St Luke's™

St. Luke's Health System
Employee Health Care Plan

Effective
April 1, 2015

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SECTION I—INTRODUCTION

This document is a description of St. Luke's Health System Employee Health Care Plan (the "*Plan*"). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *participants* against certain catastrophic health expenses.

Coverage under the *Plan* will take effect for an eligible *employee* and designated dependents when the *employee* and such dependents satisfy the waiting period and all the eligibility requirements of the *Plan*.

You are only entitled to receive benefits while the *Plan* is in effect and you, and your dependents if applicable, are properly enrolled. You do not have any permanent or vested interest in any benefits under the *Plan*.

The *Plan* will not discriminate against any *participant* based on race, sex, religion, national origin, or any other basis forbidden by law. The *Plan* will not terminate or refuse to enroll any *participant* because of health status or the healthcare needs of the *participant* or because he or she exercised any right under the *Plan*'s complaint resolution system.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of *COBRA* elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the *Plan Administrator* at no extra cost.

The *Plan* will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

You will be given SelectHealth ID cards that will provide certain information about the *Plan* in which you are enrolled. Providers and facilities may require the presentation of the ID card plus one other reliable form of identification as a condition to providing Services. The ID card does not guarantee benefits.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the appeal rights provided have been exercised and the *Plan* benefits requested in such appeals have been denied in whole or in part.

If the *Plan* is terminated, amended, or benefits are eliminated, the rights of *participants* are limited to *eligible expenses* incurred before termination, amendment or elimination.

SECTION II—SCHEDULE OF BENEFITS

A. Schedule of Medical Benefits

All benefits described in this schedule of benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the *Plan Administrator's* determination that: care and treatment is *medically necessary*; that charges are *reasonable and customary amounts*; that services, supplies and care are not *experimental/investigational*. The meanings of these italicized terms are in the Defined Terms section of this document.

The *benefit year* is the twelve (12) month period beginning April 1 and ending March 31. All annual *deductibles* and benefit maximums accumulate during the *benefit year*.

Pre-Certification

The following services must be *pre-certified* or reimbursement from the *Plan* will be reduced by 50% up to a maximum of $500 for resulting claims (if a facility claim applies the penalty will be applied to the claim).

1. *Inpatient* hospitalizations, except maternity
   a. For emergency admissions (subject to extenuating circumstances), such authorization must be obtained within forty-eight (48) hours following admission.
   b. The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery; this provision also applies for newborns.
2. Admissions to:
   a. Long term acute care *hospital* (LTACH)
   b. Rehabilitation and long-term care facility
   c. *Skilled nursing facility*
3. *Hospital* services for dental procedures
4. Restorative dental services following *accidental injury* to sound natural teeth
5. Home intravenous therapy
6. Home health services
7. Hospice services
8. Growth hormone therapy
9. Cardiac Rehabilitation
10. Breast cancer genetic testing - BRCA testing using BRAC Analysis, BRAC Analysis Rearrangement Test (BART)
11. Chemotherapy and radiation treatment
12. The following services when expected purchase price is in excess of $2,500:
    a. Rental or purchase of *durable medical equipment*, including repair, maintenance and replacement
    b. Prosthetic appliances
    c. Orthotic devices

The following *inpatient* and *outpatient* surgical procedures must be *pre-certified* or reimbursement from the *Plan* will be reduced by 50% up to a maximum of $500 for resulting claims:

- Bariatric surgery (surgical treatment of obesity) which meets the criteria for coverage outlined in Section X (BARIATRIC SURGERY BENEFIT). If criteria not met, services for bariatric surgery are not covered.
- Cochlear Implants
- Eyelid surgery
- Gastric reflux procedures, except EGD
- Hysterectomy
- Invasive treatment of lower extremity veins
- Nasal and sinus procedures
- Orthognathic and Temporomandibular Joint Disorder (TMJ) surgery
- Plastic and reconstructive surgery
- Spinal surgery
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)

The following service must be *pre-certified* or the service will not be covered by the *Plan*.

- Non-emergent ambulance transfers

Please see the Health Care Management Program section in this booklet for details.

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits payments are subject to the eligibility and other coverage restrictions and limitations of the *Plan*.

Network Provider Information

The *Plan* has entered into an agreement with a Preferred Provider Organization (PPO), or a *network*. The *network* is a group of *physicians* and *hospitals* contracted to accept negotiated rates in an effort to reduce the effect of rising health care costs while providing you with quality care. When a *participant* uses a *network provider*, that *participant* will receive a higher payment from the *Plan* than when a *non-network provider* is used. It is the *participant's* choice as to which *provider* to use.

