



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) 232-5763. (Note: the Uniform Glossary can be accessed at: www.cciio.cms.gov.)

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$5,000 per insured / \$10,000 per family per calendar year. Doesn't apply to certain preventive care or upfront benefits. Co-payments or amounts in excess of the allowed amount do not count toward the deductible .	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?	Yes. \$3,000 per insured for preferred brand name prescription drugs and \$7,500 for routine maternity services. There are no other specific deductibles .	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?	Yes. \$4,000 per insured / \$8,000 per family per calendar year.	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 ?	Co-payments, deductibles, premiums, balanced-billed charges, and health care this plan doesn't cover.	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. \$2,000,000 annual medical limit.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers ?	Yes. See www.myRegence.com or call 1 (888) 232-5763 for lists of preferred or 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 5. See your policy or plan document for additional information about excluded services .

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If you aren't clear about any of the bolded terms used in this form, see the Glossary.

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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 Preferred **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
		Preferred Provider	Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay / visit, other services 30% co-insurance	\$35 co-pay / visit, other services 50% co-insurance	\$35 co-pay / visit, other services 50% co-insurance	Co-payment applies to upfront office visit only, deductible waived (limit of 4 upfront visits per calendar year). All other services are covered at the benefits specified for the service received.
	Specialist visit	\$35 co-pay / visit, other services 30% co-insurance	\$35 co-pay / visit, other services 50% co-insurance	\$35 co-pay / visit, other services 50% co-insurance	
	Other practitioner office visit	30% co-insurance	50% co-insurance	50% co-insurance	————— none —————
	Preventive care/ screening/immunization	No charge	No charge	50% co-insurance	Deductible waived for preventive care services for non-participating providers .
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first \$200 / year, then 30% co-insurance	No charge for the first \$200 / year, then 50% co-insurance	No charge for the first \$200 / year, then 50% co-insurance	No charge for the first \$200 per calendar year for upfront outpatient laboratory and radiology services, deductible waived. Once the limit has been met and for all inpatient services, services are covered at the co-insurance specified, after deductible .
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	50% co-insurance	————— none —————
If you need drugs to treat your illness or condition	Generic drugs	\$10 co-pay / retail prescription \$30 co-pay / mail order prescription \$10 co-pay for self-administrable cancer chemotherapy drugs No charge for preventive medications			Coverage is limited to a 30-day supply retail or 90-day supply mail order. Deductible does not apply to generic drugs, certain preventive drugs and

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Preferred Provider	Participating Provider	Non–Participating Provider	
More information about prescription drug coverage is available at www.RegenceRx.com .	Preferred brand drugs	50% co–insurance / retail prescription 50% co–insurance / mail order prescription \$50 co–pay for self–administrable cancer chemotherapy drugs No charge for preventive medications			immunizations at a participating pharmacy, and self–administrable cancer chemotherapy drugs.
	Non–preferred brand drugs	\$100 co–pay for self–administrable cancer chemotherapy drugs, all other medications are not covered No charge for preventive medications			
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs above.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co–insurance	50% co–insurance	50% co–insurance	_____none_____
	Physician/surgeon fees	30% co–insurance	50% co–insurance	50% co–insurance	_____none_____
If you need immediate medical attention	Emergency room services	30% co–insurance after \$150 co–pay	30% co–insurance after \$150 co–pay	30% co–insurance after \$150 co–pay	Co–payment applies to the facility charge for each visit whether or not the deductible has been met and is waived if admitted directly to a hospital or facility on an inpatient basis.
	Emergency medical transportation	30% co–insurance	30% co–insurance	30% co–insurance	_____none_____
	Urgent care	Covered the same as the If you visit a health care provider’s office or clinic or If you have a test Common Medical Events.			_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co–insurance	50% co–insurance	50% co–insurance	_____none_____
	Physician/surgeon fee	30% co–insurance	50% co–insurance	50% co–insurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	Not covered	_____none_____
	Mental/Behavioral health inpatient services	Not covered	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	Not covered	

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Preferred Provider	Participating Provider	Non-Participating Provider	
	Substance use disorder inpatient services	Not covered	Not covered	Not covered	
If you are pregnant	Prenatal and postnatal care	30% co-insurance after maternity deductible for routine maternity services	50% co-insurance after maternity deductible for routine maternity services	50% co-insurance after maternity deductible for routine maternity services	Maternity care complications are covered the same as any injury or illness.
	Delivery and all inpatient services	30% co-insurance after maternity deductible for routine maternity services	50% co-insurance after maternity deductible for routine maternity services	50% co-insurance after maternity deductible for routine maternity services	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	50% co-insurance	Coverage is limited to 130 visits / calendar year.
	Rehabilitation services	30% co-insurance	50% co-insurance	50% co-insurance	Coverage is limited to 15 inpatient days / calendar year. Coverage is limited to 20 outpatient physical therapy visits / calendar year. Coverage is limited to 20 outpatient occupational therapy visits / calendar year. Coverage is limited to 20 outpatient speech therapy visits / calendar year.
	Habilitation services	30% co-insurance	50% co-insurance	50% co-insurance	Coverage for neurodevelopmental therapy is limited to 15 inpatient visits and 20 outpatient visits (combined with inpatient and outpatient rehabilitation services)/ calendar year.
	Skilled nursing care	30% co-insurance	50% co-insurance	50% co-insurance	Coverage is limited to 30 inpatient days / calendar year.
	Durable medical equipment	30% co-insurance	50% co-insurance	50% co-insurance	—————none—————
	Hospice service	30% co-insurance	50% co-insurance	50% co-insurance	—————none—————
If your child needs	Eye exam	Not covered	Not covered	Not covered	—————none—————

Common Medical Event	Services You May Need	Your cost if you use a			Limitations & Exceptions
		Preferred Provider	Participating Provider	Non-Participating Provider	
dental or eye care	Glasses	Not covered	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	Not covered	_____none_____

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.)		
• Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery, except congenital anomalies • Dental care (Adult)	• Hearing aids • Infertility treatment • Long-term care • Mental/Behavioral health	• Private-duty nursing • Routine eye care • Routine foot care except for diabetic patients • Substance use disorder services • Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Non-emergency care when traveling outside the U.S.		

Your Rights to Continue Coverage:

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 of the coverage area

For more information on your rights to continue coverage, contact the insurer at 1 (888) 232-5763. You may also contact your state insurance department at 1 (800) 721-3272 or www.doi.idaho.gov.

Your Grievance and Appeals Rights:

- Contact the Idaho Department of Insurance at 1 (800) 721-3272 or www.doi.idaho.gov.

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 232-5763.

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

About these Coverage Examples:

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
- Patient pays

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	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays
- Patient pays

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	

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.

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