

**Thank you for your interest in the Georgia State Lodge FOP
Endorsed Dental and Vision Plans.**

Enclosed you will find enrollment forms, highlights of the plans, and payment information. Members have the option of enrolling in the dental plan only, the vision plan only or both the dental and vision plans.

Be sure to fill in the forms completely. If you have questions while you are completing the forms contact the Doyle Rowe LTD Enrollment Hotline at 1-866-201-2524.

Choose your payment option. Monthly premiums are as follows:

	Dental Only	Vision Only	Both
Single	\$35.01	\$5.53	\$40.54
Single + One	\$68.08	\$13.79	\$81.87
Family	\$110.91	\$13.79	\$124.70

You may pay your premium via monthly bank draft or quarterly, semi-annual or annual check. If you choose to pay your premiums using a check, you must supply either Visa or Mastercard information as well. Your credit card will only be charged if your payment is not received by the 15th of the month in which it is due. If you choose to remit payment via quarterly, semi-annual or annual check please include your first payment. You will be billed 30 days before your next payment is due. **Please make checks payable to: Doyle Rowe LTD.** Be sure to write FOPUHC on the memo line. Bank drafts or credit card payments will appear as a payment made to Doyle Rowe LTD on your bank or credit card statement.

Applications received by the 20th of each month will become effective on the first of the next month, those received after the 20th will become effective on the first of the month following the next month, e.g. forms received on May 19 will become effective on June 1, those received on May 21 will become effective on July 1. Remember a one year enrollment is required.

You may visit www.myuhcvision.com to locate a provider, track claim status, trace an order or obtain answers to frequently asked questions.

Or

www.myuhcdental.com to find an in network dentist. Simply click the “dentist locator,” select Options PPO and enter your zip code. You may also track claim status, and access cost estimate tools using this site.

Please return your completed forms to:

**Doyle Rowe LTD
105 S. York Street, Suite 230
Elmhurst, IL 60126**

Again, please direct your questions to Doyle Rowe LTD at 1-866-201-2524.

United Healthcare Dental and Vision are privileged to offer benefits to the members of the Georgia State Lodge FOP. We look forward to providing you with quality, affordable dental and vision plans.



Premium Payment Option and Authorization

Last Name	First Name	Middle Initial
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Street	City	State	Zip
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Phone	Fax	E-mail
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Payment Option (Select One)

A. Financial Institution Debit Authorization - membership premium deducted from bank account:

Monthly Electronic Fund Transfer Type: Checking Savings

Account Holder Name: _____

Bank Account Number: _____

Bank Routing Number: _____

Account Owner Signature (if different than applicant) _____

B. Membership premium to be billed to my home address (select one). Make checks payable to Doyle Rowe LTD

Quarterly (first quarter premium enclosed)

Semi-Annually (first six months premium enclosed)

Annually (first years premium enclosed)

Those choosing to pay by check must supply a credit card number. Credit cards will *not* be charged unless payment is not received by the 15th of the month in which payment is due.

Credit Card Type (select one): Visa Mastercard

Name (as it appears on the card) _____

Credit Card Number _____

Expiration Date _____ / _____
Month/Year

I hereby authorize Doyle Rowe LTD to accept payment by monthly bank draft or quarterly, semi-annual or annual check for the plan(s) I have chosen to enroll in using a separate enrollment form. I understand that if I choose to pay by check, a valid credit card must remain on file and will be charged in the event that payment is not received within 15 days of the due date. I hereby authorize Doyle Rowe LTD to make recurring charges to the credit card listed above. This authority will remain in effect for a period of not less than one year from the effective date of coverage and thereafter until cancelled by written notice to Doyle Rowe LTD from me.

Signature

Date

UnitedHealthcare VisionSM

UnitedHealthcare has been trusted for more than 40 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.