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

- **Medical Emergency**. In a *medical emergency*, a *participant* should try to access a *network provider* for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network providers* will be covered until the *participant's* condition has stabilized to the extent that they can be safely transferred to a *network provider's* care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels.
- **No Choice of Provider**. If, while receiving treatment at a *network* facility, a *participant* receives ancillary services or supplies from a *non-network provider* in a situation in which they have no control over *provider* selection (such as in the selection of an emergency room *physician*, an

anesthesiologist, or a *provider* for diagnostic services), such *non-network* services or supplies will be covered at *network* benefit levels. *Durable medical equipment* is included in this provision if provided while confined as *inpatient* or in the emergency room. Services provided during an office visit or associated with an office visit do not apply to this provision. The *participant* will be responsible for notifying the *Claims Administrator* for a review of any claim that meets this definition.

- **Specialty Provider Gaps.** There are certain *provider* specialties in which there are currently no *providers* that participate in the BrightPath network. These *provider* specialty "gaps" will be paid at the 80% *network co-insurance* level until the specialty gap is filled. The *participant* will be responsible for notifying the *Claims Administrator* for a review of any claim that meets this definition.

- **Travel Network (Outside of Idaho).** Professional/*Physician* Services: If a *participant* lives or is traveling outside the State of Idaho, benefits will be processed at the 80% benefit level if services are received from a *provider* in the MultiPlan Complementary Network.

  Hospital/Facility Services: Any non-emergency facility services have to be provided by a *BrightPath facility* in order to receive the 80% benefit level. If a *participant* received services at a non-*BrightPath facility*, the benefits will be processed at the 60% benefit level, and the *participant* may be responsible for the difference between the amount the *provider* bills and the maximum amount allowed (*balance billing*). This applies for all *non-network providers*.

- **Employees who work in the Baker City OR, Ontario OR, or Fruitland ID locations:**

  Hospital/Facility Services: Any non-emergency facility services have to be provided by either a *BrightPath facility* or a Multiplan Complementary Network in order to receive the 80% benefit level. If a *participant* received services at a non-*BrightPath facility or a non-MultiPlan Complimentary Network*, the benefits will be processed at the 60% benefit level, and the *participant* may be responsible for the difference between the amount the *provider* bills and the maximum amount allowed (*balance billing*).

Additional information about this option, as well as a list of *network providers*, will be given to *participants*, at no cost, and updated as needed.

You may obtain more information about the *providers* in the *network* by contacting SelectHealth or the *networks* by phone or by visiting their website.

SelectHealth	**BrightPath**	**MultiPlan**
1-800-538-5038	**1-208-381-1564 or**	**1-800-672-2140**
selecthealth.org	**1-877-814-5505**	www.multiplan.com
Both in and out of Idaho	**www.yourbrightpath.com**	**Outside of Idaho**
	Idaho	

B. PPO Plan

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	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Annual Aggregate Benefit Maximum All covered medical services apply to the *annual aggregate benefit maximum* except for the following: *chiropractic services*, diabetes self-management education services, temporomandibular joint disorder (TMJ), and transplant travel benefits.		
Per *participant*	No Annual Maximum	
Deductible		
Per *participant*	$700	
Per family	$1,400	
Out-of-Pocket Maximum		
Per *participant*	$3,000	None
Per family	$6,000	None

The *Plan* will pay the designated percentages of *eligible expenses* until the *network out-of-pocket maximum* is reached, at which time the *Plan* will pay 100% of the remainder of covered *network* expenses for the rest of the *benefit year* unless stated otherwise.

The *benefit year* is the twelve (12) month period beginning April 1 and ending March 31. All annual *deductibles* and benefit maximums accumulate during the *benefit year*.

If a *non-network provider* is used, the benefits will continue to pay at the *non-network co-insurance* level, even if the *out-of-pocket maximum* has been met, and the *participant* may be responsible for the difference between what the *network* allows and what the *provider* charges.

Note: The following charges do not apply toward the *out-of-pocket maximum*:

- Penalties
- Non-*eligible expenses*
- Dental charges
- Vision charges
- Charges in excess of the *maximum allowance*

PPO PLAN

PPO PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PROFESSIONAL SERVICES *Physician* Assistants and Nurse Practitioners are covered at the level of coverage of the supervising *physician*.			
Allergy Testing and Treatment	80% after *deductible*	60% after *deductible*	Includes RAST testing.
Ambulance	80% after *deductible*		Inter-facility transfers pay at 100% and **require *pre-certification.*** Please refer to Section V, Health Care Management Program, regarding non-emergent ambulance transfers.
Bariatric Surgery	80% after *deductible* at St. Luke's facilites	Not Covered	Procedure must be performed at St. Luke's by an American Society for Metabolic and Bariatric Surgery (ASMBS) Center of Excellence surgeon. Refer to the Bariatric Surgery section of this document for surgical criteria and eligibility requirements. Limited to one Bariatric Surgery per Lifetime.
Chemotherapy	80% after *deductible*	60% after *deductible*	
Chiropractic Services	80% after *deductible*	60% after *deductible*	Includes diagnostic x-rays. **Annual maximum**: $600 per *participant.*
Contraceptives			
Primary Care Provider	100%	60% after *deductible*	Oral contraceptives are covered under the Prescription Drug Program.
Specialist	100%	60% after *deductible*	
Dental Injury	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.** Services are covered only for the twelve (12) month period immediately following the date of *accidental injury*.
Diabetic Self-Management Education	80% after *deductible*	60% after *deductible*	**Annual Maximum**: $500 per *participant*. Refer to the Eligible Expenses section for more information regarding ongoing diabetic education.

