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, 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What ~~is not included~~ in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & OtherImportant Information
		Indian Health CareProvider (IHCP) (You will pay the least)	Non-IHCP 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	No charge	No charge	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	No charge	
	Preventive care/screening/ immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	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	No charge	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	No charge	No charge	Pre-Authorization required for certain medication. 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	No charge	
	Non-preferred brand drugs	No charge	No charge	
	Specialty drugs	No charge	No charge	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	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	No charge	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	What You Will Pay		Limitations, Exceptions, & OtherImportant Information
		Indian Health CareProvider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	No charge	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	No charge	
	Urgent care	No charge	No charge	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Preauthorization is required. 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	No charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Pre-Authorization is required for inpatient mental health services, including residential treatment. 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	No charge	
If you are pregnant	Office visits	No charge	No charge	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Childbirth/delivery professional	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	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	No charge	20 Visits Per Year. Pre-Authorization required for inpatient services. 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	No charge	Pre-Authorization required for inpatient services. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & OtherImportant Information
		Indian Health CareProvider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
	Skilled nursing care	No charge	No charge	30 days per year; Pre-Authorization Required. 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	No charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Hospice services	No charge	No charge	12 months; Pre-Authorization required for inpatient hospice. 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	No charge	Coverage limited to one exam/year. 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	No charge	Coverage limited to one pair of glasses/year. 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	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.