Copays for in-network services

Comprehensive Exam	\$	10.00
Materials	\$	25.00

Rates

Employee Only	\$	5.80
Employee + Family	\$	14.48

Benefit Frequency

Comprehensive Exam	12 months
Spectacle Lenses	12 months
Frames	24 months
Contact Lenses (in lieu of eye glasses)	12 months

Out of Network Reimbursement

Network Copays do not apply

Comprehensive Exam	Up to \$40
Lenses	
Single Vision	Up to \$40
Bifocal	Up to \$60
Trifocal	Up to \$80
Lenticular	Up to \$80
Frames	Up to \$45
Contact Lenses in lieu of eyeglasses	
Elective	Up to \$150
Necessary ¹	Up to \$210

You do not need to submit a claim for In-Network benefits. However, you must submit a claim to UnitedHealthcare Vision for benefit reimbursement for Out-of-Network services.

Covered in Full (after applicable copays)

In-Network Benefits:

- Comprehensive Exam
- Lenses
 - Standard Single Vision
 - Standard Lined Bifocal
 - Standard Lined Trifocal
 - Standard Lenticular Lenses
- Contact Lenses (in lieu of eyeglasses)
 - Elective
 - Necessary¹
- Frame
- Lens Options
 - Standard Scratch Resistant Coating

Frame Benefit

- Private Practice Provider- \$50 wholesale allowance (approximate retail value of \$120-\$150)
- Retail Chain Provider- \$130 retail frame allowance

Network Contact Lens Benefit

Covered-in-full contact lenses in lieu of eyeglasses. The covered-in-full contact lens benefit at network providers includes fitting/evaluation, contacts, and two follow-up visits (after \$25 copay). For those who choose disposable lenses, up to 6 boxes are included when obtained from a network provider.

Additional Materials Discount Program

UnitedHealthcare Vision now offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses.²

UnitedHealthcare VisionSM

Vision Care Benefits

Copays Exam	\$	10.00
Materials	\$	25.00
Frequency	Exams	12 Months
	Lenses	12 Months
	Frames	24 Months
	Contacts	12 Months

(Contacts are in lieu of lenses and frames)

This card does not guarantee eligibility and benefits

SAMPLE ILLUSTRATION OF SAVINGS

Cost	Employee Only	Employee + Family ³
Monthly Premium	\$5.80	\$14.48
Annual Premium	\$69.60	\$173.76
Plus Copays	\$35.00	\$140.00
Total Cost to Employee	\$104.60	\$313.76

Exam and Materials Covered by UnitedHealthcare Vision's Vision Plan	Estimated Cost Without a Vision Plan ⁴	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Only			
Exam, Single Vision, & Covered-in-full frames	\$275.00	\$104.60	\$170.40
Employee + Family³			
Exam, Single Vision, & Covered-in-full frames	\$1,100.00	\$313.76	\$786.24

¹Necessary contact lenses are determined at the provider'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; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

²Once all of your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

³For purposes of this sample calculation, Employee + Family is calculated with four (4) members

⁴Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail costs may vary by provider.

Important to Remember:

- Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.
- Your **\$150** contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have **\$120** towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. If you choose disposable contacts, you may receive up to **6** boxes of disposable contacts (depending on prescription). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

UnitedHealthcare Vision has partnered with Laser Vision Network of America (LVNA) to provide our members with access to discounted laser correction providers. Call 1-888-563-4497 or visit www.uhclasik.com.

- Lens Options such as progressive lenses, polycarbonate lenses, tints and anti-reflective coating may be available at a discount.
- Out of Network Reimbursement: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address:

UnitedHealthcare Vision Attn. Claim Dept. P.O. Box 30978 Salt Lake City, UT 84130

Please note: Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations. If there are differences in this document and the Group Policy, the Group Policy is the governing document.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

FOR MORE INFORMATION

Customer Service: 1.800.638.3120

Monday through Friday: 8:00 a.m. - 11:00 p.m. ET

Saturday: 9:00 a.m. - 6:30 p.m. ET

Provider Locator: 1.800.839.3242

TDD for the hearing impaired: 1.800.524.3157

Submit Out-of-Network Claims to:

UnitedHealthcare Vision Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

For more information about your UnitedHealthcare Vision plan, visit

www.myuhcvision.com, or call Customer Service.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company 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 and associated COC form number VCOC.INT.06.TX.

