DRL
Doyle Rowe LTD

Thank you for your interest in the IMRF endorsed United HealthCare Vision plan. Please read carefully before completing your application

Page 1:
MEMBER INFORMATION: If you are the surviving spouse of an IMRF member use **YOUR** social security number and **YOUR** date of birth under member information.

COVERAGE SELECTION: Please check the applicable box. Retirees are considered employees for the purpose of this form. Note: if you are a surviving spouse, or a spouse only desiring coverage check the "Employee only" box. **Monthly vision plan rates are as follows: Individual $7.50, Retiree +1 $13.25, Family $21.70.**

FAMILY INFORMATION: Complete if your spouse, and/or dependent child is to be enrolled. Children must be unmarried and under age 26 to be eligible.

Other Vision Coverage Information: If you and/or your spouse or dependents are currently enrolled in another vision plan and are also going to enroll in the IMRF endorsed plan check the "yes" box and provide the information about the other carrier. Otherwise check the "no" box.

Please read the authorization carefully.

Page 2:
Please sign and date the application in the space provided.

The remainder of this page is for office use only.

Please note: Enrollment in the **United HealthCare Vision** plan requires a **one year commitment. Coverage will become effective on the first of the month following receipt of your application if received before the 25th of the month. If your application is received after the 25th of the month, coverage will become effective the first of the month after the month following receipt.**

Return completed forms to: **Doyle Rowe LTD 1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523.** Please contact Doyle Rowe LTD at 1-800-564-7227 with any questions. Thank you.

Sincerely,

Doyle Rowe LTD

ILLINOIS MUNICIPAL RETIREMENT FUND (IMRF)

UnitedHealthcare®

Vision Benefit Summary

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.

In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eyeglasses.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Twice every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Materials	$ 10.00
Retinal Screening	$ 39.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[2]	
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 Dependents - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider).	
Contact Lens Benefit[3] (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com)	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$125.00
Necessary contact lenses[4]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[3]	Up to $125.00
Necessary Contacts in Lieu of Eyeglasses[4]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.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 high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[1]On all orders processed through a company owned and contracted lab network.
[2]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[3]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[4] Necessary 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, 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.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $125.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

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, 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 full fee 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. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. 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 or VPOL.13TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.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.

Enrollment Form

Group Vision Care Insurance
Provided by United HealthCare Insurance Company

Requested Effective Date of Coverage __/__/____

Member Information

Social Security Number: _____ Date of Birth _____/_____/_____

Last Name:_____ First Name:_____ MI_____

Address:_____

City:_____ State_____ Zip Code_____

Home Phone:_____ Email Address:_____

Gender: ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Coverage Selection (Dollar amounts indicate monthly premium)

Plan Coverage (Check one): ☐ Employee Only $7.50 ☐ Employee + Spouse $13.25 ☐ Employee + Family $21.70

Family Information

First Name	MI	Last Name(if Different) SSN	DOB	Gender	Relationship

Other Vision Coverage Information

On the day the coverage begins will you, your spouse or any of your dependents be covered under any other vision care insurance plan or policy including another United HealthCare Insurance Company vision care insurance plan or Medicare? ☐ Yes ☐ No

Spouse Name: _____ Name of Other Carrier:_____

Dependent Name: _____ Name of Other Carrier:_____

Dependent Name: _____ Name of Other Carrier:_____

Dependent Name: _____ Name of Other Carrier:_____

I hereby declare that all the statements made above are, to the best of my knowledge and belief true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

The Certificate provides vision care insurance benefits only. Review your Certificate carefully.

(TURN OVER TO COMPLETE APPLICATION)

Fraud Warning Notice(s): Please review the notice that applies to your state.

{For applicants in Arkansas and West Virginia:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.}

{For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.}

{For applicants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.}

{For applicants in Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.}

{For applicants in Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.}

{For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties>}

{For applicants in New Mexico:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESNETS FALSE INFORMATINO IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PE**NALTIES.}**

{For applicants in Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud,}

{For applicants in Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.}

{For applicants in Oregon:
Any person who makes and intentional misstatement that is material to the risk may be fou nd guilty of insurance fraud by a court of law.}

{For applicants in the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

{For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.}

{For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.}

The undersigned wishes to enroll in the United HealthCare Vision plan and understands that a one year enrollment is required.

