Zone 9 - Iowa, Louisiana, Massachusetts, New Mexico, Pennsylvania, Virgin Islands

For groups with effective dates **07/01/2020 - 09/30/2020**

UnitedHealthcare
Vision Plans

For Groups with 2-100 Employees

Our vision plans deliver more for less.

For over 50 years, we've been offering flexible vision coverage with an integrated approach to wellness to more than 18 million members. With over 100,000 retail and private providers in our network, it's easy and convenient for our members to take advantage of their benefits.

Clear benefits and value.

- Routine eye exams
- Complete sets of eyeglasses or contacts
- Polycarbonate lenses for dependent children
- For diabetics: a second exam and $0 retinal screening photography
- For children under 13: a second exam and new frames and lenses if their prescription changes by at least .5 diopter

Access to exclusive discounts.

- 15% off standard laser vision correction prices or 5% off promotional prices at any in-network surgeon
- Discounts on extra pairs of eyewear
- 20%-40% discount on popular lens options
- Preferred pricing on premium hearing aids
- 10% off contact lenses ordered through uhccontacts.com

Plan and wellness support.

- Toll-free customer service with evening and weekend hours
- Online benefit and claims information
- Online and telephonic wellness support

Here's an example of how our members save:

Vision Service	Without our plan	With our plan
If you prefer glasses:		
Routine eye exam	$60	$10
Glasses (frames and lenses) copay	$0	$25
Frames	$130	$0
Standard progressive lenses	$219	$70
Standard anti-reflective coating	$70	$40
Standard scratch-resistant coating	$27	$0
Annual premium	$0	$68
Total cost	**$506**	**$213**
If you prefer contact lenses:		
Routine eye exam	$65	$25
Fitting at example provider	$65	$35
Materials (contact lenses)	$136	$31
Total cost	**$266**	**$91**

NOTE: This is a sample savings chart. It does not show specific plan designs or vision provider costs. This example reflects a $130 frame allowance, $105 contact lens allowance and $30 contact lens fitting allowance. Plan allowance and copayments may be different. The following states: WA, MT and PR will not include a contact lens benefit with two allowances. These states will have an allowance for the purchase of contact lenses only.

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Zone 9 - Iowa, Louisiana, Massachusetts, New Mexico, Pennsylvania, Virgin Islands

For groups with effective dates **July 01, 2020 - September 30, 2020**

Contribution Plan Number	Exam/Lenses*/ Frames (months)	Copay	Frame Allowance	Contact Lens Allowance	Fit/Eval Allowance	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Employer Paid									
S1026	12/12/24	$15/$30	$130	$ 105	$ 30	$4.30	$8.16	$9.57	$13.47
SL004	12/12/24	$10/$25	$100	$ 105	$ 30	$4.57	$8.67	$10.17	$14.31
S1025	12/12/12	$15/$30	$130	$ 105	$ 30	$4.62	$8.76	$10.28	$14.47
S1004	12/12/24	$10/$25	$130	$ 105	$ 30	$4.90	$9.30	$10.91	$15.36
S1076	12/12/24	$10/$25	$130	$ 125	$ 40	$5.33	$10.12	$11.87	$16.71
SH424	12/12/24	$15/$30	$175	$ 175	$ 40	$5.48	$10.41	$12.21	$17.18
SH106	12/12/24	$10/$25	$150	$ 150	$ 40	$5.78	$10.96	$12.86	$18.10
S1102	12/12/12	$10/$25	$130	$ 150	$ 40	$5.94	$11.27	$13.22	$18.60
S1001	12/12/12	$10/$10	$130	$ 105	$ 30	$6.24	$11.84	$13.89	$19.55
SH416	12/12/24	$10/$25	$200	$ 200	$ 40	$6.58	$12.49	$14.66	$20.63
SH418	12/12/12	$10/$25	$175	$ 175	$ 30	$6.62	$12.56	$14.74	$20.74
SH413	12/12/12	$10/$25	$200	$ 200	$ 40	$7.07	$13.43	$15.75	$22.17
SH410	12/12/12	$10/$10	$150	$ 150	$ 40	$7.36	$13.97	$16.39	$23.06
S1021	12/12/12	$0/$0	$130	$ 105	$ 30	$7.41	$14.07	$16.51	$23.23
Voluntary									
S1008	12/12/24	$10/$25	$130	$ 105	$ 30	$5.95	$11.29	$13.25	$18.65
SH370	12/12/24	$15/$30	$150	$ 125	$ 40	$6.11	$11.61	$13.62	$19.16
S1077	12/12/24	$10/$25	$130	$ 125	$ 40	$6.48	$12.29	$14.42	$20.30
SH425	12/12/24	$15/$30	$175	$ 175	$ 40	$6.66	$12.64	$14.83	$20.87
SH006	12/12/12	$10/$25	$150	$ 105	$ 30	$6.69	$12.69	$14.88	$20.95
S1107	12/12/24	$10/$25	$130	$ 150	$ 40	$6.71	$12.74	$14.94	$21.03
S105V	12/12/12	$20/$20	$130	$ 125	$ 40	$6.76	$12.82	$15.04	$21.17
S104V	12/12/12	$10/$25	$130	$ 125	$ 40	$6.96	$13.21	$15.50	$21.82
SH107	12/12/24	$10/$25	$150	$ 150	$ 40	$7.02	$13.32	$15.62	$21.99
SH501	12/12/12	$10/$25	$150	$ 150	$ 40	$7.54	$14.31	$16.79	$23.63
SH005	12/12/12	$10/$10	$150	$ 105	$ 30	$7.93	$15.05	$17.66	$24.85
SH115	12/12/24	$10/$0	$150	$ 150	$ 40	$8.61	$16.34	$19.17	$26.98
SH415	12/12/12	$10/$25	$200	$ 200	$ 40	$9.89	$18.77	$22.02	$31.00

* Lenses or contacts may be received every 12 months, but not both.

* Polycarbonate lenses for dependent children are covered in full for all plans. Polycarbonate lenses covered for all members for plan SH370. Standard Progressive lenses covered in full for plans SH415 and SH426.

Participation and Contribution Requirements:

Employer Paid: 50 - 100% employer contribution for both employees & dependents. At least 75% participation of eligible employees less valid waivers, not to fall below 50% of total eligible employees.	**Voluntary Dependents: 0- 49% employer contribution for employees. No employer contribution requirements for dependents.** Two eligible, only 1 to enroll.
• 24 month rate guarantee • Monthly premiums	• 10% level broker commission is included

For a group quote with additional tier structure, situs states or plan designs, please contact your UnitedHealthcare Account Executive.

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