




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.stlukeshealthplan.org or call 1-833-478-5853 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers \$250 / individual or \$500 / family; for out-of-network providers \$18,200 / individual or \$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 office visits, vision exams, tier one and tier two prescription drugs, lifestyle medicine, urgent care, certain durable medical equipment, nutritional counseling, diabetic education and diabetic nutrition education, and hospice and respite care 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 \$900 individual / \$1,800 family; for out-of-network providers \$45,500 individual / \$91,000 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.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-

Important Questions	Answers	Why This Matters:
		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	\$10 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	60% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$50 copay	60% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.stlukeshhealthplan.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	20% coinsurance	20% coinsurance	Pre-Authorization required for certain medication.
	Non-preferred brand drugs	30% coinsurance	30% coinsurance	Pre-Authorization required for certain medication.
	Specialty drugs	20% coinsurance	20% 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	Emergency room care	\$75 copay	\$75 copay	None

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

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)	
medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	\$25 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	60% coinsurance	Pre-Authorization required for inpatient services.
	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
- 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. 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: 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](#) \$250
- [Specialist \[cost sharing\]](#) \$10
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$850

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[cost sharing\]](#) \$10
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$850

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[cost sharing\]](#) \$10
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$750

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