Applicant Signature **Date**

Organization Name: Illinois Municipal Retirement Fund Policy: GH49 Enrollee Effective Date ___/___/____

Please return enrollment form to and IMRF Premium Deduction Authorization to: Doyle Rowe LTD 1301 W. 22nd Street Suite 101 Oak Brook, IL 60523

Group vision care insurance products are underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut

Health Care Program Premium Deduction Authorization for IMRF-endorsed Plans

IMRF Form 7.10E (Rev. 08/2013)

- Please indicate which program you are **NEWLY** applying for by checking the appropriate box(es) below.
- Fill out the front page of this form only; the back page will be filled out by the plan administrator.
- **Please note**: All programs except for Sav-Rx **require additional applications**.
- **Return completed form to**: Doyle Rowe Ltd.,1301 W. 22nd Street, Suite 101, Oak Brook, IL 60523.
- **If you have any questions contact Doyle Rowe at 1-800-564-7227 or www.doylerowe.com**.

PLEASE PRINT OR TYPE

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	IMRF MEMBER ID OR LAST 4 DIGITS OF SSN

(If applicable) SPOUSE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR., SR., II, ETC.)

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	_____ - _____ - _____

HOME STREET (MAILING) ADDRESS

CITY, STATE, AND ZIP	DAYTIME TELEPHONE NUMBER (with Area Code)
	( )

To be completed by applicant. Please note that all programs except Sav-Rx require a separate application form. CHECK ONLY THE PLAN YOU ARE NEWLY ENROLLING IN.

Seniors Choice	☐ Individual	☐ Spouse	**Humana Local PPO**	☐ Individual	☐ Spouse	
United Health Care Medicare Complete	☐ Individual	☐ Spouse	**Humana Regional PPO**	☐ Individual	☐ Spouse	
Health Care Alliance HMO	☐ Individual	☐ Spouse	**Humana Group PDP Plan**	☐ Individual	☐ Spouse	
Health Care Alliance PPO	☐ Individual	☐ Spouse	**Sav-Rx Advantage Card**	☐ Individual	☐ Spouse	
Blue Cross Blue Shield of Illinois	☐ Individual	☐ Spouse	**Delta Dental of Illinois**	☐ Individual	☐ Spouse	☐ Family
Blue Cross Blue Shield of Texas	☐ Individual	☐ Spouse	**United Health Care Vision Plan**	☐ Individual	☐ Spouse	☐ Family

Member Authorization

I authorize and request the Illinois Municipal Retirement Fund (IMRF) to deduct premiums for the selected program(s) from my IMRF benefit payment and to remit the amount deducted to the health care program. I authorize IMRF to release information to the health care program in order to ensure proper handling of premiums. I understand IMRF will adjust deductions in response to changes in the premiums. I further understand that IMRF will cease making any deduction if the premiums exceed my IMRF benefit amount.
This authorization is not an assignment of my right to receive payment. This authorization will remain in effect with IMRF until cancelled by written notice from me or until IMRF is notified that a premium deduction is no longer required.

MEMBER SIGNATURE* _____ DATE (MM/DD/YYYY) _____

SPOUSE'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

***Member signs if member is receiving benefit payment; Spouse signs if spouse is receiving surviving spouse benefit or if spouse is enrolling in the Sav-Rx Advantage Card program.**

FOR IMRF USE ONLY	Date Entered	Date Effective

THIS PAGE TO BE COMPLETED BY PLAN ADMINISTRATOR

Plan Name	Plan Code	Member	Plan Code	Spouse	Coverage Effective
Seniors Choice					
Blue Cross Blue Shield of Illinois					
Blue Cross Blue Shield of Texas					
Health Care Alliance HMO					
Health Care Alliance PPO					
Humana Local PPO					
Humana Regional PPO					
Humana Group PDP Plan					
Sav-Rx Advantage Card					

Delta Dental of Illinois

PLAN CODE_____ Member_____ Coverage Effective Date _____

PLAN CODE_____ Spouse_____ Coverage Effective Date _____

PLAN CODE_____ Family_____ Coverage Effective Date _____

Delta Dental of Illinois (P)

