# Individual Outline of Coverage

**Effective 1/1/2023**

St Luke's™ Health Plan

This is an Expanded Bronze plan as defined by the Affordable Care Act

**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.

## Summary of Deductibles and Out-of-Pocket Maximums for Medical Benefits [1, 2, 4]

| Deductible | In-Network | Out-of-Network |
|---|---|---|
| Individual | $8,500 | $18,200 |
| Family | $17,000 | $36,400 |
| **Maximum Out-of-Pocket** | **In-Network** | **Out-of-Network** |
| Individual | $9,100 | $91,000 |
| Family | $18,200 | $182,000 |

## Summary of Medical Benefits See Footnotes

| | Deductible Applies | Applies to Out-of- Pocket Maximum | What you pay for In-Network services* | What you pay for Wrap Network services* | What you pay for Out-of-Network services* |
|---|---|---|---|---|---|
| ***If "No" Deductible Applies, you pay only the Copay amount shown; If "Yes" Deductible Applies you pay either the Copay $ or Coinsurance % shown after Deductible is met.** | | | | | |
| **Allergy Care** | For Office Visit Amount, see PCP/Specialist Below | | | | |
| Testing | Yes | ✓ | $100 Copay | 60% | 60% |
| Injections | Yes | ✓ | 50% | 60% | 60% |
| **Ambulance Services** | Yes | ✓ | 50% | 50% | 50% |
| **Anesthesia** | Yes | ✓ | 50% | 50% if at an In-Network Facility<br>60% if at an Out-of-Network Facility | 50% if at an In-Network Facility<br>60% if at an Out-of-Network Facility |
| **Applied Behavior Analysis (ABA) Therapy** | Yes | ✓ | 50% | 60% | 60% |

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| **Autologous Blood Donation/Blood Transfusion** | Yes | ✓ | 50% | 60% | 60% |
| **Bariatric Surgery** | | | | | |
| **Inpatient / Outpatient** (facility and professional) | Yes | ✓ | 50% | 60% | 60% |
| **Office Visit**<br>Specialist<br>Other Provider | <br>No<br>No | ✓ | <br>$120 copay<br>$0 copay | 60% | 60% |
| **Biofeedback** | Yes | ✓ | 50% | 60% | 60% |
| **Chemical Dependency**<br>Pre-Authorization is required for inpatient behavioral health services, including residential treatment. | | | | | |
| **Inpatient** (facility and professional) | Yes | ✓ | 50% | 60% | 60% |
| **Outpatient** (facility) | Yes | ✓ | 50% | 60% | 60% |
| **Outpatient** (professional) | No | ✓ | $0 Copay | 60% | 60% |
| **Office Visit** | No | ✓ | $0 Copay | 60% | 60% |
| **Chiropractic Spinal Manipulation**<br>Limit of 18 visits per calendar year | Yes | ✓ | $100 Copay | 60% | 60% |
| **Clinical Trials** | Coverage is based on place of service and only as outlined under Clinical Trials. | | | | |
| **Dental Trauma**<br>Pre-Authorization is required for inpatient services. | | | | | |
| **Office Visit** | Yes | ✓ | 50% | 60% | 60% |
| **All Other Places of Service** | Yes | ✓ | 50% | 60% | 60% |
| **Diabetic Education and Diabetic Nutrition Education** | No | ✓ | $0 Copay | 60% | 60% |
| **Diagnostic Services** | | | | | |
| **Inpatient** | Yes | ✓ | 50% | 60% | 60% |
| **Outpatient (facility)**<br>**Outpatient (professional)**<br>Cardiovascular<br>CT/MRI/PET<br>Pathology/Other Radiology | Yes | ✓ | <br>50%<br>50%<br>$75 Copay<br>$250 Copay<br>$150 Copay | 60% | 60% |
| All Other In-Office Diagnostic | Yes | ✓ | 50% | 60% | 60% |
| **Dialysis Services** | | | | | |
| **Inpatient** | Yes | ✓ | 50% | 60% | 60% |

