UNITED HEALTHCARE VISION 2026

Member: **DUNELAND SCHOOL CORPORATION**

This benefit summary outlines your eligibility and benefit coverage

Please note: Consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations. If there are differences in this page description and the Group Policy, the Group Policy is the governing document.

Please Note: Member must be eligible at date of service to receive benefit.

In Network Coverage Frequency

Category	Benefit Eligibility	Frequency
Exam	Available	1 every 12 month(s)
Maternity Exam	Available	2 every 12 month(s)
Non-Selection Contact Lens Fit	Available	1 every 12 month(s)
Necessary Contact Lens Fit	Available	1 every 12 month(s)
Frame	Available	1 every 24 month(s)
Lenses	Available	1 every 12 month(s)
Non-Selection Contact Lenses[1]	Available	Every 12 month(s)
Maternity Replacement Frames	Available	1 every 24 month(s)
Maternity Replacement All Lenses	Available	1 every 12 month(s)

[1] Contact Lenses are in Lieu of Eyeglasses

In Network Coverage

Vision Care Services	Patient Responsibility (includes applicable copay)
Professional Services	
Exam	$10.00
Maternity Exam	$10.00
Necessary Contact Lens Fit	Covered-in-Full
Non-Selection Contact Lens Fit	Balance over your $30.00 Benefit Allowance
Frames	
Frame	Balance over your $150.00 Benefit Allowance

Your frame allowance is applied toward the retail price of a frame at any network provider. If the frame costs less than the allowance, you have no additional out of pocket expense. If the frame costs more than the allowance, you are only responsible for the difference.

Lenses	
Lenses / Blended Bifocals	80% of Billed Charges
Lenses / Free-form SV Lenses	80% of Billed Charges
Lenses / MF Aspheric Lenses	80% of Billed Charges
Lenses / Occupational Double Seg Lenses	80% of Billed Charges
Lenses / Progressive Lenses: Non-Formulary	80% of Billed Charges
Lenses / Progressive Lenses: Tier I	$75.00

Lenses / Progressive Lenses: Tier II	$120.00
Lenses / Progressive Lenses: Tier III	$170.00
Lenses / Progressive Lenses: Tier IV	$220.00
Lenses / Progressive Lenses: Tier V	$270.00
Lenses / Standard Lenses	$20.00
Lenses / SV Aspheric Lenses	80% of Billed Charges

Lens Materials

(Pricing shown is in addition to Patient Responsibility from Lens section above)

High Index 1.66 - 1.73	$63.00
High Index less than or equal to 1.66	$53.00
High Index, >= 1.74	80% of Billed Charges
Polycarbonate Lenses	Covered-in-Full for Ages 0-18
Polycarbonate Lenses	$33.00 for Ages 19+

Lens Options

Anti-Reflective Coating: Non-Formulary	80% of Billed Charges
Anti-Reflective Coating: Tier I	$30.00
Anti-Reflective Coating: Tier II	$50.00
Anti-Reflective Coating: Tier III	$75.00
Anti-Reflective Coating: Tier IV	$95.00
Chemistrie Clip	100% of Billed Charges
Edge Coating	80% of Billed Charges
Miscellaneous Lens Options	80% of Billed Charges
One Year Scratch Warranty	$10.00
Oversize Lenses	80% of Billed Charges
Photochromic	$67.00
Polarized	80% of Billed Charges
Polished Edges / Roll & Polish	$13.00
Scratch Coating	Covered-in-Full
Tint	$14.00
UV Coating	$16.00

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.

Contact Lenses

Necessary Contact Lenses [1]	$20.00
Non-Selection Contact Lenses[1]	Balance over your $150.00 Benefit Allowance

Your elective contact lens allowance is applied toward the purchase of contact lenses at a network provider. If your contacts cost less than the allowance, you have no additional out of pocket expense. If your contacts cost more than the allowance, you are only responsible for the difference.

[1] Contact Lenses are in Lieu of Eyeglasses

Out of Network Coverage Frequency

(Out of network frequency follows your In network frequency schedule)

Category	Benefit Eligibility	Frequency
Exam	Available	1 every 12 month(s)
Maternity Exam	Available	2 every 12 month(s)
Frame	Available	1 every 24 month(s)
Progressive Lenses	Available	1 every 12 month(s)
Single Vision Lenses	Available	1 every 12 month(s)
Bifocal Lenses	Available	1 every 12 month(s)
Trifocal Lenses	Available	1 every 12 month(s)
Lenticular Lenses	Available	1 every 12 month(s)
OON Contact Lenses[1]	Available	Every 12 month(s)
Maternity Replacement Frames	Available	1 every 24 month(s)
Maternity Replacement OON Bifocal Lenses	Available	1 every 12 month(s)
Maternity Replacement OON Lenticular Lenses	Available	1 every 12 month(s)
Maternity Replacement OON Progressive Lenses	Available	1 every 12 month(s)
Maternity Replacement OON Single Vision Lenses	Available	1 every 12 month(s)
Maternity Replacement OON Trifocal Lenses	Available	1 every 12 month(s)

[1] Contact Lenses are in Lieu of Eyeglasses

Out of Network Coverage

Vision Care Services	Patient Reimbursement (includes applicable copay)
Professional Services	
Exam + Refraction	Up to $40.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

Frames	
Frame	Up to $45.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

Lenses	
Bifocal Lenses	Up to $60.00
Lenticular Lenses	Up to $80.00
Progressive Lenses	Up to $60.00
Single Vision Lenses	Up to $40.00
Trifocal Lenses	Up to $80.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

Contact Lenses	
Necessary Contact Lens[1]	Up to $210.00

OON Contact Lenses[1]	Up to $125.00

Please note: Receipts must be submitted together at the same time for services and materials purchased on different dates to receive reimbursement. We will reimburse you for covered expenses according to the schedule shown above.

[1] Contact Lenses are in Lieu of Eyeglasses