Vision Elite Plan 1010-1

FOR HEALTH NET MEMBERS

It's the vision coverage you want with the convenience you need.

Real convenience means you have choice. Like getting affordable eye care services from a network of ophthalmologists, optometrists and opticians.

Providers can be found online at **eyemedvisioncare.com**. This plan offers discounts on LASIK and PRK laser vision corrections from U.S. Laser Network.

Benefits description	Plan benefits	
	In-network member pays	**Out-of-network member reimbursement**
Exam with dilation as necessary	$10 copay	Up to $40
Exam options		
Standard contact lens fit and follow-up	Up to $55 copay	N/A
Premium contact lens fit and follow-up	10% off retail	N/A
Standard plastic lenses		
Single vision	$10 copay	Up to $40
Bifocal	$10 copay	Up to $60
Trifocal	$10 copay	Up to $80
Lenticular	$10 copay	Up to $80
Standard progressive lenses	$75 copay	Up to $60
Premium progressive lenses	$75 copay plus 80% of charge less $120 allowance	Up to $60
Frames		
Any frame available at a provider location	$0 copay, $150 retail allowance for any frame plus 20% discount off balance over allowance	Up to $45

Questions?
Call Envolve Vision at 1-866-392-6058

(continued)

Benefits description	Plan benefits	
Lens Options		
UV coating	$15 copay	N/A
Tint *(solid and gradient)*	$15 copay	N/A
Standard scratch-resistant	$15 copay	N/A
Standard polycarbonate	$40 copay	N/A
Standard anti-reflective	$45 copay	N/A
Other add-ons and services	20% discount	N/A
Contact lenses *(includes materials only)*	$120 allowance	N/A
Conventional	$0 copay, plus 15% discount off balance over allowance	Up to $105
Disposables	$0 copay, plus balance over allowance	Up to $105
Medically necessary	$0 copay	Up to $210
Laser vision correction		
LASIK or PRK from U.S. Laser Network. Insureds must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount.	15% off retail price or 5% off promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frames	Once every 12 months	

Plan limitations and exclusions

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Services provided as a result of any workers' compensation law.
- Plano (non-prescription lenses and non-prescription sunglasses) – except for a 20% discount.
- Two pairs of glasses in lieu of bifocals.
- Excludes certain frame brands in which the manufacturer imposes a no-discount policy.

Insureds will receive a 20% discount on the remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to a provider's professional services or to contact lenses. Retail prices may vary by location.

Discounts do not apply to benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

This summary presents general information only and does not include all benefits, details and exclusions. Please refer to your Certificate of Insurance for terms and conditions of coverage, including which services are limited or excluded from coverage.

1/2025