PO PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PROFESSIONAL SERVICES continued			
Durable Medical Equipment	80% after *deductible*	60% after *deductible*	***Pre-certification* is required** when expected purchase price is in excess of $2,500, including repair, maintenance and replacement.
Genetic Counseling	80% after *deductible*	60% after *deductible*	**Annual Maximum**: Two (2) visits per *participant.*
Genetic Testing	80% after *deductible*	60% after *deductible*	***Pre-certification* is required for breast cancer genetic testing.**
Home Health Care	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Home Infusion Therapy	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Hospice Care	100% *deductible* waived	100% *deductible* waived	Includes bereavement counseling. ***Pre-certification* is required.**
Inpatient Physician			
Primary Care Provider	90% after *deductible*	60% after *deductible*	
Specialist	80% after *deductible*	60% after *deductible*	
Occupational Therapy	80% after *deductible*	60% after *deductible*	**Annual visit maximum:** Twenty (20) visits combined physical, occupational and speech therapy per *participant*. Therapy provided in the home applies to the annual visit maximum. *Inpatient* therapy does not apply to the annual visit maximum.
Office Visits			
Primary Care Provider (PCP)	$25 *co-pay* then 100% *deductible* waived	60% after *deductible*	*Co-payment* applies to the office visit only. All other services performed during the office visit are paid at the applicable benefit level.
Specialist	$50 *co-pay* then 100% *deductible* waived	60% after *deductible*	
Orthotics/Prosthetics	80% after *deductible*	60% after *deductible*	***Pre-certification* is required** when expected purchase price is in excess of $1,000.

PPO PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PROFESSIONAL SERVICES continued			
Physical Therapy	80% after *deductible*	60% after *deductible*	**Annual visit maximum:** Twenty (20) visits combined physical, occupational and speech therapy per *participant.* Therapy provided in the home applies to the annual visit maximum. *Inpatient* therapy does not apply to the annual visit maximum.
Radiation Therapy	80% after *deductible*	60% after *deductible*	
Speech Therapy	80% after *deductible*	60% after *deductible*	**Annual visit maximum**: Twenty (20) visits combined physical, occupational and speech therapy per *participant.* Therapy provided in the home applies to the annual visit maximum. *Inpatient* therapy does not apply to the annual visit maximum.
Spinal Manipulations	80% after *deductible*	60% after *deductible*	Manipulations not provided by a chiropractor.
Lower Back Pain Services coordinated through the St. Luke's Center for Spine Wellness (CSW)			
Initial Evaluation	100% *deductible* waived		See St. Luke's Center for Spine Wellness (CSW) Section for more information regarding this benefit. Lower back pain services and treatment not coordinated through the CSW will be covered at the applicable standard benefit level. This benefit is subject to all other *Plan* provisions including *pre-certification.* Specific services and *provider* must be referred by the CSW. Does not include surgical services.
Primary Care and Specialist Office Visits referred by the CSW	$25 *co-payment* then 100%, *deductible* waived		
Surgical Services	Covered at the applicable standard benefit level		
St. Luke's Healthy U CoPartner Program			
Initial Comprehensive Care Coordination and Planning Visit	100% *deductible* waived		The initial Comprehensive Care Coordination and Planning visit through St. Luke's Healthy U CoPartner program will be covered at 100% and will not be subject to normal *Plan co-insurance* or *co-payments.* Any tests, treatment, or services provided during or after the Healthy U CoPartner initial visit will continue to be subject to applicable *Plan co-insurance* and *co-payment* provisions.
Surgical Services			
Primary Care provider	90% after *deductible*	60% after *deductible*	
Specialist	80% after *deductible*	60% after *deductible*	

PPO PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PROFESSIONAL SERVICES continued			
Temporomandibular Joint/Orthognathic Services	80% after *deductible*	60% after *deductible*	**Annual Maximum**: $1,000 per *participant.*
MENTAL HEALTH & SUBSTANCE ABUSE			
Inpatient Facility	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Inpatient Physician Services	90% after *deductible*	60% after *deductible*	
Outpatient	$25 *co-pay* then 100% *deductible* waived	60% after *deductible*	
PREVENTIVE CARE			
Routine Preventive Care	100% *deductible* waived	Not Covered	Please refer to Appendix A, Preventive Care Services, for a further description and limitations to this benefit.
TRANSPLANTS			
Organ Transplants	80% after *deductible*	60% after *deductible*	**Annual Transplant Travel Maximum**: Covered at 100% up to $10,000 combined for *participant* and donor. Refer to the Transplant Program section of this document for more information. ***Pre-certification* is required.**
VALUE BASED BENEFITS - DIABETES			
Covered services for members who are diabetics: **Two office Visits per plan year** **One retinal exam** **One LDL Cholesterol test** **One urinary mico albumin test**	100% *deductible* waived	60% after *deductible*	See St. Luke's Value Based Benefits – Diabetes section for more information regarding this benefit. The Value Based Benefit is provided to encourage members with Diabetes to receive appropriate treatment for their conditions and to adhere to medication regimens. Members who received all of the covered services within the past 12 months will have no copay for the following items: Glucometer, Test Strips, and Lancets

