

UnitedHealthcare Vision Plan

(Formerly Spectera Vision)

<http://www.myuhcvision.com>

Customer Service: 1-800-638-3120
 UnitedHealthcare Vision Hours: 7:00 a.m. to 10:00 p.m. Monday – Friday CST;
 8:00 a.m. to 4:30 p.m. CST Saturdays

Provider Locator: 1-800-839-3242

Provider: UnitedHealthcare Vision - UHCV (Formerly Spectera Vision)

Vision: Services must be obtained from a participating provider in order to receive In-Network benefits. Out-of-Network benefits provide a scheduled reimbursement.

Section 1.01 SUMMARY OF BENEFITS

(a) IN-NETWORK BENEFITS

Co-payments: \$10 Exam / \$10 Materials

Exam: Once every 12 months (from last date of service), after co-payment.

Lenses: Once every 12 months (from last date of service), after co-payment. Standard single vision lined bifocal and trifocal covered in full. All patient options including progressive lenses, UV coating, and tints are available at UHVC's preferred price, which is typically 20%-40% less than retail.

Frames: Once every 12 months (from last date of service), after co-payment. You receive a \$50 wholesale frame allowance (approximately retail value of \$120 - \$150) at private practice providers, or a \$130 frame allowance at retail chain providers.

Contact Lenses: Once every 12 months (from last date of service), after co-payment. In lieu of lenses and a frame, you may select contact lenses. UHVC covers a wide variety of contact lenses and disposable contact lenses from many leading manufacturers. Selection contact lens benefit includes evaluation/fitting fees, contacts and up to 2 follow-up visits. Or you can apply a \$105 allowance towards Non-Selection contact lenses and fitting/evaluation fees. Materials co-pay does not apply for Non-Selection contacts. Toric, gas permeable, and bifocal contacts are all examples of Non-Selection contacts.

You will be reimbursed up to:

Exam	\$40	Frames:	\$45
Lenses		Contacts:	
Single	\$40	Elective	\$105
Bifocal	\$60	Medically Necessary	\$210
Trifocal	\$80		
Lenticular	\$80		

<i>Vision 2008-2009</i>	<i>Per Paycheck 24 Pay Periods</i>	<i>Monthly Rate</i>	<i>Per Paycheck 18 Pay Periods</i>	<i>Monthly Rate</i>
Employee Only	3.87	7.74	4.73	9.46
Employee + Spouse	8.26	16.52	10.10	20.20
Employee + Child(ren)	6.62	13.24	8.09	16.18
Employee + Family	12.66	25.32	15.47	30.94

How to File an Out-of-Network Claim:

In order to receive reimbursement, all you need to do is submit the itemized paid receipt(s), along with the primary insured's unique identification number and patient's name and date of birth, to the following address:

UnitedHealthcare Vision
 P.O. Box 30978
 Salt Lake City, UT 84130
 Attention: Claims Department