Cost-saving illustration – glasses & contact lenses



Exam & glasses received at network private practice provider

Service received	UnitedHealthcare Vision plan	No plan
Routine eye exam*	\$10.00	\$60.00
Material copay	\$25.00	\$0.00
Designer frames (\$47 wholesale cost)**	\$0.00	\$141.00
Single vision lens	\$0.00	\$60.00
Standard scratch-resistant coating	\$0.00	\$27.00
Total due to provider for services	\$35.00	\$288.00
Annual premium***	\$68.80	\$0.00
Total annual out-of-pocket cost	\$138.80	\$288.00

For exam & glasses with optional upgrades received at network retail chain provider

Service received	UnitedHealthcare Vision plan	No plan
Routine eye exam*	\$10.00	\$60.00
Material copay	\$25.00	\$0.00
Designer frames (\$130 retail price at retail provider)**	\$0.00	\$130.00
Progressive lens, basic	\$70.00	\$219.00
Standard anti-reflective coating	\$40.00	\$70.00
Standard scratch-resistant coating	\$0.00	\$27.00
Total due to provider for services	\$145.00	\$506.00
Annual premium***	\$68.80	\$0.00
Total annual out-of-pocket cost	\$213.80	\$506.00

*Routine eye exam with refraction—Our plan cost is a typical copay. Your actual copay may vary from the illustration.

**The frame benefit is based on the wholesale cost at private practice providers and the retail cost at our retail providers to give the best value to our customers. The cost of the frames "without a plan" in the above examples is based on a \$47 wholesale cost marked up three times (for a retail cost of \$141) and a retail price of \$130. Frame mark-up varies by provider. If you select a frame with a higher wholesale/retail cost than your plan allowance, you will only pay the difference (plus any applicable materials copay).

***Annual Premium—based on an employee-only annual premium of \$86, minus the pre-tax savings of 20%. Individual tax savings will depend upon your tax bracket. Annual Premium cost will be prorated and deducted from pay cycle before taxes.

This information is a generalized savings illustration and is not reflective of any specific plan or provider costs. Your plan's premiums and copays may vary from the above example. The charges for services and materials without a plan may vary by provider. In the illustration above, charges for services without a vision plan were derived from internal data provided by our company-owned retail stores and contracted retail chains.

Covered-in-full contact lens benefit at a network retail provider

Service description	UnitedHealthcare Vision plan	No plan
Routine eye exam*	\$10.00	\$60.00
Material copay	\$25.00	\$0.00
Evaluation and fitting fees	\$0.00	\$85.00
Acuvue® 2 contact lenses, (four boxes at \$22 retail each)	\$0.00	\$88.00
Total due to provider for services	\$35.00	\$233.00
Annual premium***	\$68.80	\$0.00
Total annual out-of-pocket cost	\$103.80	\$233.00

Contact lens allowance benefit for lenses outside the covered-in-full selection at a network retail provider

Service description	UnitedHealthcare Vision plan	No plan
Routine eye exam*	\$10.00	\$60.00
Material copay	\$0.00	\$0.00
Evaluation and fitting fees	\$110.00	\$110.00
Acuvue Advance for Astigmatism (four boxes at \$44 retail each)	\$176.00	\$176.00
Contact lens allowance**	-\$150.00	\$0.00
Total due to provider for services	\$146.00	\$346.00
Annual premium***	\$68.80	\$0.00
Total annual out-of-pocket cost	\$214.80	\$346.00

*Routine eye exam with refraction — Our plan cost is a typical copay. Your actual copay may vary from the illustration.

**Contact Lens Allowance may vary by plan.

***Annual Premium — based on an employee-only annual premium of \$88, minus the pre-tax savings of 20%. Individual tax savings will depend upon your tax bracket. Annual Premium cost will be prorated and deducted from pay cycle before taxes.

This information is a generalized savings illustration and is not reflective of any specific plan or provider costs. Your plan's premiums and copays may vary from the above example. The charges for services and materials without a plan may vary by provider. In the illustration above, charges for services without a vision plan were derived from internal data provided by our company-owned retail stores and contracted retail chains.

UnitedHealthcare Vision®

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Visit us at
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