Nez Perce County

Regence BlueShield of Idaho, Inc.

Choice Vision Plan

Effective Date: October 1, 2018

Vision Benefit Summary	
Annual Costs	
Deductible per Calendar Year	$0 Member / $0 Family

	Member Responsibility VSP Doctor	*Member Responsibility Out-of-Network Provider*
Routine Vision Examination Limit: One vision examination per Member every Calendar year. Coverage is limited to $**45** for out-of-network providers.	No charge	No Charge up to the out-of-network provider limit
Routine vision examination and vision hardware Coverage for the examination is limited to 1 every calendar year. Coverage for frames is limited to every calendar year. Frame or elective contact lens* allowance is limited to $**250** from VSP doctors. Frame allowance is limited to $135 for VSP approved wholesale/retail vendor Coverage is limited to glass or plastic single vision lenses, lined bifocal lenses, lined trifocal lenses, standard progressive lens or elective contact lenses* every calendar / plan year. Examination and vision hardware allowance from an out-of-network provider is limited to: **$45** examination; $70 frames; $30 single vision lens, $50 lined bifocal or standard progressive lens, $65 lined trifocal lens, $100 lenticular lens, $105 elective contacts*, or $210 necessary contact lenses*. *Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be	No charge up to the VSP doctor limit	No Charge up to the out-of-network provider limit

	Member Responsibility VSP Doctor	*Member Responsibility Out-of-Network Provider*
eligible for any frames and/or lenses until the next calendar year.		
Contact Lens Evaluation and Fitting Examination Limit: One contact lens evaluation and fitting examination every year**.** *Coverage from an out-of-network provider is limited to the $105 elective contact lens allowance.	**$**60 copay / visit	No charge up to the out-of-network provider limit*
Low Vision Supplemental Testing Limited to $125 for out-of-network providers. Coverage for supplemental testing and supplemental care aids is limited to a combined maximum of $1,000 once every Calendar year**.**	**No** charge	No charge up to the out-of-network provider limit
Low Vision Supplemental Aids Limited to $125 for out-of-network providers. Coverage for supplemental testing and supplemental care aids is limited to a combined maximum of $1,000	25%	25%

General Exclusions

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law.

Certain Contact Lens Expenses: artistically-painted or non-prescription contact lenses; contact lens modification, polishing or cleaning; refitting of contact lenses after the initial (90-day) fitting period; additional office visits associated with contact lens pathology; and contact lens insurance policies or service agreements.

Conditions Caused By Active Participation In a War or Insurrection: The treatment of any condition caused by or arising out of a Member's active participation in a war or insurrection.

Conditions Incurred In or Aggravated During Performances In the Uniformed Services: The treatment of any Member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

Corneal Refractive Therapy (CRT): Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia) or reversals or revisions of surgical procedures which alter the refractive character of the eye.

Corrective Vision Treatment of an Experimental Nature

Cosmetic Services and Supplies: Services and supplies for beautification, cosmetic or aesthetic purposes. Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Expenses Before Coverage Begins or After Coverage Ends: Except for Medically Necessary services and supplies to treat a Congenital Anomaly, We do not cover services and supplies incurred before Your Effective Date under the Contract or after Your termination under the Contract.

Facility Charges: Services and supplies provided in connection with facility services.

Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program, except for facilities that contract with Us and except as required by law, such as for cases of medical emergency or for coverage provided by Medicaid. We do not cover government facilities outside the service area (except as required by law for emergency services).

Investigational Services: Investigational treatments or procedures (Health Interventions), services, supplies and accommodations provided in connection with Investigational treatments or procedures (Health Interventions). We also exclude any services or supplies provided under an Investigational protocol.

Medical or Surgical Treatment of the Eyes: Medical or surgical treatment of the eyes, including reversals or revisions of surgical procedures of the eye.

Motor Vehicle Coverage and Other Available Insurance: Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the Coordination of Benefits provision shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage, excess coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Member, whether or not the Member makes a claim under such coverage. Further, the Member is responsible for any cost-sharing required by the other insurance coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract.

Non-Direct Patient Care: Services that are not direct patient care, including: appointments scheduled and not kept (missed appointments); charges for preparing or duplicating medical reports and chart notes; itemized bills or claim forms (even at Our request); and visits or consultations that are not in person (including telephone consultations and e-mail exchanges).

Orthoptics or Vision Training: Orthoptics or vision training and any associated supplemental testing.

Personal Comfort Items: Items that are primarily for comfort, convenience, cosmetics, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.

Plano Lenses (Less Than a ± .50 Diopter Power)

Replacement of Lenses and Frames: Except at the normal intervals when services are otherwise available, We do not cover replacement of lenses and frames which are lost or broken.

Riot, Rebellion and Illegal Acts: Services and supplies for treatment of an Illness, Injury or condition caused by a Member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a Member arising directly from an act deemed illegal by an officer or a court of law.

Self-Help, Self-Care, Training or Instructional Programs: Self-help, non-vision self-care and training programs. This exclusion does not apply to services for training or educating a Member when provided without separate charge in connection with Covered Services.

Services and Supplies Provided by a Member of Your Family: Services and supplies provided to You by a member of Your immediate family. For purposes of this provision, "immediate family" means: You and Your parents, parents' spouses or domestic partners, spouse **[**or domestic partner**]**, children, stepchildren, siblings and half-siblings; Your spouse's **[**or domestic partner's**]** parents, parents' spouses or domestic partners, siblings and half-siblings; Your child's or stepchild's spouse or domestic partner; and any other of Your relatives by blood or marriage or who shares a residence with You.

Services and Supplies That Are Not Medically Necessary: Services and supplies that are not Medically Necessary for the treatment of the diagnosis or correction of visual acuity.

Third-Party Liability: Services and supplies for treatment of Illness or Injury for which a third-party is or may be responsible.

Travel and Transportation Expenses: Travel and transportation expenses.

Two Pair of Glasses in Lieu of Bifocals

Work-Related Conditions: Expenses for services and supplies incurred as a result of any work-related Injury or Illness, including any claims that are resolved related to a disputed claim settlement. We may require the Member to file a claim for workers' compensation benefits before providing any benefits under this coverage. We do not cover services and supplies received for work-related Injuries or Illnesses even if the service or supply is not a covered workers' compensation benefit. The only exception is if a Member is exempt from state or federal workers' compensation law.

Please note: This benefit summary provides a brief description or illustration of your health care plan benefits, limitations and/or exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, **www.Regence.com**. Please refer to your benefits booklet or Summary Plan Description for a complete list of benefits, the limitations and/or exclusions that apply, and a definition of medical necessity. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

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VSP is a separate and independent company that provides vision services for Regence BlueShield of Idaho members