



**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](http://www.myRegence.com) or by calling 1 (877) 508-7359. (Note: the Uniform Glossary can be accessed at: [www.cciio.cms.gov](http://www.cciio.cms.gov).)

| Important Questions                                       | Answers                                                                                                                                                                                                                                                                      | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <b>deductible</b> ?                   | <b>\$1,500</b> per insured / <b>\$3,000</b> per family per calendar year.<br>Doesn't apply to certain preventive care or certain preventive medications.<br><b>Co-payments</b> or amounts in excess of the <b>allowed amount</b> do not count toward the <b>deductible</b> . | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .                                                                                             |
| Are there other <b>deductibles</b> for specific services? | No.                                                                                                                                                                                                                                                                          | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                              |
| Is there an <b>out-of-pocket limit</b> on my expenses?    | Yes. <b>\$5,000</b> per insured / <b>\$10,000</b> per family per calendar year.                                                                                                                                                                                              | The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> ?  | <b>Premiums</b> , balance-billed charges, and health care this plan doesn't cover.                                                                                                                                                                                           | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| Is there an overall annual limit on what the plan pays?   | Yes. <b>\$2,000,000</b> 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 <b>network</b> of <b>providers</b> ? | Yes. See <a href="http://www.myRegence.com">www.myRegence.com</a> or call 1 (877) 508-7359 for lists of <b>preferred</b> or participating <b>providers</b> .                                                                                                                 | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <b>specialist</b> ?         | No. You don't need a referral to see a <b>specialist</b> .                                                                                                                                                                                                                   | You can see the <b>specialist</b> 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 <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

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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 | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           | _____none_____                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                               | Specialist visit                                 | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           |                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | Other practitioner office visit                  | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           | _____none_____                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                               | Preventive care/ screening/immunization          | No charge                                                             | No charge              | 50% co–insurance           | <b>Deductible</b> waived for preventive care services for non–participating providers.                                                                                                                                                                                                                 |
| If you have a test                                                                                                                                                                            | Diagnostic test (x–ray, blood work)              | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           | _____none_____                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                     | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           |                                                                                                                                                                                                                                                                                                        |
| If you need drugs to treat your illness or condition<br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.RegenceRx.com">www.RegenceRx.com</a> | Generic drugs                                    | 50% co–insurance / retail and mail order prescription                 |                        |                            | Coverage is limited to 90–day supply retail / mail order for generic; 30–day supply retail / mail order for injectable medications and self–administrable cancer chemotherapy medications. <b>Deductible</b> does not apply to certain preventive drugs and immunizations at a participating pharmacy. |
|                                                                                                                                                                                               | Preferred brand drugs                            | 50% co–insurance / retail and mail order prescription                 |                        |                            |                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | Non–preferred brand drugs                        | Not covered                                                           |                        |                            |                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                               | 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)   | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           | _____none_____                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                               | Physician/surgeon fees                           | 50% co–insurance                                                      | 50% co–insurance       | 50% co–insurance           | _____none_____                                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                   | Services You May Need                        | Your cost if you use a                                                                                                                    |                        |                            | Limitations & Exceptions                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                              | Preferred Provider                                                                                                                        | Participating Provider | Non-Participating Provider |                                                                                                                                                                                                                                                                                                                |
| If you need immediate medical attention                                | Emergency room services                      | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           | _____none_____                                                                                                                                                                                                                                                                                                 |
|                                                                        | Emergency medical transportation             | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           | _____none_____                                                                                                                                                                                                                                                                                                 |
|                                                                        | Urgent care                                  | Covered the same as the <b>If you visit a health care provider's office or clinic</b> or <b>If you have a test</b> Common Medical Events. |                        |                            | _____none_____                                                                                                                                                                                                                                                                                                 |
| If you have a hospital stay                                            | Facility fee (e.g., hospital room)           | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           | _____none_____                                                                                                                                                                                                                                                                                                 |
|                                                                        | Physician/surgeon fee                        | 50% 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 | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           | Coverage is limited to 20 outpatient visits / year.<br>Coverage is limited to 8 inpatient days / year.                                                                                                                                                                                                         |
|                                                                        | Mental/Behavioral health inpatient services  | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           |                                                                                                                                                                                                                                                                                                                |
|                                                                        | Substance use disorder outpatient services   | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           |                                                                                                                                                                                                                                                                                                                |
|                                                                        | Substance use disorder inpatient services    | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           |                                                                                                                                                                                                                                                                                                                |
| If you are pregnant                                                    | Prenatal and postnatal care                  | Not covered                                                                                                                               | Not covered            | Not covered                | Maternity care complications are covered the same as any injury or illness.                                                                                                                                                                                                                                    |
|                                                                        | Delivery and all inpatient services          | Not covered                                                                                                                               | Not covered            | Not covered                |                                                                                                                                                                                                                                                                                                                |
| If you need help recovering or have other special health needs         | Home health care                             | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           | Coverage is limited to 130 visits / calendar year.                                                                                                                                                                                                                                                             |
|                                                                        | Rehabilitation services                      | 50% co-insurance                                                                                                                          | 50% co-insurance       | 50% co-insurance           | Coverage is limited to 15 inpatient days / calendar year.<br>Coverage is limited to 20 outpatient physical therapy visits / calendar year.<br>Coverage is limited to 20 outpatient occupational therapy visits / calendar year.<br>Coverage is limited to 20 outpatient speech therapy visits / calendar year. |