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| **Outpatient** | Yes | ✓ | 50% | 60% | 60% |
| **In Office** | Yes | ✓ | 50% | 60% | 60% |
| **Durable Medical Equipment and Supplies** | | | | | |
| **Breast Pumps** | No | ✓ | $0 Copay | 0% | 60% |
| **Durable Medical Equipment** | Yes | ✓ | 50% | 60% | 60% |
| **Medical Supplies** | No | ✓ | $0 Copay | 60% | 60% |
| **Oral Appliances for Sleep Apnea** | Yes | ✓ | 50% | 60% | 60% |
| **Orthopedic Appliances/Braces** | No | ✓ | 1 Set Per Year | 60% | 60% |
| **Prosthetic Devices** | No | ✓ | 1 Set Per Year | 60% | 60% |
| **Wigs** | No | ✓ | 1 Per Year for certain diagnoses | 60% | 60% |
| **Emergency Care** | | | | | |
| **Emergency Department** (facility) Copay is waived if member is admitted to the hospital | Yes | ✓ | $500 Copay | $500 Copay | $500 Copay |
| **Emergency Department** (professional) | Yes | ✓ | 50% | 50% | 50% |
| **Urgent Care** | No | ✓ | $50 Copay | 60% | 60% |
| **Family Planning** | For Office Visit Amount See PCP/Specialist Below | | | | |
| **Devices, Implants and Injections** | No | ✓ | 0% | 0% | 60% |
| **Contraceptive Diagnostic Testing** | No | ✓ | 0% | 0% | 60% |
| **Sterilizations** | No | ✓ | 0% | 0% | 60% |
| **Voluntary Termination of Pregnancy** (Not covered unless the mother's life is at risk or pregnancy is the result of rape or incest.) | Yes | ✓ | 0% | 60% | 60% |
| **Foot Orthotics** | Yes | ✓ | 50% | 60% | 60% |
| **Genetic Services** | | | | | |
| **BRCA Testing** | Yes | ✓ | $0 Copay | 0% | 60% |
| **All Other Genetic Testing** | Yes | ✓ | 50% | 60% | 60% |

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| **Genetic Counseling** | Yes | ✓ | 50% | 60% | 60% |
| **Habilitative Services**<br>Pre-Authorization required for inpatient services. | | | | | |
| **Inpatient** (facility and professional) | Yes | ✓ | 50% | 60% | 60% |
| **Outpatient**<br>Facility<br>Professional | <br>Yes<br>No | ✓ | <br>50%<br>$80 Copay | 60% | 60% |
| **In Office** | No | ✓ | $80 Copay | 60% | 60% |
| **Hearing** | | | | | |
| **Routine Hearing Exams** | Yes | ✓ | 50% | 60% | 60% |
| **Medically Necessary Hearing Exams** | Yes | ✓ | 50% | 60% | 60% |
| **Hearing Aids/Appliances** (Limit Two Aids every 3 calendar years) | Yes | ✓ | 50% | 60% | 60% |
| **Home Health Care** | | | | | |
| **Home Health Care** | Yes | ✓ | $0 Copay | 60% | 60% |
| **Phototherapy** (home) | Yes | ✓ | $0 Copay | 60% | 60% |
| **Hospice** | | | | | |
| **Hospice Care**<br>12 Month Maximum | No | ✓ | $0 Copay | 60% | 60% |
| **Respite Care**<br>10-day Maximum Per Year. | No | ✓ | $0 Copay | 60% | 60% |
| **Hospital Inpatient Outpatient Surgery and Services**<br>Pre-Authorization required for some. | | | | | |
| **Inpatient / Outpatient** | Yes | ✓ | 50% | 60% | 60% |
| **Hospitalist** | Yes | ✓ | 50% | 60% | 60% |
| **Professional Services** (Surgeon / Assistant Surgeon) | Yes | ✓ | 50% | 50% if at an In-Network Facility<br>60% if at an Out-of-Network Facility | 50% if at an In-Network Facility<br>60% if at an Out-of-Network Facility |
| **Infertility Diagnostic Services** | Yes | ✓ | 50% | 60% | 60% |

