



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 [stlukeshhealthplan.org](http://stlukeshhealthplan.org) or call 833-840-3600. 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>	For In- <a href="#">network</a> Providers: \$4,000 individual / \$8,000 family For <a href="#">Out-of-network Providers</a> : \$8,000 individual / \$16,000 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> and children's vision exams 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 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>	No	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 In- <a href="#">network</a> Providers: \$6,500 individual / \$13,000 family For <a href="#">Out-of-network Providers</a> : \$13,000 individual / \$26,000 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 1-833-840-3600 for a list of <a href="#">network providers</a> .	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.

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

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a referral.

 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 <a href="#">provider's office</a> or <a href="#">clinic</a>	<a href="#">Primary care deductible</a> visit to treat an injury or illness	No Charge	60% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	No Charge	60% <a href="#">coinsurance</a>	OB-GYN and Oncology visits receive primary care benefits
	<a href="#">Preventive care/screening/immunization</a>	No Charge; <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)	No Charge	60% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">stlukeshealthplan.org</a>	Generic drugs	Preferred Generic: No Charge Non-Preferred Generic: \$10 per prescription	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required for certain medications
	Preferred brand drugs	35% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required for certain medications
	Non-preferred brand drugs	50% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required for certain medications
	<a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required for certain medications
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

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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)	
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No Charge Hospital Outpatient: 40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Inpatient services	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required
If you are pregnant	Office visits	No Charge	60% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	No Charge	60% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	40% <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>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	No Charge	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required for inpatient services.
	<a href="#">Habilitation services</a>	No Charge	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required for inpatient services.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	30 days per year. <a href="#">Pre-Authorization</a> required for inpatient services.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Pre-Authorization</a> required
	<a href="#">Hospice services</a>	No Charge	60% <a href="#">coinsurance</a>	12 months. <a href="#">Pre-Authorization</a> required for inpatient hospice services
If your child needs dental or eye care	Children's eye exam	No Charge; <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	1 per year
	Children's glasses	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	1 pair lenses/frames per year

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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)	
	Children's dental check-up	Not covered	Not covered	Not covered

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Infertility treatment</li> <li>• Private duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Long-term care</li> <li>• Routine eye care (adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Temporomandibular Joint Disorder (TMJ)</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Weight loss programs as part of a program approved by St. Luke's Health Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> </ul>

**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 1-833-840-3600 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 1-833-840-3600 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 1-833-840-3600.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-840-3600.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-840-3600.

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-840-3600.

*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](#) \$4,000
- [Specialist \[cost sharing\]](#) \$0
- 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*)

<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="#">deductible</a>	\$4,000
<a href="#">copayment</a>	\$0
<a href="#">coinsurance</a>	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,560</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist \[cost sharing\]](#) \$0
- 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*)

<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="#">deductible</a>	\$4,000
<a href="#">copayment</a>	\$0
<a href="#">coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,520</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist \[cost sharing\]](#) \$0
- 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*)

<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="#">deductible</a>	\$2,800
<a href="#">copayment</a>	\$0
<a href="#">coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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