City of Chubbuck Health Plan Trust

Plan Sponsor – City of Chubbuck
Claims Administrator – Regence BlueShield of Idaho, Inc.

Coverage Period: 01/01/2019 – 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Self-Funded | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the contribution) 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, contact the Plan Trustee by calling 1 (208) 239-3279. For general definitions of common terms, such as allowed amount, balance billing, cost-sharing, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,000 single / $7,000 family per calendar year. Doesn't apply to certain preventive care or certain preventive medications that are on the Optimum Value Medication List. Amounts in excess of the allowed amount do not count toward the deductible.	Single: You must pay all the costs up to the single deductible amount before this plan begins to pay for covered services you use. Family: No one claimant will be required to meet more than the single deductible amount toward the family deductible in a calendar year before this plan begins to pay his/her covered services, and this plan will begin to pay for all claimant's covered services when the family deductible is met. 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?	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 out-of-pocket limit on my expenses?	Yes. $5,000 single / $10,000 family* per calendar year. *A claimant on family coverage will not have his or her out-of-pocket limit exceed $5,000.	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?	Plan charges for coverages, 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 network of providers?	Yes. See regence.com/PreferredIdaho or call 1 (866) 240-9580 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 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.

Questions: Call **1 (866) 240-9580** or visit **regence.com**.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Cost Sharing 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 Cost Sharing 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 providers by charging you lower deductibles, copayments and Cost Sharing 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 and Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Cost Sharing	40% Cost Sharing	——————none——————
	Specialist visit	20% Cost Sharing	40% Cost Sharing	
	Other practitioner office visit	20% Cost Sharing for spinal manipulations	40% Cost Sharing for spinal manipulations	Coverage is limited to 18 spinal manipulations / year.
	Preventive care/ screening/immunization	No Charge	40% Cost Sharing	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% Cost Sharing	40% Cost Sharing	——————none——————
	Imaging (CT/PET scans, MRIs)	20% Cost Sharing	40% Cost Sharing	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/formulary/2018/3tierPML	Generic drugs	20% Cost Sharing / retail and mail order prescription		Coverage is limited to a 90-day supply retail or mail order or 30-day supply injectable and specialty drugs. Deductible does not apply to certain preventive drugs, women's contraceptives or immunizations at a participating pharmacy. You do not need to meet any deductible when you fill prescriptions for generic drugs or brand-name drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List.
	Preferred brand drugs	20% Cost Sharing / retail and mail order prescription		
	Non-preferred brand drugs	20% Cost Sharing / retail and mail order prescription		
	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above.		

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 and Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Cost Sharing for ambulatory surgery center and 20% cost sharing for all other facilities	40% Cost Sharing	————————none————
	Physician/surgeon fees	10% Cost Sharing for ambulatory surgery center physicians and 20% cost sharing for all other physicians	40% Cost Sharing for spinal manipulations	————————none————
If you need immediate medical attention	Emergency room services	20% Cost Sharing	20% Cost Sharing	————————none————
	Emergency medical transportation	20% Cost Sharing	20% Cost Sharing	————————none————
	Urgent Care	Covered the same as 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% Cost Sharing	40% Cost Sharing	————————none————
	Physician/surgeon fees	20% Cost Sharing	40% Cost Sharing	————————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	20% Cost Sharing	40% Cost Sharing	————————none————
	Mental/behavioral health inpatient services	20% Cost Sharing	40% Cost Sharing	
	Substance use disorder outpatient services	20% Cost Sharing	40% Cost Sharing	
	Substance use disorder inpatient services	20% Cost Sharing	40% Cost Sharing	
If you are pregnant	Prenatal and postnatal care	20% Cost Sharing	40% Cost Sharing	Maternity services for children are not covered
	Delivery and all inpatient services	20% Cost Sharing	40% Cost Sharing	

