Individual Bronze HDHP (ZCS)

2025 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.

Annual Medical Deductible	In-Network	Out-of-Network
The total deductible you pay per plan year.	$0 **Individual** $0 **Family**	$0 **Individual** $0 **Family**
Annual Out-of-Pocket Maximum	**In-Network**	**Out-of-Network**
The combined total for your deductible(s), coinsurance, and copays per plan year.	$0 **Individual** $0 **Family**	$0 **Individual** $0 **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 Services Professional medical services including in-person, face-to-face office visits, and Telehealth office visits. 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 Visits		
Primary Care Provider (PCP)	$0	$0
Obstetrics/Gynecology Provider (OBGYN)	$0	$0
Oncology Provider	$0	$0
Specialist Provider	$0	$0
Chiropractic Care	$0	$0
Other Visit Related Services	$0	$0
Telehealth		
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
St. Luke's Lifestyle Medicine		
Lifestyle Medicine Shared Medical Appointment (Specialist)	$0	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

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 test 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 for in-network services	**What you pay for out-of-network services**
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. For imaging, lab and diagnostic services performed in the Emergency Room see applicable section.		
	What you pay for in-network services	**What you pay for out-of-network services**
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. Prior 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	$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.		
	What you pay for in-network services	**What you pay for out-of-network services**
Inpatient/Outpatient Facility Services	$0	$0
Physician/Provider Services (Global)	$0	$0

Mental Health Care Mental health care supports emotional, psychological, and social wellbeing. Prior authorization required for inpatient, residential and partial hospitalization.		
	What you pay for in-network services	**What you pay for out-of-network services**
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

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 for in-network services	**What you pay for out-of-network services**
Advanced Diagnostic Imaging (MRIs, CTs, PET)	$0	$0
Diagnostic Laboratory	$0	$0
Diagnostic Procedures (X-rays, EKGs, Ultrasounds)	$0	$0
Infertility Diagnostic	$0	$0

Rehabilitation Therapy Coverage for disabling conditions is provided through inpatient and 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. Prior authorization required for inpatient services.		
	What you pay for in-network services	**What you pay for out-of-network services**
Inpatient Rehabilitation	$0	$0
Skilled Nursing Facility	$0	$0
Occupational, Physical and Speech Therapy	$0	$0
Other Outpatient Rehabilitation Therapy (including Cardiac, Pulmonary, Respiratory, PAD)	$0	$0

Durable Medical Equipment (DME) DME is medical equipment that can withstand repeated use, is not disposable, is used for a medically therapeutic purpose, is generally not useful in the absence of sickness or injury and is appropriate for use in the home. Prior authorization is required for certain DME		
	What you pay for in-network services	**What you pay for out-of-network services**
Breast Pumps	$0	$0
Wigs	$0	$0
Other Medical Equipment and Supplies	$0	$0

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 Exam for Pediatric (ages 18 and younger); one per year	$0	$0
Preventive Eye Exam for Adults (ages 19 and older) eye exams	Not Covered	Not Covered
Medically Necessary Eye Exams (all ages)	$0	$0
Vision Hardware (limit one pair of lenses and frames or one pair of contacts per calendar year)		
Pediatric (ages 18 and younger)	$0	$0

Other Services		
	What you pay for in-network services	**What you pay for out-of-network services**
Allergy Testing and Injections	$0	$0
Diabetes Education	$0	$0
Hearing Aids *(Hearing aids are covered for dependent children aged 25 and younger only.)*	$0	$0
Home Health	$0	$0
Hospice Care	$0	$0
Nutritional Counseling	$0	$0
Pediatric Dental Care	Not Covered	Not Covered
All Other Covered Services	$0	$0

Pharmacy Benefit Services	
	What you pay for in-network services
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
Mail Order (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 First Choice Health or First Health networks. To determine if your provider is in network go to 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 towards 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 agent, a stand-alone dental insurance provider or Your Health Idaho if you wish to purchase a stand-alone dental care product.