# Regence BlueShield of Idaho: Regence Vision Plan

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 10/01/2013 - 09/30/2014**

**Coverage for:** Individual & Eligible Family

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myRegence.com or by calling 1 (888) 367-2117. (Note: the Uniform Glossary can be accessed at: www.cciio.cms.gov.)

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** member / **$0** family per calendar year. | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | No. | There's no limit on how much you could pay during a coverage period for your share of the cost of covered services. |
| **What is not included in the out–of–pocket limit?** | This plan has no **out-of-pocket limit**. | Not applicable because there's no **out-of-pocket limit** on your expenses. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.myRegence.com or call 1 (888) 367-2117 for lists of in-network or out-of-network **providers**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about **excluded services**. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered vision care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a vision examination is $50, your **co-insurance** payment of 20% would be $10. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network provider charges $150 for a vision examination and the **allowed amount** is $50, you may have to pay the $100 difference. (This is called **balance billing**.)

| Common Medical Event | Services You May Need | Your cost if you use a | | | Limitations & Exceptions |
|---|---|---|---|---|---|
| | | Preferred Provider | Participating Provider | Non-Participating Provider | |
| **If you visit an eye care provider's office or clinic** | Routine vision examination | No charge | No charge | No charge | Coverage is limited to 1 routine eye exam per year.<br><br>Coverage is limited to $150 for covered vision hardware per year and you pay any balance. |
| | Vision hardware | No charge up to $150 hardware maximum | No charge up to $150 hardware maximum | No charge up to $150 hardware maximum | |

## Excluded Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Contact fittings
- Cosmetic services and supplies
- Fees, taxes, interest
- Non-direct patient care
- Medical services
- Personal comfort items
- Prescription medication
- Vision therapy and surgery