Carrier Name: United HealthCare

Plan Name: SL004

In-Network Eye Exam: $10

Out-of-Network Eye Exam: Up to $40.00

In-Network Single Vision Lens: $25

Out-of-Network Single Vision Lens: Up to $40.00

In-Network Lined Bi-Focal Lens: $25

Out-of-Network Lined Bi-Focal Lens: Up to $60.00

In-Network Lined Tri-Focal Lens: $25

Out-of-Network Lined Tri-Focal Lens: Up to $80.00

In-Network Lenticular Lens: $25

Out-of-Network Lenticular Lens: Up to $80.00

In-Network Contact Lens Allowance: $105.00

Out-of-Network Contact Lens Allowance: Up to $80.00

In-Network Frame Allowance: $100.00 retail frame allowance

Out-of-Network Frame Allowance: Up to $45.00

Exam Frequency: Once every 12 months

Lens Frequency: Once every 12 months

Frame Frequency: Once every 24 months

Out of Network Explanation: Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits.

Plan Year: 11/18

Network Name:

Member Website: myuhcvision.com

Customer Service Phone Number: (800) 638-3120