PLAN CODE_____ Member_____ Coverage Effective Date _____

PLAN CODE_____ Spouse_____ Coverage Effective Date _____

PLAN CODE_____ Family_____ Coverage Effective Date _____

United Health Care Vision Plan

PLAN CODE_____ Member_____ Coverage Effective Date _____

PLAN CODE_____ Spouse_____ Coverage Effective Date _____

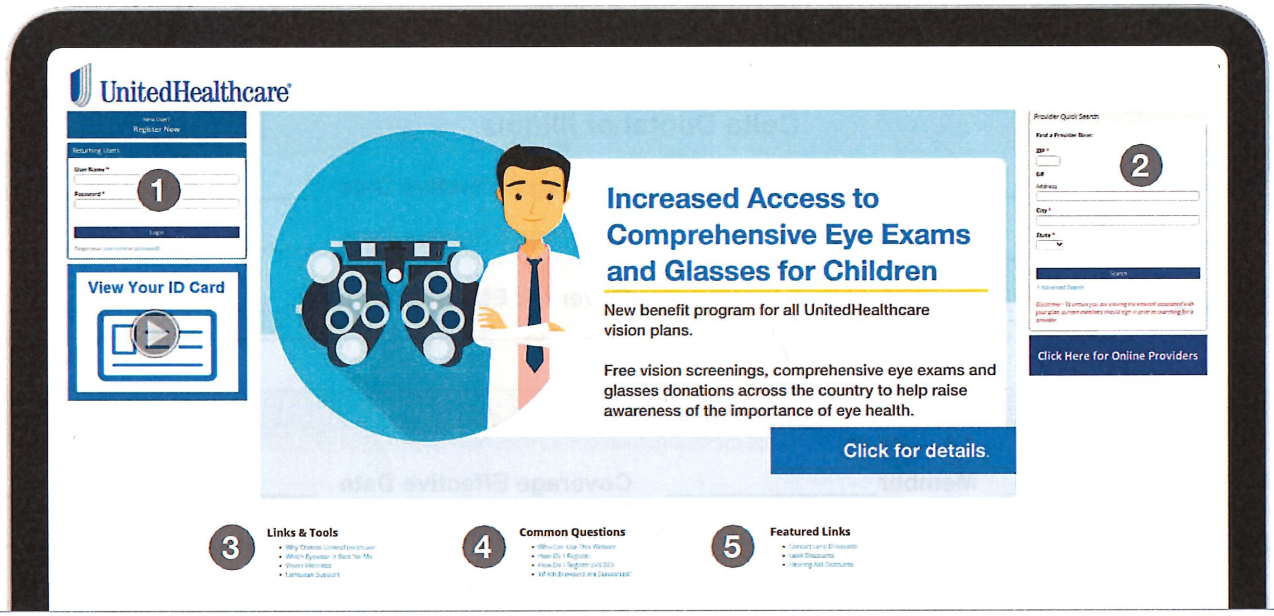
PLAN CODE_____ Family_____ Coverage Effective Date _____

Illinois Municipal Retirement Fund
2211 York Road Suite 500 Oak Brook, IL 60523-2337
Member Services Representatives 1-800-ASK IMRF (1-800-275-4673) Fax: (630) 706-4289
www.imrf.org

Discover myuhcvision.com.

Visit our easy-to-use self-service member website to:

- Verify benefits and eligibility.
- Print a member ID card.
- Locate a provider.
- Access online offers and services.
- Find answers to frequently asked questions.



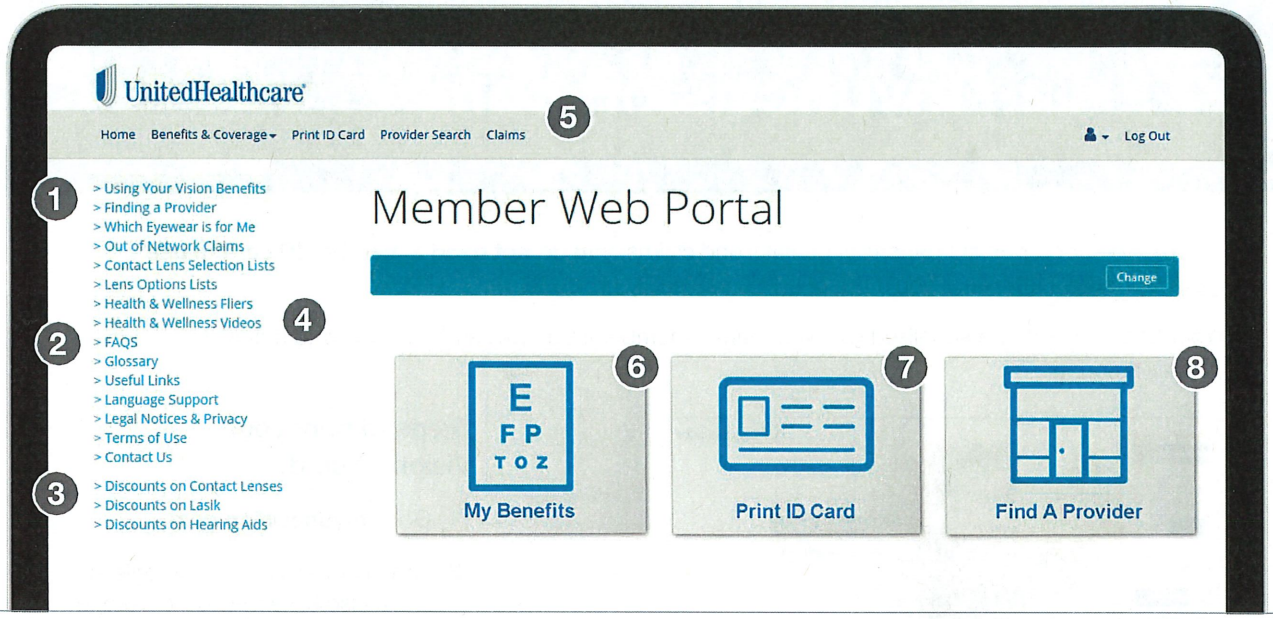
A few things to look for when you get there:

