Routine Vision Examination Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for routine vision exams, as described below for Covered Persons over the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

UnitedHealthcare Insurance Company

William J Golden, President

Section 1: Benefits for Routine Vision Examinations

Benefits are available for Vision Care Services from a Spectera Eyecare Networks Network or out-of-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek payment from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Routine Vision Examinations.* Reimbursement will be limited to the amounts stated below.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits.*

Annual Deductible

Benefits for Vision Care Services provided under this Rider are subject to any Annual Deductible stated in the *Schedule of Benefits.* Any amount you pay in Co-payments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the *Schedule of Benefits.*

What Are the Benefit Descriptions?

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-insurance stated below.

Routine Vision Examination

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for the exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.

- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the internal eye.
- Visual Field testing.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Vision Care Service	**What Is the Frequency of Service?**	**Network Benefit - The Amount You Pay Based on the Contracted Rate**	**Out-of-Network Benefit - The Amount You Pay Based on Billed Charges**
Routine Vision Exam or Refraction only in lieu of a complete exam.	Once every 24 months.	$25 per exam. Not subject to payment of the Annual Deductible.	50% of the billed charge.

Section 2: Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Routine Vision Examinations,* Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Certificate.*

Section 3: Claims for Routine Vision Examinations

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek payment from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Routine Vision Examinations

To file a claim for reimbursement for Vision Care Services rendered by an out-of-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or an out-of-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.

- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate:*

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under this Rider.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service(s) - routine vision exams listed in this Rider in *Section 1: Benefits for Routine Vision Examinations.*