



The Summary of Benefits and Coverage (SBC) document will help you choose a vision plan. The SBC shows you how you and the plan would share the cost for covered vision care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to <https://regence.com>. For provider or benefit questions call VSP at 1-844-299-3041. For membership questions call Regence at 1-800-854-5585. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-800-854-5585 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there other deductibles for specific services?	No.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
What is the out-of-pocket limit for this plan?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a network provider?	Yes. See https://vsp.com/eye-doctor or call 1-844-299-3041 for a list of VSP doctors.	This <u>plan</u> uses a vision <u>provider network</u> (Vision Service Plan). You will pay less if you use a vision <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network</u> vision <u>provider</u> , and you might receive a bill from a vision <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you visit a vision care <u>provider's</u> office or clinic</p>	Routine vision examination	\$20 <u>copay</u> , then no charge up to the VSP doctor limit	\$20 <u>copay</u> , then no charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 routine eye examination every 12 months Routine eye examination limited to \$50 for <u>out-of-network providers</u>.</p>
	Vision hardware	\$20 <u>copay</u> , then no charge up to the VSP doctor limit	\$20 <u>copay</u> , then no charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 pair of frames every 24 months Frames limited to \$130 for VSP doctors. Frames limited to \$70 for VSP approved wholesale/retail vendors. Frames limited to \$50 for <u>out-of-network providers</u>.</p> <p>1 pair of standard, or blue-light filter, glass or plastic lenses every 12 months for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; Non-prescription ready-made sunglasses; Non-prescription ready-made blue-light filter glasses; or Contact lenses.*</p> <p>Elective contact lenses* limited up to \$130 for VSP doctors. Necessary contact lenses* limited to a 12 month supply for VSP doctors.</p> <p>Single vision lenses limited to \$50 for <u>out-of-network providers</u>.</p>

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<p>Lined bifocal lenses limited to \$80 for <u>out-of-network providers</u>.</p> <p>Standard progressive lenses limited to \$95 for <u>out-of-network providers</u>.</p> <p>Lined trifocal lenses limited to \$95 for <u>out-of-network providers</u>.</p> <p>Lenticular lenses limited to \$125 for <u>out-of-network providers</u>.</p> <p>Elective contact lenses* (including fitting/evaluation services) limited to \$70 once every 12 months for <u>out-of-network providers</u>.</p> <p>Necessary contact lenses* (including fitting/evaluation services) limited to a 12 month supply up to \$125 for <u>out-of-network providers</u>.</p> <p>*Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any other types of lenses for the next 12 months and frames for the next 24 months.</p>
	Contact lens evaluation and fitting examination	No charge	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 contact lens evaluation and fitting examination every 12 months</p> <p>Elective contact lens evaluation and fitting examination (including elective contact lenses) limited to \$70 for <u>out-of-network providers</u>.</p> <p>Necessary contact lens evaluation and fitting examination (including necessary contact lenses) limited to \$125 for <u>out-of-network providers</u>.</p>
	Low vision supplemental examinations (testing)	No charge	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for</p>

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Low vision supplemental care aids	25% <u>coinsurance</u>	25% <u>coinsurance</u>	reimbursement. \$1,000 low vision maximum every 24 months, including supplemental examinations (testing) and care aids 2 supplemental examinations every 24 months Supplemental examinations limited to \$125 for <u>out-of-network providers</u> .

Excluded Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
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| <ul style="list-style-type: none">• Corrective vision treatment of an experimental nature• Cosmetic services and supplies | <ul style="list-style-type: none">• Fees, taxes and interest• Medical or surgical treatment of the eyes• Non-direct patient care | <ul style="list-style-type: none">• Orthoptics or vision training• Pediatric vision (under age 19)• Two pair of glasses in lieu of bifocals |
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Are there services covered before you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
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What is not included in the out-of-pocket limit?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a network provider?	Yes. See https://vsp.com/eye-doctor or call 1-844-299-3041 for a list of VSP doctors.	This <u>plan</u> uses a vision <u>provider network</u> (Vision Service Plan). You will pay less if you use a vision <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network</u> vision <u>provider</u> , and you might receive a bill from a vision <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you visit a vision care <u>provider's</u> office or clinic</p>	Routine vision examination	No charge	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 routine eye examination / plan year Routine eye examination limited to \$50 for <u>out-of-network providers</u>.</p>
	Vision hardware	No charge up to the VSP doctor limit	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 pair of frames every 24 months Frames limited to \$130 for VSP doctors. Frames limited to \$70 for VSP approved wholesale/retail vendors. Frames limited to \$50 for <u>out-of-network providers</u>.</p> <p>1 pair of standard, or blue-light filter, glass or plastic lenses every 12 months for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; Non-prescription ready-made sunglasses; Non-prescription ready-made blue-light filter glasses; or Contact lenses.*</p> <p>Elective contact lenses* limited up to \$130 for VSP doctors. Necessary contact lenses* limited to a 12 month supply for VSP doctors.</p> <p>Single vision lenses limited to \$50 for <u>out-of-network providers</u>.</p>

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				<p>Lined bifocal lenses limited to \$80 for <u>out-of-network providers</u>.</p> <p>Standard progressive lenses limited to \$95 for <u>out-of-network providers</u>.</p> <p>Lined trifocal lenses limited to \$95 for <u>out-of-network providers</u>.</p> <p>Lenticular lenses limited to \$125 for <u>out-of-network providers</u>.</p> <p>Elective contact lenses* (including fitting/evaluation services) limited to \$70 once every 12 months for <u>out-of-network providers</u>.</p> <p>Necessary contact lenses* (including fitting/evaluation services) limited to a 12 month supply up to \$125 for <u>out-of-network providers</u>.</p> <p>*Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any other types of lenses for the next 12 months and frames for the next 24 months.</p>
	Contact lens evaluation and fitting examination	No charge	No charge up to the <u>out-of-network provider</u> limit	<p>For services provided by an <u>out-of-network provider</u>, you pay all charges up front then submit a <u>claim</u> for reimbursement.</p> <p>1 contact lens evaluation and fitting examination every 12 months</p> <p>Elective contact lens evaluation and fitting examination (including elective contact lenses) limited to \$70 for <u>out-of-network providers</u>.</p> <p>Necessary contact lens evaluation and fitting examination (including necessary contact lenses) limited to \$125 for <u>out-of-network providers</u>.</p>
	Low vision supplemental examinations (testing)	25% <u>coinsurance</u>	25% <u>coinsurance</u>	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a <u>claim</u> for

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Low vision supplemental care aids	25% <u>coinsurance</u>	25% <u>coinsurance</u>	reimbursement. \$1,000 low vision maximum every 24 months, including supplemental examinations (testing) and care aids 2 supplemental examinations every 24 months Supplemental examinations limited to \$125 for <u>out-of-network providers</u> .

Excluded Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Adult vision (age 19 or older)• Corrective vision treatment of an experimental nature | <ul style="list-style-type: none">• Cosmetic services and supplies• Fees, taxes and interest• Medical or surgical treatment of the eyes | <ul style="list-style-type: none">• Non-direct patient care• Orthoptics or vision training• Two pair of glasses in lieu of bifocals |
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NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Regence:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በአዲስ አበባ ተዘጋጅተዋል፤ የሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر بہ زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذا ذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)