

**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>                                | For In-Network <a href="#">Providers</a> :<br>\$0 Individual/ \$0 Family<br>For Out-of-Network <a href="#">Providers</a> :<br>\$0 Individual/ \$0 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; medically necessary eye exams; generic 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> :<br>\$0 Individual/ \$0 Family<br>For Out-of-Network <a href="#">Providers</a> :<br>\$0 Individual/ \$0 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.                                                                                                                                                  |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <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> .                                                                                                                                                                                                                                                                                                                                                         |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://stlukeshealthplan.org">stlukeshealthplan.org</a> or call 1-833-840-3600 for a list of                                                                                                                                         | 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</a> 's <a href="#">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                                                                                                                                                        |

| Important Questions                                                          | Answers            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | network providers. | <a href="#">provider</a> for the difference between the <a href="#">provider</a> 's 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                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                 |                                                                                     | Network Provider<br>(You will pay the least)                                                           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                              |
| If you visit a health care <a href="#">provider's office or clinic</a>                                                                                                          | Primary care visit to treat an injury or illness                                    | \$0 <a href="#">copay</a>                                                                              | \$0 <a href="#">copay</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>                                                                              | \$0 <a href="#">copay</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>                          | 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>                                                                              | \$0 <a href="#">copay</a>                          | None                                                                                                                                                                         |
|                                                                                                                                                                                 | Imaging (CT/PET scans, MRIs)                                                        | \$0 <a href="#">copay</a>                                                                              | \$0 <a href="#">copay</a>                          | None                                                                                                                                                                         |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">stlukeshealthplan.org</a> | Generic drugs                                                                       | Preferred Generic:<br>\$0 <a href="#">copay</a><br>Non-preferred Generic:<br>\$0 <a href="#">copay</a> | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> required for certain medications.                                                                                                          |
|                                                                                                                                                                                 | Preferred brand drugs                                                               | \$0 <a href="#">copay</a>                                                                              |                                                    |                                                                                                                                                                              |
|                                                                                                                                                                                 | Non-preferred brand drugs                                                           | \$0 <a href="#">copay</a>                                                                              |                                                    |                                                                                                                                                                              |
|                                                                                                                                                                                 | <a href="#">Specialty drugs</a>                                                     | \$0 <a href="#">copay</a>                                                                              |                                                    |                                                                                                                                                                              |
|                                                                                                                                                                                 | Oncology drugs<br>(Specialty oncology drugs must be filled at a specialty pharmacy) | \$0 <a href="#">copay</a>                                                                              |                                                    |                                                                                                                                                                              |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                     |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                    | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                            |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | None                                                                                                                                                                                                                       |
|                                                                           | Physician/surgeon fees                           | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | None                                                                                                                                                                                                                       |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | 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>                                                                       | \$0 <a href="#">copay</a>                          | None                                                                                                                                                                                                                       |
|                                                                           | <a href="#">Urgent care</a>                      | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</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.                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> required                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                           | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> required                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit:<br>\$0 <a href="#">copay</a><br>Outpatient Facility:<br>\$0 <a href="#">copay</a> | \$0 <a href="#">copay</a>                          | 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>                                                                       | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> required                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                                    | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</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.                                               |
|                                                                           | Childbirth/delivery professional services        | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> may be required.                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services            | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> may be required.                                                                                                                                                                         |
| If you need help recovering or have                                       | <a href="#">Home health care</a>                 | \$0 <a href="#">copay</a>                                                                       | \$0 <a href="#">copay</a>                          | <a href="#">Pre-Authorization</a> required after 10 visits per calendar year.                                                                                                                                              |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                 |
|-----------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                        |
| <b>other special health needs</b>             | <a href="#">Rehabilitation services</a>   | \$0 <a href="#">copay</a>                    | \$0 <a href="#">copay</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="#">Habilitation services</a>     | \$0 <a href="#">copay</a>                    | \$0 <a href="#">copay</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>                    | \$0 <a href="#">copay</a>                          | 30 days per calendar year. <a href="#">Pre-Authorization</a> required.                                                                                                                                                 |
|                                               | <a href="#">Durable medical equipment</a> | \$0 <a href="#">copay</a>                    | \$0 <a href="#">copay</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>                          | <a href="#">Pre-Authorization</a> required.                                                                                                                                                                            |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | \$0 <a href="#">copay</a>                    | \$0 <a href="#">copay</a>                          | 1 exam per calendar year.                                                                                                                                                                                              |
|                                               | Children's glasses                        | \$0 <a href="#">copay</a>                    | \$0 <a href="#">copay</a>                          | 1 pair lenses/frames per calendar year.                                                                                                                                                                                |
|                                               | Children's dental check-up                | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                            |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                                                           |                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Dental Care</li> <li>Long-term Care</li> <li>Routine Eye Care (Adult)</li> </ul>                                                      | <ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Hearing Aids (Adults)</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine Foot Care</li> </ul> | <ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Infertility Treatment</li> <li>Private Duty Nursing</li> <li>Temporomandibular Joint Disorder (TMJ)</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                                                           |                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Weight loss programs as part of St. Luke's Lifestyle Medicine</li> </ul>                                                        | <ul style="list-style-type: none"> <li>Cochlear Implants</li> </ul>                                                                                                                       | <ul style="list-style-type: none"> <li>Hearing Aids (Pediatric)</li> </ul>                                                                                                      |

**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): Dinekehgo 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> | \$0 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$0 |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | \$0 |
| ■ Other [ <a href="#">cost sharing</a> ]                        | \$0 |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| What isn't covered                |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$60</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> | \$0 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$0 |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | \$0 |
| ■ Other [ <a href="#">cost sharing</a> ]                        | \$0 |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| What isn't covered                |             |
| Limits or exclusions              | \$20        |
| <b>The total Joe would pay is</b> | <b>\$20</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> | \$0 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$0 |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | \$0 |
| ■ Other [ <a href="#">cost sharing</a> ]                        | \$0 |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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