

Summary of Benefits 2027

St. Luke’s Advantage Rx 03 (HMO)

The Summary of Benefits is meant to help you understand what we cover and what you pay. It doesn’t list every service we cover or every limitation or exclusion. To get a complete description of your plan, see your Evidence of Coverage (EOC) on our website at medicare.stlukeshealthplan.org or contact us for a copy.

Who can join St. Luke’s Advantage Rx 03 (HMO)?

To join this Medicare Advantage plan, you must be enrolled in Medicare Part A and Part B and your permanent residence is in one of these counties: **Jerome and Twin Falls.**

If you want to compare other Medicare health plans, use the Medicare Plan Finder on [medicare.gov](https://www.medicare.gov) or ask other health plans for their Summary of Benefits booklets.

If you want to know more about the coverage and costs of Original Medicare, review the current “Medicare & You” handbook, available online at [medicare.gov](https://www.medicare.gov), or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (excluding some federal holidays). TTY users call 1-877-486-2048.

What is an HMO plan?

A Health Maintenance Organization (HMO) Medicare Advantage plan uses a network of doctors, hospitals, pharmacies and other providers. With our St. Luke’s Advantage Rx 03 (HMO) plan, you must receive care within our network—except in emergencies or when you need urgent care outside the area.

You can access our provider directory online at medicare.stlukeshealthplan.org/find-a-doctor, or call us if you require a printed copy.

Part D prescription drugs.

The St. Luke’s Advantage Rx plan covers Part D prescription drugs.

You can find our drug formulary on our website at medicare.stlukeshealthplan.org/druglist as well as a list of participating pharmacies at medicare.stlukeshealthplan.org/pharmacies.

Need assistance? The Pharmacy Help Desk is available 24 hours a day, seven days a week: 833-840-2573 (TTY users call 711).

How to reach customer service.

We accept all relay calls. Language assistance services and auxiliary aids are available at no cost.

Call: 833-840-1214 (TTY users call 711)

Hours: October 1 to March 31
Seven days a week, 8 a.m. to 8 p.m. (MT)

April 1 to September 30
Monday to Friday, 8 a.m. to 8 p.m. (MT)

PREMIUMS, DEDUCTIBLES AND LIMITS	COST
Monthly plan premium You must continue to pay your Medicare Part B premium.	\$107
Medical deductible These services apply to the medical deductible: • Inpatient care, including hospital and psychiatric admission • Ambulatory surgical services • Outpatient hospital care and observation services • Durable medical equipment (DME) • Medicare Part B drugs (including chemotherapy and radiation) • Outpatient blood services Refer to the Evidence of Coverage for details.	\$250
Pharmacy deductible Applies to Tier 3, 4 and 5 drugs. Deductible doesn’t apply to covered insulin.	\$299
Maximum out-of-pocket The most you pay out-of-pocket during the calendar year for covered services and supplies; you will still be responsible for your monthly premiums. Supplemental benefit costs do not apply to the maximum out-of-pocket limit.	\$5,950

MEDICAL BENEFITS	COST
Inpatient hospital care Covers an unlimited number of days for an inpatient hospital stay; prior authorization may be required	After deductible: Days 1-5: \$400 copay per day Days 6+: \$0 copay per day
Outpatient hospital and ambulatory surgical center services	\$0-\$400 copay after deductible Copay amount varies by service
Doctor’s office visits Primary care provider (PCP) or specialist	\$0 copay (PCP) \$30 copay (specialist)
Medicare-approved preventive care Including annual wellness exam, recommended screenings and immunizations for the flu, pneumonia and COVID-19	\$0 copay

MEDICAL BENEFITS	COST
Emergency care Copay waived if admitted to the hospital within 24 hours; includes emergency care obtained outside the U.S.	\$130 copay
Diagnostic radiology services Outpatient diagnostic radiology services (CT, MRI, PET, nuclear medicine, mammography)	\$0-\$300 copay Copay amount varies by service
Outpatient X-rays	\$15 copay
Therapeutic radiology	20% coinsurance
Lab services Including A1c and Protime Testing	\$0 copay
Genetic testing Prior authorization may be required for testing and analysis	20% coinsurance
Skilled nursing facility Prior authorization required; limited up to 100 days per benefit period; no prior hospital stay required	Days 1-20: \$0 copay per day Days 21-100: \$221 copay per day
Durable medical equipment and supplies Prior authorization may be required	20% coinsurance after deductible
Ambulance (worldwide coverage) Prior authorization required for non-emergency transportation; includes ground and air transport	\$295 copay per one-way transport
Part B drug coverage Prior authorization or step therapy is required for some drugs; insulin is covered up to a maximum of \$35 per month supply	20% coinsurance after deductible; insulin not subject to deductible

