St Luke's Health Plan **Individual: Gold**

**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 833-840-3600. 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?** | For In-network Providers: $1,800 individual / $3,600 family<br>For 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?** | No | You don't have to meet deductibles for specific services |
| **What is the out-of-pocket limit for this plan?** | For In-network Providers: $7,750 individual / $15,500 family<br>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. |
| **Will you pay less if you use a network provider?** | Yes. See www.stlukeshealthplan.org or call 1-833-840-3600 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 |

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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | | (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

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 | What You Will Pay<br>Network Provider (You will pay the least) | What You Will Pay<br>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 deductible visit to treat an injury or illness | No Charge; deductible does not apply | 60% coinsurance | None |
| | Specialist visit | $30 per visit; deductible does not apply | 60% coinsurance | OB-GYN and Oncology visits receive primary care benefits |
| | Preventive care/screening/ immunization | No Charge; deductible does not apply | 60% coinsurance | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $40 per test; deductible does not apply | 60% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $150 per test | 60% coinsurance | None |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at stlukeshealthplan.org | Generic drugs | Preferred Generic: No Charge; deductible does not apply<br>Non-Preferred Generic: $10 per prescription; deductible does not apply | 60% coinsurance | Pre-Authorization required for certain medications |
| | Preferred brand drugs | 35% coinsurance | 60% coinsurance | Pre-Authorization required for certain medications |
| | Non-preferred brand drugs | 50% coinsurance | 60% coinsurance | Pre-Authorization required for certain medications |
| | Specialty drugs | 40% coinsurance | 60% coinsurance | Pre-Authorization required for certain medications |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 60% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 60% coinsurance | None |

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| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 10% coinsurance | None |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | $30 per visit; deductible does not apply | 60% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 60% coinsurance | Pre-Authorization required |
| | Physician/surgeon fees | 10% coinsurance | 60% coinsurance | Pre-Authorization required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit: No Charge; deductible does not apply<br>Hospital Outpatient: 10% coinsurance | 60% coinsurance | None |
| | Inpatient services | 10% coinsurance | 60% coinsurance | Pre-Authorization required |
| **If you are pregnant** | Office visits | No Charge; deductible does not apply | 60% coinsurance | None |
| | Childbirth/delivery professional services | No Charge; deductible does not apply | 60% coinsurance | None |
| | Childbirth/delivery facility services | 10% coinsurance | 60% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 60% coinsurance | None |
| | Rehabilitation services | $25 per visit; deductible does not apply | 60% coinsurance | Pre-Authorization required for inpatient services. |
| | Habilitation services | $25 per visit; deductible does not apply | 60% coinsurance | Pre-Authorization required for inpatient services. |
| | Skilled nursing care | 10% coinsurance | 60% coinsurance | 30 days per year. Pre-Authorization required for inpatient services. |
| | Durable medical equipment | 10% coinsurance | 60% coinsurance | Pre-Authorization required |
| | Hospice services | No Charge; deductible does not apply | 60% coinsurance | 12 months. Pre-Authorization required for inpatient hospice services |
| **If your child needs** | Children's eye exam | No Charge; deductible | 60% coinsurance | 1 per year |

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| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **dental or eye care** | | does not apply | | |
| | Children's glasses | 10% coinsurance | 60% coinsurance | 1 pair lenses/frames per year |
| | Children's dental check-up | 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.)**

- Acupuncture
- Cosmetic Surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Temporomandibular Joint Disorder (TMJ)

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine foot care
- Weight loss programs as part of a program approved by St. Luke's Health Plan

**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 1-833-840-3600 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 1-833-840-3600 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 1-833-840-3600.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-840-3600.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-840-3600.

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-840-3600.

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

## 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 | $1,800 |
| Specialist *[cost sharing]* | $30 |
| Hospital (facility) *[cost sharing]* | 10% |
| Other *[cost sharing]* | 10% |

**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* | |
| deductible | $1,800 |
| copayment | $600 |
| coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,160** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist *[cost sharing]* | $30 |
| Hospital (facility) *[cost sharing]* | 10% |
| Other *[cost sharing]* | 10% |

**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* | |
| deductible | $1,800 |
| copayment | $200 |
| coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,620** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,800 |
| Specialist *[cost sharing]* | $30 |
| Hospital (facility) *[cost sharing]* | 10% |
| Other *[cost sharing]* | 10% |

**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* | |
| deductible | $1,800 |
| copayment | $300 |
| coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,120** |

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