


**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**



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, [stlukeshealthplan.org](http://stlukeshealthplan.org) or call 833-840-3600. 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 [www.healthcare.gov/glossary](http://www.healthcare.gov/glossary) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Indian Health Care <a href="#">Provider</a> (IHCP) or at non IHCP with <a href="#">referral</a> from IHCP: \$0 For In-Network <a href="#">Providers</a> : \$7,750 Individual/ \$15,500 Family For Out-of-Network <a href="#">Providers</a> : \$20,300 Individual/ \$40,600 Family	Generally, you must pay all of the costs from <a href="#">provider</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> ; office visits; diagnostic tests; chiropractic; medically necessary eye exams; Tier 1 and Tier 2 prescription drugs are covered before you meet your <a href="#">deductible</a> . Deductible does not apply unless otherwise stated for outlined benefits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> without cost sharing and before you meet your <a href="#">deductible</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For In-Network <a href="#">Providers</a> : \$10,150 Individual/ \$20,300 Family For Out-of-Network <a href="#">Providers</a> : \$101,500 Individual/ \$203,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">stlukeshealthplan.org</a> or call 1-833-840-3600 for a list of network providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network</a> provider, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware, your <a href="#">network</a> provider might use an out-of- <a href="#">network</a> provider for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a referral.

 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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non IHCP In-Network Provider (You will pay more)	Non IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Covers office visit only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.
	<a href="#">Specialist</a> visit	\$0 <a href="#">copay</a>	\$140 <a href="#">copay</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	OB/GYN visits receive primary care benefits.
	<a href="#">Preventive care/screening/immunization</a>	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Visit <a href="#">healthcare.gov</a> for a full list of preventive services.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non IHCP In-Network Provider (You will pay more)	Non IHCP Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://stlukeshealthplan.org">stlukeshealthplan.org</a>	Generic drugs	\$0 <a href="#">copay</a>	Preferred generic: \$25 <a href="#">copay</a> Non-preferred generic: \$35 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> required for certain medications.
	Preferred brand drugs	\$0 <a href="#">copay</a>	35% <a href="#">coinsurance deductible</a> after		
	Non-preferred brand drugs	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after		
	<a href="#">Specialty drugs</a>	\$0 <a href="#">copay</a>	40% <a href="#">coinsurance deductible</a> after		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	None
	Physician/surgeon fees	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	50% <a href="#">coinsurance deductible</a> after	Covers ER visit only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.
	<a href="#">Emergency medical transportation</a>	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	50% <a href="#">coinsurance deductible</a> after	None
	<a href="#">Urgent care</a>	\$0 <a href="#">copay</a>	\$75 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a> after	Covers office visit only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non ICHP In-Network Provider (You will pay more)	Non IHCP Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> required
	Physician/surgeon fees	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 <a href="#">copay</a>	Office Visit: \$0 <a href="#">copay</a> Outpatient Facility: 50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	For mental health office visits, coverage applies to office visit only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.
	Inpatient services	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> required
If you are pregnant	Office visits	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a> after	Covers office visit only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.
	Childbirth/delivery professional services	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> may be required.
	Childbirth/delivery facility services	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> may be required.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a> after	<a href="#">Pre-Authorization</a> required after 10 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$0 <a href="#">copay</a>	\$40 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a> after	20 combined visits per calendar year for physical, speech and occupational therapy. After 20 visits,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non ICHP In-Network Provider (You will pay more)	Non IHCP Out-of-Network Provider (You will pay the most)	
					<a href="#">Pre-Authorization</a> is required. <a href="#">Pre-Authorization</a> required for inpatient services.
	<a href="#">Habilitation services</a>	\$0 <a href="#">copay</a>	\$40 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a>	20 combined visits per calendar year for physical, speech and occupational therapy. After 20 visits, <a href="#">Pre-Authorization</a> is required. <a href="#">Pre-Authorization</a> required for inpatient services.
	<a href="#">Skilled nursing care</a>	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a>	30 days per calendar year. <a href="#">Pre-Authorization</a> required.
	<a href="#">Durable medical equipment</a>	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a>	<a href="#">Pre-Authorization</a> may be required for certain DME.
	<a href="#">Hospice services</a>	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a>	<a href="#">Pre-Authorization</a> required.
If your child needs dental or eye care	Children's eye exam	\$0 <a href="#">copay</a>	\$0 <a href="#">copay</a>	60% <a href="#">coinsurance deductible</a>	1 exam per calendar year.
	Children's glasses	\$0 <a href="#">copay</a>	50% <a href="#">coinsurance deductible</a> after	60% <a href="#">coinsurance deductible</a>	1 pair lenses/frames per calendar year.
	Children's dental check-up	Not Covered	Not Covered	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](#).)

- |                            |  |  |
|----------------------------|--|--|
| • Acupuncture              | • Bariatric Surgery                                  | • Cosmetic Surgery                       |
| • Dental Care              | • Hearing Aids (Adults)                              | • Infertility Treatment                  |
| • Long-term Care           | • Non-emergency care when traveling outside the U.S. | • Private Duty Nursing                   |
| • Routine Eye Care (Adult) | • Routine Foot Care                                  | • Temporomandibular Joint Disorder (TMJ) |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |                     |                            |
|---|---------------------|----------------------------|
| • Chiropractic Care   | • Cochlear Implants | • Hearing Aids (Pediatric) |
| • Weight loss programs as part of St. Luke's Lifestyle Medicine |                     |                            |

**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: [stlukeshealthplan.org](http://stlukeshealthplan.org) or call 1-833-840-3600 or contact the Idaho Department of Insurance at [doi.idaho.gov](http://doi.idaho.gov) or call 1-800-721-3272. 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 [www.HealthCare.gov](http://www.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 on how 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: [stlukeshealthplan.org](http://stlukeshealthplan.org) or call 833-840-3600 or contact the Idaho Department of Insurance at [doi.idaho.gov](http://doi.idaho.gov) or call 1-800-721-3272.

### 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 1-833-840-3600.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-840-3600.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-840-3600.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-840-3600.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,750
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$140
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	50%
■ Other [ <a href="#">cost sharing</a> ]	50%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$7,750
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,920</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,750
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$140
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	50%
■ Other [ <a href="#">cost sharing</a> ]	50%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$4,000
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$7,750
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$140
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	50%
■ Other [ <a href="#">cost sharing</a> ]	50%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,600</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.