



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> or call 1 (800) 854-5585. 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 (800) 854-5585 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u>? | \$2,000 individual (single coverage) / \$4,000 family per plan year. | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply." | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In- <u>network provider</u> : \$5,000 individual (single coverage) / \$10,000 family* per plan year. Out-of- <u>network provider</u> : \$6,500 individual (single coverage) / \$13,000 family per plan year. *An individual on family coverage will not have their in- <u>network out-of-pocket limit</u> exceed \$5,000. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See https://regence.com/go/ID/Preferred or call 1 (800) 854-5585 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| | | |
|--|-----|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |
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 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 | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (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 | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Telehealth services also available. |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | <u>Preventive care/screening/immunization</u> | No charge, <u>deductible</u> does not apply | 40% <u>coinsurance</u> | No charge, <u>deductible</u> does not apply for immunizations from <u>out-of-network providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://regence.com/go/2024/ID/6tier | Tier 1 (Typically, generic drugs with highest overall value) | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | <u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply for most diabetic drugs. No charge, <u>deductible</u> does not apply / retail diabetic supply (non-insulin). No charge, <u>deductible</u> does not apply / home delivery diabetic supply (non-insulin). No charge, <u>deductible</u> does not apply for drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. 34-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription |
| | Tier 2 (Typically, generic drugs with moderate overall value) | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | |
| | Tier 3 (Typically, brand drugs with moderate overall value) | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Tier 4 (Typically, brand drugs with lower overall value) | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | 20% <u>coinsurance</u> / retail prescription; 20% <u>coinsurance</u> / home delivery prescription | <p><u>Specialty drugs</u> are not available through home delivery. Coverage includes compound medications at 50% <u>coinsurance</u>. <u>Cost shares</u> for tier 3 insulin will not exceed \$100 / 30-day supply retail prescription or \$300 / 90-day supply home delivery prescription. No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u>. The first fill of <u>specialty drugs</u> 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.</p> |
| | Tier 5 (Typically, specialty drugs with moderate overall value) | 20% <u>coinsurance</u> / <u>specialty drug</u> | 90% <u>coinsurance</u> / <u>specialty drug</u> | |
| | Tier 6 (Typically, specialty drugs with lower overall value) | 20% <u>coinsurance</u> / <u>specialty drug</u> | 90% <u>coinsurance</u> / <u>specialty drug</u> | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians | 40% <u>coinsurance</u> | |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Telehealth services also available. EAP available, up to 6 sessions. |
| | Inpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | 20 outpatient visits combined for occupational and speech therapy / year 40 outpatient visits for physical therapy / year Includes physical therapy, occupational therapy and speech therapy. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | 20 neurodevelopmental visits combined for occupational and speech therapy / year 40 neurodevelopmental visits for physical therapy / year Neurodevelopmental therapy limited to individuals under age 7. Includes physical therapy, occupational therapy and speech therapy. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | 30 inpatient days / year |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Hospice services</u> | No charge | 40% <u>coinsurance</u> | |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Children's dental check-up | Not covered | Not covered | |

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
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- 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.)

- Acupuncture, 18 visits / year combined with chiropractic care
- Chiropractic care, 18 visits / year combined with acupuncture
- Hearing aids (children under age 26), 2 devices / every 3 years
- 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 (800) 854-5585. 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 (800) 854-5585 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 (800) 854-5585.

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **\$2,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductibles</u> | \$2,000 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,000 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$4,060 |
|-----------------------------------|----------------|

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **\$2,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductibles</u> | \$2,000 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$10 |

What isn't covered

| | |
|----------------------|-------|
| Limits or exclusions | \$200 |
|----------------------|-------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$2,210 |
|-----------------------------------|----------------|

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **\$2,000**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|--------------------|---------|
| <u>Deductibles</u> | \$2,000 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$200 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$2,200 |
|-----------------------------------|----------------|

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