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HEALTHSAVE PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
GENERAL PERCENTAGE PAYMENT RULE	80% after *deductible*	60% after *deductible*	Generally, most *eligible expenses* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments section provides additional information and limitations about the applicable *eligible expense*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket maximum* does not apply.
FACILITY SERVICES			
Emergency Room	80% after *deductible*		ER *physicians* are included under this benefit.
Lab, X-Ray and Diagnostic Testing	80% after *deductible*		
Intensive Care Unit	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Outpatient Services	80% after *deductible*	60% after *deductible*	
Rehabilitation Facility	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Room and Board	80% after *deductible*	60% after *deductible*	Limited to the semi-private room rate unless private room accommodations are *medically necessary* and prescribed by the *physician*. ***Pre-certification* is required.**
Skilled Nursing Facility	80% after *deductible*	60% after *deductible*	Services following a *hospital* stay for a non-occupational injury or *illness*, and provided such services are in lieu of *hospital* services. **Annual maximum**: Thirty (30) days per *participant*. ***Pre-certification* is required.**
Surgery Center	80% after *deductible*	60% after *deductible*	***Pre-certification* is required for certain procedures.** Refer to the Health Care Management Program section of this document for more information.

HEALTHSAVE PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PROFESSIONAL SERVICES *Physician Assistants and Nurse Practitioners are covered at the level of coverage of the supervising physician.*			
Allergy Testing and Treatment	80% after *deductible*	60% after *deductible*	Includes RAST testing.
Ambulance	80% after *deductible*		Inter-facility transfers pay at 100% and **require** ***pre-certification.*** Please refer to Section V, Health Care Management Program, regarding non-emergent ambulance transfers.
Bariatric Surgery	80% after *deductible*	Not covered	Procedure must be performed at St. Luke's by an American Society for Metabolic and Bariatric Surgery (ASMBS) Center of Excellence surgeon. Refer to the Bariatric Surgery section of this document for surgica criteria and eligibility requirements. Limited to one Bariatric Surgery per Lifetime.
Chemotherapy	80% after *deductible*	60% after *deductible*	

HEALTHSAVE PLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PROFESSIONAL SERVICES continued			
Chemotherapy	80% after *deductible*	60% after *deductible*	
Chiropractic Services	80% after *deductible*	60% after *deductible*	Includes diagnostic x-rays. **Annual maximum**: $600 per *participant.*
Contraceptives	100%	60% after *deductible*	Oral contraceptives are covered under the Prescription Drug Program.
Diabetic Self-Management Education	80% after *deductible*	60% after *deductible*	**Annual Maximum**: $500 per *participant*. Refer to the Eligible Expenses section for more information regarding ongoing diabetic education.
Dental Injury	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.** Services are covered only for the twelve (12) month period immediately following the date of *accidental injury*.
Durable Medical Equipment	80% after *deductible*	60% after *deductible*	***Pre-certification* is required** when expected purchase price is in excess of $2,500, including repair, maintenance and replacement.
Home Health Care	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Home Infusion Therapy	80% after *deductible*	60% after *deductible*	***Pre-certification* is required.**
Hospice Care	100% *deductible* waived	100% *deductible* waived	Includes bereavement counseling. ***Pre-certification* is required.**
Genetic Counseling	80% after *deductible*	60% after *deductible*	**Annual Maximum**: Two (2) visits per *participant.*
Genetic Testing	80% after *deductible*	60% after *deductible*	***Pre-certification* is required for breast cancer genetic testing.**
Inpatient Physician	80% after *deductible*	60% after *deductible*	

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HEALTHSAVEPLAN

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE			
Routine Preventive Care	100% *deductible* waived	Not Covered	Please refer to Appendix A, Preventive Care Services, for a further description and limitations to this benefit.
TRANSPLANTS			
Organ Transplants	80% after *deductible*	60% after *deductible*	**Annual Transplant Travel Maximum**: Covered at 100% up to $10,000 combined for *participant* and donor. Refer to the Transplant Program section of this document for more information. ***Pre-certification* is required.**

D. Schedule of Prescription Drug Benefit

The *prescription drug* benefit program is separate from the medical benefits and is administered by SelectHealth. *Prescription drug* payments apply to the out of pocket maximum.

