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SEANC
SEIU LOCAL 2008

SEANC–State Employees Association of North Carolina

SEANC has partnered with Spectera Vision to deliver affordable, innovative vision care solutions. SEANC is proud to offer dual choice benefit plan designs to all SEANC members and their dependents. You must be a member of SEANC to enroll. For information on becoming a member, contact SEANC at 800-222-2758. Visit www.seanc.org or www.myspectera.com.

Covered Benefits	In-Network Benefit Plan Options		
	Standard Plan	**Enhanced Option 1**	**Enhanced Option 2**
Exams	**Once Every 12 Months**		
	100% with a $15 copay	100% with a $15 copay	100% with a $15 copay
Lenses	**Once Every 12 Months**		**Once Every 24 Months**
	$15 copay (applied to lenses and frame); 100% coverage for single vision, lined bifocal, trifocal and lenticular lenses	$25 copay (applied to lenses and frame); 100% coverage for single vision, lined bifocal, trifocal and lenticular lenses	$25 copay (applied to lenses and frame); 100% coverage for single vision, lined bifocal, trifocal and lenticular lenses
Frames	**Once Every 24 Months**		
	$15 copay (applied to lenses and frame); $130 frame allowance at retail chain providers or private practice providers	$25 copay (applied to lenses and frame); $130 frame allowance at retail chain providers or private practice providers	$25 copay (applied to lenses and frame); $130 frame allowance at retail chain providers or private practice providers
Contact Lenses [1, 2] in lieu of glasses	**Once Every 12 Months**		**Once Every 24 Months**
	Elective: $15 copay; allowance up to $150	Elective: $25 copay; allowance up to $150	Elective: $25 copay; allowance up to $125
Cosmetic Lens Options	Scratch resistant coating, Polycarbonate lenses for children up to age 19	Scratch resistant coating, Standard and Deluxe Progressives, Anti-Reflective Lenses, Edge Coating, Tints, Polycarbonate lenses, Photochromic, UV Coating	Scratch resistant coating, Standard and Deluxe Progressives, Anti-Reflective Lenses, Edge Coating, Tints, Polycarbonate lenses, Photochromic, UV Coating

Covered-in-full elective contact lenses
The fitting/evaluation fees, contact lenses and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to six boxes are included when obtained from a network provider (up to four are included for Enhanced Option 2).

All other elective contact lenses
An allowance is applied toward the fitting/evaluation fees and purchase of non-selection contact lenses (materials copay does not apply). Gas permeable and bifocal contact lenses are all examples of non-selection contacts.

Covered-in-full elective contact lens benefit does not apply at Costco, Walmart or Sam's Club locations. The allowance for all other elective contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

Necessary contact lenses[1]
Covered-in-full (after applicable copay)

Benefits at an OUT-OF-NETWORK Provider

Please note: 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 the date of service.

Exam	up to $40	Lenticular Lenses:	up to $80
Single Vision Lenses	up to $40	Frames:	up to $45
Bifocal Lenses	up to $60	Contacts:	up to $150 (elective)[3], up to $125 for Enhanced Option 2 (elective)[3]
Trifocal Lenses	up to $80	Contacts:	up to $210 (medical)[1]

1 Necessary 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 such as keratoconus, anisometropia, irregular corneal/astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

2 Your contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.

3 The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

At a participating network provider, you will receive 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 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.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

Spectera® Vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form VPOL.06.TX and associated COC form number VCOC.INT06.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

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Vision Plan Enrollment Form

1. Check the appropriate boxes

Coverage desired, monthly rates[1]		
Standard Plan Rates		
	☐ Employee Only	$6.74
	☐ Employee + One	$12.36
	☐ Employee + Family	$20.93
Enhanced Plan, Option 1		
	☐ Employee Only	$13.33
	☐ Employee + One	$24.39
	☐ Employee + Family	$41.34
Enhanced Plan, Option 2		
	☐ Employee Only	$12.29
	☐ Employee + One	$22.51
	☐ Employee + Family	$38.14

Effective Date:

Applications received in the SEANC home office by the 10th of the month will be effective the 1st of the following month.

These rates are effective until 12/31/2021.

Forms may be faxed to SEANC office: 1-919-792-3321 or mailed to:

ATTN: Insurance Department
1621 Midtown Place
Raleigh, NC 27609

You must be a member of SEANC to enroll.

For more information on becoming a member, call 800-222-2758 or visit www.seanc.org. After enrolling, visit www.myspectera.com for network provider search, benefits and claims information.

1 Rates are in effect until 12/31/2021

2. Employee Information (please print clearly):

Social Security Number: - -			SEANC#
Your Name:	First Name	Middle Initial	Last Name
Birth Date: / /	Gender: ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership	
Address:			
Home Phone: ( ) -		Work Phone: ( ) -	
Cell Phone: ( ) -		Personal email address:	

3. List all eligible family members below (if electing dependent coverage): Adult dependent children up to age 26.

	First Name	Last Name	Birth Date	Gender
Spouse			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F
Child			/ /	☐ M ☐ F

I agree to continue enrollment in the vision plan for a period of 12 months

☐ I authorize payroll/pension deduction for this insurance ☐ I authorize bank draft

☐ I prefer to have my premiums invoiced

I, the undersigned, hereby authorize my employer to deduct premiums for the SEANC Insurance identified above from my wages/pension or bank draft on a monthly basis, in such amounts as are currently established pursuant to the SEANC insurance contract with the provider, or in such adjusted amounts as may be established by SEANC and the provider by contract subsequent to the date of this authorization. This authorization shall continue until cancelled by me by written notice to the SEANC Central Office.

Your Signature Date