UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

12/24/24 Vision Summary of Benefits

Summary of Benefits	Copayment
Exam	**$10**
Eyewear	**$10**
Frame Allowance or Contact Lenses	**$105**

Vision Care Benefits

As a special supplement to your UnitedHealthcare Health Plan, you and your family can now enjoy the advantages of vision care coverage.

Vision Care: $10 Copayment for exams
$10 Copayment for eyewear

Through an arrangement with Vision Service Plan (VSP), you are fully covered when you visit any of the over 4,000 VSP doctors for any of these services:

Vision Examinations: A complete analysis, every 12 months, of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Lenses: Every 24 months, the VSP Panel Doctor will order the proper lenses. The doctor verifies the accuracy of the finished lenses.

Frames: You are provided with an allowance of $105. This allowance provides coverage for a wide selection of frames. If you choose a frame that exceeds your plan's allowance, you will receive a 20 percent discount on the amount over your allowance. Have your doctor help you choose a frame based on your needs.

Contact Lenses: VSP offers Members preferred pricing and direct delivery on annual supplies of select brands of soft contact lenses. Even if you choose to use your benefit for glasses, you can still take advantage of this program. Visit **www.vsp.com** or ask your doctor for details.

You Select the Doctor of Your Choice

Contact Lenses: Contact lenses are furnished under the VSP Plan when the VSP doctor secures prior approval for the following conditions:

a. Following cataract surgery

b. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses

c. Anisometropia

d. Keratoconus

When VSP doctors receive approval for such cases, they are fully covered by VSP.

When Members choose contact lenses for other reasons, VSP will make an allowance toward their cost in lieu of all other benefits for that year.

Procedure for Using the Benefit

- In order to access vision care benefits, simply contact your VSP Doctor to make an appointment. If you need help locating a VSP Doctor, call 1-800-367-2660*, or visit **www.vsp.com**
- When calling the doctor's office for an appointment for you or your covered Dependents, identify yourself as a VSP patient. Indicate the organization that provides your benefits (Your employer, HMO, trust fund, etc.) and provide your VSP ID number. The VSP doctor will obtain the necessary authorization and information about your eligibility and coverage.
- When the examination has been completed, pay the Copayment(s) to the doctor for the services described herein. VSP will pay the Doctor directly according to its agreement with the doctor.

Complete Vision Examination Every 12 Months

- Selecting a doctor from the VSP list assures direct payment to the doctor and quality and cost control. However, if the Member seeks the services of doctor who is not a VSP Doctor, the Member should pay the doctor his or her full fee. The Member will be reimbursed in accordance with a reimbursement schedule.

There is no assurance that the schedule will be sufficient to pay for the examination or the glasses.

Reimbursement benefits are not assignable.

Note: When the Member obtains the services from a doctor who is not a VSP doctor and/or obtains glasses from a dispensing optician, the Member should be sure to send the itemized statement of charges to VSP along with the benefit form.

Exclusions and Limitations

Extra Cost. This plan is designed to cover your vision needs rather than cosmetic materials. If you select any of the following, there will be an extra charge:

- Blended lenses
- Contact lenses (except as noted)
- Oversize lenses
- Progressive multifocal lenses
- Photochromic lenses or tinted lenses other than Pink #1 or Pink #2
- Coated lenses
- Laminated lenses
- A frame that costs more than the plan allowance

Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses;
- Two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced 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.

Reimbursement for Services From an Out-of-Network Provider

If the Member chooses to receive services provided by an out-of-network doctor, the Member must pay that doctor's charges in full and then seek reimbursement from VSP as provided in the Reimbursement Schedule described below. Reimbursement is subject to VSP's determination of the Member's eligibility.

There is no assurance that the amounts shown on the Reimbursement Schedule will be sufficient to pay for the examination for eyeglasses or contact lenses. Reimbursement benefits are not assignable. The Member needs to mail a copy of the receipt and itemized statement of full payment that includes the eye examination, lens type and frame to VSP. The documents must include:

1. The Member's name and mailing address.
2. The Member's UnitedHealthcare of California identification number.
3. The Member's employer or group name.
4. The Patient's name, relationship to the Member and date of birth.

The data may be submitted on any generic insurance claim form available from your Non-Participating Provider.

All Claims for reimbursement must be submitted within six months of the completion of the services from which the claim is made.

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Reimbursement Schedule

Professional Fees

Vision Examination $35.00

Materials

Single Vision Lenses, up to $25.00

Bifocal Lenses, up to $40.00

Trifocal Lenses, up to $50.00

Lenticular Lenses, up to $100.00

Frames, up to $30.00

Necessary Contact Lenses $250.00

Cosmetic Contact Lenses $100.00 The Reimbursement Schedule set forth is based upon the provision of two lenses.

If only one lens is necessary, one-half of the reimbursement allowance will be paid.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-367-2660
711 (TTY)
www.uhcwest.com

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