United Healthcare

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Please note: Consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations. If there are differences in this page description and the Group Policy, the Group Policy is the governing document.

Please Note: Member must be eligible at date of service to receive benefit.

In Network Coverage Frequency

Category	Benefit Eligibility	Frequency
Exam	Available	1 every 12 month(s)
Selection Contact Lens Fit	Available	1 every 12 month(s)
Non-Selection Contact Lens Fit	Available	1 every 12 month(s)
Frame	Available	1 every 24 month(s)
Lenses	Available	1 every 12 month(s)
Selection Contact Lenses - Daily Wear[1]	Available	Every 12 month(s)
Selection Contact Lenses - Monthly Wear[1]	Available	Every 12 month(s)
Non-Selection Contact Lenses[1]	Available	Every 12 month(s)

[1] Contact Lenses are in Lieu of Eyeglasses

In Network Coverage

Vision Care Services	Patient Responsibility (includes applicable copay)
Professional Services	
Exam	$0.00
Non-Selection Contact Lens Fit	100% of Billed Charges
Selection Contact Lens Fit	Covered-in-Full
Frames	
Frame	Balance over your $130.00 Benefit Allowance

Your frame allowance is applied toward the retail price of a frame at any network provider. If the frame costs less than the allowance, you have no additional out of pocket expense. If the frame costs more than the allowance, you are only responsible for the difference.

Lenses	
Lenses / Blended Bifocals	80% of Billed Charges
Lenses / Free-form SV Lenses	80% of Billed Charges
Lenses / MF Aspheric Lenses	80% of Billed Charges
Lenses / Occupational Double Seg Lenses	80% of Billed Charges
Lenses / Progressive Lenses: Tier 1 (Standard)	$70.00
Lenses / Progressive Lenses: Tier 2 (Deluxe)	$110.00
Lenses / Progressive Lenses: Tier 3 (Premium)	$150.00

Lenses / Progressive Lenses: Tier 4 (Platinum)	$250.00
Lenses / Progressive Lenses: Tier 5 (Non-formulary)	80% of Billed Charges
Lenses / Standard Lenses	Covered-in-Full
Lenses / SV Aspheric Lenses	80% of Billed Charges

Lens Materials

(Pricing shown is in addition to Patient Responsibility from Lens section above)	
High Index 1.67 - 1.73	$63.00
High Index less than or equal to 1.66	$53.00
High Index, >= 1.74	80% of Billed Charges
Polycarbonate Lenses	Covered-in-Full for Ages 0-18
Polycarbonate Lenses	$33.00 for Ages 19+

Lens Options

Edge Coating	80% of Billed Charges
Miscellaneous Lens Options	80% of Billed Charges
Non-Formulary Anti-Reflective Coating	80% of Billed Charges
One Year Scratch Warranty	$10.00
Oversize Lenses	80% of Billed Charges
Photochromic	$67.00
Platinum Anti-Reflective Coating	$90.00
Polarized	80% of Billed Charges
Polished Edges / Roll & Polish	$13.00
Premium Anti-Reflective Coating	$80.00
Scratch Coating	Covered-in-Full
Standard Anti-Reflective Coating	$40.00
Tint	Covered-in-Full
UV Coating	Covered-in-Full

Additional Lens Options not reflected on this list may be available at a discount, please see your provider for details.

Contact Lenses

Medically Necessary Contact Lenses[1]	Covered-in-Full
Non-Selection Contact Lenses[1]	Balance over your $200.00 Benefit Allowance
Selection Contact Lenses - Daily Wear[1]	Covered-in-Full for up to 8 Boxes

Selection Contact Lenses - Monthly Wear[1]	Covered-in-Full for up to 4 Boxes

Selection Contacts
Contacts (including disposables), the fitting/evaluation fees, and up to two follow-up visits are covered-in-full up to the maximum allowed in a benefit year. Coverage for Covered Contact Lens Selection does not apply to Costco, Walmart or Sam's Club locations. The allowance for Non-selection Contact Lenses will be applied toward the purchase of all contacts at these locations.

Non-Selection Contacts
Your allowance above is the total amount available per benefit year and is applied toward the purchase of contact lenses. The material copay does not apply. If your contacts are greater than the allowance, then you are only responsible for the difference.

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[1] Contact Lenses are in Lieu of Eyeglasses

Out of Network Coverage Frequency

(Out of network frequency follows your In network frequency schedule)

Category	Benefit Eligibility	Frequency
Exam	Available	1 every 12 month(s)
Frame	Available	1 every 24 month(s)
Progressive Lenses	Available	1 every 12 month(s)
Single Vision Lenses	Available	1 every 12 month(s)
Bifocal Lenses	Available	1 every 12 month(s)
Trifocal Lenses	Available	1 every 12 month(s)
Lenticular Lenses	Available	1 every 12 month(s)
OON Contact Lenses[1]	Available	Every 12 month(s)

[1] Contact Lenses are in Lieu of Eyeglasses

Out of Network Coverage

Vision Care Services	Patient Reimbursement (includes applicable copay)
Professional Services	
Exam + Refraction	Up to $63.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

Frames	
Frame	Up to $98.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

Lenses	
Bifocal Lenses	Up to $105.00
Lenticular Lenses	Up to $80.00
Progressive Lenses	Up to $105.00
Single Vision Lenses	Up to $75.00
Trifocal Lenses	Up to $130.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

Contact Lenses	
Medically Necessary Contact Lens[1]	Up to $210.00
OON Contact Lenses[1]	Up to $130.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

[1] Contact Lenses are in Lieu of Eyeglasses