Small Group Gold

2024 Benefits Outline of Coverage

St Luke's™ Health Plan

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.

Annual Deductible	**In-Network**	**Out-of-Network**
The total deductible you pay per plan year.	$1,800 **Individual** $3,600 **Family**	$3,600 **Individual** $7,200 **Family**
Annual Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
The combined total for your deductible(s), coinsurance and copays per plan year.	$7,750 **Individual** $15,500 **Family**	$15,500 **Individual** $31,000 **Family**
	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 Medical Services
Professional medical services including physical exams and Telehealth for the purpose of diagnosing, assessing or treating illness or disease. For imaging, lab and diagnostic services see applicable section.

	What you pay for in-network services*	**What you pay for out-of-network services*** **
Office and Telehealth Visits		
Primary Care Provider (PCP)	$0	60% after Deductible
Obstetrics/Gynecology Provider (OBGYN)	$0	60% after Deductible
Specialist	$30	60% after Deductible
Telehealth Services (other than St. Luke's On-Demand Care)	Aligns with Office Visit Type	Aligns with Office Visit Type
St. Luke's On-Demand Virtual Care	$0	Out-of-Network Services Not Available
Other Visit Related Services	10% after Deductible	60% after Deductible
St. Luke's Lifestyle Medicine		
Specialist Visit	$30	Out-of-Network Services Not Available
Intensive Lifestyle Medicine Program	$0	Out-of-Network Services Not Available
Pivio – the Complete Health Improvement Program	$0	Out-of-Network Services Not Available

Maternity and Newborn Care Professional Services Services related to pregnancy and childbirth.		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Inpatient/Outpatient	10% after Deductible	60% after Deductible
Professional (OBGYN)		
Delivery and Office	$0	60% after Deductible

Urgent Care and Emergency Care Emergency care is immediate medical care that is available 24 hours a day or during extended hours in an emergency room or facility that is either stand-alone, or more often, part of a hospital or medical center.		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Urgent Care	$30	60% after Deductible
Emergency Care (Facility)	$100 after Deductible	$100 after Deductible
Emergency Care (Professional)	10% after Deductible	10% after Deductible
Ambulance	10% after Deductible	10% after Deductible

Mental Health Care Mental health care supports emotional, psychological and social wellbeing. Pre-Authorization required for inpatient, residential and partial hospitalization.		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Office Visit	$0	60% after Deductible
Inpatient	10% after Deductible	60% after Deductible
Partial Day	10% after Deductible	60% after Deductible
Outpatient Facility	10% after Deductible	60% after Deductible
Outpatient Professional	$0	60% after Deductible

Preventive Care Routine health care that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Preventive Physicals	$0	60% after Deductible
Well Woman Visits	$0	60% after Deductible
Pap Test	$0	60% after Deductible
Well Baby/Well Child Visits	$0	60% after Deductible
Preventive Mammograms	$0	60% after Deductible

Preventive Colonoscopy	$0	60% after Deductible
Preventive Sigmoidoscopy	$0	60% after Deductible
Immunizations	$0	60% after Deductible

Inpatient and Outpatient Hospital Services
Inpatient care refers to any medical service that requires admission into a hospital. Inpatient care tends to be directed toward more serious ailments and trauma that require one or more days of overnight stay at a hospital. Outpatient care refers to medical services provided that don't require a prolonged stay at a facility. Pre-Authorization required for inpatient and certain outpatient services.

	What you pay for in-network services*	What you pay for out-of-network services***
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

Imaging, Lab and other Diagnostic Services
Laboratory and radiology services include blood and urine tests, CT scans, MRI and EEG which are used to diagnose and regulate conditions.

