

OPTICAL NON -PANEL (OUT OF NETWORK) PROVIDER SCHEDULE

If you or a dependent obtain services from an out of network provider, you will be reimbursed by UPSE Benefit Plan based upon the schedule below upon submission of a detailed paid receipt with your name and social security number for the services provided.

Exam	\$25.00
Frame	\$25.00
Single Vision Lenses	\$25.00
Bifocal Lenses	\$35.00
Trifocal Lenses	\$32.00
Tint	\$12.00
Contact Lenses	\$100.00 (no exam)
Contact Lenses	\$125.00 (including exam)

The Vision Benefit entitles you or your dependent to the following, UP TO THE MAXIMUM BENEFIT SET FORTH ABOVE.

1. Choice of glass or plastic single vision, bifocal or trifocal lenses;
2. Selection from the Collection of frames offered under the Plan;
3. All ranges of prescriptions, including cataract lenses;
4. Oversize lenses;
5. Fashion tinting plastic lenses;
6. Gradient tints;
7. Grey #3 prescription sunglasses in glass;
8. Soft standard daily wear contact lenses (in lieu of all eyeglasses);
9. Photo chromatic lenses; and
10. Invisible bifocal lenses.

No payment will be made under this benefit for expenses incurred in connection with:

1. Medical or surgical treatment of the eye;
2. Lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
3. Special procedures, such as orthopaedics or vision training, and special supplies, such as non-prescription sunglasses and subnormal vision aids;
4. Radial keratotomy; or
5. Charges which you are not legally required to pay or for charges which would not have been made if no coverage had existed.

In addition, for in-network/out-network benefits an out pocket expense in the amount paid up to a maximum of \$25.00 for member and spouse (not a dependent child) upon submission of a detailed receipt with your name, social security number and the services provided.