Solstice Vision Plan SV 4
Summary of Benefits

BENEFIT FREQUENCY	
Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months

IN-NETWORK SERVICES

COPAYS	
Exam(s)	$10.00
Eyeglasses (lenses and frame)	$25.00
Contact lenses instead of Eyeglasses	$25.00

FRAME BENEFIT	
Frame allowance	$130.00

LENS OPTIONS (Covered in full with your plan)
Tints, Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19)

CONTACT LENS BENEFIT	
Elective contact lenses	
Formulary contact lenses- 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 4 boxes are included when obtained from an in-network provider
Non-Formulary contact lenses- An allowance is applied toward the purchase of contact lenses outside the Formulary. Contact lens copay is waived	$130.00
Necessary contact lenses[1]	Covered in full after copay (if applicable).

OUT-OF-NETWORK REIMBURSEMENTS (COPAYS DO NOT APPLY)

Exam(s)	Up to $40.00
Frames	Up to $45.00
Eyeglass lenses[2]	Up to $40.00 - $80.00
Elective Contacts instead of Eyeglasses	Up to $130.00
Necessary Contacts instead of Eyeglasses[1]	Up to $210.00

1. 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 frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.
2. Out-of-Network reimbursements for Eyeglass Lenses will vary by lens type: Single Vision up to $40, Lined Bifocal and Progressive up to $60, Trifocal up to $80, Lenticular up to $80.

IMPORTANT TO REMEMBER

IN-NETWORK

- Patient lens options which are not covered-in-full may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details.

CHOICE AND ACCESS OF VISION CARE PROVIDERS

Solstice Vision plans, powered by UnitedHealthcare, offers a vision program through national network including both private practice and retail chain providers. Please refer to your Certificate of Coverage for a full explanation of benefits. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - Participant pays all billed charges to the provider, and Solstice Vision plans, powered by UnitedHealthcare, reimburse the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

CUSTOMER SERVICE IS AVAILABLE TOLL-FREE AT (800) 638-3120
MONDAY - FRIDAY (FROM 8:00 A.M. - 11:00 P.M. ET), SATURDAY (FROM 9:00 A.M. - 6:30 P.M. ET)

DISCLAIMER

READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, 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, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA, or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher that if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.