

UPMC Health Benefits, Inc.

Prime Plus \$0 Copay

	Frequency ³			
	In-Network ¹	Out-of-Network ²	Employee/ Spouse/Adult Dependents	Children Through Age 18
Benefit				
Examination	Covered at 100%; you pay \$0.	Up to \$30	Once every benefit period.	Once every benefit period.
Lenses (for eyeglasses) – Standard glass or plastic. Out-of-Network amount reflects the total amount reimbursed for Covered Services.				
Single Vision	Covered at 100%; you pay \$0.	Up to \$25	Once every benefit period.	Once every benefit period.
Bifocal	Covered at 100%; you pay \$0.	Up to \$35	Once every benefit period.	Once every benefit period.
Trifocal	Covered at 100%; you pay \$0.	Up to \$45	Once every benefit period.	Once every benefit period.
Polycarbonate Lenses (up to age 19)	Covered at 100%; you pay \$0.	Not Covered	Not Covered	Once every benefit period.
Tint	Covered at 100%; you pay \$0.	Not Covered	Once every benefit period.	Once every benefit period.
UV Coating	Covered at 100%; you pay \$0.	Not Covered	Once every benefit period.	Once every benefit period.
Scratch Coating	Covered at 100%; you pay \$0.	Not Covered	Once every benefit period.	Once every benefit period.
Standard Progressive (Tier 1)	Covered at 100%; you pay \$0.	Not Covered	Once every benefit period.	Once every benefit period.
Frames – Frame reimbursement is based on retail value. Any remainder above the Member's frame allowance is to be charged to the Member, minus a 30% discount, and can be collected at the time of service when a Participating Vision Provider is used. Discount does not apply at Retail Locations for certain proprietary frame brands or when services are received from an Out-of-Network vision provider				
Frames	\$100	Up to \$30	Once every benefit period.	Once every benefit period.
Contact Lenses (in lieu of eyeglasses) — Contact lens reimbursement is based on retail value. The following discounts apply when a Participating Vision Provider is used for any balance exceeding the plan allowance: 15% for conventional; 10% for disposable. Contact lens fitting and follow-up reimbursement is separate from contact lens materials. Discount may not apply at Retail Locations or Contact Fill®.				
Standard / Extended Contact Lens Fitting and Follow Up	Covered at 100%; you pay \$0.	Up to \$20- Daily wear Up to \$30- Extended wear	Once every benefit period.	Once every benefit period.
Specialty Contact Lens Fitting and Follow Up ⁴	\$50	Up to \$50	Once every benefit period.	Once every benefit period.

UPMC Health Benefits, Inc.

Frequency ³				
	In-Network ¹	Out-of-Network ²	Employee/ Spouse/Adult Dependents	Children Through Age 18
Benefit				
Contact Lens Material (including conventional and disposable)	\$100	Up to \$30- Daily wear	Once every benefit period.	Once every benefit period.

For further lens selections, refer to the Additional Lens Options Covered by Your Plan document.

¹In-Network Vision Providers may also include Participating Vision Providers who choose to use an Out-of-Network lab

²Out-of-Network reimbursement is based on Usual, Customary, and Reasonable charges as determined by UPMC Health Plan. Nonparticipating Vision Provider may bill the Member the difference between the Provider's billed charges and the plan allowance.

³Frequency is based on the Member's Benefit Period.

⁴For specialty contact lens fitting, the Provider may bill the Member the difference between the Provider's billed charges and the plan/Member's allowance. Participating Vision Provider cannot balance bill for standard lens evaluation when received in-network.

UPMC Health Benefits, Inc.

