2020 Plan Year



Benefit Highlights

Eligibility: Any active employee employed at 75% effort per pay period (avg. 30

hours/week) or greater; and appointed for a duration of at least one

semester or 120 days or greater.

Frequency: Eye Exam, Frames/Lenses, Contact Lenses—Every 12 months

Eye Exam: \$0 Copay

Lenses: Single, Bifocal, Trifocal. Standard and Deluxe Progressive—Included

Frames: \$130 Allowance + 30% off amount over allowance

Contact Lenses: Formulary—up to 4 boxes

Non-Formulary—\$130 Allowance

Medically Necessary—Included

Fit and Follow-Up: Formulary—Included

Non-Formulary—Applies towards \$130 Allowance

All information above assumes use of an In-Network provider. Out-of- Network charges will vary.

Premiums: Employee Only: \$7.39

Employee + Spouse: \$12.45

Employee + Child(ren): \$12.72

Family: \$20.50

For more information or to Locate a Provider,

please visit myuhcvision.com

Please Note: This information is only a product highlight. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersed plan design features. United HealthCare Destroits Provided by: United HealthCare Insurance Company, Hartford, Connecticity, United HealthCare Insurance Company, Hartford, Connecticity, United HealthCare Sociate Research