

E & E Co., Ltd.
Summary of Benefits
Basic Life and AD&D Insurance



Effective Date	April 1, 2022
Eligibility	All Active Full Time Employees working a minimum of 30 hours per week.
Non-Contributory Basic Employee Life and AD&D Benefit	\$50,000
	Guarantee Issue Limit: \$50,000
	Please see the certificate of coverage for the complete Benefit Schedule.
Additional Benefits	
Waiver of Premium	If you become totally disabled your life insurance premium may be waived. See the certificate of coverage for details
Accelerated Death Benefit	If you are diagnosed as terminally ill you may receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.
Conversion	Included. Please see the certificate of coverage for provision details.
Benefit Reductions	Initial benefit age reduction is the percent of the face amount, any subsequent benefit age reductions are the percent of the original amounts.
Basic EE Life and AD&D	65% at age 65, 50% at age 70
	Coverage terminates at employee's retirement
Evidence of Insurability Requirements	
	Late Entrant (did not enroll within 31 days of eligibility): For Employee coverage, evidence of good health/insurability is required for any requested amount.

Important Details

This Summary of Benefits sheet is an overview of the Life Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

You must be Actively at Work with your employer on the day your coverage takes effect.

This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.

Annual Earnings are defined in UnitedHealthcare's contract with your employer.

Benefit Reduction Examples:

- 65% at age 65, 50% at age 70: Coverage reduces to 65% of the face amount at age 65; to 50% of the original amount at age 70.
- 65% at age 65, 45% at age 70, 25% at age 75: Coverage reduces to 65% of the face amount at age 65; to 45% of the original amount at age 70; to 25% of the original amount at age 75.

Exclusions:

AD&D Insurance does not cover losses caused by or contributed by:

Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft.*

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Value-Added Services (All features may not apply. Some states may have restrictions.)

Beneficiary Services: Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. For more information, call 866-302-4480.

- Toll-free line available 24/7 as well as referrals for face-to-face counseling. Specialists provide in-depth consultation, information and referral to community resources such as grief support groups. Includes access to a national network of credentialed clinicians for grief and loss counseling. Beneficiaries receive two complimentary sessions.**
- Financial and Legal Services. Telephonic access to financial consultants for assistance with financial decision-making. Includes access to a network of 22,000 attorneys for either a 30-minute telephonic or an in-person consultation. Clients may retain the same attorney for representation at a discounted rate. CLC, Inc. provides access to legal services.
- Communication Support. We provide a "Beneficiary Kit" with informational resources to help beneficiaries with the emotional and financial process that follows the loss of a loved one.

Wealth Management Account: An enhanced benefit payment process. Life claim proceeds in excess of \$5,000 will automatically be deposited into an OptumBank Wealth Management Account (WMA). Beneficiaries receive an FDIC-insured, beneficiary-owned, interest earning account with convenient access to their claim proceeds via debit card or checkbook.***

**Beneficiary Services offered through United Behavioral Health, a company of UnitedHealth Group.

***Eligibility for automatic deposit into an OptumHealth Bank Wealth Management Account is subject to qualifying conditions evaluated by OptumHealth Bank and UnitedHealthcare Specialty Benefits at the time of claim review to include limited availability in certain states. For more information please contact your Specialty Benefits representative. OptumHealth Bank, Member FDIC, is part of the financial services unit of OptumHealth, a health and wellness company serving more than 60 million people. OptumHealth is a UnitedHealth Group (NYSE:UNH) company.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI.

United HealthCare Services, Inc.®			Dental Plan	
Contributory Options PPO 20 / covered dental services			Custom/NEW_24536843/MAC	
	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50	\$0	\$0
Family Annual Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	\$1,500 per person per Calendar Year	\$1,500 per person per Calendar Year	\$1,500 per person per Lifetime	\$1,500 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	
COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs	100%	100%		
Lab and Other Diagnostic Tests	100%	100%		
PREVENTIVE SERVICES				
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)	100%	100%		
Sealants	100%	100%		
Space Maintainers	100%	100%		
BASIC SERVICES				
Restorations, Amalgams or Composite (Anterior & Posterior)	90%	90%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services	90%	90%		
Simple Extractions	90%	90%		
Oral Surgery (incl. surgical extractions)	90%	90%		
Periodontics	90%	90%		
Endodontics	90%	90%		
MAJOR SERVICES				
Inlays/Onlays/Crowns	60%	60%	See Exclusions and Limitations section for benefit guidelines.	
Dentures and Removable Prosthetics	60%	60%		
Fixed Partial Dentures (Bridges)	60%	60%		
ORTHODONTIC SERVICES				
Diagnose or correct misalignment of the teeth or bite	50%	50%		

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider. For a complete list of amounts, please refer to your Certificate of Coverage.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment, and
- D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

