Health Net Health Plan of Oregon, Inc.
Vision Benefits
SUPPLEMENTAL BENEFIT SCHEDULE PREFERRED 1025-2/15

Purpose and Function of this Schedule

The purpose of this schedule is to provide vision benefits to Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Group Medical and Hospital Service Agreement and its attachments, except as expressly amended by benefits provision of this Schedule, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premiums and Copayments.

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 $25 Copayment.	You are reimbursed up to $40.
Lined bifocal lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $60.
Lined trifocal lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $80.
Lenticular lenses	Covered in full after a $25 Copayment.	You are reimbursed up to $80.
Standard progressive lenses	Covered in full after a $90 Copayment	You are reimbursed up to $60.
Premium progressive lenses	$90 Copayment, then 80% of total charge less $120 allowance.	You are reimbursed up to $60.
Frame	Covered up to $100 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 and frame) –Materials		
Conventional	You receive a maximum allowance of $90, 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 $90, 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 24 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 for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.

  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.

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