St Luke's Health Plan

Individual: Silver 250

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

Coverage Period: 01/01/2024-12/31/2024
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 833-478-5853. 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: $250 individual / $500 family For Out-of-network Providers: $18,900 individual / $37,800 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; St. Luke's On-Demand Virtual Care; 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: $900 individual / $1,800 family For Out-of-network Providers: $47,250 individual / $94,500 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 1-833-478-5853 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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	$10 per visit; deductible does not apply	60% coinsurance	OB-GYN 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)	$20 per test; deductible does not apply	60% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 per test	60% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at stlukeshealthplan.org	Generic drugs	Preferred Generic: No Charge; deductible does not apply Non-Preferred Generic: $10 per prescription; deductible does not apply	60% coinsurance	Pre-Authorization required for certain medications
	Preferred brand drugs	15% coinsurance	60% coinsurance	Pre-Authorization required for certain medications
	Non-preferred brand drugs	30% coinsurance	60% coinsurance	Pre-Authorization required for certain medications
	Specialty drugs	20% 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$50 per visit	$50 per visit	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$10 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 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	$10 per visit; deductible does not apply	60% coinsurance	Pre-Authorization required for inpatient services.
	Habilitation services	$10 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	None
	Hospice services	No Charge; deductible	60% coinsurance	12 months. Pre-Authorization required for

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		does not apply		inpatient hospice services
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	60% coinsurance	1 per year
	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 1-833-478-5853 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 1-833-478-5853 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 1-833-478-5853.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-478-5853.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-478-5853.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-478-5853.

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	**$250**
Specialist *[cost sharing]*	**$20**
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	$250
copayment	$400
coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

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

The plan's overall deductible	**$250**
Specialist *[cost sharing]*	**$20**
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	$250
copayment	$100
coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$870**

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

The plan's overall deductible	**$250**
Specialist *[cost sharing]*	**$20**
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	$250
copayment	$200
coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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