- 1 PERIODIC ORAL EVALUATION Limited to 2 times per Calendar Year.
- 2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per 60 month period.
- 3 BITEWING RADIOGRAPHS Limited to 1 series of films per 12 month period for members through the age of 17; 1 series of bitewings per 24 month period for members age 18 and over.
 - A - Periapical(s) - 4 single x-rays are covered per 12-month period
 - B - Covered at 2 series per 24-month period
- 4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
- 5 DENTAL PROPHYLAXIS Limited to 2 times per Calendar year.
- 6 FLUORIDE TREATMENTS Limited to covered persons under the age of 18 years, and limited to 2 times per consecutive 12 months.
- 7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- 8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- 9 RESTORATIONS (Amalgam or Composite) Limited to 1 time per 24 month period
- 10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
- 11 INLAYS, ONLAYS, AND VENEERS Covered only when a filling cannot restore the tooth. Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 7 year period per tooth for members age 12 and older if the tooth has extensive loss of natural tooth structure, due to decay or tooth fracture such that restoration cannot be used to restore the tooth.
- 12 CROWNS Limited to 1 time per 7 year period per tooth for members age 12 and older if the tooth has extensive loss of natural tooth structure, due to decay or tooth fracture such that restoration cannot be used to restore the tooth.
 - Crown Repair - A: Covered 1 time per 12-month period per tooth when the submitted narrative from the treating Dentist supports the procedure.
- 13 POST AND CORES Covered only for teeth that have had root canal therapy.
- 14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
- 15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per 36 months, if the tooth has a pocket depth of 4 millimeters or greater.
- 16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
- 17 PERIODONTAL MAINTENANCE Limited to 2 times per Calendar Year. Any combination of this procedure and dental cleanings, following active or adjunctive periodontal therapy, exclusive of gross debridement.
- 18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 20 RELINING AND REBASING DENTURES Covered 1 per 24-month period: when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and only 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).
- 21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments - Covered 2 times per 12-months period: When the denture is the permanent prosthetic appliance; and only after 6-months following initial placement of the denture.
 - Partial and Bridge Adjustment: Covered 2 times per 24-month period: When the partial or bridge is the permanent prosthetic appliance; and only after 6 months following initial placement of the partial or bridge.
 - Fixed Prosthetic Services(Bridge) Covered 1 time per 7 year period:
- 22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- 23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
- 24 FULL MOUTH DEBRIDEMENT Limited to 1 time per life time.
- 25 GENERAL ANESTHESIA Covered only when clinically necessary.
- 26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
- 27 PERIODONTAL SURGERY Only 1 complex surgical periodontal service is a benefit covered 36 month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater
- 28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 7 years per tooth for members age 12 and older if the tooth has extensive loss of natural tooth structure, due to decay or tooth fracture such that restoration cannot be used to restore the tooth.
- 29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

- 1 Dental Services that are not Necessary.
- 2 Hospitalization or other facility charges.
- 3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- 5 Any Dental Procedure not directly associated with dental disease.
- 6 Any Dental Procedure not performed in a dental setting.
- 7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- 8 Placement of dental implants, implant-supported abutments and prostheses.
- 9 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 10 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- 11 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- 12 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- 13 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- 14 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- 15 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- 16 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- 17 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- 18 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 19 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- 20 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 21 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situated in the state of Arizona, in order to comply with state regulations.
- 22 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- 23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- 24 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- 25 Foreign Services are not Covered unless required as an Emergency.
- 26 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- 27 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.



E & E Co., Ltd.

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

Exam with Materials		
Benefit Frequency		
	Comprehensive Exam(s)	Once every 12 months
	Eyeglass Lenses	Once every 12 months
	Frames	Once every 12 months
	Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services		
Copays		
	Exam(s)	\$ 25.00
	Eyeglasses (lenses and frame)	\$ 25.00
	Contact lenses instead of Eyeglasses	\$ 25.00
	Retinal Screening	\$ 39.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage) ¹		
	Private Practice Provider	\$130.00 retail frame allowance
	Retail Chain Provider	\$130.00 retail frame allowance
Lens Options		
	Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full.	
Contact Lens Benefit ²		
	Elective contact lenses Allowance is applied toward the purchase of contact lenses. Contact lens copay is waived.	\$130.00
	Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	\$40.00
	Necessary contact lenses³	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit		
	Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.	
Out-of-Network Reimbursements (Copays do not apply)		
	Exam(s)	Up to \$49.00
	Frames	Up to \$50.00
	Single Vision Lenses	Up to \$35.00
	Lined Bifocal and Progressive Lenses	Up to \$49.00
	Lined Trifocal Lenses	Up to \$74.00
	Lenticular Lenses	Up to \$80.00
	Elective Contacts instead of Eyeglasses ²	Up to \$105.00
	Contact Lens Fitting and Evaluation	Up to \$0.00
	Necessary Contacts instead of Eyeglasses ³	Up to \$250.00

Discounts

Laser vision

UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction providers. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at \$945 per eye for Traditional LASIK and \$1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

Additional Material

At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Hearing Aids

As a UnitedHealthcare vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHChearing.com. When placing your order use promo code MYVISION to get the special price discount.

¹30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.

²Contact lenses are instead of eyeglass lenses and/or eyeglass frames.

³Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient lens options which are not covered-in-full may be available at a discount at participating providers. 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. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.

Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program.

Please refer to your Certificate of Coverage for a full explanation of benefits.

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - 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. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

UnitedHealthcare®



Vision Benefit Card

E & E Co., Ltd.

Copays

Exam(s)	\$25.00		
Eyeglasses	\$25.00	Retinal Screening	\$ 39.00
Contacts	\$25.00		

Powered by UnitedHealthcare Vision Network



myuhcvision.com

Customer Service & Provider Locator: (800) 638-3120

TDD for Hearing Impaired: (877) 735-2929

To print a personalized ID card, please log on to our website and select 'Group/Plan' then select 'Print ID card' from the member benefits page.