

UnitedHealthcare Vision 2024 Summary of Benefits and Coverage

We rely on our sight more than any other sense, and the Publix Group Vision Plan provides vision benefits at an affordable cost. This summary lists the most common covered services and materials, along with your share of the cost. The complete Schedule of Benefits, including the applicable exclusions and limitations are available by visiting the UnitedHealthcare Vision website. Visit publix.org and log in to PASSport to find associate pay period deductions for all coverage tiers and a link to the provider website, including a provider locator. You also may call UnitedHealthcare Vision toll-free at 1-800-815-8119. ID cards are not issued or needed to access benefits. You will need to provide your name, date of birth and nine-digit personnel number (including any necessary leading zeros) to make an appointment.

Network Provider² Patient Pays

Out-of-Network Provider³ Patient Pays

COMPREHENSIVE EYE EXAM¹

(once every calendar year)

\$10 copay – No deductible

Full charge less \$40 allowance

PAIR OF LENSES FOR EYEGLASSES⁴

(once every calendar year)

Standard single vision

\$15 copay – No deductible

Full charge less \$40 allowance

Standard lined bifocal

\$15 copay – No deductible

Full charge less \$60 allowance

Standard lined trifocal

\$15 copay – No deductible

Full charge less \$80 allowance

Standard lenticular

\$15 copay – No deductible

Full charge less \$80 allowance

Progressive (cosmetic option)

\$15 copay plus additional cost
(\$70 standard, \$110 deluxe or \$150 premium) –
No deductible

Full charge less approximately
\$60 allowance

FRAMES^{4,5}

(once every two calendar years)

\$0 – No deductible

Full charge less \$45 allowance

CONTACT LENSES

(in lieu of frames and lenses)

Covered elective contact lenses (includes

fitting/evaluation fees, up to eight boxes of contact lenses and up to two follow-up visits)

\$15 copay – No deductible

Full charge less \$200 allowance

All other elective contact lenses (allowance

is applied toward fitting/evaluation fees and purchase of contact lenses)⁶

Full charge less \$200 allowance

Full charge less \$200 allowance

Medically necessary contact lenses⁷

\$15 copay – No deductible

Full charge less \$210 allowance

LASER EYE SURGERY (LASIK)

15% discount off full charge or
5% discount off promotional price

No discount is offered

¹ Pregnant or breastfeeding women and children up to age 13 are eligible for a second eye exam each calendar year. If their vision prescription changes 0.5 diopter or more in a calendar year, they are eligible for a second pair of glasses (frames and lenses). The exam and materials copays still apply. The second pair does not include contact lenses or fittings.

² Providers located at competitors such as Costco, Target and Walmart are excluded from this plan even if they otherwise accept UnitedHealthcare Vision insurance.

³ When receiving services or materials from an out-of-network provider, you are responsible for paying the provider's full charge at the time of your visit. The allowances shown in this column are the maximum amounts you may be reimbursed upon filing a claim for benefits with UnitedHealthcare Vision, unless otherwise noted. If the provider's charge is less than the maximum allowance shown, you may be reimbursed only up to the provider's charge. Progressive lenses are shown with an approximate allowance, not a maximum allowance.

⁴ The \$15 copay applies to the entire purchase of eyeglasses (frames and/or lenses) from a network provider. Polycarbonate lenses for adults, polycarbonate lenses for children up to age 19 and standard scratch-resistant coating are covered in full with a network provider. Other lens options, such as tints, UV coating, anti-reflective coating and blue light protection, are available under the plan from a network provider for an additional cost. Prescription sunglasses are available from a network provider, in lieu of standard frames and lenses or contact lenses, at the \$15 copay plus an additional cost for tinting.

⁵ The UnitedHealthcare Vision benefit of \$130 applies to all frames in the network provider's office. If you wish to select a frame with a higher price (e.g. a designer frame), you are responsible for paying the provider a reduced cost for the frame.

⁶ The UnitedHealthcare Vision list of covered elective contact lenses is frequently updated. Contact your network provider to determine whether your contact lenses are included on this list.

⁷ Medically necessary contact lenses are prescribed at the doctor's discretion for one or more of the following conditions: following post cataract surgery without intraocular lens implant, to correct extreme vision problems that cannot be corrected with spectacle lenses, with certain conditions of anisometropia and with certain conditions of keratoconus. If your doctor considers your contacts medically necessary, ask your doctor to contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision may make before you purchase such contact lenses.

