Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 9/1/2023 – 8/31/2024 Regence BlueShield of Idaho, Inc.: Regence HSA Healthplan 3.0℠ Coverage for:** Individual and Eligible Family | **Plan Type:** PPO

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 https://regence.com/go/2023/booklet/ID/HSA3.051-100 or call 1 (888) 367-2117. 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 or call 1 (888) 367-2117 to request a copy.

What is the overall deductible?	$2,500 individual (single coverage) / $5,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services coveredbefore you meet your deductible?	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 healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductiblesfor specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual (single coverage) / $10,000family* per calendar year. *An individual on family coverage will not havetheir out-of-pocket limit exceed $6,850.	The out-of-pocket limit is the most you could pay in a year for covered services. If youhave other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in theout-of-pocket limit?	Premiums, balance-billing charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you usea network provider?	Yes. See https://regence.com/go/ID/Preferredor call 1 (888) 367-2117 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 beforeyou get services.
Do you need a referral to see a specialist?	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 (You will pay the least)	Limitations, Exceptions, & Other Important Information (You will pay the most)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance 50% coinsurance [redacted]	None
	Preventive care/screening/ immunization	No charge 50% coinsurance You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	None
	Diagnostic test (x-ray,		

If you have a test	blood work)	30% coinsurance	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				Prescription drugs not on the Drug List are not covered, unless an exception is approved.

Medication List.
90-day supply / retail prescription (your cost share is per 30-day supply)
90-day supply / home delivery (mail order) prescription
30-day supply / specialty drug prescription Specialty drugs are not available through home delivery (mail order).
Coverage includes compound medications at 50% coinsurance.
Cost shares for tier 2 insulin will not exceed $100 / 30-day supply retail prescription or $300 / 90-day supply home delivery (mail order) prescription.
No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance.

Tier 2 30% coinsurance / retail prescription 30% coinsurance / home delivery prescription

If you need drugs to treat your illness or condition
More information about **prescription drug coverage** is available at https://regence.com/go/ 2023/ID/3tier

Tier 1 30% coinsurance / retail prescription 30% coinsurance / home delivery prescription

Tier 3 30% coinsurance / retail prescription 30% coinsurance / home delivery prescription
Deductible does not apply for tier 2 insulin and drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value

Specialty drugs Refer to tier 2 and tier 3 drugs above.

90% coinsurance / specialty drug
The first fill of specialty drugs for hemophilia may be provided by a retail pharmacy; additional fills must be provided by a specialty pharmacy or a specialty pharmacy designated as a hemophilia treatment center.

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
			20% coinsurance for

	ambulatory surgery centers;	center physicians;
50% coinsurance None	30% coinsurance for all other facilities	30% coinsurance for all other physicians
	surgery	
If you have outpatient Facility fee (e.g., ambulatory surgery center)	Physician/surgeon fees 20% coinsurance for ambulatory surgery	50% coinsurance None
[redacted]	[redacted]	[redacted]
transportation	30% coinsurance	30% coinsurance None
Emergency medical		
If you need immediate medical attention		
Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.	None
Facility fee (e.g.,		
If you have a hospital	30% coinsurance	50% coinsurance None hospital room)
stay Physician/surgeon fees	30% coinsurance	50% coinsurance None
If you need mental health, behavioral health, or substance	Outpatient services 30% coinsurance	50% coinsurance None
abuse services	Inpatient services 30% coinsurance	50% coinsurance None
professional services	Office visits 30% coinsurance 50% coinsurance Childbirth/delivery 30% coinsurance 50% coinsurance **If you are pregnant** Childbirth/delivery facility services 30% coinsurance 50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity caremay include tests and services described elsewhere inthe SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You Will Pay (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	[redacted]			130 visits / year
				22 inpatient days / year
		coinsurance	Habilitation services 30% coinsurance 50%	Includes physical therapy, occupational therapy and speech therapy.
If you need help recovering or have other special health needs				28 neurodevelopmental visits / year
		coinsurance		Neurodevelopmental therapy limited to individuals under age 7.
	Rehabilitation services	30% coinsurance	50%	Includes physical therapy, occupational therapy and speech therapy.
				30 outpatient visits / year
	[redacted]			
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	[redacted]			
If your child needs	[redacted]			**dental or eye care**
				Children's dental check-up
		Not covered	Not covered	None

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.)

- Abortion, except when performed to preserve the life of the enrolled individual
- Acupuncture
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) • Chiropractic care, spinal manipulations only • Hearing aids • Non-emergency care when traveling outside the U.S.

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, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2117. 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 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) 367-2117 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Idaho Department of Insurance by calling 1 (208) 334-4250 or the toll-free message line at 1 (800) 721-3272; by writing to the Idaho Department of Insurance, Consumer Affairs, 700 W State Street, 3rd Floor; P.O. Box 83720, Boise, ID 83720-0043; through the Internet at: doi.idaho.gov; or by E-mail at: consumeraffairs@doi.idaho.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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) 367-2117.

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.

