Health Net Health Plan of Oregon, Inc.

OR Supplemental Benefit Schedule
Adult Vision Benefits (E1010-1)

Purpose and Function

The Supplemental Benefit Schedule describes additional coverage that is available to the Group. If this coverage has been selected by the Group, it will be included in the Group Agreement that is issued for the contract year in which the coverage applies. **This is meant to be a brief summary only and does not include all services, cost shares, limitations or exclusions. Please refer to the Group Agreement for terms and conditions of coverage.**

The benefits for eye examination and eyewear are covered for adults age 19 and over as shown below and are subject to the limitations, options, and exclusions as described herein. To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center at the number at the bottom of this Schedule. When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

Benefits

Benefits are based on the following Schedule:

	Participating Provider	Any Other Provider
Exam	After you pay a $10 Copayment, covered services are paid in full by the plan.	You are reimbursed up to $40 of the cost for covered services.
Exam Options (fit and follow-up)		
Standard contact lenses	After you pay up to $55, covered services are paid in full by the plan.	You receive no discount.
Premium contact lenses	You receive 10% off retail cost.	You receive no discount.
Eyewear (lenses and frame)		
Single vision lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $40.
Lined bifocal lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $60.
Lined trifocal lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $80.
Lined lenticular lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $80.
Standard progressive lenses	Covered in full after a $75 Copayment.	You are reimbursed up to $60.
Premium progressive lenses	$75 Copayment, then 80% of total charge less $120 allowance.	You are reimbursed up to $60.
Frame	Covered up to $150 allowance. You will receive a 20% discount on the balance over your allowance.	You are reimbursed up to $45.
Lens Options		
UV Coating	Covered in full after a $15 Copayment. **	You receive no discount.
Tint, solid and gradient	Covered in full after a $15 Copayment. **	You receive no discount.
Standard scratch-resistance	Covered in full after a $15 Copayment. **	You receive no discount.
Standard polycarbonate	Covered in full after a $40 Copayment. **	You receive no discount.
Standard anti-reflective	Covered in full after a $45 Copayment. **	You receive no discount.
Other add-ons and services	You receive 20% off retail cost. **	You receive no discount.

** Your Copayment or eyewear discount applies to any optional items purchased with your lenses and/or frames from a Participating Provider. Listed items are examples of optional items.

Contact lenses (instead of spectacle lenses) –Materials		
Conventional	You receive a maximum allowance of $120, plus a discount of 15% over your allowance.	You are reimbursed up to $105 of the cost for covered services.
Disposables	You receive a maximum allowance of $120, you are responsible for remaining balance over your allowance.	You are reimbursed up to $105 of the cost for covered services.
Medically Necessary	Paid in full.	You are reimbursed up to $210 of the cost for covered services.

Frequency of Service

Examination	Once every 12 months from the last date of service.
Lenses	Once every 12 months from the last date of service.
Frame	Once every 12 months from the last date of service.
Contact lenses in lieu of lenses	Once every 12 months from the last date of service.

Limitations, Options and Exclusions

- To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center.

  When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

- There is no benefit for professional services or materials connected with:

  a. Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.

  b. Aniseikonic lenses.

  c. Medical or surgical treatment of the eyes or supporting structures.

  d. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this plan.

  e. Services provided as a result of any Workers' Compensation law.

  f. Plano non-prescription lenses and non-prescription sunglasses.

  g. Lost or broken materials except at normal intervals when services are otherwise available.

- Benefits may not be combined with any discount, promotional offering, or other group benefits plans. Allowances are one-time use benefits; no remaining balance.

- Value Added Discounts

  Contact Lenses – Participating Providers offer preferred pricing and direct delivery on annual supplies of select brands of disposable contact lenses.

  Lasik or PRK – You may have a discount available for these services. Please contact our Customer Contact Center for more information.

Continued Eyewear Savings – After your initial benefits have been utilized, you may be able to receive ongoing discounts on additional eyewear purchases at Participating Provider locations. Please contact our Customer Contact Center for more information.

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This summary presents general information only and does not include all benefits, details and exclusions.

Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and serviced by Envolve Vision, Inc. Envolve Vision, Inc. and Health Net Health Plan of Oregon, Inc. are subsidiaries of Centene Corporation.