Individual Gold (ZCS)

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.	$0 **Individual** $0 **Family**	$0 **Individual** $0 **Family**
Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
The combined total for your deductible(s), coinsurance and copays per calendar year.	$0 **Individual** $0 **Family**	$0 **Individual** $0 **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	$0
Obstetrics/Gynecology Provider (OBGYN)	$0	$0
Oncology Provider	$0	$0
Specialist Provider	$0	$0
Chiropractic Care (18 visits per calendar year)	$0	$0
St. Luke's Lifestyle Medicine	$0	Out-of-Network Services Not Available
Other Visit Related Services	$0	$0
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	$0

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	$0

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	$0	$0
Emergency Room	$0	$0
Ambulance	$0	$0

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	$0	$0
Inpatient Hospital*	$0	$0
Medical/Surgical Professional (Physician, Surgeon Assistant, Hospitalist, Anesthesiologist, Radiologist)*	$0	$0

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	$0	$0
Physician/Provider Services (Global)	$0	$0

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	$0
Inpatient Care (Chemical Dependency Rehabilitation, Inpatient Psychiatric, Residential Treatment Programs)*	$0	$0
Outpatient Facility (Intensive Outpatient Programs, Partial Hospitalization Programs)	$0	$0

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)	$0	$0
Diagnostic Labs/Procedures (X-rays, EKGs, Ultrasounds, Allergy Tests, etc.)	$0	$0
Infertility Diagnostic	$0	$0

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*	$0	$0
Skilled Nursing Facility (30 days per calendar year)*	$0	$0
Occupational, Physical and Speech Therapy (Prior Authorization required after 20 combined visits per calendar year)*	$0	$0
Other Outpatient Rehabilitation Therapy (including Cardiac, Pulmonary, Respiratory, PAD)	$0	$0

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	$0
Wigs (one per calendar year up to $150)*	$0	$0
Other Durable Medical Equipment*	$0	$0

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	$0
Medically Necessary (limited to include diagnosis and/or treatment of an eye disease)		
Medically Necessary Eye Exams (all ages)	$0	$0
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)	$0	$0

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

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)	$0
Tier 3 (Preferred Brand)	$0
Tier 4 (Non-preferred Brand)	$0
Tier 5 (Specialty)	$0
Home Delivery (31-to-100-day supply)	
Affordable Care Act (ACA) Preventive Drugs	$0
Tier 1 (Preferred Generics)	$0
Tier 2 (Non-preferred Generics)	$0
Tier 3 (Preferred Brand)	$0
Tier 4 (Non-preferred Brand)	$0

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.