



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 (866) 240-9580. 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 (866) 240-9580 to request a copy.**

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$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 <u>deductible</u>?	Not applicable.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	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 <u>out-of-pocket limit</u>?	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 <u>network provider</u>?	Yes. See https://regence.com/go/OR/VSPNetwork 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 <u>referral</u> to see a <u>specialist</u>?	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 and 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 claim for reimbursement.</p> <p>1 routine eye examination / calendar year Routine eye examination limited to \$45 for <u>out-of-network providers</u>.</p> <p>1 pair of frames / calendar year Frames limited to \$150 for VSP doctors. Frames limited to \$80 for VSP approved wholesale/retail vendors. Frames limited to \$70 for <u>out-of-network providers</u>.</p> <p>1 pair of glass or plastic lenses / calendar year for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; or Contact lenses*.</p> <p>Elective contact lenses* limited up to \$150 for VSP doctors. Necessary contact lenses* limited to a calendar year supply for VSP doctors.</p> <p>Lenses from out-of-network providers limited to: \$30 for single vision lenses \$50 for lined bifocal or standard progressive lenses \$65 for lined trifocal lenses \$100 for lenticular lenses \$105 for elective contact lenses* (including fitting/evaluation services) \$210 for necessary contact lenses* (including</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)	
				fitting/evaluation services) *Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames or other types of lenses until the next calendar year.
	Contact lens evaluation and fitting examination	\$60 <u>copay</u> / evaluation/fitting examination	No charge up to the <u>out-of-network provider limit</u>	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a claim for reimbursement. 1 contact lens evaluation and fitting examination / calendar year Elective contact lens evaluation and fitting examination (including elective contacts lenses) limited to \$105 for <u>out-of-network providers</u> . Necessary contact lens evaluation and fitting examination (including necessary contacts lenses) limited to \$210 for <u>out-of-network providers</u> .
	Low vision supplemental examinations (testing)	No charge	No charge up to the <u>out-of-network provider limit</u>	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a claim for reimbursement.
	Low vision supplemental care aids	25% <u>coinsurance</u>	25% <u>coinsurance</u>	\$1,000 low vision maximum / 2 calendar years 2 supplemental examinations / 2 calendar years Supplemental examinations (testing) limited to \$125 for <u>out-of-network providers</u> .

Excluded Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Corrective vision treatment of an experimental nature • Cosmetic services and supplies • Personal comfort items 	<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 • Plano lenses • Two pair of glasses in lieu of bifocals