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| **Infusion Therapy**<br>(includes infusion therapy provided in the home)<br>Pre-Authorization required for certain infusion therapy medications. | Yes | ✓ | 50% | 60% | 60% |
| **Lifestyle Medicine** | | | | | |
| **Office Visit**<br>Specialist<br>Other Provider | <br>No<br>No | ✓ | <br>$120 Copay<br>$0 Copay | 60% | 60% |
| **Maternity and Newborn Care** | | | | | |
| **Inpatient /Outpatient** | Yes | ✓ | 50% | 60% | 60% |
| **Professional**<br>Delivery and Office | No | ✓ | $0 Copay | 60% | 60% |
| **Mental Health Care**<br>Pre-Authorization required for inpatient, residential and partial hospitalization. | | | | | |
| **Inpatient**<br>(facility and professional) | Yes | ✓ | 50% | 60% | 60% |
| **Partial Day Treatment (PDT)** | Yes | ✓ | 50% | 60% | 60% |
| **Outpatient**<br>Facility<br>Professional | <br>Yes<br>No | ✓ | <br>50%<br>$0 Copay | <br>60%<br>60% | <br>60%<br>60% |
| **Office Visit** | No | ✓ | $0 Copay | 60% | 60% |
| **Nutritional Counseling** | | | | | |
| **Outpatient / Office** | No | | $0 Copay | 60% | 60% |
| **Nutritional and Dietary Formulas** | No | | $0 Copay | 60% | 60% |
| **Oral Surgery** | Yes | ✓ | 50% | 60% | 60% |
| **Pharmacy**<br>*Pharmacy benefits: For the HSA Qualified plans, deductible applies first to all tiers of medications, unless the medication is included on the preventative medication list. For all other plans, deductible applies to tiers 3-5. | | | | | |
| Retail (1 to 30 Day Supply) | | | | | |
| Tier 1 (Preferred Generics) | No | ✓ | $20 Copay | | |
| Tier 2 (Non-preferred Generics) | No | ✓ | $30 Copay | | |
| Tier 3 (Preferred Brand) | Yes | ✓ | 40% | | |
| Tier 4 (Non-preferred Brand) | Yes | ✓ | 50% | | |
| Tier 5 (Specialty) | Yes | ✓ | 40% | | |

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|---|---|---|---|---|---|
| Mail Order (84 to 100 Day Supply) | | | | | |
| Tier 1 (Preferred Generics) | No | ✓ | $40 Copay | | |
| Tier 2 (Non-preferred Generics) | No | ✓ | $60 Copay | | |
| Tier 3 (Preferred Brand) | Yes | ✓ | 35% | | |
| Tier 4 (Non-preferred Brand) | Yes | ✓ | 45% | | |
| Podiatric Care | Yes | ✓ | $0 Copay | 60% | 60% |
| **Preventive Care** | | | | | |
| All Preventive Care Services required by the Affordable Care Act are covered. St. Luke's Health Plan follows the guidance and recommendations set forth by the Centers for Disease Control and Prevention and the US Preventive Services Task Force (USPSTF) in considering the frequency of immunizations, screenings, and tests. See Preventive Care section for additional details. | | | | | |
| **Periodic Exams** | No | ✓ | $0 Copay | 0% | 60% |
| **Immunizations** | No | ✓ | $0 Copay | 0% | 60% |
| **Mammogram** | No | ✓ | $0 Copay | 0% | 60% |
| **Colonoscopy** | No | ✓ | $0 Copay | 0% | 60% |
| **Preventive Medications (See Pharmacy Prescription Drug List for Details)** | | | | | |
| **Sigmoidoscopy** | No | ✓ (Out-of-Network only) | $0 Copay | 0% | 60% |
| **Fecal Occult Blood Test** | No | ✓ (Out-of-Network only) | $0 Copay | 0% | 60% |
| **Pap Test** | No | ✓ (Out-of-Network only) | $0 Copay | 0% | 60% |
| **Prostate Cancer Screening (PSA)** | No | ✓ (Out-of-Network only) | $0 Copay | 0% | 60% |
| **FIT-Fecal DNA** | No | ✓ (Out-of-Network only) | $0 Copay | 0% | 60% |
| **Additional Screening and Counseling** Obesity Screening and Counseling, Nutritional Counseling, Bone Density Screening | No | ✓ (Out-of-Network only) | $0 Copay | 0% | 60% |
| **Professional / Physician Services** | | | | | |
| **Office Visit** | | | | | |
| Primary Care Provider (PCP) | No | ✓ | $0 Copay | 60% | 60% |
| Specialist | No | ✓ | $120 Copay | 60% | 60% |

