




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, 1-833-478-5853

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.stlukeshhealthplan.org](http://www.stlukeshhealthplan.org) or call 1-833-478-5853 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For <a href="#">network providers</a> : \$5,000 / individual or \$10,000 / family; for <a href="#">out-of-network providers</a> \$18,200 / individual or \$36,400 / family  | Generally, you must pay all of the costs from <a href="#">providers</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> , maternity services, primary care office visits, Mental Health/Substance Abuse office visits, vision exams, tier one and tier two prescription drugs, certain durable medical equipment, nutritional counseling, lifestyle medicine, emergency care, urgent care, diabetic education and diabetic nutrition education, and hospice and respite care are covered before you meet your <a href="#">deductible</a> . | 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 services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> .  |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these 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> \$7,500 individual / \$15,000 family; for <a href="#">out-of-network providers</a> \$45,500 individual / \$91,000 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 limits</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="#">Copayments</a> for certain services, <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 1-833-478-5853 for a list of <a href="#">network providers</a> .  | This <a href="#">plan</a> uses a <a href="#">provider 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 <a href="#">out-of-network provider</a> , 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 provider</a> might use an |

| Important Questions  | Answers | Why This Matters:   |
|--|---------|---|
|  |         | <a href="#">out-of-network provider</a> 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.     | 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                                  | 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> ; <a href="#">deductible</a> does not apply   | 60% <a href="#">coinsurance</a>   | None   |
|  | <a href="#">Specialist</a> visit                       | \$30 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  | 60% <a href="#">coinsurance</a>   | None   |
|  | <a href="#">Preventive care/screening/immunization</a> | \$0 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply   | 60% <a href="#">coinsurance</a>   | None   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 30% <a href="#">coinsurance</a>   | 60% <a href="#">coinsurance</a>   | None   |
|  | Imaging (CT/PET scans, MRIs)                           | \$200 <a href="#">copay</a>   | 60% <a href="#">coinsurance</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="http://www.stlukeshhealthplan.org">www.stlukeshhealthplan.org</a> | Generic drugs  | \$0 <a href="#">copay</a> preferred generic / \$10 <a href="#">copay</a> non-preferred generic; <a href="#">deductible</a> does not apply | \$0 <a href="#">copay</a> preferred generic / \$10 <a href="#">copay</a> non-preferred generic; <a href="#">deductible</a> does not apply | Pre-Authorization required for certain medication.     |
|  | Preferred brand drugs                                  | 40% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Pre-Authorization required for certain medication.     |
|  | Non-preferred brand drugs                              | 50% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>   | Pre-Authorization required for certain medication.     |
|  | <a href="#">Specialty drugs</a>                        | 40% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>   | Pre-Authorization required for certain medication.     |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 30% <a href="#">coinsurance</a>   | 60% <a href="#">coinsurance</a>   | None   |
|  | Physician/surgeon fees                                 | 30% <a href="#">coinsurance</a>   | 60% <a href="#">coinsurance</a>   | None   |
| If you need immediate  | <a href="#">Emergency room care</a>                    | \$450 <a href="#">copay</a>   | \$450 <a href="#">copay</a>   | None   |

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

| 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) |  |
| medical attention   | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>                    | None   |
|   | <a href="#">Urgent care</a>                      | \$50 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply | 60% <a href="#">coinsurance</a>                    | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | Pre-Authorization required.  |
|   | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | None   |
|   | Inpatient services                               | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | Pre-Authorization is required for inpatient mental health services, including residential treatment. |
| If you are pregnant   | Office visits                                    | \$0 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  | 60% <a href="#">coinsurance</a>                    | None   |
|   | Childbirth/delivery professional services        | \$0 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  | 60% <a href="#">coinsurance</a>                    | None   |
|   | Childbirth/delivery facility services            | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | None   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | \$0 <a href="#">copay</a>  | 60% <a href="#">coinsurance</a>                    | None   |
|   | <a href="#">Rehabilitation services</a>          | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | 20 Visits Per Year. Pre-Authorization required for inpatient services.                               |
|   | <a href="#">Habilitation services</a>            | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | Pre-Authorization required for inpatient services  |
|   | <a href="#">Skilled nursing care</a>             | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | 30 Days Per Year. Pre-Authorization required.  |
|   | <a href="#">Durable medical equipment</a>        | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | None   |
|   | <a href="#">Hospice services</a>                 | \$0 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  | 60% <a href="#">coinsurance</a>                    | 12 Months; Pre-Authorization required for inpatient hospice.   |
| If your child needs dental or eye care                                    | Children's eye exam                              | \$0 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply  | 60% <a href="#">coinsurance</a>                    | 1 Per Year   |
|   | Children's glasses                               | 30% <a href="#">coinsurance</a>  | 60% <a href="#">coinsurance</a>                    | 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](http://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
- Vision Hardware for Adults (ages 19 and older)
- Routine Eye Exams for Adults (ages 19 and older)
- Travel immunizations

### 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](http://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](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: 1-833-478-5853.

### 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, kwijigo holne' 1-833-478-5853.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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](#) \$5,000
- [Specialist \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$5,000        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$6,500</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$60           |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$4,060</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |

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