| Common Medical Event                   | Services You May Need     | Your cost if you use a |                        |                            | Limitations & Exceptions                                                                                                                                                           |
|----------------------------------------|---------------------------|------------------------|------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                           | Preferred Provider     | Participating Provider | Non-Participating Provider |                                                                                                                                                                                    |
|                                        | Habilitation services     | 50% co-insurance       | 50% co-insurance       | 50% co-insurance           | Coverage for neurodevelopmental therapy is limited to 15 inpatient days and 20 outpatient visits (combined with inpatient and outpatient rehabilitation services) / calendar year. |
|                                        | Skilled nursing care      | 50% co-insurance       | 50% co-insurance       | 50% co-insurance           | Coverage is limited to 30 inpatient days / calendar year.                                                                                                                          |
|                                        | Durable medical equipment | 50% co-insurance       | 50% co-insurance       | 50% co-insurance           | —————none—————                                                                                                                                                                     |
|                                        | Hospice service           | 50% co-insurance       | 50% co-insurance       | 50% co-insurance           | —————none—————                                                                                                                                                                     |
| If your child needs dental or eye care | Eye exam                  | Not covered            | Not covered            | Not covered                | —————none—————                                                                                                                                                                     |
|                                        | Glasses                   | Not covered            | Not covered            | Not covered                |                                                                                                                                                                                    |
|                                        | 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.)                                                                             |                                                                                                                                                        |                                                                                                                                                                                                 |
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Cosmetic surgery, except congenital anomalies</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care</li><li>• Routine foot care except for diabetic patients</li><li>• Routine maternity services</li><li>• Weight loss programs</li></ul> |
| 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.)                                                       |                                                                                                                                                        |                                                                                                                                                                                                 |
| <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>                                                                                                        |                                                                                                                                                        |                                                                                                                                                                                                 |

## 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 (877) 508-7359. You may also contact your state insurance department at 1 (800) 721-3272 or [www.doi.idaho.gov](http://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](http://www.doi.idaho.gov).

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (877) 508-7359.

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

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## 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 \$110
- Patient pays \$7,430

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$20           |
| Co-pays              | \$0            |
| Co-insurance         | \$0            |
| Limits or exclusions | \$7,410        |
| <b>Total</b>         | <b>\$7,430</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$1,960
- Patient pays \$3,440

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,500        |
| Co-pays              | \$0            |
| Co-insurance         | \$1,900        |
| Limits or exclusions | \$40           |
| <b>Total</b>         | <b>\$3,440</b> |

## 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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