varies by provider.)		
Contact lens benefit[4] (applies for Exam and Materials Benefit Only)		
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 4 boxes are included when obtained from a network provider. **All other elective contact lenses** A $105.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). **Necessary contact lenses**[3] Covered in full after applicable copay.		

Out-of-network reimbursements (Copays do not apply)	**Exam Only Benefit**	**Exam and Materials Benefit**
Exam	$40.00	$40.00
Frames	N/A	$45.00
Single Vision Lenses	N/A	$40.00
Bifocal Lenses	N/A	$60.00
Trifocal Lenses	N/A	$80.00
Lenticular Lenses	N/A	$80.00
Elective Contacts in Lieu of Eye Glasses[2]	N/A	$105.00
Necessary Contacts in Lieu of Eye Glasses[3]	N/A	$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 Lasik***Plus*** 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 the Exam and Materials Benefit, your $105.00 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 $75.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- For the Exam and Materials Benefit, 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.
- 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. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.
- For the Exam and Materials Benefit, UnitedHealthcare Vision offers an Additional Materials Discount Program. 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.

[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] Coverage for Covered Contact Lens Selection 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.

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, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, 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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