	What you pay for in-network services*	What you pay for out-of-network services***
Advanced Diagnostic Imaging (MRIs, CTs, PET)	$150 after Deductible	60% after Deductible
Diagnostic Laboratory	$40	60% after Deductible
Diagnostic X-ray	$40	60% after Deductible
Cardiovascular Diagnostic	$40	60% after Deductible
Infertility Diagnostic	10% after Deductible	60% after Deductible

Habilitative and Rehabilitation Therapy
Habilitative services help a person keep, learn or improve skills and functioning for daily living. Rehabilitation services are measures taken to promote optimum attainable levels of physical, cognitive, emotional, psychological, social and economic usefulness, and thereafter to maintain the individual at the maximal functional level Pre-Authorization required for inpatient services.

	What you pay for in-network services*	What you pay for out-of-network services***
Inpatient Physical Rehabilitation	10% after Deductible	60% after Deductible
Outpatient or Office		
Occupational Therapy	$25	60% after Deductible
Physical Therapy	$25	60% after Deductible
Speech Therapy	$25	60% after Deductible

Durable Medical Equipment and Supplies Equipment and supplies ordered by a health care provider for everyday or extended use. All Equipment, Orthotic Devices and Prosthetic Appliances with costs of more than $1,000 require a Pre-Authorization.		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Breast Pumps	$0	60% after Deductible
Orthopedic Appliances/Braces	10% after Deductible	60% after Deductible
Prosthetic Devices	10% after Deductible	60% after Deductible
Wigs	$0	60% after Deductible
Other Medical Equipment and Supplies	10% after Deductible	60% after Deductible

Vision Care Vision care is the care and treatment of eyes, eyesight conditions, and vision.		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Preventive Eye Exams		
Pediatric (ages 18 and younger) one per year	$0	60% after Deductible
Adults (ages 19 and older) eye exams not covered	Not Covered	Not Covered
Medically Necessary Eye Exams (all ages)	10% after Deductible	60% after Deductible
Vision Hardware (limit one pair of lenses and frames or one pair of contacts per calendar year)		
Pediatric (ages 18 and younger)	10% after Deductible	60% after Deductible

Other Services		
	What you pay for in-network services*	**What you pay for out-of-network services*** **
Allergy Testing	10% after Deductible	60% after Deductible
Chiropractic Care	$40	60% after Deductible
Diabetes Education	$0	60% after Deductible
Hearing Aids	$0	60% after Deductible
Home Health	10% after Deductible	60% after Deductible
Hospice	$0	60% after Deductible
Nutritional Counseling	$0	60% after Deductible
Transportation and Lodging for Covered Organ Transplants	$7,500 per year after Deductible	60% after Deductible

Pediatric Dental Care****	Not Covered	Not Covered
Skilled Nursing Facilities	10% after Deductible	60% after Deductible
Tobacco Cessation Counseling	$0	60% after Deductible
All Other Services	10% after Deductible	60% after Deductible

Pharmacy**	
	What you pay for in-network services*
Retail (1 to 30 Day Supply)	
Tier 1 (Preferred Generics)	$0
Tier 2 (Non-preferred Generics)	$10
Tier 3 (Preferred Brand)	35% after Deductible
Tier 4 (Non-preferred Brand)	50% after Deductible
Tier 5 (Specialty)	40% after Deductible
Maintenance Medications (31 to 100 Day Supply)	
Tier 1 (Preferred Generics)	$0
Tier 2 (Non-preferred Generics)	$20
Tier 3 (Preferred Brand)	30% after Deductible
Tier 4 (Non-preferred Brand)	45% after Deductible

Footnotes

*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 First Choice Health or First Health networks. To determine if your provider is in network go to https://www.stlukeshealthplan.org/find-a-doctor.

** 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 prescription 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 towards the Member's outstanding Deductible or Out-of-Pocket Maximum. St. Luke's Health Plan will help coordinate these assistance programs for you.

*** All out-of-network services are subject to deductible unless otherwise noted.

****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 agent, a stand-alone dental insurance provider or Your Health Idaho if you wish to purchase a stand-alone dental care product.