cbia health connections VISION

UnitedHealthcare

12/12/12

Rates valid through December 2024

Voluntary Vision

	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Vision Exam	$15 copay	Up to $40
Materials: Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$30 copay[1]	See below
Frequencies: Based on last date of service	Exam: Once every 12 months Lenses: Once every 12 months Frames: Once every 12 months	
Pair of Lenses (for Eyewear)		
• Standard single vision lenses	Covered in full after applicable copay[1]	Up to $40
• Standard lined bifocal lenses		Up to $60
• Standard lined trifocal lenses	Includes standard scratch-resistant coating	Up to $80
• Standard lenticular lenses		Up to $80
Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.		
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay[1])	Up to $45
Contact Lenses[2]		
• **Covered contact lens selection** It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay[1])	Up to $105
• **Non-selection contacts** You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $105 (material copay is waived)	Up to $105
• **Necessary contact lenses[4]**	Covered in full after applicable copay[1]	Up to $210

Monthly Rates

Employee: $5.49 Employee & Spouse: $11.54 Employee & Children: $13.57 Family: $19.99

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Costco, 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.

[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneals/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

Eff. 1.1.19; Rev. 11.22

cbia health connections VISION

UnitedHealthcare

12/12/24

Rates valid through December 2024

Voluntary Vision

	IN-NETWORK	OUT-OF-NETWORK
Comprehensive Vision Exam	$15 copay	Up to $40
Materials: Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$30 copay[1]	See below
Frequencies: Based on last date of service	Exam: Once every 12 months Lenses: Once every 12 months Frames: Once every 24 months	
Pair of Lenses (for Eyewear)		
• Standard single vision lenses	Covered in full after applicable copay[1]	Up to $40
• Standard lined bifocal lenses		Up to $60
• Standard lined trifocal lenses	Includes standard scratch-resistant coating	Up to $80
• Standard lenticular lenses		Up to $80
Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.		
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay[1])	Up to $45
Contact Lenses[2]		
• **Covered contact lens selection** It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay[1])	Up to $105
• **Non-selection contacts** You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $105 (material copay is waived)	Up to $105
• **Necessary contact lenses[4]**	Covered in full after applicable copay[1]	Up to $210

Monthly Rates

Employee: $5.10 Employee & Spouse: $9.69 Employee & Children: $11.33 Family: $15.97

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Costco, 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.

[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneals/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

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CBIA Health Connections Voluntary Vision coverage provided by UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates.

Eff. 1.1.19; Rev. 11.22