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 and Exceptions
If you need help recovering or have other special health needs	Home health care	20% Cost Sharing	40% Cost Sharing	Coverage is limited to 130 visits / year.
	Rehabilitation services	20% Cost Sharing	40% Cost Sharing	Coverage is limited to 22 inpatient days / year. Coverage is limited to 30 outpatient visits / year.
	Habilitation services	20% Cost Sharing	40% Cost Sharing	Coverage for neurodevelopmental therapy is limited to 28 outpatient visits / year. Coverage for neurodevelopmental therapy is limited to services for claimants through age 6.
	Skilled nursing care	20% Cost Sharing	40% Cost Sharing	Coverage is limited to 60 inpatient days / year.
	Durable medical equipment	20% Cost Sharing	40% Cost Sharing	——————none——————
	Hospice service	20% Cost Sharing	40% Cost Sharing	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 excluded services.)		
• Acupuncture	• Hearing aids	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery, except congenital anomalies	• Long-term care	• Vision hardware
• Dental care (Adult)	• Private-duty nursing	• 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.)	
• Chiropractic care	• 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 **charge for coverage**, which may be significantly higher than the **charge for coverages** 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 Regence BlueShield of Idaho, Inc. at 1 (866) 240-9580. 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 Regence BlueShield of Idaho, Inc. at 1 (866) 240-9580 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 721-3272 or www.doi.idaho.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:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (866) 240-9580.

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: $3,530**
- **Patient pays: $4,010**

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	$3,000
Cost Sharing	$860
Limits or exclusions	$150
Total	**$4,010**

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

- **Amount owed to providers: $5,400**
- **Plan pays: $1,900**
- **Patient pays: $3,500**

Sample care costs:	
Prescriptions	$2,700
Medical Equipment and Supplies	$2,100
Office Visits and Procedures	$900
Education	$900
Laboratory tests	$500
Vaccines, other preventive	$200
Total	**$7,540**
Patient Pays:	
Deductibles	$3,000
Cost Sharing	$460
Limits or exclusions	$40
Total	**$3,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **amounts you pay for coverage**.
- 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** and **cost sharing** 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 Example 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 **amount you pay for coverage**. Generally, the lower the **amount you pay for coverage**, the more you'll pay in out-of-pocket costs, such as **deductibles** and **cost sharing.** 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.

Questions: Call 1 (866) 240-9580 or visit us at regence.com/booklet/2018/ID/XL/HSA3.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1 (866) 240-9580 to request a copy.

DISCRIMINATION IS AGAINST THE LAW

This Notice has Important Information. Regence BlueShield of Idaho, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This notice has important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information, and other information about your application or coverage, in your own language at no cost. Call 888-344-6347. (TTY: 711)

HELP IN OTHER LANGUAGES
The following translations help people who do not read English understand their rights and responsibilities and who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Spanish: Este aviso tiene información importante. Regence BlueShield of Idaho, Inc. cumple con las leyes de derechos civiles federales aplicables y no discrimina sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Este aviso tiene información importante sobre su solicitud o cobertura. Busque las fechas importantes en este aviso. Es posible que tenga que tomar alguna acción en un determinado plazo para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y otra información sobre su solicitud o cobertura, en su propio idioma y sin costo. Llame al 888-344-6347. (TTY: 711)

Chinese Traditional: 本通知含有重要資訊。Regence BlueShield of Idaho, Inc. 遵守適用之聯邦政府民權法，不會因種族、膚色、原始出生國籍、年齡、身心障礙或性別的不同而予以差別待遇。本通知含有有關您申請或進行承保的重要資訊。請留意本通知內的重要日期。請在期限之前採取行動，以確保您的醫療保障或協助支付費用。您有權索取使用您語言撰寫的這類資訊，以及有關您申請或承保的相關資訊。請撥打 888-344-6347 索取。（聽障專線：711
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Vietnamese: Thông báo này có Thông tin Quan trọng. Regence BlueShield of Idaho, Inc. tuân thủ luật pháp Liên bang về quyền công dân hiện hành và không phân biệt đối xử theo chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật hoặc giới tính. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Quý vị có quyền lấy thông tin này và thông tin khác về đơn đăng ký hoặc bảo hiểm, bằng ngôn ngữ của mình miễn phí. Gọi số 888-344-6347. (TTY: 711)

