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, [insert contact information]. 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.stlukeshealthplan.org or call 1-833-478-5853 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or network providers $5,500 / individual or $11,000 / family; 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 and primary 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. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	$0 at IHCP or with IHCP referral at non-IHCP. There are no other specific deductibles.	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 $8,500 individual / $17,000 family; for out- of-network providers $91,000 individual / $182,000	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.stlukeshealthplan.org 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.

Important Questions	Answers	Why This Matters:
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	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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$0 copay; deductible does not apply	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Specialist visit	No charge	$30 copay; deductible does not apply	60% coinsurance	
	Preventive care/ screening/ immunization	No charge	$0 copay; deductible does not apply	60% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Imaging (CT/PET scans, MRIs)	No charge	$200 copay	60% coinsurance	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.stlukeshealthplan.org	Generic drugs	No charge	$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. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Preferred brand drugs	No charge	40% coinsurance	40% coinsurance	
	Non-preferred brand drugs	No charge	50% coinsurance	50% coinsurance	
	Specialty drugs	No charge	40% coinsurance	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	40% coinsurance	60% coinsurance	
If you need immediate medical attention	Emergency room care	No charge	$450 copay	$450 copay	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Emergency medical transportation	No charge	40% coinsurance	40% coinsurance	
	Urgent care	No charge	$50 copay; deductible does not apply	60% coinsurance	

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	40% coinsurance	60% coinsurance	Pre-Authorization Required. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	40% coinsurance	60% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	40% coinsurance	60% coinsurance	Pre-Authorization required for inpatient mental health services, including residential treatment.. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Inpatient services	No charge	40% coinsurance	60% coinsurance	
If you are pregnant	Office visits	No charge	$0 copay; deductible does not apply	60% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Childbirth/delivery professional services	No charge	$0 copay; deductible does not apply	60% coinsurance	
	Childbirth/delivery facility services	No charge	40% coinsurance	60% coinsurance	

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	Home health care	No charge	$0 copay	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out- of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Rehabilitation services	No charge	40% coinsurance	60% coinsurance	20 Visits Per Year. Pre-Authorization required for inpatient services. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Habilitation services	No charge	40% coinsurance for inpatient / 40% coinsurance for outpatient facility / $30 copay for outpatient professional and in office with no deductible applying	60% coinsurance	Pre-Authorization required for inpatient services. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Skilled nursing care	No charge	40% coinsurance	60% coinsurance	30 days per year; Pre-Authorization Required. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Durable medical equipment	No charge	40% coinsurance	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out- of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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

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
	Hospice services	No charge	$0 copay; deductible does not apply	60% coinsurance	12 Months; Pre-Authorization required for inpatient hospice. Preauthorization is required. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If your child needs dental or eye care	Children's eye exam	No charge	$0 copay; deductible does not apply	60% coinsurance	Coverage limited to one exam/year. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Children's glasses	No charge	40% coinsurance	60% coinsurance	Coverage limited to one pair of glasses/year. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Children's dental check-up	No charge	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- 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: 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 833-478-5853.

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

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

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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	$5,500
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$5,500
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$7,300**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well- controlled condition)

The plan's overall deductible	$5,500
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$4,000
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,060**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,500
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$2,100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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