



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.Regence.com or by calling 1 (888) 367-2119.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$1,000 member/ \$2,000 family per calendar year. Out-of-network: \$2,000 member/ \$4,000 family per calendar year. Doesn't apply to upfront lab and x-ray or upfront benefits. Additionally, doesn't apply to the following in-network services: certain preventive care or outpatient mental health and substance abuse. Copayments 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 <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$3,500 member/ \$7,000 family per calendar year. Out-of-network: \$7,000 member/ \$14,000 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 <u>out-of-pocket limit</u> ?	Premiums , balance-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 .
Does this plan use a <u>network of providers</u> ?	Yes. See www.Regence.com or call 1 (888) 367-2119 for lists of in-network or out-of-network 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 <u>specialist</u> ?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without permission from this plan.

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

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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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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 in-network and out-of-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay / visit, other services 20% coinsurance	40% coinsurance	Copayment applies to each in-network upfront visit only, deductible waived. Expanded services (medical, surgical services and therapeutic injections), deductible waived for in-network providers . All other services are covered at the coinsurance specified, after deductible .
	Specialist visit	\$45 copay / visit, other services 20% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance for spinal manipulations	40% coinsurance for spinal manipulations	Coverage is limited to 10 spinal manipulations / year.
	Preventive care/ screening/immunization	No charge	40% coinsurance	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first \$400 / year, then 20% coinsurance	No charge for the first \$400 / year, then 40% coinsurance	No charge for the first \$400 per 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 coinsurance specified, after deductible .
	Imaging (CT/PET scans, MRIs)	No charge for the first \$400 / year, then 20% coinsurance	No charge for the first \$400 / year, then 40% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	\$10 copay / retail prescription \$25 copay / mail order prescription		Out-of-pocket limit: \$3,500 / member / year. Coverage is limited to a 30-day supply retail or 90-day supply mail order.
	Preferred brand drugs	35% coinsurance / retail prescription		

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about prescription drug coverage is available at www.Regence.com		30% coinsurance / mail order prescription		Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance . The first fill of generic and brand-name (non-self-administrable cancer chemotherapy) specialty drugs is allowed at a retail pharmacy; additional fills for generic and brand-name specialty drugs and all self-administrable cancer chemotherapy drugs must be filled by a specialty pharmacy.
	Non-preferred brand drugs	50% coinsurance / retail prescription 50% coinsurance / mail order prescription		
	Specialty drugs	\$10 copay / generic specialty drug and generic self-administrable cancer chemotherapy drug 35% coinsurance up to \$300 / brand-name specialty drug on the formulary and brand-name self-administrable cancer chemotherapy drug on the formulary 50% coinsurance up to \$300 / brand-name specialty drug not on the formulary and brand-name self-administrable cancer chemotherapy drug not on the formulary		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	20% coinsurance after \$150 copay / visit	20% coinsurance after \$150 copay / visit	
	Emergency medical transportation	20% coinsurance	20% coinsurance	—————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)	20% coinsurance	40% coinsurance	Transplant coverage is subject to a 12 month waiting period. This waiting period may be reduced or eliminated by creditable coverage.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
If you have mental health, behavioral	Mental/Behavioral health outpatient services	No charge for outpatient testing and non-therapy	40% coinsurance	Copayment applies for each in-network providers outpatient therapy visit only.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
health, or substance abuse needs		services, \$25 copay for outpatient therapy visits		Deductible waived for outpatient services for in-network providers .
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	No charge for outpatient testing and non-therapy services, \$25 copay for outpatient therapy visits	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Adoption coverage is paid at the in-network benefit limited to \$4,000 / pregnancy.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 130 visits / year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 15 inpatient days / year. Coverage is limited to 40 outpatient visits / year.
	Habilitation services	20% coinsurance	40% coinsurance	Coverage for neurodevelopmental therapy is limited to 40 outpatient visits / year. Coverage for neurodevelopmental therapy is limited to services for members through age 6.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 60 inpatient days / year.
	Durable medical equipment	20% coinsurance	40% coinsurance	—————none—————
	Hospice service	20% coinsurance	40% coinsurance	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	—————none—————
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	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 <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery, except congenital anomalies• Dental care (Adult)	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Private-duty nursing	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care• Vision hardware• Weight loss programs except for nutritional counseling

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">• Chiropractic care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1 (888) 367-2119. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (888) 367-2119 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 439-3805 or www.insurance.utah.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1 (888) 367-2119.

—————*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:** \$5,200
- **Patient pays:** \$2,340

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	\$1,000
Copays	\$20
Coinsurance	\$1,170
Limits or exclusions	\$150
Total	\$2,340

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

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,610
- **Patient pays:** \$1,790

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	\$290
Copays	\$410
Coinsurance	1,050
Limits or exclusions	\$40
Total	\$1,790

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**, **copayments**, and **coinsurance** 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?

X 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?

X 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 **copayments**, **deductibles**, and **coinsurance**. 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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SUPPLEMENT TO SUMMARY OF BENEFITS AND COVERAGE

On October 7, 2015, Congress passed the Protecting Affordable Coverage for Employees Act (“the PACE Act” or “the Act”).

Prior to the Act, as part of federal health reform, health plans sponsored by employers with between 51 and 100 employees were scheduled to become part of the small employer health insurance market beginning January 1, 2016, joining the plans sponsored by employers with 1 to 50 employees that already comprised that market. The Act permits (but does not require) a state to retain health plans of employers of 51 to 100 employees in the state’s large employer health insurance market. Promptly after the Act’s passage, the State of Utah (and most other states) made that choice.

Because plans of employers of 51 to 100 employees were scheduled to join the small employer market, we did not develop large group materials specific to them, such as summaries of benefits and coverage (SBCs). While we are hard at work preparing those documents now, the late timing of the PACE Act has posed a significant challenge. Consequently, we are providing this supplement to the enclosed/attached summary of benefits and coverage until such time as this information can be incorporated into it. This supplement includes the following two notifications that Utah state law requires be provided.

1. In addition to the adoption benefit noted under “Limitations & Exceptions” for the “If you are pregnant” event in the summary of benefits and coverage, please be aware that this “adoption indemnity” benefit is not exchangeable for infertility treatment benefits.
2. In addition to the other information under Excluded Services & Other Covered Services in the summary of benefits and coverage, please be aware of the following examples:

Exclusion Examples

The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
 - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
 - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.