City of Kenosha

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.

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.

| | |
|---|---|
| **Rates** | |
| Employee | $8.99 Monthly |
| Employee + Spouse | $17.08 Monthly |
| Employee + Child(ren) | $17.84 Monthly |
| Employee + Family | $27.52 Monthly |
| **Copays for in-network services** | |
| Exam | $10.00 |
| Materials | $25.00 |
| **Benefit frequency** | |
| Comprehensive Exam | Once every 12 months |
| Spectacle Lenses | Once every 12 months |
| Frames | Once every 24 months |
| Contact Lenses in Lieu of Eye Glasses | Once every 12 months |
| **Frame benefit** | |
| Private Practice Provider | $130.00 retail frame allowance |
| Retail Chain Provider | $130.00 retail frame allowance |
| **Lens options** | |
| Standard scratch-resistant coating – covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.) | |
| **Contact lens benefit** | |
| **Covered-in-full elective contact lenses**[2]<br>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 6 boxes are included when obtained from a network provider.<br>**All other elective contact lenses**<br>A $150.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.<br>**Necessary contact lenses**[3]<br>Covered in full after applicable copay. | |
| **Out-of-network reimbursements up to** (Copays do not apply) | |
| Exam | $40.00 |
| Frames | $45.00 |
| Single Vision Lenses | $40.00 |
| Bifocal Lenses | $60.00 |
| Trifocal Lenses | $80.00 |
| Lenticular Lenses | $80.00 |
| Elective Contacts in Lieu of Eye Glasses[2] | $150.00 |
| Necessary Contacts in Lieu of Eye Glasses[3] | $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 LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com. | |

**Sample Illustration of Savings**

| Cost | Employee | Employee + Spouse | Employee + Child(ren) | Employee + Family |
|---|---|---|---|---|
| Annual Premium | $107.88 | $204.96 | $214.08 | $330.24 |
| Approx. Pre-Tax Savings (20%)[4] | $21.58 | $40.99 | $42.82 | $66.05 |
| Annual Tax-Adjusted Premium | $86.30 | $163.97 | $171.26 | $264.19 |
| Plus Copays | $35.00 | $70.00 | $105.00 | $140.00 |
| **Total Cost to Employee** | **$121.30** | **$233.97** | **$276.26** | **$404.19** |

| Exam and Materials Covered by UnitedHealthcare Vision Plan | Estimated Cost Without a Vision Plan[5] | Less Employee Cost | Total Savings with UnitedHealthcare Vision |
|---|---|---|---|
| Employee<br>Exam, Single Vision & Covered-in-Full Frames | $275.00 | $121.30 | $153.70 |
| Employee + Spouse<br>Exam, Single Vision & Covered-in-Full Frames | $550.00 | $233.97 | $316.03 |
| Employee + Child(ren)[6]<br>Exam, Single Vision & Covered-in-Full Frames | $825.00 | $276.26 | $548.74 |
| Employee + Family[7]<br>Exam, Single Vision & Covered-in-Full Frames | $1,100.00 | $404.19 | $695.81 |

[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 of anisometropia; with certain conditions of keratoconus. 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] Actual tax savings will depend upon your individual tax bracket.

[5] Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by provider.

[6] For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

[7] For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

[8] Coverage for Covered Contact Lens Selection does not apply at 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.

**Important to Remember:**

- Benefit frequency based on last date of service.
- Your $150.00 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 $120.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to our website to print off 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.
- 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.

**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 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 and associated COC form number VCOC.INT.06.TX.

UnitedHealthcare®

UnitedHealthcare Vision℠

| TO BE COMPLETED BY BENEFITS OFFICE: | |
|---|---|
| Effective Date: | |
| Sub Code: | Client Code: |
| G/L Account: | |

# Vision Plan Enrollment Form

## I. Check the Appropriate Boxes

**Coverage Desired**

- ☐ Employee Only $ 8.99
- ☐ Employee + Spouse $17.08
- ☐ Employee + Child(ren) $17.84
- ☐ Employee + Family $27.52

- ☐ New Enrollment
- ☐ Qualifying Event
- ☐ Open Enrollment
- ☐ Cancel Coverage
- ☐ Waive Coverage
- ☐ No Change

**Qualifying Event Allowing Change**

- ☐ Marriage
- ☐ Newborn Child
- ☐ Other Insurance
- ☐ Death
- ☐ Divorce
- ☐ Last Name/Address Change
- ☐ Adoption/legal custody of child
- ☐ Legal custody of parent
- ☐ Dependent child married/reached age limit

## II. Employee Information (please print clearly):

Member SSN Number ____ - ____ - ____

Your Name _____
(First) (Middle Initial) (Last)

Birth Date ____/____/____

Address _____

_____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

## III. List All Eligible Family Members Below (if electing dependent coverage):

| | First and Last Name | SSN | Birth Date | Full Time Student? | Sex |
|---|---|---|---|---|---|
| Spouse | | - - | / / | not applicable | ☐M / ☐F |
| Child | | - - | / / | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | - - | / / | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | - - | / / | ☐ Yes ☐ No | ☐M / ☐F |
| Child | | - - | / / | ☐ Yes ☐ No | ☐M / ☐F |

*I agree to the above election in the vision plan for the plan year, with the exception of an approved, qualifying event.*

*Your Signature*_____ *Date*_____

Spectera, Inc. administers vision benefits underwritten by the following entities United HealthCare Insurance Company (except NY) and United HealthCare Insurance Company of New York (NY only).