PPO Plan

Purchased at St. Luke's Pharmacy * (90 day maximum supply)	**SelectHealth Participating Pharmacy** (15 day maximum supply)
Generic *co-payment*: $10	**Generic *co-payment*:** $10
***Brand Formulary co-payment 0- 30 days supply*:** $25% of prescription price Minimum of $30 up to a maximum of $60	***Brand Formulary co-payment 0- 30 days supply*:** $25% of prescription price Minimum of $30 up to a maximum of $60
***Brand Formulary co-payment 31 - 90 days supply*:** $25% of prescription price Minimum of $60 up to a maximum of $120	***Brand Formulary co-payment 31 - 90 days supply*:** $25% of prescription price Minimum of $60 up to a maximum of $120
***Brand Non Formulary co-payment 0-30 days supply*:** $50% of prescription price Minimum of $60 up to a maximum of $100	***Brand Non Formulary co-payment 0-30 days supply*:** $50% of prescription price Minimum of $60 up to a maximum of $100
***Brand Non Formulary co-payment 31-90 days supply*:** $50% of prescription price Minimum of $120 up to a maximum of $200	***Brand Non Formulary co-payment 31-90 days supply*:** $50% of prescription price Minimum of $120 up to a maximum of $200
Specialty drug prescription co-payment $200	***Specialty drug prescription co-payment*** $200

*For *employees* who work outside the Treasure Valley, this benefit level applies for prescriptions purchased at either a St. Luke's Pharmacy or a SelectHealth participating *pharmacy*. If a *prescription drug* is not available to be filled at a St. Luke's Pharmacy (for example certain compound medications), a 30 day maximum supply will be allowed.

Under the PPO Plan, tobacco/smoking cessation coverage is limited to a one hundred and eighty-two (182)-day supply per *plan year*. Smoking cessation drugs eligible for coverage are listed on the Preferred Drug List maintained by the Plan Administrator and will be covered at no cost to the member.

HealthSave Plan

Purchased at St. Luke's Pharmacy * (90 day maximum supply)	**SelectHealth Participating Pharmacy** (15 day maximum supply)
Preventive Prescriptions[1]	**Preventive Prescriptions**[1]
Generics Covered at 100% at participating pharmacies	Covered at 100% at participating pharmacies
Preventive Formulary and Non-Formulary Covered at 90% at participating pharmacies	Preventive Formulary and Non-Formulary Covered at 90% at participating pharmacies
Covered at 60% at non-participating pharmacies	Covered at 60% at non-participating pharmacies
[1]For a list of preventive medications, please go to www.selecthealth.org	[1]For a list of preventive medications, please go to www.selecthealth.org
All other covered Prescriptions	**All other covered Prescriptions**
Covered at 80% after deductible at participating pharmacies	Covered at 80% after deductible at participating pharmacies
Covered at 60% at non-participating pharmacies	Covered at 60% at non-participating pharmacies

*For *employees* who work outside the Treasure Valley, this benefit level applies for prescriptions purchased at either a St. Luke's Pharmacy or a SelectHealth participating *pharmacy*. If a *prescription drug* is not available to be filled at a St. Luke's Pharmacy (for example certain compound medications), a 30 day maximum supply will be allowed.

Claims for reimbursement of *prescription drugs* may be submitted to SelectHealth at:

SelectHealth
Attn: Pharmacy Services
P.O, Box 30192
Salt Lake City, Utah 84130-0192

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the SelectHealth Drug Coverage List, which is incorporated by reference and located online at selecthealth.org/pharmacy, or call SelectHealth at (800) 538-5038.

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F. Schedule of Dental Benefits

The dental *Plans* described in this document are administered by Delta Dental. For information regarding eligibility, claims status, or other questions pertaining to the dental *Plan*, contact Delta Dental at (208) 489-3580. For a listing of contracted PPO and Premier *providers*, visit www.deltadental.com.

The *benefit year* is the twelve (12) month period beginning April 1 and ending March 31. All annual *deductibles* and benefit maximums accumulate during the *benefit year*.

Benefits	**Incentive Dental**		**Dental Plus**	
Provider Network	PPO	Premier	PPO	Premier
Maximum Plan Year Benefit (per *participant*)	$1,200	$1,000	$1,200	$1,000
Orthodontic Lifetime Maximum (per *participant*)	No coverage		$1,000	
Plan Year Deductible				
Single:	No *deductible*		$30	$50
Two-Party:			$60	$100
Family:			$90	$150
Plan Payment Percentages				
Preventive & Diagnostic (exams, x-rays, teeth cleanings, sealants)	70, 80, 90, 100%*	70, 80, 90, 100%*	100% (not subject to *deductible*)	80% (not subject to *deductible*)
Basic (fillings, root canals, extractions, minor oral surgery)	70, 80, 90, 100%*	70, 80, 90, 100%*	80%	70%
Major (crowns, onlays, bridges, dentures)	50%	40%	50%	40%
Orthodontics (child & adult) **	No coverage		50% (not subject to *deductible*)	50% (not subject to *deductible*)

* Benefit payments start at 70% during the *participant's* first year on the Incentive dental *Plan* and increase 10% each year up to 100% as long as the *participant* receives a preventive dental exam each consecutive year. For each year that the *participant* does not receive preventive dental care, the benefit payment will decrease by 10%.

**There is a one (1)-year waiting period the *participant's* effective date before the orthodontic benefit begins.

SECTION III—ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. Eligibility Requirements

Eligible Classes of Employees

All *active employees* of the *employer*.

