



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health 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 [regence.com/go/2020/booklet/WW/GoldHSA1500](http://regence.com/go/2020/booklet/WW/GoldHSA1500) or call 1 (888) 367-2112. 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](http://healthcare.gov/sbc-glossary) or call 1 (888) 367-2112 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-network: \$1,500 individual (single coverage) / \$3,000 family per calendar year. Out-of-network: \$5,000 individual (single coverage) / \$10,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	In-network: \$4,500 individual (single coverage) / \$9,000 family* per calendar year. Out-of-network: \$10,000 individual (single coverage) / \$20,000 family per calendar year. *A member on family coverage will not have his or her out-of-pocket limit exceed \$4,500.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://regence.com/go/WW/Preferred">regence.com/go/WW/Preferred</a> or call 1 (888) 367-2112 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage includes primary care visits at a retail clinic. Acupuncture services are limited to 12 visits / year. Spinal manipulations are limited to 10 / year.
<b>If you visit a health care provider's office or clinic</b>	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://regence.com/go/druglist/2020/WW/6tier">prescription drug coverage</a> is available at <a href="https://regence.com/go/druglist/2020/WW/6tier">regence.com/go/druglist/2020/WW/6tier</a> .	Preferred generic drugs & generic drugs	10% <u>coinsurance</u> * / preferred generic retail prescription 5% <u>coinsurance</u> / preferred generic mail order prescription 25% <u>coinsurance</u> * / generic retail prescription 20% <u>coinsurance</u> / generic mail order prescription		No coverage for <u>prescription drugs</u> not on the Drug List or <u>prescription drugs</u> from an out-of-network pharmacy. Limited to a 90-day supply retail, mail order and self-injectable drugs. Limited to a 30-day supply <u>specialty drugs</u> (including preferred) and self-administrable cancer chemotherapy drugs. <u>Deductible</u> does not apply for generic drugs and brand name drugs (including preferred) designated as preventive for chronic diseases that are on the Optimum Value Medication List. No charge for FDA-approved women's contraceptives prescribed by a health care <u>provider</u> and for certain preventive drugs and immunizations at a participating pharmacy. The first fill for <u>specialty drugs</u> (including preferred) may be provided at a retail pharmacy, additional fills and fills for specialty self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is subject to 20% <u>coinsurance</u> . *5% <u>coinsurance</u> discount when filled at a preferred retail pharmacy.
	Preferred brand drugs	25% <u>coinsurance</u> * / retail prescription 20% <u>coinsurance</u> / mail order prescription		
	Brand drugs	50% <u>coinsurance</u> * / retail prescription 45% <u>coinsurance</u> / mail order prescription		
	Preferred <u>specialty drugs</u> & <u>specialty drugs</u>	20% <u>coinsurance</u> / preferred <u>specialty drugs</u> 50% <u>coinsurance</u> / <u>specialty drugs</u>		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	50% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to \$3,500 / day for inpatient non-emergency admissions in out-of- <u>network</u> facilities.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to \$3,500 / day for inpatient non-emergency admissions in out-of- <u>network</u> facilities.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain preventive services. Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to \$3,500 / day for inpatient non-emergency admissions in out-of- <u>network</u> facilities.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 130 visits / year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 inpatient days and 25 outpatient visits / year. Limited to \$3,500 / day for inpatient non-emergency admissions in out-of- <u>network</u> facilities.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Habilitative services is limited to 30 inpatient days and 25 outpatient visits / year. Limited to \$3,500 / day for inpatient non-emergency admissions in out-of- <u>network</u> facilities. Neurodevelopmental therapy is limited to 25 outpatient visits / year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 inpatient days / year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 14 respite days / lifetime.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	50% <u>coinsurance</u>	Limited to 1 routine exam / year for individuals under age 19.
	Children's glasses	No charge	50% <u>coinsurance</u>	Limited to 1 pair of lenses (2 lenses) and 1 standard frame / year for individuals under age 19.
	Children's dental check-up	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental services.

## Excluded Services & Other Covered 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.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware (Adult)
- Weight loss programs, except as covered under preventive care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Termination of pregnancy

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or [cciio.cms.gov](http://cciio.cms.gov) or your state insurance department. You may also contact the plan at 1 (888) 367-2112. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 1 (800) 318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (888) 367-2112 or visit [regence.com](http://regence.com) or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:** Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 367-2112

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,146
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,706</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,248
<i>What isn't covered</i>	
Limits or exclusions	\$255
<b>The total Joe would pay is</b>	<b>\$3,003</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$85
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,585</b>

## 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 differently because of race, color, national origin, age, disability, or sex.

