2020-2021 Medical Plan Summary

Benefits	PPO Plan		HealthSave Plan	
	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Provider Network In-State	St. Luke's Health Partners (SLHP)	Non-SLHP	St. Luke's Health Partners (SLHP)	Non-SLHP
Plan Year Deductible (April 1, 2020 - March 31, 2021) (applies to all covered services except where noted) *Must be met by 2+ members	$800 per individual $1,600 per family*		$1,500 employee only coverage $3,000 family	
Out-of-pocket Maximum Includes deductibles, co-pays & prescriptions *Must be met by 2+ members	$3,500 individual $7,000 Family*	None	$4,000 individual $8,000 Family*	None
Annual Maximum Benefit Excludes chiropractic services, cochlear implants, diabetes self-management education services, bariatric surgery co-pay, TMJ and transplant travel benefits	No Maximum		No Maximum	
Lifetime Maximum	No Maximum		No Maximum	
Office Visits **Primary Care Provider** (includes family practice, internal medicine, pediatrics and obstetrics/ gynecology)	$25 co-pay per visit (not subject to deductible)	60%	80%	60%
Specialists	$50 co-pay per visit (not subject to deductible)	60%	80%	60%
Preventive Care & Immunizations	100%	Not covered	100%	Not covered
Inpatient & Outpatient Hospital Services	SLHP facilities 80%	Non-SLHP facilities 60%	SLHP facilities 80%	Non-SLHP facilities 60%
Medical/Surgical Professional Services	90% primary care 80% specialist	60%	80%	60%
Emergency Care Outpatient Emergency services *Co-pay waived if admitted to hospital	$250 co-pay* per visit (not subject to deductible) **Note:** Co-pay includes emergency room provider charges & facility charges but does **not** include diagnostic testing.		80%	80%
Emergency services are covered 80% of maximum allowance when admitted to a network facility. If admitted to a non-network facility, your expenses will be covered at the in-network benefit until you are medically stable for transport to a network facility. If transport is certified by SelectHealth, transport charges will be covered at 100% of maximum allowance. Participants not transferred in this manner will be subject to the 60% benefit level.				
Diagnostic Services (X-ray & Lab) (including diagnostic mammography)	80%	60%	80%	60%
Outpatient Rehabilitation Therapies (physical, speech & occupational therapies) Limited to 30 visits combined per plan year	80%	60%	80%	60%
Inpatient Physical Rehabilitation	80%	60%	80%	60%

2020-2021 Medical Plan Summary

Benefits	PPO Plan		HealthSave Plan	
	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Outpatient Mental Health and Substance Abuse Treatment	$25 co-pay per visit (not subject to deductible)	60%	80%	60%
Inpatient Mental Health and Substance Abuse Treatment	SLHP facilities 80%	Non-SLHP facilities 60%	SLHP facilities 80%	Non-SLHP facilities 60%
Inpatient Mental Health and Substance Abuse Professional Services	90%	60%	80%	60%
TMJ & Orthognathic Services Limited to $1,000 per plan year	80%	60%	80%	60%
Post Mastectomy Reconstructive Surgery	80%	60%	80%	60%
Transplant Services $10,000 travel benefit per plan year	80%	60%	80%	60%
Bariatric/Obesity Surgery (only at St. Luke's) *Surgery eligibility protocol applies *Co-pay not subject to deductible *Limited to one surgery per lifetime	80%* + $2,000 co-pay*	Not covered	80%* + $2,000 co-pay*	Not covered
Chiropractic Services Limited to $600 per plan year	80%	60%	80%	60%
Diabetes Self-Management Education Services Limited to $500 per plan year	80%	60%	80%	60%
Lower Back Pain Services St. Luke's Clinic – Spine Care Call (208) 333-BACK (2225)	Treatment for lower back pain coordinated through St. Luke's Clinic – Spine Care will be covered as follows: Initial evaluation will be covered at 100%, and Spine Care-referred services/providers will be covered at $25 co-pay (office visit) or 90% (co-insurance), deductible waived. Surgical services and treatment not coordinated through St. Luke's Clinic – Spine Care will be covered at the applicable standard benefits.		Not applicable	
Value-Based Benefits – Diabetes *Members **under the age of 18** who have completed two office visits within the past 12 months will receive glucometer, test strips and lancets with no cost share.	Services with no cost share for *members with diabetes: a. Two office visits c. One LDL cholesterol test b. One retinal exam d. One urinary micro albumin test Additionally, members with diabetes, **over age 18**, who have received ALL of the above services in the past 12 months will have **no** co-pays for: a. Glucometer b. Test strips c. Lancets		Not applicable	
Out-of-State Services				
Network In Utah	**SelectCare**	**Non-SelectCare**	**SelectCare**	**Non-SelectCare**
Medical/Surgical Professional Services	80%	60%	80%	60%
Facility Fees	60%[2]	60%	60%[2]	60%
Network Outside Utah	**PHCS/MultiPlan**	**Non-PHCS/MultiPlan**	**PHCS/MultiPlan**	**Non-PHCS/MultiPlan**
Medical/Surgical Professional Services	80%	60%	80%	60%
Facility Fees	60%[3]	60%	60%[3]	60%

