DIESELUSAGROUP® - INCORPORATED -	United Healthcare Vision Plan Year Effective January 1, 2016	
PLAN NAME	**Primary Plan**	
EXAM	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Exam	$10 Copay	Up to $40 reimbursement
LENSES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Single Vision	$20 Copay	Up to $40 reimbursement
Lined Bifocal	$20 Copay	Up to $60 reimbursement
Lined Trifocal	$20 Copay	Up to $60 reimbursement
Lenticular	$20 Copay	Up to $80 reimbursement
FRAMES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Retail Frame Allowance	Up to $130 reimbursement	Up to $45 reimbursement
Discount on Frame Overage at participating providers	30%	None
ELECTIVE CONTACT LENSES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Covered Selection Contacts	Up to 4 boxes	Up to $105 reimbursement
Non-Selection Contacts	Up to $105 reimbursement	Up to $105 reimbursement
Necessary Contact Lenses	100%	Up to $210 reimbursement
LENS OPTIONS	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Standard Scratch Resistant Coating	Covered in full	None
Other Lens Upgrades	Discount varies from 20% - 60% off retail pricing	None
BENEFIT FREQUENCY		
Exam	Once every 12 months	
Spectacle Lenses	Once every 12 months	
Frames	Once every 24 months	
Contact Lenses	Once every 12 months	
EMPLOYEE COST PER PAY PERIOD (26 PERIODS)		
Employee	**$2.60**	
Employee/Spouse	**$4.41**	
Employee/Child(ren)	**$4.62**	
Family	**$6.46**	

Note: This is a general summary of benefits. Please consult the certificate of coverage for complete details of the plan. If there is a discrepancy between this summary and the actual certificate will prevail.