■ **The plan's overall deductible $2,500** ■ **The plan's overall deductible $2,500** ■ **The plan's overall deductible $2,500**■ **Specialist coinsurance 30%** ■ **Specialist coinsurance 30%** ■ **Specialist coinsurance 30%**■ **Hospital (facility) coinsurance 30%** ■ **Hospital (facility) coinsurance 30%** ■ **Hospital (facility) coinsurance 30%**■ **Other coinsurance 30%** ■ **Other coinsurance 30%** ■ **Other coinsurance 30%**

This EXAMPLE event includes services like: This EXAMPLE event includes services like: This EXAMPLE event includes services like: Specialist office visits (*prenatal care)* Primary care physician office visits *(including* Emergency room care *(including medical supplies)* Childbirth/Delivery Professional Services *disease education)* Diagnostic test *(x-ray)* Childbirth/Delivery Facility Services Diagnostic tests *(blood work)* Durable medical equipment *(crutches)* Diagnostic tests (*ultrasounds and blood work)* Prescription drugs Rehabilitation services *(physical therapy)* Specialist visit *(anesthesia)* Durable medical equipment *(glucose meter)*

Total Example Cost [redacted] **Total Example Cost** [redacted] **Total Example Cost** [redacted]

In this example, Peg would pay: In this example, Joe would pay: In this example, Mia would pay: *Cost Sharing Cost Sharing Cost Sharing* Deductibles $2,500 Deductibles $2,029 Deductibles $2,500Copayments [redacted] $0 [redacted] $0Coinsurance $2,500 Coinsurance $937 Coinsurance $90*What isn't covered What isn't covered What isn't covered* Limits or exclusions $61 Limits or exclusions $178 Limits or exclusions $0**The total Peg would pay is** [redacted] **The total Joe would pay is** [redacted] **The total Mia would pay is** [redacted]

The plan would be responsible for the other costs of these EXAMPLE covered services.

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.

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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。

ti’go **Diné**
Bizaad, saad
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, បសវាជំនួយខ្នកភាសា ោយមិនគិត្ឈ្នួល គឺអាចមានសំរាប់បំរើ អ្នក។ ចូរ ទូរស័ព្ទ1-888-344- 6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇਤੁਸੀਂ ਪੰ ਜਾਬੀ ਬੋਲਿਹੇ, ਤਾਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344- 6347 (TTY: 711) 'ਤੇਕਾਲ 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 ሊያግዝዎት ተዘጋጀተዋል፤ 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 दिनहोस्: तपाइंलेनेपाली बोल्नहुन्छ भनेतपाइंको दनदतत भाषा सहायता सेवाहरू दनिःशल्ुक रूपमा उपलब्ध छ । फोन गनुहोस्1-888-344-6347 (दिदिवाइ: 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: ถา้คุณพดู ภาษาไทยคุณสามารถใชบ้ ริการช่วยเหลือทางภาษาไดฟ้ รี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,
ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیالت زبانی بصورت رایگان برای شما
.تماس بگیرید 6347-344-888-1) TTY: فراهم می باشد. با (711

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347
)رقم هاتف الصم والبكم 711
:TTY (

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 9/1/2023 – 8/31/2024 Regence BlueShield of Idaho, Inc.: Regence Choice Vision Plan Coverage for:** Individual and Eligible Family

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 https://regence.com. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions call Regence at 1 (888) 367-2117. 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 or call 1 (888) 367-2117 to request a copy.

What is the overall deductible?	$0	See the Common Vision Event chart below for your costs for services this plan covers.
Are there services coveredbefore you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this plan covers.
Are there other deductiblesfor specific services?	No.	See the Common Vision Event 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 theout-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you usea network provider?	Yes. See https://regence.com/go/ID/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This plan uses a vision provider network (Vision Service Plan). You will pay less if youuse a vision provider in the plan's network. You will pay the most if you use an out-of- network vision provider, and you might receive a bill from a vision provider for the difference between the provider's charge and what your plan pays (balance

		billing).
Do you 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	Limitations, Exceptions, & Other Important Information	What You Will Pay (You will pay the least)	What You Will Pay (You will pay the most)
examination	No charge	No charge up to the out-of-network provider limit Routine vision		For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement.
If you visit a vision care provider's office or clinic		1 routine eye examination / calendar year Routine eye examination limited to $45 for out-of- network providers. For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 pair of frames / calendar year Frames limited to $200 for VSP doctors. Frames limited to $110 for VSP approved wholesale/retail vendors. Frames limited to $70 for out-of-network providers. 1 pair of standard glass or plastic lenses / calendar year for either:		

Vision hardware limit	No charge up to the VSP doctor No charge up to the out-of- network provider limit	Lined trifocal lenses; Lenticular lenses; or Contact lenses*. Elective contact lenses* limited up to $200 for VSP doctors. Necessary contact lenses* limited to a calendar year supply for VSP doctors.	Single vision lenses limited to $30 for out-of-network providers. Lined bifocal (or standard progressive) lenses limited to $50 for out-of-network providers.

Services You May Need	Limitations, Exceptions, & Other Important Information	What You Will Pay Common Vision Event (You will pay the least)	(You will pay the most)
			Lined trifocal lenses limited to $65 for out-of-network providers. Lenticular lenses limited to $100 for out-of-network providers. Elective contact lenses* (including fitting/evaluation services) limited to $105 once / calendar year for out-of-network providers. Necessary contact lenses* (including fitting/evaluation services) limited to a calendar year supply up to $210 for out-of-network providers. *Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames or other types of lenses until the next calendar year. For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 contact lens evaluation and fitting examination /

and fitting examination	$60 copay	No charge up to the out-of-network provider limit	care aids Elective contact lens evaluation and fitting examination (including elective contact lenses) limited to $105 for out-of-network providers. Necessary contact lens evaluation and fitting examination (including necessary contact lenses) limited to $210 for out-of-network providers. For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement.
examinations (testing)	No charge	No charge up to the out-of-network provider limit	$1,000 low vision maximum / 2 calendar years, including supplemental examinations (testing) and care aids 2 supplemental examinations / 2 calendar years Supplemental examinations limited to $125 for out-of- network providers.
Low vision supplemental			

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 and interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Plano lenses
- Two pair of glasses in lieu of bifocals

VSP is a separate company that provides vision benefit services.