Initial Eligibility Requirements for Employee Coverage

A person is eligible for *employee* coverage from the first day of the month following the date he or she is hired or transferred to:

1. a full-time, part time Level III or part time level II *employee* of the *employer* who is regularly scheduled to work at least thirty-two (32) hours per two-week pay period and who is being compensated for specified duties performed; and
2. a class eligible for coverage

In addition, coverage under the *Plan* may be provided to certain former *employees* who are participating in a severance pay arrangement of the *employer.*

Eligible Classes of Dependents

A dependent is any one of the following persons:

1. A covered *employee's* spouse.

   The term "spouse" refers to the *employee's* opposite-gender legally married spouse, as determined in accordance with the laws of the State of Idaho or same-gender spouse who is legally married under state or national law that recognizes same-gender marriages, unless the *participant* and such spouse are legally separated or divorced. The *Plan Administrator* may require documentation proving a legal marital relationship.

2. A covered *employee's* child from birth to the limiting age of twenty-six (26) years without regard to student status, marital status, financial dependency or residency status with the *employee* or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birth month.

   The term "child" shall include:

   a. A natural child of the *employee*,

   b. A legally adopted child or child placed with a covered *employee* and for whom legal adoption proceedings have been initiated,

   c. A child for whom the *employee* is a *legal guardian*,

   d. Stepchild, as long as a natural parent remains married to the *employee*,

   e. A child of a *participant* who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO).

   The phrase "placed for adoption" refers to a child whom the *employee* intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such *employee* of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

A *participant* of this *Plan* may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the *Plan Administrator.*

The *Plan Administrator* may require documentation proving dependent eligibility, including, but not limited to, birth certificates, tax records, and/or adoption decrees.

3. A covered dependent child or qualified dependent who meets all of the eligibility requirements except for age and has been *totally disabled* since before the limiting age, and are incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered *employee* for financial support and maintenance, and is unmarried. Documentation of a dependent child's disability or *illness* must be provided to the *Plan Administrator* within sixty (60) days of the date the child would otherwise cease to be a dependent or at the qualifying event. The *Plan Administrator* will review the documentation provided and will notify the *participant* if the over-age dependent is eligible to start or continue coverage under the *Plan.* If approved, coverage will be restored with no lapse in coverage, and applicable *employee* contributions will be deducted. The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

   The *Plan Administrator* reserves the right to have such dependent examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity.

These persons are excluded as dependents: other individuals living in the covered *employee's* home, but who are not eligible as defined; the legally separated or divorced former spouse of the *employee*; any person who is on active duty in any military service of any country; foster children, or any person who does not otherwise meet the eligibility requirements.

If a person covered under this *Plan* changes status from *employee* to dependent or dependent to *employee*, and the person is covered continuously under this *Plan* before, during and after the change in status, credit will be given for *deductibles* and all amounts applied to maximums.

If both mother and father are *employees*, their children will be covered as dependents of the mother or father, but not of both.

Individuals will no longer be eligible dependents if they cease full-time residence in the United States.

Eligibility Requirements for Dependent Coverage

A family member of an *employee* will become eligible for dependent coverage on the first day that the *employee* is eligible for *employee* coverage and the family member satisfies the requirements for dependent coverage.

At any time, the *Plan* may require proof that a spouse or a child qualifies or continues to qualify as a dependent as defined by this *Plan.*

B. **Medicare Part D Prescription Drug Plans for Medicare Eligible Participants**

Participants enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D *Prescription Drug* benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is *creditable coverage.* Because this *Plan's prescription drug* coverage is *creditable coverage,* you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* will coordinate benefit payment with *Medicare*. Refer to the Maintenance of Benefits section of the *Plan* for information on how this *Plan* will coordinate benefit payment.

C. **Funding - Cost of the Plan**

St. Luke's Health System, Ltd. shares the cost of *employee* and dependent coverage under this *Plan* with the covered *employees*. Such portion of the cost may vary depending upon the *employee's* participation and level of qualification in the Healthy U program. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed and submitted with the enrollment application.

The level of any *employee* contributions is set by the *Plan Administrator*. The *Plan Administrator* reserves the right to change the level of *employee* contributions.

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your benefit elections. Failure to submit the required informati
the dependent.

Enrollment Requirements for Changes in Status

It is your responsibility to advise your *employer* in writing of any change in dependent status including marriage, divorce, legal separation, the addition of a newborn, adoption of a child, and deletion of a covered child. Failure to provide this information could result in loss of eligibility and/or coverage under the *Plan*.

A newborn child, a child placed for adoption, or a newly adopted child of a covered *employee* who has dependent coverage is not automatically enrolled in this *Plan*. You must enroll your newborn child, child placed for adoption, or newly adopted child within sixty (60) days of the date of birth, date of placement for adoption, or date of adoption. Your claim for maternity expenses is not considered as notification to your *employer* for coverage.

