UPMC Vision *Advantage*

Standard Vision PPO (51)

Benefit	In-Network	Out-of-Network	Frequency: Employee/Spouse/ Adult Dependents	Frequency: Children through age 18
Copayment (applies to vision exam)	$15	N/A		
Examination (less copayment)	100%	$40	24 months	12 months
Lenses (for glasses) Lens reimbursement percentage is based on the base cost of the lens and does not include overages or lens add-ons. Out of network amount reflects the total amount reimbursed for services.				
Single Vision	100%	$40	24 months	12 months
Bifocal	100%	$50	24 months	12 months
Trifocal	100%	$75	24 months	12 months
Polycarbonate Lens Material **Available in-network at no cost for children under age 19**	100%	Not Covered	Not Covered	12 months
UPMC Vision Advantage does cover progressive lenses at 100% of the base cost of the lens when treated by a participating provider. Any additional charges above the base cost are not covered and are to be billed to the member. Payment may vary based on the type of lens billed to the plan. Progressive lenses received from a non-participating provider are reimbursed at $75.				
Frames Frame reimbursement is based on retail value. The plan will reimburse the participating provider 70% of the member's maximum for frames. The remaining 30% is a contractual discount to the plan and cannot be billed to the member. Any remainder above the member's frame allowance is to be charged to the member, minus a 20% discount and can be collected at the time of service when a participating provider is used.				
Frames	$60	$35	24 months	24 months
Contact Lenses (In Lieu of Glasses) Contact lens fitting and follow-up reimbursement is separate from contact lens material. For specialty contact lens evaluation, the provider may bill the patient the difference between the provider's billed charges and the plan/member allowance. Provider cannot balance bill for standard lens evaluation when received in-network. Contact lens material is reimbursed at 100% of billed charges up to the member's plan maximum when a participating provider is used.				
Contact Lens Fitting and Follow Up	$50	$40	24 months	12 months
Contact Lens Material	$75	$60	24 months	12 months

Out of network reimbursement is based on Usual, Customary, and Reasonable as determined by UPMC Vision *Advantage*.

Members are eligible for a 20% discount on additional examinations, frames and lenses for glasses received from a participating provider prior to the next eligibility period.

20% Discount does not apply to contact lenses.

Lens reimbursement is based on the base cost of the lens and does not include coverage for lens add-ons and or treatments (such as coatings, tinting, polarization, photochromatics). These services are not covered by or to be billed to UPMC Vision *Advantage*. Participating providers are to discount these services by 20%.

UPMC Vision *Advantage* participants are eligible for discounts on LASIK Surgery when received by one of the following preferred providers: **UPMC Eye Center, TLC Vision, or QualSight**

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

Pediatric Vision Services are covered in compliance with requirements under the Affordable Care Act (ACA) for members of group plans with 50 or fewer employees. Find eligibility and benefit details in your Certificate of Insurance and Pediatric Vision EHB Rider at *My*Health OnLine or call Member Services.