

# Optional Vision Benefit

Personalize Your Coverage



Keep your family's vision health in sight by adding our optional Vision Benefit rider to your dental plan today. Our extensive vision care network includes – 24,000 private practice and retail chain providers.\* We'll help keep your family seeing clearly and with savings you will focus on!

## We're here to help you.

Use [www.myuhcvision.com/goldenrule](http://www.myuhcvision.com/goldenrule) to find a provider in your area, access your plan information, see your claim status, find general vision information, and more.

## UnitedHealthcare Vision Benefit Rider

You may use a non-network provider, but by staying in-network you are eligible to receive better discounts:

- Eye exam — \$10 copay – once every 12 months.
- Frames — \$25 copay – once every 24 months.
- Lenses — \$25 copay – once every 12 months
- Contacts in lieu of glasses — \$25 copay – once every 12 months.

### See how you can save by using our Vision network

Service/Material	You Pay	In-network We Pay	Out-of-network We Pay
Eye exam once every 12 months	\$ 10 copay	100%	Up to \$ 40
Frames <sup>2</sup> once every 24 months	\$ 25 copay <sup>1</sup>	100% <sup>2</sup>	Up to \$ 45
Single Vision lenses	\$ 25 copay <sup>1</sup>	100%	Up to \$ 40
Bifocal lenses	\$ 25 copay <sup>1</sup>	100%	Up to \$ 60
Trifocal or Lenticular lenses	\$ 25 copay <sup>1</sup>	100%	Up to \$ 80
Contacts <sup>3</sup> in lieu of glasses	\$ 25 copay	100% <sup>3</sup>	Up to \$105

<sup>1</sup> Purchase frames and lenses at the same time from a Preferred Provider and you pay only one copay.

<sup>2</sup> Frames chosen from the Covered Frames Selection at a Preferred Provider. For non-selection Frames, there is an allowance of \$50 wholesale or \$130 retail, depending on type of Preferred Provider. No copay with non-selection Frames.

<sup>3</sup> Contacts chosen from the Covered Contact Lens Selection at a Preferred Provider. Non-selection lenses will receive an allowance. No copay for non-selection Contact Lenses.

\*Network availability may vary by state, and a specific vision care provider's contract status can change at any time. Therefore, before you receive care, it is recommended that you verify with the vision care provider that he or she is still contracted with the network.

Policy Form SA-S-1384

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UnitedHealthOne 

## Covered Expenses

Subject to all policy provisions, the following vision expenses are covered:

- Comprehensive eye examinations. Benefits are limited to 1 exam per 12 months.
- Prescription eyewear. Benefits are limited to 1 pair of prescription single vision lenses per 12 months and 1 pair of frames per 24 months:
  - Spectacle lenses as prescribed by an ophthalmologist or optometrist; frames and their fitting and subsequent adjustments to maintain comfort and efficiency; or
  - Elective contact lenses that are in lieu of prescription spectacle lenses and frames; and
  - Medically necessary contact lenses and professional services when prescribed or received following cataract surgery or to correct extreme visual acuity problems that cannot be corrected with spectacle lenses.

Please Note: This vision benefit program is designed to cover vision needs rather than cosmetic extras. Cosmetic extras include: blended lenses, oversize lenses, photochromic lenses, tinted lenses except pink #1 or #2, progressive multifocal lenses, coating of a lens or lenses, laminating of a lens or lenses, frames that cost more than the plan allowance, cosmetic lenses, optional cosmetic processes, and UV (ultraviolet) protected lenses.

If you or your covered dependent select a cosmetic extra, the plan will pay the medically necessary costs of the allowed lenses and you or your covered dependent will be responsible for the additional cost of the cosmetic extra.

## Definitions

- **Comprehensive eye examination** means an examination by an ophthalmologist or optometrist to determine the health of the eye, including glaucoma tests and refractive examinations to measure the eye for corrective lenses.
- **Medically necessary** means a comprehensive eye examination or prescription eyewear that is necessary and appropriate to determine the health of the eye or correct visual acuity. This determination will be made by us based on our consultation with an appropriate licensed ophthalmologist or optometrist. A comprehensive eye examination or prescription eyewear will not be considered medically necessary if: (A) it is provided only as a convenience to the covered person or provider; (B) it is not appropriate for the covered person's diagnosis or symptoms; or (C) it exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment to the covered person.
- **Vision benefit preferred provider** is an ophthalmologist or optometrist who has contracted with the vision benefit network and is licensed and otherwise qualified to practice vision care and/or provide vision care materials.
- **Vision benefit non-preferred provider** is any ophthalmologist, optometrist, optician, or other licensed and qualified vision care provider who has not contracted with the vision benefit network to provide vision care services and/or vision care materials.

## How the Vision Program Works

Copayment, deductible amounts and coinsurance may differ when services are rendered and billed directly by a:

- A. Vision benefit preferred provider; or
- B. Vision benefit non-preferred provider.

We have a contract with a vision benefit network. Vision benefit preferred providers agree to discount their service fees. You or your covered dependents pay any applicable copayments, deductible amount or coinsurance. Vision benefit preferred providers then agree to accept our benefit payment as payment in full for covered expenses.

We do not have a contract with vision benefit non-preferred providers. You or your covered dependent must pay any applicable copayments, deductible amount or coinsurance. After satisfaction of applicable copayments, deductible amount or coinsurance benefits are limited up to the applicable allowance amount.

When the amount of actual charges exceeds the allowance amount, the vision benefit non-network providers may bill you or your covered dependent for the excess amount.

## Exclusions and Limitations:

No benefits are payable for the following vision expenses:

- Orthoptics or vision therapy training and any associated supplemental testing;
- Plano lenses (a lens with no prescription on it);
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear, required by an employer as a condition of employment;
- Corrective vision treatment of an experimental or investigative nature;
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK);
- Elective contact lenses if prescription spectacle lenses and frames are received in any 12 month period;
- Prescription spectacle lenses and frames if elective contact lenses are received in any 24 month period;
- Eyewear except prescription eyewear;
- Charges that exceed the allowance amount; and
- Services or treatments that are already excluded in the General Exclusions and Limitations section of the certificate or policy.

### List of CO Counties with No Participating UHC Vision Providers

Archuleta, Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Ouray, Park, Pitkin, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, Yuma