If two *employees* (the mother and father of the child(ren) are covered under the *Plan* and the *employee* who is covering the dependent child(ren) terminates coverage, the dependent coverage may be continued by the other covered *employee* with no waiting period as long as coverage has been continuous.

If an *employee* ceases participation in the *Plan* because the *employee* transfers to non-benefits-eligible employment status with *employer*, such *employee* and his or her eligible dependents may participate again on the first day of the month following the date of his or her change to benefits-eligible status with the *employer*, provided that such *employee* submits such appropriate forms within the thirty (30) day period beginning on the date of transfer as determined by the *employer*.

If an *employee* ceases participation in the *Plan* because of non-payment of a required premium, then, except as provided for FMLA Leaves and USERRA leaves, such *employee* and his or her eligible dependents may participate again on the first day of the month following the payment of any delinquent premiums and completion of any declared Open Enrollment period, provided that such *employee* satisfies the conditions of eligibility and successfully completes the enrollment process designated by the *Plan Administrator*.

eligible as a dependent child under the *Plan*), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

iii. The coverage of the *employee* or dependent who had lost the coverage was under *COBRA* and the *COBRA* coverage was exhausted, or was not under *COBRA* and either the coverage was terminated as a result of loss of eligibility for the coverage or *employer* contributions towards the coverage were terminated.

iv. In the case of coverage offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live or work in the service area, loss of eligibility for the coverage because the *employee* no longer resides, lives or works in the service area (whether or not the choice of the *employee*);

v. In the case of coverage offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in the service area, loss of eligibility for the coverage because the *employee* no longer resides, lives or works in the service area (whether or not the choice of the *employee*) and no other benefit package is available to the *employee*;

If the *employee* or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the *Plan*), that individual does not have a special enrollment right. In addition, *employer* contributions include contributions by any current or former *employer* (of the individual or another person) that was contributing to coverage for the individual.

2. **Dependent beneficiaries.** If:

   a. The *employee* is a *participant* under this *Plan* or has met the waiting period applicable to becoming a *participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period, and

   b. A person becomes a dependent of the *employee* through marriage, birth, adoption or placement for adoption; then the dependent (and if not otherwise enrolled, the *employee)* may be enrolled under this *Plan*.

In the case of the birth or adoption of a child, the spouse of the covered *employee* may be enrolled as a dependent of the covered *employee* if the spouse is otherwise eligible for coverage. If the *employee* is not enrolled at the time of the event, the *employee* must enroll under this special enrollment period in order for his eligible dependents to enroll.

The dependent special enrollment period is a period of sixty (60) days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this special enrollment, the *employee* must request enrollment during this sixty (60) day period.

The coverage of the dependent and/or *employee* enrolled in the special enrollment period will be effective as follows provided the employee successfully completes the request for enrollment and the enrollment request is timely received by the *Plan Administrator*:

1) in the case of marriage, the first day of the first month beginning after the date of marriage; or

2) in the case of a dependent's birth, as of the date of birth; or

3) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

If a dependent ceases participation in the *Plan* because the *employee* is transferred to a non-benefits eligible status, or because of the *employee's* nonpayment of a required premium, the dependent may participate again with the related *employee* in accordance with the provisions for open enrollment or a special enrollment right. If dependent otherwise ceases participation, the dependent may participate again on the first day of the *plan year* following the completion of any Open Enrollment Period provided the *employee* has successfully completed the enrollment process designated by the *Plan Administrator*. The Plan will also recognize other special enrollment rights as required by federal law.

G. **Medicaid and State Child Health Insurance Programs**

An *employee* or dependent who is eligible, but not enrolled in this *Plan*, may enroll if:

a. The *employee* or dependent is covered under a *Medicaid* plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the *employee* or dependent is terminated due to loss of eligibility for such coverage, and the *employee* or dependent requests enrollment in this *Plan* within sixty (60) days after such *Medicaid* or CHIP coverage is terminated.

b. The *employee* or dependent becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a *Medicaid* or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or dependent requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or dependent is determined to be eligible for such assistance.

If a dependent becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received by *employer* unless an earlier date is established by the *employer* or by regulation.

H. **Open Enrollment**

Every year during the annual open enrollment period, covered *employees* and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the open enrollment period, eligible *employees* and dependents who are not covered under the *Plan* may enroll in the *Plan* provided the *employee* successfully completes the enrollment process by the published enrollment deadline. A *participant* may elect to switch between *medical plan coverage options*, drop coverage for a *participant*, add coverage for an eligible dependent or dependents, and switch between Dental *Plan* coverage options.

Benefit choices made during the open enrollment period will become effective April 1 and remain in effect until the next April 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of other coverage creating a special enrollment right. To the extent previously satisfied, coverage waiting periods will be considered satisfied when changing from one plan to another plan.

A *participant* who fails to make an election during open enrollment will automatically retain his or her present coverages unless *participants* are given advance notice of a different default procedure.

Participants will receive detailed information regarding open enrollment from their *employer*.

I. Effective Date

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* as of the first day of the calendar month following the date that the *employee* satisfies all of the following:

1. the eligibility requirement;
2. the *active employee* requirement; and
3. the enrollment requirements of the *Plan*.