	Additional Discounted Services performed by Participating Vision Provider
NVA EYEESSENTIAL® Plan*	The NVA EYEESSENTIAL® Plan is an additional benefit available to all members once the benefits as described in this Schedule of Benefits have been exhausted for the term. Benefit frequencies are unlimited, excluding examination. For more information, see the Plan document in your enrollment materials or on the UPMC Health Plan member site. To see if your vision provider is participating visit www.upmchealthplan.com and select Find Care
Mail-Order Contact Lens Replacement Program	For more information on this program, call Contact Fill® at 1-866-234-1393, or visit www.contactfill.com
Lasik Surgery	Participants are also eligible for discounts on LASIK surgery, when received at one of the following preferred providers: UPMC Eye Center, TLC Vision, Qualsight, or LCA.

*Not all Participating Vision Providers participate in the NVA Essential network

IMPORTANT: IF MEMBERS CHOOSE EXTRA OPTIONS, THEY ARE RESPONSIBLE FOR THE ADDITIONAL COST OF THE OPTIONS PAID DIRECTLY TO THE PROVIDER.

This Vision Schedule of Benefits may expand or restrict the benefits set forth in your Vision Certificate of Insurance. See the Vision Certificate of Insurance for the details of the terms of coverage for your health benefit plan. In the event that the terms of your Vision Certificate of Insurance conflict with this Vision Schedule of Benefits the terms of this Vision Schedule of Benefits control.

*Pediatric Vision Services (if applicable) are covered as required under the Affordable Care Act (ACA) for Members enrolled in ACA-compliant group plans. Find eligibility and benefit details in your Pediatric Vision Certificate of Insurance and Pediatric Vision Schedule of Benefits on the UPMC Health Plan member site or call Member Services.**

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

UPMC Health Benefits, Inc.

Additional Lens Options Covered by Your Plan

Lens Options		Fixed Fee
Progressives (add to bifocal base)		
Progressives - Tier 1		\$60.00
Progressives - Tier 2		\$90.00
Progressives - Tier 3		\$110.00
Progressives - Tier 4		\$125.00
Progressives - Tier 5		\$145.00
Progressives - Tier 6		\$170.00
Progressives - Tier 7		\$190.00
Materials		
High Index Plastic 1.53-1.60/Trivex		\$50.00
High Index Plastic 1.66/1.67		\$71.00
High Index Plastic 1.70 and above		\$80.00
Polycarbonate (Adults)		\$30.00
Aspheric		
Aspheric (Plastic/Poly) SV		\$30.00
Aspheric (Plastic/Poly) MF		\$35.00
Anti-Reflective Coating		
Anti-Reflective Coating - Tier 1		\$45.00
Anti-Reflective Coating - Tier 2		\$65.00
Anti-Reflective Coating - Tier 3		\$85.00
Anti-Reflective Coating - Tier 4		\$110.00
Polarized		
Polarized - Tier 1		\$70.00
Polarized - Tier 2		\$80.00
Polarized - Tier 3		\$110.00
Polarized - Tier 4		\$125.00
Polarized - Tier 5		\$150.00
Polarized - Tier 6		\$175.00
Photochromics		
Transitions VII		\$75.00
Transitions VII MF		\$90.00
Transitions XTRActive		\$110.00
Transitions Vantage		\$125.00
Near Variable Lenses		
Essilor Computer MF		\$65.00

UPMC Health Benefits, Inc.

Lens Options	Fixed Fee
Specialty and Digital Single Vision	
Digital SV Tier 1	\$100.00
Digital SV Tier 2	\$145.00
Other Lens Treatments and Services	
Mirror - Solid and Single Gradient	\$60.00
Mirror - Double Gradient	\$70.00
Overpower (+6.00D or 3.00D Cylinder, per Lens)	Included
Add Power over 4.00D	Included
Prism over Range (over 3D per Eye)	Included
Press on Prism	\$30.00
Double Facetting	\$75.00
Facetted Lenses (includes Polish)	\$55.00
Slab Off	\$100.00
Rimless Drill	\$20.00
Groove Rimless	Included
Center Thickness Below 1.5	\$16.50
Plastic Dyes - Solid	\$8.00
Plastic Dyes - Single Gradient	\$10.00
Plastic Dyes - Double/Triple Gradient	\$20.00
UV Protection	\$20.00
UV Protection - Backside (Add on to Front Side UV)	\$15.00
Scratch Resistant - Standard	\$15.00
Scratch Resistant TD2	\$30.00
Scratch Resistant w/Optifog Technology	\$55.00
Edge Polish, Roll Edge, Roll & Polish	\$20.00
Edge Coating	\$30.00
Blue Light Blocking Lenses	
Blue Light Blocker - Tier 1	\$40.00
Blue Light Blocker - Tier 2	\$60.00
Blue Light Blocker - Tier 3	\$120.00

