St. Luke's Hospital

Premium Plan
2022 SCHEDULE OF BENEFITS

(This Summary of Benefits provides a simplified overview of the medical plan. The plan is governed by the terms of legal documents. We have taken care to ensure that the following are accurate. However, if there is a conflict between this Summary of Benefits chart and the legal documents, the legal documents will be followed.)

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	**ST. LUKE'S NETWORK** Tier 1	**UNITED HEALTHCARE NETWORK** Tier 2	**OUT OF NETWORK** Tier 3
Calendar Year Deductible			
• Individual	$200	$600	$1,500
• Family	$450	$1,500	$2,200
Calendar Year Out-of-Pocket Maximum (Includes deductible amount listed above) • Individual	$1,250	$3,700	$6,325
• Family	$2,000	7,000	$11,360
Pharmacy Calendar Year Out-of-Pocket Maximum			
• Individual	$750	$1,000	$2,500
• Family	$1,050	$1,500	$5,000
Pre-Certification Requirements* • Inpatient ◦ Elective admissions must be pre-certified prior to any elective admission to a Hospital, Hospice Facility, Residential Treatment Facility or Skilled Nursing Facility, or within 2 working days for emergency admissions. ◦ A $500 deductible for each period of confinement may be imposed for failure to pre-certify inpatient confinements. This deductible does not apply to the Out-of-Pocket Maximum. • Treatment Plan Certification ◦ Treatment plans may be required for some services (i.e., Chemotherapy) in order to determine length and type of service for payment purposes. • Additional Care Requiring Precertification ◦ Clinical Trials ◦ Spinal/Back Surgery for Tier 2 and Tier 3 ◦ Pain Management including injectables for Tier 2 and Tier 3 ***All plan options may require pre-certification, pre-determination, preauthorization, treatment plan information, or a letter of medical necessity depending upon the specific medical treatment or procedure. You may contact UMR at 1-800-826-9781 for specific information.**			
Hospital / Facility Services • Inpatient	90% After deductible	75% After deductible	60% After deductible
• Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services	90% After deductible	75% After deductible	60% After deductible
• Outpatient – CT Scan, MRI and PET Scan	90% After deductible	75% After deductible	60% After deductible
Emergency Room Services Only Medical Emergencies as defined by the Plan are covered. Copay waived if patient is admitted as an Inpatient, then Inpatient benefits apply	$200 copay then 100% No deductible	$200 copay then 100% No deductible	$200 copay then 100% No deductible

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	**ST. LUKE'S NETWORK** Tier 1	**UNITED HEALTHCARE NETWORK** Tier 2	**OUT OF NETWORK** Tier 3
Urgent Care Facility	$20 copay then 100% No deductible	$35 copay then 100% No deductible	60% After deductible
Pre-Admission Testing	90% After deductible	75% After deductible	60% After deductible
Outpatient Surgery At Hospital or Ambulatory Surgical Center • Facility	90% After deductible	75% After deductible	60% After deductible
• Surgeon and Anesthesiologist • Pathologist and Radiologist	90% After Tier 1 deductible		60% After deductible
Voluntary Second Surgical Opinion • Primary Care Physician	$10 copay 100% No deductible		60% After deductible
• Specialist	$15 copay 100% No deductible		60% After deductible
Physician Office Services – All services performed in the Physician's office including: • Office visits or Telehealth visits • Surgical procedures • Laboratory and x-ray (test obtained and processed in office only) • Eye Exam, limited to **1 per calendar year** • Allergy injections • Allergy testing • Chemotherapy administration, injectables, medications, casts, and other treatment materials (see Pre-cert requirements). - Primary Care Physician	$10 copay then 100% No deductible		60% After deductible
- Specialist	$15 copay then 100% No deductible		60% After deductible
Physician Services Other – Inpatient or Outpatient • Surgeon and Assistant Surgeon • Anesthesiologist, Radiologist and Pathologist – services rendered by a Tier 3 Anesthesiologist, Radiologist or Pathologist at a Tier 1 or Tier 2 facility will be paid at the higher coinsurance level of the facility.	90% After Tier 1 deductible		60% After deductible
Labs Performed Outside Physician Office – Diagnostic	90% After deductible	75% After deductible	60% After deductible
Wellness Care • Preventative/Routine adult office visit (18yrs+), including diabetes screening, routine lab and x-ray, counseling and screening for HIV, as necessary to obtain covered preventative services, **1 per calendar year** (all appropriate immunizations per UMR guidelines) - Facility	100% No deductible		60% After deductible
- Physician	100% No deductible		100% After deductible

