


**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, visit [stlukeshealthplan.org](http://stlukeshealthplan.org) or call 833-377-1311. 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>	\$0 at Indian Health Care <a href="#">Provider</a> (IHCP) or with IHCP <a href="#">referral</a> at non-IHCP; or <a href="#">network providers</a> \$7,750 individual / \$15,500 family. <a href="#">Out-of-network</a> providers \$18,400 individual / \$36,800 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; Tier 1 and Tier 2 prescription drugs are covered before you meet your	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>	\$0 at IHCP or with IHCP <a href="#">referral</a> at non-IHCP. There are no other specific deductibles.	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 <a href="#">network providers</a> \$9,200 individual / \$18,400 family; for <a href="#">out-of-network providers</a> \$92,000 individual / \$184,000 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.
<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://www.stlukeshhealthplan.org">www.stlukeshhealthplan.org</a> or call 1-833-377-1311 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services without a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Specialist</a> visit	No charge	\$140 per visit; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/ screening/ immunization</a>	No charge	No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	\$150 per test; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Imaging (CT/PET scans, MRIs)	No charge	\$250 per test	60% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [stlukeshhealthplan.org](http://stlukeshhealthplan.org)  
2024\_05\_SBCIndExpBronze\_LCS

Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://stlukeshealthplan.org">stlukeshealthplan.org</a></p>	Generic drugs	No charge	Preferred Generic: \$25 per prescription; <a href="#">deductible</a> does not apply. Non-Preferred Generic: \$35 per prescription; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	<p>Pre-Authorization required for certain medication. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a>. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a>, you may have to pay the difference (<a href="#">balance billing</a>).</p>
	Preferred brand drugs	No charge	35% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	No charge	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<p><a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a>. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a>, you may have to pay the difference (<a href="#">balance billing</a>).</p>
	Physician/surgeon fees	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	No charge	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<p><a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a>. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a>, you may have to pay the difference (<a href="#">balance billing</a>).</p>
	<a href="#">Emergency medical transportation</a>	No charge	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	No charge	\$140 per visit; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Pre-Authorization required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Physician/surgeon fees	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office Visit: No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	Pre-Authorization required for inpatient mental health services, including residential treatment. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Inpatient services	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	No charge	No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Childbirth/delivery professional services	No charge	No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Rehabilitation services</a>	No charge	\$40 per visit; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	20 Visits Per Year. Pre-Authorization required for inpatient services. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Habilitation services</a>	No charge	\$40 per visit; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	Pre-Authorization required for inpatient services. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Skilled nursing care</a>	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	30 days per year; Pre-Authorization Required. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Durable medical equipment</a>	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . Pre-Authorization required. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [stlukeshealthplan.org](#)  
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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<a href="#">Hospice services</a>	No charge	No Charge; <a href="#">deductible</a>	60% <a href="#">coinsurance</a>	12 Months; Pre-Authorization required for inpatient hospice. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
If your child needs dental or eye care	Children's eye exam	No charge	No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	Coverage limited to one exam/year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Children's glasses	No charge	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Coverage limited to one pair of glasses/year. <a href="#">Cost sharing</a> waived at non-IHCP with IHCP <a href="#">referral</a> . If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Children's dental check-up	No charge	Not covered	Not covered	Not covered

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## 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: [stlukeshealthplan.org](http://stlukeshealthplan.org) or call 1-833-377-1311 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 1-833-377-1311 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 1-833-377-1311.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-377-1311.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-377-1311.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-377-1311.

*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](#) \$7,750
- [Specialist \[cost sharing\]](#) \$140
- Hospital (facility) [\[cost sharing\]](#) 50%
- Other [\[cost sharing\]](#) 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>	\$1,000
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$9,210</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$7,750
- [Specialist \[cost sharing\]](#) \$140
- Hospital (facility) [\[cost sharing\]](#) 50%
- Other [\[cost sharing\]](#) 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>	\$3,900
<a href="#">Copayments</a>	\$500
<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 [plan's](#) overall [deductible](#) \$7,750
- [Specialist \[cost sharing\]](#) \$140
- Hospital (facility) [\[cost sharing\]](#) 50%
- Other [\[cost sharing\]](#) 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>	\$2,000
<a href="#">Copayments</a>	\$600
<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.

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.