Small Group Gold

2025 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 Medical 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 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	60% after Deductible
Obstetrics/Gynecology Provider (OBGYN)	$0	60% after Deductible
Oncology Provider	$0	60% after Deductible
Specialist Provider	$30	60% after Deductible
Chiropractic Care	$40	60% after Deductible
Other Visit Related Services	10% after Deductible	60% after Deductible
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	60% after Deductible
St. Luke's Lifestyle Medicine		
Lifestyle Medicine Shared Medical Appointment (Specialist)	$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

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	60% after Deductible

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	$30	60% after Deductible
Emergency Room	10% after Deductible	10% after Deductible
Ambulance	10% after Deductible	10% after Deductible

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	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

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	10% after Deductible	60% after Deductible
Physician/Provider Services (Global)	$0	60% after Deductible

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	60% after Deductible
Inpatient Care (Chemical Dependency Rehabilitation, Inpatient Psychiatric, Residential Treatment Programs)	10% after Deductible	60% after Deductible
Outpatient Facility (Intensive Outpatient Programs, Partial Hospitalization Programs)	10% after Deductible	60% after Deductible

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)	$150 after Deductible	60% after Deductible
Diagnostic Laboratory	$40	60% after Deductible
Diagnostic Procedures (X-rays, EKGs, ultrasounds)	$40	60% after Deductible
Infertility Diagnostic	10% after Deductible	60% after Deductible

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	10% after Deductible	60% after Deductible
Skilled Nursing Facility	10% after Deductible	60% after Deductible
Occupational, Physical and Speech Therapy	$25	60% after Deductible
Other Outpatient Rehabilitation Therapy (including Cardiac, Pulmonary, Respiratory, PAD)	$25	60% after Deductible

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	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 Exam for Pediatric (ages 18 and younger); one per year	$0	60% after Deductible
Preventive Eye Exam for Adults (ages 19 and older) eye exams	Not Covered	Not Covered
Medically Necessary Eye Exams (all ages)	$0	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 and Injections	10% after Deductible	60% after Deductible
Diabetes Education	$0	60% after Deductible
Hearing Aids *(Hearing aids are covered for dependent children aged 25 and younger only.)*	10% after Deductible	60% after Deductible
Home Health	10% after Deductible	60% after Deductible
Hospice Care	$0	60% after Deductible
Nutritional Counseling	$0	60% after Deductible
Pediatric Dental Care****	Not Covered	Not Covered
All Other Covered Services	10% after Deductible	60% after Deductible

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)	$10
Tier 3 (Preferred Brand)	35% after Deductible
Tier 4 (Non-preferred Brand)	50% after Deductible
Tier 5 (Specialty)	40% after Deductible
Mail Order (31 to 100 Day Supply)	
Affordable Care Act (ACA) Preventive Drugs	$0
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

1. In-network benefits apply for services rendered through St. Luke's Health Partners in the defined service area, when traveling o r 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.