[1]Out-of-Network (OON) or Non-Contracting are providers who do not contract with St. Luke's Health Partners (SLHP), BrightPath, SelectCare or PHCS/MultiPlan. OON providers may bill you for amounts over the maximum allowance. To receive the highest level of benefit available to you, please check to see whether service providers are contracting (in-network) before receiving services (including all lab and other services your provider may order on your behalf).

[2]May be considered for in-network coverage if facility service is not available within the SLHP or BrightPath network.

[3]May be considered for in-network coverage if facility service is not available within the SLHP, BrightPath, AND the SelectCare network.

This summary chart describes the general features of the plans; it is not a contract. All provisions of the St. Luke's Health System Employee Health Care Plan Document apply.

2020-2021 Prescription Plan Summary

HealthSave Prescription Plan Summary – Effective April 1, 2020		
Prescription	**In-Network**	**Out-of-Network**
Preventive Generic[1]	100%	60%
Preventive Formulary[1]	90%	60%
Preventive Non-Formulary[1]	90%	60%
Non-Preventive[2]	80%	60%
Specialty[3]	80%	60%

[1]For a list of preventive medications, please go to www.selecthealth.org.
[2]All non-preventive prescriptions are subject to the deductible; total cost of prescription will be charged until deductible is met.
[3]All specialty medications must be filled through a St. Luke's Outpatient Pharmacy or the Intermountain Home Delivery Pharmacy.

PPO Prescription Plan Summary – Effective April 1, 2020		
Prescription	**Days Supply**	**Co-pay/Coinsurance**
Generic	0-90	$10
Brand Formulary	0-30	25% coinsurance: minimum of $45, maximum of $90*
	31-90	25% coinsurance: minimum of $90, maximum of $180*
Brand Non-Formulary	0-30	50% coinsurance: minimum of $90, maximum of $120*
	31-90	50% coinsurance: minimum of $180, maximum of $240*
Specialty[1]	0-30	$200

*If the cost of the drug is less than the minimum co-pay, member pays the price of the drug.
[1]All specialty medications must be filled through a St. Luke's Outpatient Pharmacy or the Intermountain Home Delivery Pharmacy.

St. Luke's Pharmacies – Hours of Operation

Boise Hospital: Monday-Friday, 7 a.m.-7 p.m.
Saturday, 8 a.m.-3 p.m.

Meridian Hospital: Monday-Friday, 8 a.m.-7 p.m.
Saturday, 8 a.m.-3 p.m.

Nampa Hospital: Monday-Friday, 10 a.m.-6 p.m.
Saturday, 10 a.m.-3 p.m.

All St. Luke's pharmacies are closed on Sundays and holidays.