### **Regence:**

**Provides free aids and services to people with disabilities to communicate effectively with us, such as:**

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

**Provides free language services to people whose primary language is not English, such as:**

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

### **Medicare Customer Service**

1-800-541-8981 (TTY: 711)

### **Customer Service for all other plans**

1-888-344-6347 (TTY: 711)

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 with our civil rights coordinator below:

### **Medicare Customer Service**

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

1-866-749-0355, (TTY: 711)

Fax: 1-888-309-8784

medicareappeals@regence.com

### **Customer Service for all other plans**

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regence.com

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 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, DC 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, kojí' 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, 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፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው 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 निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइप: 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)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ຄວນມີຜ້ອມໃຫ້ທ່ານ. ໂທ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajjila 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 فاذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)



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 regence.com. For provider or benefit questions call VSP at 1 (800) 877-7195. For membership questions, call Regence at 1 (888) 367-2112. 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](http://healthcare.gov/sbc-glossary) or call 1 (888) 367-2112 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	See the chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	See the chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See <a href="http://regence.com/go/VSPNetwork">regence.com/go/VSPNetwork</a> or call 1 (800) 877-7195 for a list of network providers.	This plan uses a provider network (VSP Choice). You will pay less if you use a physician or other health care provider in the plan's network. You will pay the most if you use an out-of-network provider. Be aware, your network doctor may use an out-of-network provider for some services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You pay the least)	Out-of-network Provider (You pay the most)	
<b>If you visit a vision care provider's office or clinic</b>	Routine vision examination	No charge	0% <u>coinsurance</u> up to the <u>out-of-network</u> limit for examination	Limited to 1 routine eye examination / every calendar year. Limited to \$45 / every calendar year for <u>out-of-network providers</u> and you pay the balance.
	Vision hardware	Frames: No charge up to the <u>network</u> limit for frames or contact lenses Lenses: No charge for one pair of standard glass or plastic single vision, lined bifocal, lined trifocal or lenticular lenses	Frames: 0% <u>coinsurance</u> up to the <u>out-of-network</u> limit for frames or contact lenses Lenses: 0% <u>coinsurance</u> up to the <u>out-of-network</u> limit for frames or contact lenses	Frames or elective contact lenses* from a <u>network provider</u> are limited to \$150 / every calendar year and you pay any balance. Frames from a VSP approved wholesale/retail vendor are limited to \$80 / every calendar year and you pay any balance. Frames from an <u>out-of-network provider</u> are limited to \$70 / year and you pay any balance. Lenses from an <u>out-of-network provider</u> are limited to: \$30 for single vision lenses; \$50 for lined bifocal or standard progressive lenses; \$65 for lined trifocal lenses; or \$100 for lenticular lenses. Contact lenses from an <u>out-of-network provider</u> are limited to \$105 for elective contacts* or \$210 for necessary contacts* / every calendar year and you pay any balance. *Contact lenses are instead of all other frame and lens benefits. When you receive elective contact lenses, you will not be eligible for any frames and/or lenses until the next calendar year.
	Contact lens evaluation and fitting examination	\$60 <u>copay</u>	No charge up to the <u>out-of-network provider</u> limit*	Coverage is limited to 1 contact lens evaluation and fitting examination every calendar year. *Coverage from an <u>out-of-network provider</u> is included in the elective contact lens or necessary contact lens allowance described above under Vision hardware.
	Low vision benefits	No charge for supplemental testing; 25% <u>coinsurance</u> for supplemental care aids	No charge up to \$125 for supplemental testing; 25% <u>coinsurance</u> for supplemental care aids	Supplemental testing and supplemental care aids are limited to a combined maximum of \$1,000 every two calendar years and you pay any balance.

**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.)**

- Corrective vision treatment of an experimental nature
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Pediatric vision (under age 19)
- Personal comfort items
- Plano lenses
- Two pair of glasses instead of bifocals

## NONDISCRIMINATION NOTICE

VSP provides administration for your Regence vision plan. 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 differently because of race, color, national origin, age, disability, or sex.

### **Regence:**

**Provides free aids and services to people with disabilities to communicate effectively with us, such as:**

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

**Provides free language services to people whose primary language is not English, such as:**

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

### **VSP**

Medicare 1-844-872-6065  
Commercial 1-844-299-3041  
(TTY: 1-800-428-4833)

If you believe that VSP or 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 with our civil rights coordinator below:

### **Regence**

#### **Medicare Customer Service**

Civil Rights Coordinator  
MS: B32AG, PO Box 1827  
Medford, OR 97501  
1-866-749-0355, (TTY: 711)  
Fax: 1-888-309-8784  
medicareappeals@regence.com

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 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, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

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

#### **Customer Service for all other plans**

Civil Rights Coordinator  
MS CS B32B, P.O. Box 1271  
Portland, OR 97207-1271  
1-888-344-6347, (TTY: 711)  
CS@regence.com

**Language assistance**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: TTY: 1-800-428-4833).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (ATS : 1-800-428-4833)

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。Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yánílti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833.)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

ማስታወሻ:- የሚናገሩት ቋንቋ እማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (መስማት ለተሳናቸው:- 1-800-428-4833)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (телетайп: 1-800-428-4833)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (टिटिवाइ: 1-800-428-4833)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

## Language assistance

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 Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-428-4833)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (TTY: 1-800-428-4833) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذا ذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم Medicare: 1-844-872-6065; Commercial: 1-844-299-3041 (رقم هاتف الصم والبكم والكم (TTY: 1-800-428-4833)