Individual Silver 250

2026 Benefits Outline of Coverage

Important: This is an Outline of Coverage only – please consult your Master Policy for additional details on medical benefit descriptions, benefit limits and choosing a provider.

Medical/Pharmacy Deductible	In-Network	Out-of-Network
The total deductible you pay per calendar year.	$250 **Individual** $500 **Family**	$20,300 **Individual** $40,600 **Family**
Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
The combined total for your deductible(s), coinsurance and copays per calendar year.	$1,100 **Individual** $2,200 **Family**	$50,750 **Individual** $101,500 **Family**
This plan offers an embedded maximum plan deductible, which means when family coverage is elected, each individual will meet no more than the individual medical/pharmacy maximum deductible amount, but the family will meet no more than the specified family medical/pharmacy maximum deductible amount, regardless of family size.		

Professional Services

Professional medical services including in-person, face-to-face office visits, and Telehealth office visits. Coverage applies to office visits only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.

	What You Pay In-Network	What You Pay Out-of-Network
Office Visits		
Primary Care Provider (PCP)	$0	60% after Deductible
Obstetrics/Gynecology Provider (OBGYN)	$0	60% after Deductible
Oncology Provider	$0	60% after Deductible
Specialist Provider	$25	60% after Deductible
Chiropractic Care (18 visits per calendar year)	$40	60% after Deductible
St. Luke's Lifestyle Medicine	$0	Out-of-Network Services Not Available
Other Visit Related Services	10% after Deductible	60% after Deductible
Telehealth/Virtual Care		
St. Luke's On-Demand Virtual Care	$0	Out-of-Network Services Not Available
Telehealth Office Visit (other than St. Luke's On-Demand Care)	Aligns with Visit Type	Aligns with Visit Type
Other Telehealth Services (Telephone Visits, E-visits, Remote Patient Monitoring, E-consults, Collaborative Care Services)	$0	60% after Deductible

Preventive Care

Preventive care is provided by or under the supervision of your provider, and includes all services required by the Affordable Care Act, including but not limited to periodic exams and preventive screenings, immunizations, mammograms, colonoscopies, preventive medication, pap tests and other preventive care. Preventive care does not include diagnostic treatment, lab, x-ray, follow-up care, or maintenance care of existing or chronic disease.

	What You Pay In-Network	What You Pay Out-of-Network
Preventive Care	$0	60% after Deductible

Urgent and Emergent Care

Emergency Department visits (including pre-stabilization, post-stabilization, certain ancillary services) and urgent care visits to evaluate an urgent medical condition are covered at in-network and out-of-network facilities. Coverage applies to urgent and emergent care only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.

	What You Pay In-Network	What You Pay Out-of-Network
Urgent Care Visit	$25	60% after Deductible
Emergency Room	10% after Deductible	10% after Deductible
Ambulance	10% after Deductible	10% after Deductible

Inpatient and Outpatient Hospital Services

Covered inpatient care includes room and board, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while in the hospital. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

	What You Pay In-Network	What You Pay Out-of-Network
Bariatric Surgery	Not Covered	Not Covered
Outpatient Hospital and Ambulatory Surgical Centers	10% after Deductible	60% after Deductible
Inpatient Hospital*	10% after Deductible	60% after Deductible
Medical/Surgical Professional (Physician, Surgeon Assistant, Hospitalist, Anesthesiologist, Radiologist)*	10% after Deductible	60% after Deductible

Maternity and Newborn Care Services

Services related to pregnancy, childbirth and complications of pregnancy are covered. Coverage applies to office visits only. All other services performed during the maternity office visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.

	What You Pay In-Network	What You Pay Out-of-Network
Inpatient/Outpatient Facility Services	10% after Deductible	60% after Deductible
Physician/Provider Services (Global)	$0	60% after Deductible

Mental Health Care and Chemical Dependency

Mental health care supports emotional, psychological and social wellbeing. For mental health office visits, coverage applies to office visit only. All other services performed during the visit are paid at the applicable benefits level, including but not limited to diagnostic imaging and labs.