Korean: 이 공지 사항에는 중요 정보가 들어 있습니다**.** Regence BlueShield of Idaho, Inc.은 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 따라 차별하지 않습니다. 이 공지 사항에는 해당 신청서 또는 적용 범위에 관한 중요한 정보가 있습니다. 이 공지 사항의 주요 날짜를 찾아 보십시오. 해당 건강 보험을 그대로 유지하거나 비용을 지원 받으려면 특정 기한까지 조치를 취하셔야 합니다. 귀하는 모국어로 작성된 본 정보나 해당 신청서 또는 보장 범위에 대한 기타 정보를 무료로 받을 수 있는 권리가 있습니다. 888-344-6347로 연락하십시오. (TTY: 711)

Russian: В данном Уведомлении содержится важная информация. Regence BlueShield of Idaho, Inc. несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 888-344-6347. (TTY: 711)

Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon. Ang Regence BlueShield of Idaho, Inc. ay sumusunod sa mga naaangkop na Pederal na batas sa mga karapatang sibil at hindi nagdidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. Ang abiso na ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o coverage. Hanapin ang mga importanteng petsa sa abiso na ito. Maaaring kailangan mong gumawa ng hakbang hanggang sa mga partikular na takdang araw upang mapanatili mo ang iyong coverage sa kalusugan o tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito, at iba pang impormasyon tungkol sa iyong aplikasyon o coverage, sa iyong sariling wika nang walang bayad. Tumawag sa 888-344-6347. (TTY: 711)

Ukrainian: Це повідомлення містить важливу інформацію. Regence BlueShield of Idaho, Inc. дотримується застосовного федерального законодавства про громадянські права та не проводить політику дискримінації за расовою приналежністю, кольором шкіри, походженням, віком, інвалідністю та статевою ознакою. Це повідомлення містить важливу інформацію про пов’язану з вами програму або страхове покриття. Зверніть увагу на ключові дати в цьому повідомленні. Щоб зберегти за собою план медичного страхування або право отримувати грошову допомогу, можливо, вам потрібно буде вжити відповідні заходи, для яких установлено певні часові обмеження. Ви маєте право на безкоштовне отримання рідною мовою як цієї інформації, так і будь-якої іншої, пов’язаної з програмою чи страховим покриттям. Телефонуйте за таким номером: 888-344-6347 (телетайп: 711).

Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងសនេះមានព័ត៌មានសំខាន់ ។ Regence BlueShield of Idaho, Inc. អនុលោមលៅតាមច្បាប់របស់សហព័នធសតីពីសិទ្ធិពលរដ្ឋ លហើយមិនមានការលរើសលអើងច្បាំល ោះពូជសាសន៍ ពណ៌សមបុរ សញ្ជាតិលដ្ើម អាយុ ពិការភាព ឬលេខ្ល ើយ ។ លសចក្តីជូនដំណឹងលនោះមានព័ត៌មានសំខាន់សតីអំពី ក្បសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អនក ។ សូមរក្តមើលកាលបរិលច្បេទរ្ំខាន់ៗក្នុងលសចក្តី ជូនដំណឹងលនោះ ។ អនក្អាច្បតរូវចាត់វិធានការឲ្យបានត្តឹមកាលបរិលច្បេទ្ំណត់ លដ្ើមបីរក្ាបាននូវការធានារ៉ាប់រងសុខភាព ឬបានទ្ួលការជួយលច្បញការច្បាំណាយថ្លៃថលទំសុខភាពរបស់អនក ។ អនក្អានសិទ្ធិទ្ួលបានព័ត៌មានលនោះ និងព័ត៌មានដ្ួ អំពី ក្បសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អនក ជាភាសាថដ្លអនក្តរ្តើ លោយមិនបាច្បាបង់ត្បាក់ល ើយ ។ លៅមក្តលខ 888-344-6347 ។ (អនក្តិបាក្បាតប់ ឬពិបាក្ថិយាយថដ្លត្តើ TTY សូមលៅមក្តលខ ៖ 711)__