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, [TBD]. 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.[TBD].com or call 1-833-478-5853 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,800 / individual or $3,600 / family; for out- of-network providers $18,200 individual / $36,400 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, maternity services, primary care office visits; Mental Health/Substance Abuse, bariatric surgery office visits; vision exams; tier 1-2 prescription drugs; nutritional counseling; lifestyle medicine; habilitative services; emergency care; urgent care; DME and supplies, such as breast pumps, medical supplies, orthopedic appliances/braces, prosthetic devices, and wigs; diabetic (nutrition) education; and hospice and respite care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $6,500 individual / $13,000 family; for out- of-network providers $91,000 individual / $182,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See www.[TBD].com or call 1-833-478-5853 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and

		what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services without a referral before you see the specialist.

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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay; deductible does not apply	60% coinsurance	None
	Specialist visit	$25 copay; deductible does not apply	60% coinsurance	None
	Preventive care/screening/ immunization	$0 copay; deductible does not apply	60% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance deductible does apply	60% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$150 copay	60% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.stlukeshealthplan.org	Generic drugs	$0 copay preferred generic / $10 copay non-preferred generic; deductible does not apply	$0 copay preferred generic / $10 copay non-preferred generic; deductible does not apply	Pre-Authorization required for certain medication.
	Preferred brand drugs	40% coinsurance	40% coinsurance	Pre-Authorization required for certain medication.
	Non-preferred brand drugs	50% coinsurance	50% coinsurance	Pre-Authorization required for certain medication.
	Specialty drugs	40% coinsurance	40% coinsurance	Pre-Authorization required for certain medication.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	60% coinsurance	None
	Physician/surgeon fees	10% coinsurance	60% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay	$200 copay	None
	Emergency medical	10% coinsurance	10% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.stlukeshealthplan.org

	transportation			
	Urgent care	$35 copay; deductible does not apply	60% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	60% coinsurance	Pre-Authorization required.
	Physician/surgeon fees	10% coinsurance	60% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	60% coinsurance	None
	Inpatient services	10% coinsurance	60% coinsurance	Pre-Authorization is required for inpatient mental health services, including residential treatment.
If you are pregnant	Office visits	$0 copay; deductible does not apply	60% coinsurance	None
	Childbirth/delivery professional services	$0 copay; deductible does not apply	60% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	60% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$0 copay	60% coinsurance	None
	Rehabilitation services	10% coinsurance	60% coinsurance	20 Visits Per Year. Pre-Authorization required for inpatient services.
	Habilitation services	10% coinsurance for inpatient / 10% coinsurance for outpatient facility / $25 copay for outpatient professional and in office with no deductible applying	60% coinsurance	None
	Skilled nursing care	10% coinsurance	60% coinsurance	30 Days Per Year. Pre-Authorization required.
	Durable medical equipment	10% coinsurance	60% coinsurance	None
	Hospice services	$0 copay; deductible does not apply	60% coinsurance	12 Months; Pre-Authorization required for inpatient hospice.
If your child needs dental or eye care	Children's eye exam	$0 copay; deductible does not apply	60% coinsurance	1 Per Year
	Children's glasses	10% coinsurance	60% coinsurance	1 Pair Lenses/Frame Per Year
	Children's dental check-up	Not covered	Not covered	Not covered

[* For more information about limitations and exceptions, see the plan or policy document at www.stlukeshealthplan.org

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.)

- Temporomandibular Joint (TMJ) Disorder
- Travel Immunizations
- Vision Hardware for Adults (ages 19 and older)
- Routine Preventive Eye Exams for Adults (ages 19 and older)

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

- Vision Exams
- Glasses/Contacts
- Cardiovascular
- PT/OT/ST
- Chiropractor
- CT/MRI/Pet Scans
- Pathology/Other Radiology

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: Your Health Idaho at yourhealthidaho.org. 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 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: [TBD].

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 1-833-478-5853

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-478-5853

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-833-478-5853

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-478-5853

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,800
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,600**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$1,800
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$70
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,670**

Mia's Simple Fracture

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

The plan's overall deductible	$1,800
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,120**

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