	What You Pay In-Network	What You Pay Out-of-Network
Mental Health Office Visit	$0	60% after Deductible
Inpatient Care (Chemical Dependency Rehabilitation, Inpatient Psychiatric, Residential Treatment Programs)*	10% after Deductible	60% after Deductible
Outpatient Facility (Intensive Outpatient Programs, Partial Hospitalization Programs)	10% after Deductible	60% after Deductible

Outpatient Diagnostic Services Laboratory and radiology services are covered for diagnostic purposes when medically necessary and ordered by a qualified health care provider.		
	What You Pay In-Network	**What You Pay Out-of-Network**
Advanced Diagnostic Imaging (MRIs, CTs, PET)	10% after Deductible	60% after Deductible
Diagnostic Labs/Procedures (X-rays, EKGs, Ultrasounds, Allergy Tests, etc.)	$30	60% after Deductible
Infertility Diagnostic	10% after Deductible	60% after Deductible

Rehabilitation Therapy Coverage for disabling conditions is provided through inpatient, outpatient rehabilitation therapy. The services are rendered to restore and significantly improve function that was previously present but lost due to acute injury or illness.		
	What You Pay In-Network	**What You Pay Out-of-Network**
Inpatient Rehabilitation*	10% after Deductible	60% after Deductible
Skilled Nursing Facility (30 days per calendar year)*	10% after Deductible	60% after Deductible
Occupational, Physical and Speech Therapy (Prior Authorization required after 20 combined visits per calendar year)*	$25	60% after Deductible
Other Outpatient Rehabilitation Therapy (including Cardiac, Pulmonary, Respiratory, PAD)	$25	60% after Deductible

Durable Medical Equipment (DME) Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs or crutches.		
	What You Pay In-Network	**What You Pay Out-of-Network**
Breast Pumps (one per pregnancy)*	$0	60% after Deductible
Wigs (one per calendar year up to $150)*	$0	60% after Deductible
Other Durable Medical Equipment*	10% after Deductible	60% after Deductible

Vision Care Vision care is the care and treatment of eyes, eyesight conditions and vision.		
	What You Pay In-Network	**What You Pay Out-of-Network**
Preventive/Routine		
Preventive/Routine Eye Exam for Adults (ages 19 and older) eye exams	Not Covered	Not Covered
Preventive/Routine Eye Exam for Pediatric (ages 18 and younger); one per calendar year	$0	60% after Deductible
Medically Necessary (limited to include diagnosis and/or treatment of an eye disease)		
Medically Necessary Eye Exams (all ages)	$0	60% after Deductible
Vision Hardware (limited to one pair of lenses and frames or one pair of contacts per calendar year)		
Adults (ages 19 and older)	Not Covered	Not Covered
Pediatric (ages 18 and younger)	10% after Deductible	60% after Deductible

Other Services		
	What You Pay In-Network	**What You Pay Out-of-Network**
Allergy Injections	10% after Deductible	60% after Deductible
Diabetes Education	$0	60% after Deductible
Hearing Aids *(dependent children up to age 26; limited to 2 hearing aids every 3 years)*	10% after Deductible	60% after Deductible
Home Health (Prior Authorization required after 10 visits per calendar year)*	10% after Deductible	60% after Deductible
Hospice Care*	$0	60% after Deductible
Infusion Therapy (Infused Medications, Gene Therapy, Immunotherapy)*	10% after Deductible	60% after Deductible
Nutritional Counseling	$0	60% after Deductible
Pediatric Dental Care	Not Covered	Not Covered
All Other Covered Services	10% after Deductible	60% after Deductible

Pharmacy Benefit Services More information about prescription drug coverage is available at stlukeshealthplan.org/member/resources/pharmacy.	
	What You Pay In-Network
Retail (1-to-30-day supply)	
Affordable Care Act (ACA) Preventive Drugs	$0
Tier 1 (Preferred Generics)	$0
Tier 2 (Non-preferred Generics)	$10
Tier 3 (Preferred Brand)	15% after Deductible
Tier 4 (Non-preferred Brand)	30% after Deductible
Tier 5 (Specialty)	20% after Deductible
Home Delivery (31-to-100-day supply)	
Affordable Care Act (ACA) Preventive Drugs	$0
Tier 1 (Preferred Generics)	$0
Tier 2 (Non-preferred Generics)	$20
Tier 3 (Preferred Brand)	10% after Deductible
Tier 4 (Non-preferred Brand)	25% after Deductible

Footnotes

1. In-network benefits apply for services rendered through St. Luke's Health Partners in the defined service area. When traveling or using care outside of the service area, utilize the applicable nationwide network. To determine if your provider is in-network, visit stlukeshealthplan.org/find-a-doctor.
2. Under the Smart Co-pay program, the manufacturer will pay all or a portion of a member's copayment or coinsurance through the manufacturer's assistance program. When manufacturer assistance is available on select medications, a member's copayment or coinsurance amount may reflect up to the maximum value of any manufacturer assistance. The amount paid by the manufacturer does not apply to the member's outstanding deductible or out-of-pocket maximum. St. Luke's Health Plan will help coordinate these assistance programs for you.
3. All out-of-network services are subject to deductible unless otherwise noted.
4. This Individual Policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance broker or agent, a stand-alone dental insurance provider or Your Health Idaho if you wish to purchase a stand-alone dental care product.
5. * Prior Authorization may be required. Please refer to your master policy or contact customer support for more clarification.