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
• Well woman gynecological exams and pap smear, including routine lab processing, as necessary to obtain covered preventative services • Obstetrical Care, as necessary to obtain specified preventative services including routine prenatal visits, tobacco cessation counseling and immunizations (note: this does not include delivery or high risk maternity services) • Screening and counseling for STD's and domestic violence • HPV testing and counseling (30yrs+ 1 every 3 years) • 2 ultrasounds covered at 100% of allowable, gestational diabetes screening (2 per pregnancy) • Approved contraceptive methods, including sterilization • Breastfeeding supplies, counseling and support, including rental of breast pump. Covers purchase of non-hospital grade breast pump or new supplies for existing pump (1 per pregnancy) - Facility	100% No deductible		60% After deductible
- Physician	100% No deductible		100% No deductible
• Mammograms - Facility	100% No deductible		. 60% After deductible
- Physician	100% No deductible		100% No deductible
• Colonoscopy, limited to 1 routine test every 10 years starting at age 50. Includes anesthesia - Facility	100% No deductible		60% After deductible
- Physician	100% No deductible		100% No deductible
• Well man PSA, including routine lab, limited to 1 per calendar year. - Facility	100% No deductible		60% After deductible
- Physician	100% No deductible		100% No deductible
• Well baby care/pediatric exams (up to age 18), including all appropriate immunizations per UMR guidelines, lab and x-ray. (Note: annual school physicals are not covered.) - Facility	100% No deductible		50% No deductible
- Primary Care Physician	100% No deductible		100% No deductible
• Other preventative/routine care as required under the Women's Preventative Services	100% No deductible		60% No deductible

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Mental/Nervous Disorders • Inpatient Treatment - Partial/Day program - Residential Treatment Facility	90% After Tier 1 deductible		60% After deductible
• Outpatient Treatment - Primary Care Physician	$10 copay 100% No deductible		60% After deductible
- Specialist	$15 copay 100% No deductible		60% After deductible
Alcoholism and Drug Abuse • Inpatient Treatment - Partial/Day program - Residential Treatment Facility	90% After Tier 1 deductible		60% After deductible
• Outpatient Treatment - Primary Care Physician	$10 copay 100% No deductible		60% After deductible
- Specialist	$15 copay 100% No deductible		60% After deductible
Skilled Nursing Facility All stays are pre-certified for medical necessity.	90% After deductible	75% After deductible	60% After deductible
Clinical Trials • Includes services typically provided for other conditions • *Excludes investigational items or devices, data collection costs or services outside established standards of care.	85% After deductible*	75% After deductible*	60% After deductible*
Home Health Care Must be within 14 days of a Hospital or Skilled Nursing Facility confinement, with a maximum of 90 visits (in combination with Outpatient Hospice Care) in a 12-month period. (Excludes custodial care).	90% After deductible	75% After deductible	60% After deductible
Hospice Care Services • Inpatient (See pre-certification requirements)	90% After deductible	75% After deductible	60% After deductible
• Outpatient	90% After deductible	75% After deductible	60% After deductible
Private Duty Nursing $5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care). • Inpatient	90% After Tier 2 deductible		50% After deductible
• Outpatient	90% After Tier 2 deductible		50% After deductible
Maternity Female Employees and Dependents	Same as any other Illness		
Newborn Well newborn covered first 5 days only by mother's coverage for nursery. Physician and circumcision (excludes grandchildren).	Same as any other Illness		
Ambulance Services	90% After Tier 1 deductible		

