Samaritan Health Plans

SAMARITAN VISION PLAN BENEFITS

This Plan pays for vision examinations, and corrective lenses and frames (when prescribed by a licensed ophthalmologist or licensed optometrist) for you and your insured dependents. The Plan allows you to choose any licensed ophthalmologist, optician, or optometrist. However, for eye examinations, there is a difference in reimbursement for participating vision providers and non-participating vision providers.

Deductibles

There is no deductible for covered vision services or supplies and the benefits are paid, up to the limits listed in your Summary of Benefits, for services at participating vision providers. Allowed charge means the charge for covered services up to the maximum plan allowance. These vision care benefits are provided on a benefit year basis.

Small group plans

Medical embedded (pediatric) vision coverage is primary to the Vision Only plan that is purchased separately. Medical deductibles do not need to be met prior to obtaining the Vision Only plan coverage, however IF there is a deductible required for the medical plan with embedded (pediatric) vision coverage, the deductible may need to be met first.

COVERED BENEFITS

Eye Examinations: One complete routine, non-medical, eye exam (including eye refraction exam) per calendar year.

Vision Hardware and/or Accessories: The following hardware and/or accessories are covered every 1 year at a combined benefit maximum limit of $175 :

- Single Vision Lenses
- Polycarbonate Lenses (when appropriate)
- Bifocal Lenses
- Trifocal Lenses
- Contacts
- Contact Lenses
- Frames
- Lenses (including PolyCarb lenses) are covered when eyeglasses are first acquired or when required by a change in prescription
- Progressive lenses (viralux, no line bifocals) are covered, if prescribed and billed appropriately by a licensed provider and for a diagnosis not excluded in our plan

VISION BENEFITS	
IN-NETWORK	OUT-OF-NETWORK
$25 Copay	$25, then 70% co-insurance

LIMITATIONS AND EXCLUSIONS

The vision care benefit will only pay for the items listed above up to the allowable amount per individual and per calendar year.

The following are not covered benefits under this Plan:

- Visual field charting;
- Fitting fees for lenses or eye glasses
- Orthoptics or vision training;
- Lenticular lenses;
- Contact lenses, except as shown in the Schedule
- Subnormal vision aids;
- Aniseikonic lenses;
- High index lenses;
- Photochromatic, transition and nonprescription tinted lenses
- Hardware repairs
- Nonprescription lenses; or
- More than the allowance for a standard prescription when multi-focal hard resin lenses, coated lenses or no-line bifocals (blended type) are chosen;
- Extra charges for fashion eyewear features such as blended, coated, flint glass, oversize lenses or extra charges for special frames
- Medical or surgical treatment of the eyes;
- Services and supplies that are payable under a workers' compensation or occupational disease law;
- Any expense which results from an act of declared or undeclared war or armed aggression;
- Any expense which is in excess of the maximum plan allowance;
- Any eye examination required as a condition of employment; and
- Any expense paid in whole or in part by any other provision of the Group Health Insurance Plan provided by the Policyholder.

PROVISIONS

Your member certificate, this policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. This policy is an extension of your coverage outlined in your member certificate. Any exclusions and limitations outlined in your member certificate are also for this policy. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions (ORS 743.411). This document must be used in conjunction with your current Member Policy.