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| **Office Visit Related Services** | Yes | ✓ | 50% | 60% | 60% |
| **Telemedicine** | No | ✓ | $0 Copay | 60% | 60% |
| **Reconstructive, Corrective and Cosmetic Services**<br>Limited Medical Benefit; see Reconstructive, Corrective and Cosmetic Services for details. | | | | | |
| **Inpatient/Outpatient**<br>(facility and professional) | Yes | ✓ | 50% | 60% | 60% |
| **Rehabilitation Therapy**<br>Pre-Authorization required for inpatient services. | | | | | |
| **Inpatient**<br>(facility and professional) | Yes | ✓ | 50% | 60% | 60% |
| **Outpatient**<br>Facility<br>Professional<br>(20 visits per Calendar Year combined with outpatient professional) | Yes<br>No | ✓ | 50%<br>$80 Copay | 60% | 60% |
| **Skilled Nursing Facility**<br>30 days per calendar year.<br>Pre-Authorization required. | Yes | ✓ | 50% | 60% | 60% |
| **Temporomandibular Joint (TMJ) Disorder** | Not Covered | | | | |
| **Tobacco Cessation Counseling** | Yes | ✓ | 0% | 0% | 60% |
| **Transgender/Gender Affirming Services**<br>Gender affirming surgical treatments are limited to Members aged 18 and older.<br>Pre-Authorization required. | Covered based on place of service. | | | | |
| **Transplants - Organ and bone marrow (recipient and donor services)** | Covered based on place of service | | | | |
| **Transportation and Lodging**<br>$7,500 maximum per calendar year. | Yes | ✓ | 50% | 60% | 60% |
| **Vision Care** | | | | | |
| **Preventive Eye Exams** | | | | | |
| **Pediatric** (ages 18 and younger) One Per Year | No | ✓ | $0 Copay | 0% | 60% |
| **Adult** (ages 19 and older) | Not Covered | | | | |

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|---|---|---|---|---|---|
| **Medically Necessary Eye Exams** (all ages) | Yes | ✓ | $120 Copay | 60% | 60% |
| **Vision Hardware**<br>Limit one pair of lenses and frames or one pair of contacts per calendar year. | | | | | |
| Pediatric (ages 18 and younger) | Yes | ✓ | 50% | 60% | 60% |
| Adult (ages 19 and older) | Not Covered | | | | |

## Footnotes

1. All Deductible/Copay/Coinsurance amounts are based on the allowed amounts and not on the Providers billed charges. Be aware that your actual costs for services provided by an Out-of-Network provider may exceed this policy's Maximum Out-of-Pocket for Out-of-Network services. Your costs for the following covered services do not accumulate toward the Maximum Out-of-Pocket amount if delivered by an Out-of-Network Provider: Dental Services, Vision Services and Prescription Drug Services. In addition, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by St. Luke's Health Plan, and that amount is not counted toward the Out-of-Network Maximum Out-of-Pocket.
2. Certain Services as noted on this Outline of Coverage and in your Master Policy are not subject to the Deductible.
3. Preauthorization is required for certain services. Benefits may not be as great or denied if you do not Pre-Authorize certain services with Wrap and Out-of-Network Providers. Please refer to your Master Policy, for details.
4. To find a provider see Choosing a Provider in the Master Policy: stlukeshealthplan.org/find-a-doctor.
5. Frequency and/or quantity limitations apply to some services – refer to Summary of Benefit Limits section in your Master Policy.
6. All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization. For more information, refer to your Master Policy or call Member Services at 1-833-478-5853 weekdays, from 9:00 am - 6:00 pm (MT). TTY users should call 1-866-876-5924.