

Group Vision Care Table of Benefits

Third Party Administrator: Spectera, Inc.

Claim Administrator: UnitedHealthcare Insurance Company, 6220 Old Dobbin Lane, Columbia, MD 21045. Telephone No. 1-800-839-3242

The following Services will be covered in full, subject to a Copayment, when obtained from Network Providers.

When obtaining these Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Copayment at a Network Provider" in the chart below.

When obtaining these Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

SERVICE	FREQUENCY OF SERVICE	COPAYMENT AT A NETWORK PROVIDER	NON-NETWORK BENEFIT
Routine Vision Examination or Refraction only in lieu of a complete exam	Once every 12 months	\$10.00	Up to \$40.00
Eyeglass Frames	Once every 24 months ¹	\$20.00 ² (100% of the billed charge to a maximum of \$130.00)	Up to \$45.00
Eyeglass Lenses	Once every 12 months ¹		
• Single Vision		\$20.00 ²	Up to \$40.00
• Bifocal		\$20.00 ²	Up to \$60.00
• Trifocal		\$20.00 ²	Up to \$80.00
• Lenticular		\$20.00 ²	Up to \$80.00
Contact Lenses	Once every 12 months ¹	\$20.00 (up to 4 boxes from the Covered Contact Lens Selection) ³	Up to \$105.00
• Necessary		\$20.00	Up to \$210.00

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
 - Standard Scratch-Resistant Coating

¹You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

²If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

³You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of \$105.00. No Copayment will apply to non-selection Contact Lenses. Coverage for Covered Contact Lens Selection will not apply at Walmart, Sam's Club and Costco locations. The allowance for Non-selection Contact Lenses will be used.