1. Access or registration to online plans.
2. Provider locator using your ZIP code or city and state.
3. Educational information and videos to help keep your eyes healthier.
4. Answers to common questions about using the website.
5. Links to special offers and other services.

CONTINUED

UnitedHealthcare

Learn how to make the most of your plan.



A few things to look for after you sign in:

1. Lens and contact lens coverage details.
2. Answers to frequently asked questions.
3. Special contact lens, Lasik and hearing aid offers:
4. Educational information and videos.
5. Claims status.
6. Benefits summaries.
7. Printable ID cards.
8. Provider locator using your ZIP code or city and state.

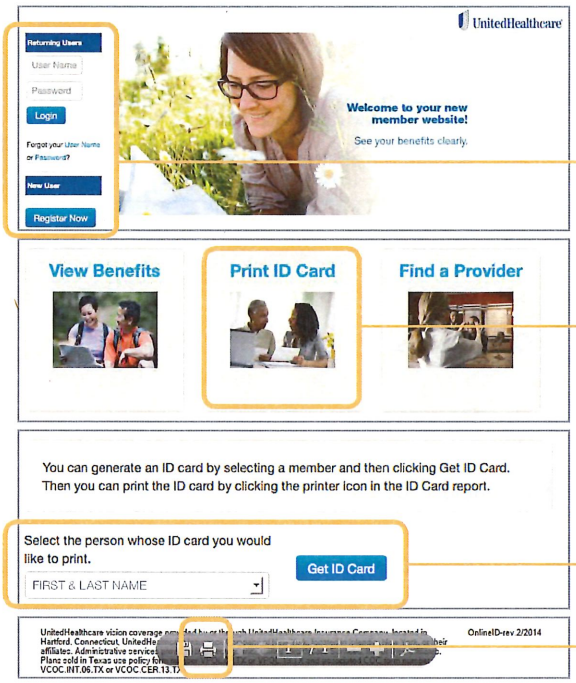
Call: 1-800-638-3120 | **Visit: myuhcvision.com**

UnitedHealthcare®

How to print your vision ID card using **myuhcvision.com**

Thanks to our convenient paperless benefits and claims, **you do not need a member ID card to use your benefits**. However, if you'd like one, you can easily print one.

Your ID card will be personalized with your name, member ID, as well as your exam and materials co-pay amounts.



Steps to print your Vision ID card:

1. Go to **myuhcvision.com**
2. Log in or register. Do not register if you also have medical coverage with UnitedHealthcare.
3. Click on "Print ID Card" If you do not see this option, click on the blue "Select" button next to your plan name.
4. From the drop down menu, select the person whose ID card you would like to print. Click on "Get ID Card."
5. This generates a document with your ID card called *How to Use Your Vision Care Benefits*. Scroll to the bottom of this document. A toolbar will appear; click on the printer icon to print.

Sample Personalized ID Card

UnitedHealthcare®

Member Name: [First, Last]
Member ID: [XXXXXXXXX-XX]
Member Web: www.myuhcvision.com
Customer Service: (800) 638-3120

Vision Identification Card

fold here

Vision Care Benefits
Exam Copay: [$XX.XX]
Material Copay: [$XX.XX]

Submit Out-of-Network Claims to:
UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Note to Providers:
For more information about this UnitedHealthcare Vision plan, please visit us online at www.Spectera.com or call 1-800-638-3120.

UnitedHealthcare®

100-10442 11/15