St Luke's Health Plan

Individual: Silver (LCS)

Coverage Period: 01/01/2025-12/31/2025

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage for: Single/Family | Plan Type: POS

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, visit stlukeshealthplan.org or call 833-377-1311. 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.healthcare.gov/glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or network providers $5,700 individual / $11,400 family; out- of-network providers $18,400 individual / $36,800 family.	Generally, you must pay all of the costs from provider up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care; office visits; diagnostic tests; chiropractic; Tier 1 and Tier 2 prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care without cost sharing and before you meet your deductible.
Are there other deductibles for specific services?	$0 at IHCP or with IHCP referral at non-IHCP. There are no other specific deductibles.	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	For In-network Providers: $9,200 individual / $18,400 family For Out-of-network Providers: $92,000 individual / $184,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

* For more information about limitations and exceptions, see the plan or policy document at stlukeshealthplan.org

Will you pay less if you use a network provider?	Yes. See www.stlukeshealthplan.org or call 1-833-377-1311 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services without a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No Charge; deductible does not apply	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). OB-GYN and Oncology visits receive primary care benefits
	Specialist visit	No charge	$60 per visit; deductible does not apply	60% coinsurance	
	Preventive care/ screening/ immunization	No charge	No Charge; deductible does not apply	60% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	$80 per test; deductible does not apply	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. 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	$200 per test	60% coinsurance	

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at stlukeshealthplan.org	Generic drugs	No charge	Preferred Generic: No Charge; deductible does not apply Non-Preferred Generic: $10 per prescription;	60% coinsurance	Pre-Authorization required for certain medication. Cost sharing waived at non-IHCP with IHCP referral. 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	35% coinsurance	60% coinsurance	
	Non-preferred brand drugs	No charge	50% coinsurance	60% coinsurance	
	Specialty drugs	No charge	40% coinsurance	60% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. 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	40% coinsurance	60% coinsurance	
If you need immediate medical attention	Emergency room care	No charge	40% coinsurance	40% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. 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	40% coinsurance	40% coinsurance	
	Urgent care	No charge	$60 per visit; deductible does not apply	60% coinsurance	

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% coinsurance	60% coinsurance	Pre-Authorization required. Cost sharing waived at non-IHCP with IHCP referral. 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	40% coinsurance	60% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office Visit: No Charge; deductible does not apply Hospital Outpatient: 40% coinsurance	60% coinsurance	Pre-Authorization required for inpatient mental health services, including residential treatment. Cost sharing waived at non-IHCP with IHCP referral. 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	40% coinsurance	60% coinsurance	
If you are pregnant	Office visits	No charge	No Charge; deductible does not apply	60% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Childbirth/delivery professional services	No charge	No Charge; deductible does not apply	60% coinsurance	
	Childbirth/delivery facility services	No charge	40% coinsurance	60% coinsurance	

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. 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	$40 per visit; deductible does not apply	60% coinsurance	20 Visits Per Year. Pre-Authorization required for inpatient services. Cost sharing waived at non-IHCP with IHCP referral. 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	$40 per visit; deductible does not apply	60% coinsurance	Pre-Authorization required for inpatient services. Cost sharing waived at non-IHCP with IHCP referral. If an out- of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Skilled nursing care	No charge	40% coinsurance	60% coinsurance	30 days per year; Pre-Authorization Required. Cost sharing waived at non-IHCP with IHCP referral. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).

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	Durable medical equipment	No charge	40% coinsurance	60% coinsurance	Cost sharing waived at non-IHCP with IHCP referral. Pre-Authorization required. 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	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	No charge	No Charge; deductible does not apply	60% coinsurance	12 Months; Pre-Authorization required for inpatient hospice. Cost sharing waived at non-IHCP with IHCP referral. 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; deductible does not apply	60% coinsurance	Coverage limited to one exam/year. Cost sharing waived at non-IHCP with IHCP referral. 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	40% coinsurance	60% coinsurance	Coverage limited to one pair of glasses/year. Cost sharing waived at non-IHCP with IHCP referral. 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	No charge	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)

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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: stlukeshealthplan.org or call 1-833-377-1311 or contact the Idaho Department of Insurance at doi.idaho.gov or call 1-800-721-3272. 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: stlukeshealthplan.org or call 1-833-377-1311 or contact the Idaho Department of Insurance at doi.idaho.gov or call 1-800-721-3272.

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 1-833-377-1311.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-377-1311.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-377-1311.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-377-1311.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at stlukeshealthplan.org

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	**$5,700**
Specialist *[cost sharing]*	**$60**
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	$5,700
Copayments	$800
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,660**

Managing Joe's Type 2 Diabetes

(one year of routine in-network care of a well- controlled condition)

The plan's overall deductible	**$5,700**
Specialist *[cost sharing]*	**$60**
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	$3,900
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,120**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,700**
Specialist *[cost sharing]*	**$60**
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	$2,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.