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Physical Therapy Maximum of 60 visits in combination with occupational therapy and speech therapy.			
• Facility	90% After deductible	75% After deductible	60% After deductible
• Physician - Primary Care Physician	$10 copay-100% No deductible	$20 copay-100% No deductible	60% After deductible
- Specialist	$15 copay-100% No deductible	$30 copay-100% No deductible	60% After deductible
Occupational Therapy Maximum of 60 visits in combination with physical therapy and speech therapy.			
• Facility	90% After deductible	75% After deductible	60% After deductible
• Physician - Primary care Physician	$10 copay-100% No deductible	$20 copay-100% No deductible	60% After deductible
- Specialist	$15 copay-100% No deductible	$30 copay-100% No deductible	60% After deductible
Speech Therapy Maximum of 60 visits in combination with physical therapy and occupational therapy.			
• Facility	90% After deductible	75% After deductible	60% After deductible
• Physician - Primary Care Physician	$10 copay-100% No deductible	$20 copay-100% No deductible	60% After deductible
- Specialist	$15 copay-100% No deductible	$30 copay-100% No deductible	60% After deductible
Habilitation Services	90% After deductible	75% After deductible	60% After deductible
Inhalation Therapy and Radiation Therapy • Facility	90% After deductible	75% After deductible	60% After deductible
• Physician - Primary Care Physician	$10 copay-100% No deductible	$20 copay-100% No deductible	60% After deductible
- Specialist	$15 copay-100% No deductible	$30 copay-100% No deductible	60% After deductible
Transplant Services: - Physician - Facility – Designated Transplant Centers of Excellence	90% After Tier 1 deductible		Not Covered
Transplant Services: - Travel and housing Maximum Benefit per transplant	$10,000		Not Covered

DESCRIPTION OF MEDICAL BENEFITS – Premium	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Durable Medical Equipment – Charges over $500 must be pre-certified.	85% After Tier 2 deductible		60% After deductible
Artificial Limbs/Prosthesis	90% After Tier 2 deductible		60% After deductible
Chiropractic Care	Not Covered		
All Other Covered Facility Charges	90% After deductible	85% After deductible	60% After deductible
All Other Covered Physician Charges	90% After Tier 1 deductible		60% After deductible
Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders	90% After Tier 1 deductible		60% After deductible

Pharmacy Benefits		
Prescription Drugs The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office. (*Refer to Appendix Section D for additional information)*	**Tier 1 & Tier 2-3 First Fills (Copay)**	**Tier 2 – 3 Refills (Copay)**
• Retail – (Prescriptions refilled at Tier 1 network will be discounted).	Generic - $10.00 Preferred - $25.00 Non–Preferred - $50.00	Generic - $15.00 Preferred - $30.00 Non-Preferred - $75.00
• Specialty Rx/30-day All specialty prescriptions must be filled through MedImpact or at St. Luke's Hospital pharmacy	**Copay $150.00**	
• Mail Order / 90-day Generic Preferred Brand Non-Preferred Brand	 $20.00 copay $50.00 copay $100.00 copay	 $30.00 copay $67.50 copay $187.00 copay

Note:

1. Covered Expenses rendered by a non-Tier 1 or Tier 2 provider will be paid at the Tier 1 level (not subject to usual and customary limits) if the Covered Person is a student attending school outside the service area, except in the case of elective surgery, or routine visits or checkups.
2. Covered Person traveling outside the service area with a Medical Emergency will have hospital charge paid at the Tier 1 level.
3. For questions about services not provided at St. Luke's Hospital please contact the Benefits Office.

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