MENTAL HEALTHCARE	COST
Inpatient psychiatric services Prior authorization may be required; 190-day lifetime limit for care not provided in a general hospital	After deductible: Days 1-5: \$400 copay per day Days 6+: \$0 copay per day
Outpatient services Per group or individual therapy visit	\$0 copay

ALTERNATIVE CARE	COST
Non-Medicare-covered acupuncture visits No prior authorization required; maximum 18 visits per calendar year	\$30 copay
Medicare-covered acupuncture visits For chronic low back pain; maximum 20 visits per calendar year	\$30 copay
Medicare-covered chiropractic visits Prior authorization required after 18 visits	\$15 copay
Occupational, physical or speech therapy visits Prior authorization is required after the 20 th combined visit	\$20 copay

Extra benefits.

Here are some more benefits provided under your plan.

HEARING	COST
Routine or Medicare-covered hearing exam One per calendar year	\$0 copay
Hearing aid allowance Applies to one or two hearing aids once every three years	\$1,000 allowance

VISION	COST
Routine eye exam Including exam to treat glaucoma and diabetic retinopathy	\$0 copay
Routine prescription eyeglasses or contact lenses Covered once per calendar year	\$150 reimbursement
Eyeglasses or contact lenses after cataract surgery	\$0 copay

PREVENTIVE DENTAL	COST
Oral exams Up to two per calendar year	\$0 copay
Routine or periodontal maintenance cleaning Up to two per calendar year combined	\$0 copay
Dental x-rays Covers bitewings once per calendar year and full-mouth x-rays once every five years from last date of service	\$0 copay

Dental benefits are administered by Delta Dental of Idaho. Services are covered when received from participating Delta Dental network providers. Out-of-network services are not covered. Limitations, exclusions and eligibility requirements may apply. Refer to the Evidence of Coverage (EOC) for complete details.

OTHER	COST
Foot care Routine podiatry services including diagnosis and treatment of injuries or conditions; limit six visits per calendar year; copays for these services do not apply to maximum out-of-pocket	\$30 copay
Cancer screenings and oncology office visits Includes one supplemental breast screening per calendar year (such as breast MRI or ultrasound) for high-risk individuals when medically necessary	\$0 copay
St. Luke’s On-Demand Virtual Care Same-day visit with a St. Luke’s provider; extended evening and weekend hours	\$0 copay
St. Luke’s Lifestyle Medicine Comprehensive program for lifestyle and behavior change	\$0 copay

Your prescription benefits.

Pharmacy deductible: You are responsible for the cost of your prescription drugs until you have met the deductible.

Tiers 1 and 2: \$0
Tiers 3, 4 and 5: \$299

Insulin: Your deductible does not apply to covered insulin; you won’t pay more than \$35 per one-month supply of each covered insulin product, regardless of the cost-sharing tier.

You may pay less for certain drugs if you get a 100-day supply. Covered insulin costs no more than \$70 for a two- or three-month supply.

The cost-sharing table below shows what you will pay for your prescription medications. During the initial coverage stage, you pay your copay/coinsurance and the rest is covered by the plan.

RETAIL PHARMACY	1-30 DAYS
Tier 1: Preferred generic	\$0
Tier 2: Generic	\$5
Tier 3: Preferred brand	25%
Tier 4: Non-preferred	35%
Tier 5: Specialty	30%

Out-of-pocket costs (copay or coinsurance) up to \$2,400, your share is:

When your out-of-pocket drug costs reach the \$2,400 annual out-of-pocket cost set by Medicare, the plan pays the full cost for your covered drugs for the rest of the calendar year.

Review the full list of tiers and drug formularies at medicare.stlukeshealthplan.org/druglist. Part D pharmacy benefits administration is managed by Judi Rx.

Need help paying for prescriptions?

The Medicare Prescription Payment Plan is an option that works with your current drug coverage to help you manage your out-of-pocket drug costs by spreading them across monthly payments throughout the year. It may help you manage your expenses; it does not save you money or lower your drug costs. Participation is voluntary. To learn more and see if this payment option is right for you, visit medicare.gov/prescription-payment-plan.

Disclaimers

The information provided is a brief summary of your benefits, not a complete description. Limitations, copays and restrictions may apply. See your Evidence of Coverage (EOC) for the specific details of your plan.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service team or see your EOC for more information, including cost-sharing for out-of-network services.

St. Luke’s Advantage Rx 03 (HMO) is a Medicare Advantage plan with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in St. Luke’s Advantage Rx (HMO) depends on contract renewal.