Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual and/or Family | **Plan Type:** Vision

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.vsp.com or by calling 1-800-877-7195.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Doesn't apply	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Doesn't apply	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Doesn't apply	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Doesn't apply	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes. $115 for frames every 24 months, $105 for contacts per year	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.vsp.com **or call 1-800-877-7195** for a list of participating 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 4. See your policy or plan document for additional information about **excluded services**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health 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 an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. 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 hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	**Vision Examination**	100% with $10.00 copay	Up to $35	• Once every 12 months • Optional cosmetic processes
Vision Care Materials	**Frames**	Up to $115	Up to $45	• 20% discount off the amount over your allowance • Once every 24 months
Contact Lenses (fitting and evaluation)	**Necessary professional materials**	100% up to $105	Up to $105	• 15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting • use the full contact lens allowance toward contact lenses

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
	Elective Professional materials	Up to $105	Up to $105	15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting
Lenses	**Single Vision**	100% with $25.00 copay	Up to $25	• Once every 12 months
	Bifocal	100% with $25.00 copay	Up to $40	Once every 12 months
	Trifocal	100% with $25.00 copay	Up to $55	Once every 12 months
	Lenticular	100% with $25.00 copay	Up to $80	Once every 12 months

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
Additional Benefits	**LOW VISION** Professional services for severe visual problems not corrected with regular lenses, including: Supplemental Testing(includes evaluation, diagnosis and prescription of vision aids where indicated)	100%	Up to $125	Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.
	Supplemental Aids	75% of cost	75% of cost	

Excluded Services & Other Covered Services:

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

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
- Services/materials not indicated as covered Plan Benefits on the enclosed insert.
- Corrective vision treatment of an Experimental Nature

Other Covered Services with Limitations and Exclusions (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Standard and premium fit contact lens wearers a covered-in-full contact lens exam after a copay that will never exceed $60
- $7540/$4100 Coverage examples
- Anti-reflective coating
- Mirror coating
- Scratch coating
- Color coating
- Laminated lenses
- Polycarbonate lenses
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Blended lenses or Cosmetic lenses
- Oversize lenses or Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Certain limitations on low vision care
- Laser Vision Correction- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.

Your Rights to Continue Coverage:

**** Individual health insurance sample –**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

OR

**** Group health coverage sample –**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

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

About these Coverage Examples:

This does not apply to your Vision Coverage

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $0
- **Patient pays** $7,540

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Co-pays	$30
Co-insurance	$1320
Limits or exclusions	$0
Total	**$7,540**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

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- **Amount owed to providers:** $4,100
- **Plan pays** $0
- **Patient pays** $ 4,100

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$800
Co-pays	$500
Co-insurance	$240
Limits or exclusions	$80
Total	**$4,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.