UHC - New York

For groups with effective dates 7/1/2023 - 9/30/2023

Vision plans that deliver more for less

For over 55 years, UnitedHealthcare has been offering flexible vision coverage with an integrated approach to wellness. With over 120,000 retail and private providers in our network, we're helping make it easier and more convenient for your employees 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 those with diabetes: A second exam and $0 retinal screening photography
- For children under 13 and members who are pregnant or breastfeeding: A second exam and new frames and lenses if their prescription changes by at least .5 diopter

Access to discounts

- Up to 35% off the national average price of laser vision correction at QualSight® LASIK
- 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

How your employees can save

Vision service	Without our plan	With our plan
If they prefer glasses:		
Routine eye exam	$60	$10
Glasses (frames and lenses) copay	$0	$25
Frames	$130	$0
Tier I progressive	$219	$55
Tier I anti-reflective coating	$70	$30
Standard scratch-resistant coating	$27	$0
Annual premium	$0	$68
Total cost	**$506**	**$188**
If they 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 and territory don't include a contact lens benefit with 2 allowances: WA, MT and PR. These states have an allowance for the purchase of contact lenses only. Costs shown do not include vision plan premiums. Additional costs may apply.

Learn more

Contact your broker or UnitedHealthcare representative for more information

United Healthcare

*Vision discounts are not available for New York- or North Dakota-based employers.

The rates and benefits provided are for general information and discussion purposes only and are not valid unless approved by UnitedHealthcare Specialty Benefits. This rate quote is not an offer or guarantee of coverage. The group should not, under any circumstances, cancel its existing coverage unless and until coverage is offered by UnitedHealthcare Specialty Benefits and final rates have been accepted by and initial premium paid by the groups. Final rates are determined by UnitedHealthcare Specialty Benefits' underwriting guidelines and final enrollment.

Specialty benefits and programs may not be available in all states or for all group sizes. Components subject to change.

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 their 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.13.TX 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. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete coverage details, contact either your broker or the company.

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	Contribution Plan Number	Exam/Lenses* /Frames (months)	Copay	Frame Allowance	Contact Lens Allowance	Fit/Eval Allowance	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
50% to 100% Employer Paid	S1001	12/12/12	$10/$10	$130	$105	$30	$4.95	$9.40	$11.02	$15.52
	S1004	12/12/24	$10/$25	$130	$105	$30	$3.89	$7.38	$8.66	$12.19
	S1021	12/12/12	$0/$0	$130	$105	$30	$5.88	$11.16	$13.09	$18.43
	S1025	12/12/12	$15/$30	$130	$105	$30	$3.94	$7.48	$8.78	$12.36
	S1026	12/12/24	$15/$30	$130	$105	$30	$3.67	$6.97	$8.17	$11.51
	S1076	12/12/24	$10/$25	$130	$125	$40	$4.23	$8.03	$9.42	$13.26
	S1102	12/12/12	$10/$25	$130	$150	$40	$4.71	$8.94	$10.49	$14.76
	SH106	12/12/24	$10/$25	$150	$150	$40	$4.58	$8.70	$10.20	$14.36
	SH410	12/12/12	$10/$10	$150	$150	$40	$5.84	$11.08	$13.00	$18.29
	SH413	12/12/12	$10/$25	$200	$200	$40	$5.61	$10.65	$12.49	$17.59
	SH416	12/12/24	$10/$25	$200	$200	$40	$5.22	$9.91	$11.63	$16.36
	SH418	12/12/12	$10/$25	$175	$175	$30	$5.25	$9.97	$11.69	$16.46
	SH424	12/12/24	$15/$30	$175	$175	$40	$4.68	$8.89	$10.42	$14.67
	SL004	12/12/24	$10/$25	$100	$105	$30	$3.63	$6.88	$8.08	$11.37
Voluntary	Contribution Plan Number	Exam/Lenses* /Frames (months)	Copay	Frame Allowance	Contact Lens Allowance	Fit/Eval Allowance	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
	S1008	12/12/24	$10/$25	$130	$105	$30	$4.42	$8.39	$9.84	$13.85
	S1077	12/12/24	$10/$25	$130	$125	$40	$4.81	$9.13	$10.71	$15.07
	S1107	12/12/24	$10/$25	$130	$150	$40	$4.98	$9.45	$11.09	$15.61
	S104V	12/12/12	$10/$25	$130	$125	$40	$5.17	$9.81	$11.50	$16.19
	S105V	12/12/12	$20/$20	$130	$125	$40	$5.18	$9.83	$11.53	$16.23
	SH005	12/12/12	$10/$10	$150	$105	$30	$5.88	$11.16	$13.10	$18.44
	SH006	12/12/12	$10/$25	$150	$105	$30	$4.96	$9.42	$11.05	$15.55
	SH107	12/12/24	$10/$25	$150	$150	$40	$5.21	$9.88	$11.59	$16.32
	SH115	12/12/24	$10/$0	$150	$150	$40	$6.45	$12.24	$14.36	$20.22
	SH370	12/12/24	$15/$30	$150	$125	$40	$4.89	$9.27	$10.88	$15.31
	SH415	12/12/12	$10/$25	$200	$200	$40	$7.34	$13.92	$16.33	$22.98
	SH417	12/12/24	$10/$25	$200	$200	$40	$5.94	$11.26	$13.21	$18.60
	SH425	12/12/24	$15/$30	$175	$175	$40	$5.32	$10.10	$11.84	$16.67

* 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:

50% to 100% 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: 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.

Fully Insured quotes: The Dental and/or Vision premium includes expenses related to state & federal taxes, fees, and assessments. It may also include additional new taxes, fees and assessments from the Afffordable Care Act.

The rates and benefits provided are for general information and discussion purposes only and are not valid unless approved by UnitedHealthcare Specialty Benefits. This rate quote is not an offer or guarantee of coverage. The group should not, under any circumstances, cancel its existing coverage unless and until coverage is offered by UnitedHealthcare Specialty Benefits and final rates have been accepted by and initial premium paid by the groups. Final rates are determined by UnitedHealthcare Specialty Benefit's underwriting guidelines and final enrollment. The insurance Policy, not general rates and descriptions on this rate sheet, will form the contract between the insured and the insurance company, and the Certificate of Coverage issued to the subscriber will provide the legal description of coverage.

UnitedHealthcare 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 number VPOL.06.TX and associated COC form number VCOC.INT.06.TX.

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