

Regence Vision Plan



Regence BlueShield of Idaho is an
Independent Licensee of the Blue Cross
and Blue Shield Association

CLARKSTON SCHOOL DISTRICT
Effective Date: October 1, 2012

Benefit Summary

You Select Your Provider and Control Your Out-of-Pocket Expenses

- **Category 1.** You choose to see a preferred provider and save the most in your out-of-pocket expenses. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. You can find a list of providers at our Website or by calling Customer Service.
- **Category 2.** You choose to see a participating provider and your out-of-pocket expenses will generally be higher than if you choose Category 1 because we may negotiate larger discounts with preferred providers that will result in lower out-of-pocket amounts for you. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services.
- **Category 3.** You choose to see a provider that does not have a participating contract with us and your out-of-pocket expenses will generally be higher than Category 1. **Also, choosing this category means you may be billed for balances beyond any deductible, copayment, and/or coinsurance.** This is sometimes referred to as balance billing.

Covered Medical Services (Per Member)	Member Responsibility Category 1	Member Responsibility Category 2	Member Responsibility Category 3
Vision Services <ul style="list-style-type: none">▪ Exam: 1 routine eye exam per calendar year▪ Hardware: \$150 per calendar year maximum benefit	0%	0%	0%

BlueCard[®] Program (Out of Area Services)

The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call 1 (800) 810-BLUE (2583).

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.

Vision Exclusions

Condition 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.

Condition 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.

Contact Fittings

Cosmetic Services and Supplies

Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract.

Facility Charges

Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a provider might bill.

Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.

Vision Exclusions

Motor Vehicle No-Fault Coverage

Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing or duplicating medical reports and chart notes, itemized bills or claim forms and visits or consultations that are not in person, including telephone consultations and email exchanges.

Personal Comfort Items: Items that are primarily for comfort, convenience, cosmetics, environmental control or education.

Services and Supplies Provided by a Member of Your Family**Services and Supplies That Are Not Medically Necessary**

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

Vision Care: Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye.

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. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

Please note: This benefit summary provides a brief description of your health care plan benefits, limitations and 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.myRegence.com**. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.



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Contact Customer Service at 1 (888) 367-2117

Or write to us at 1602 21st Avenue, Lewiston, ID
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www.regence.com