Members receive a twenty (20%) percent discount on lens options not included in the schedule above. Fixed prices/discounts do not apply at Retail Locations. Discounts are not insured benefits. In certain states, Members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

UPMC Health Benefits, Inc.

Your vision plan includes the NVA EYEESSENTIAL® Discount Plan, which provides significant discounts on eyecare services and materials through participating NVA network providers. The fees listed on this document capture the discounted rate payable by the member. Not all Participating Vision Providers participate in the NVA EYEESSENTIAL® discount plan network. We encourage you to verify your provider's participation in this network prior to receiving services. To see if your vision provider is participating visit www.upmchealthplan.com and select Find Care.

- After enrolled Members have exhausted their benefits as described on the first page in this Schedule of Benefits, they are eligible to access the NVA EYEESSENTIAL® Plan discount on additional purchases during the Benefit Period.

Please Note: The NVA EYEESSENTIAL® Plan is an in-network benefit only. Benefit frequency is unlimited, except for vision exams. The NVA EYEESSENTIAL® Plan discount program prices do not apply at retail locations. In certain states, Members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. To see if your vision provider is participating in the NVA EYEESSENTIAL® Plan visit www.upmchealthplan.com and select Find Care.

Service Material	Member Discounted Cost
Comprehensive Vision Examination (Including Dilation as Professionally Indicated) Once Every 12 Months	\$10.00 discount
Lenses – Standard Glass or Plastic	
Single	\$35.00
Bifocal	\$55.00
Trifocal	\$70.00
Lenticular	\$70.00
Lens Options	
UV Coating	\$12.00
Tint (Solid and Gradient)	\$12.00
Scratch-Resistant Coating (Standard)	\$15.00
Polycarbonate (Standard)	\$35.00
Anti-Reflective Coating (Standard)	\$45.00
Polarized	\$75.00
Transitions (Standard)	Single Vision – \$65.00 Bifocal and Trifocal – \$70.00

UPMC Health Benefits, Inc.

Progressives (Standard)	\$50 + Bifocal/Trifocal Charge ¹
Other Add-On Services	20% Off Retail
Frames	
Frames ²	35% Off Retail
Contact Lenses - Discount does not apply at Contact Fill®. Discounts do not apply to certain brands of contact lenses.	
Conventional	15% Off Retail
Disposable	10% Off Retail
Fitting and Follow-Up	10% Off Retail

¹Progressive (Standard) -Progressive lens copayment is based on the base cost of the lens plus additional copayments. Member cost is the total of \$50 plus the cost of bifocal or trifocal lens, depending on the lens type prescribed.

²Any eligible frame at a Participating Vision Provider's location.

UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219
www.upmchealthplan.com

UPMC Health Benefits, Inc.

UPMC Health Plan Nondiscrimination Notice

UPMC Health Plan, on behalf of itself and its affiliates, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

UPMC Health Benefits, Inc.

Translation Services

UPMC for You

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: **1-800-286-4242** (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-286-4242 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-286-4242 (телетайп: 711).

UPMC for Kids

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: **1-800-650-8762** (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-650-8762 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните

1-800-650-8762 (телетайп: 711).

UPMC Community HealthChoices

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: **1-844-833-0523** (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-833-0523 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-833-0523 (телетайп: 711).