United Healthcare Vision Plan 2024

Plan Code	**Vision Plan - Drivers** SH368
Rate Guaranteed (Months)	24
Plan Type Description	Voluntary
# of Employees	21
Frequency (Months)	
Exam(s)	12 Months
Lenses (eyeglasses or contacts)	12 Months
Frames	24 Months
In-Network	
Copay for Exam(s)	$10
Copay for Materials	$25
Copay for Retinal Screening for Diabetics	$0
Copay for 2nd Exam for Diabetics	$10
Contact Lens Allowance	$125
Contact Lens Fitting Allowance	$40
Non-Formulary Contact Lens Allowance (Material copay does not apply)	N/A
Copay for Formulary Contact Lenses, Fitting and Evaluation	N/A
Necessary Contact Lenses	100%
Retail Frame Allowance	$150
	30% discount on frame overage at participating providers
Covered Lens Options	Std Scratch Coating, Polycarb to age 19, Polycarb for Adults
Out-of-Network	
Reimbursement for Exam	Up to $40
Reimbursement for Single Vision Lenses	Up to $40
Reimbursement for Bifocal Lenses Reimbursement for Trifocal Lenses Reimbursement for Frame	Up to $60 Up to $80
Reimbursement for Contact Lenses Reimbursement for Necessary Contact Lenses	Up to $45 Up to $100 Up to $210
Vision Monthly Premium	
Employee Only	$5.94
Employee & Spouse	$11.27
Employee & Child(ren)	$13.22
Employee & Family	$18.62