Active Employee Requirement

An *employee* must be an *active employee* (as defined by this *Plan*) for this coverage to take effect.

Effective Date of Dependent Coverage

A dependent's coverage will take effect on the day that the eligibility requirements are met; the *employee* is covered under the *Plan*; and all enrollment requirements are met.

J. Termination of Coverage

When coverage under this *Plan* stops, *participants* will receive a certificate that will show the period of *creditable coverage* under this *Plan*. The *Plan* maintains written procedures that explain how to request this certificate. Please contact the *Plan Administrator* for a copy of these procedures and further details.

The *employer* or *Plan* has the right to rescind any coverage of the *employee* and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the *Plan*. The *employer* or *Plan* may either void coverage for the *employee* and/or covered dependents for the period of time coverage was in effect, terminate coverage as of a date to be determined at the *Plan's* discretion, or immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days' advance written notice of such action. The *employer* will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The *employer* reserves the right to collect additional monies if claims are paid in excess of the *employee's* and/or dependent's paid contributions.

When Employee Coverage Terminates

Employee coverage will terminate on the last day of the month in which the earliest of the following occurs unless otherwise noted below (Except in certain circumstances, a covered *employee* may be eligible for *COBRA* continuation coverage. For a complete explanation of when *COBRA* continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under *COBRA*.):

1. The employment relationship between the *employer* and the *participant* ceases. For coverage purposes, the employment relationship is deemed ceased when the *participant* ceases *active service* or when a *leave of absence* terminates and the *participant* does not return to *active service*;

2. The *participant* enters the military or coast guard of any country or international organization other than the United States on a full-time active duty basis, except if on an approved personal *leave of absence*;
3. The date the *Plan* terminates;
4. The *participant* ceases to maintain full-time residency in the United States of America;
5. The end of the period for which the last *Plan* contribution was paid on account of such person;
6. The end of the period for which the last contribution was paid by the *participant*.
7. The *participant* ceases to meet the eligibility requirements for coverage;
8. The *participant* waives (or has deemed to have waived) *Plan* coverage using procedures established by the *Plan Administrator*, such as open enrollment or Qualified Change in Status procedures; or
9. Twelve (12) weeks after the *participant* enters the military or coast guard of the United States unless the *participant* continues *Plan* coverage on a self-pay basis.
10. The date of the *employee's* death.

Notwithstanding the above, a *participant* shall continue to participate in the *Plan* following termination of employment to the extent set forth in a written reduction in force, voluntary separation, or similar *Plan* document of the *employer*, or a severance or similar written agreement entered into by the *employer*.

When Dependent Coverage Terminates

A dependent's coverage will terminate on the last day of the month in which the earliest of the following occurs unless otherwise noted below (Except in certain circumstances, a covered dependent may be eligible for *COBRA* continuation coverage. For a complete explanation of when *COBRA* continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under *COBRA*.):

1. The end of the period for which the last *Plan* contribution was paid on account of such person;
2. The end of the period for which the last *employee* contribution was paid;
3. The related *employee's* coverage terminates (including death);
4. The *employee* ceases to meet *employee* eligibility requirements;
5. The date such person ceases to qualify as a dependent under the terms of the *Plan* (including marriage and divorce);
6. The dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any *plan year*;
7. The dependent ceases to maintain full-time residence in the United States;
8. Dependent coverage terminates under the *Plan*; or
9. The date the *Plan* terminates.

K. Continuation during Family and Medical Leave

This *Plan* shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the *employer* will maintain coverage under this *Plan* on the same conditions as coverage would have been provided if the covered *employee* had been continuously employed during the entire leave period.

If *Plan* coverage terminates during the FMLA leave, coverage will be reinstated for the *employee* and his or her covered dependents if the *employee* returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this *Plan* when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, waiting periods will not be imposed unless they were in effect for the *employee* and/or his or her dependents when *Plan* coverage terminated.

L. **Employees on Military Leave**

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to *employees* and their dependents covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's dependents under such an election shall be the lesser of:
    a. The twenty-four (24) month period beginning on the date on which the person's absence begins; or
    b. The period ending on the date on which the person was required to apply for or return to a position of employment and fails to do so.
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator*. The *employee* may also have continuation rights under USERRA. In general, the *employee* must meet the same requirements for electing USERRA coverage as are required under *COBRA* continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The *employee* may elect USERRA continuation coverage for the *employee* and their dependents. Only the *employee* has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

SECTION IV—MEDICAL BENEFITS

D. Out-of-Pocket Maximum

Eligible expenses are payable at the percentages shown each *benefit year* until the *out-of-pocket maximum* shown in the Schedule of Medical Benefits is reached. Then, *eligible expenses* incurred by a *participant* will be payable at 100% (except for the charges excluded) for the rest of the *benefit year*.

E. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to surgery and prostheses following a covered mastectomy.

The *Plan* will pay charges incurred for a *participant* who is receiving benefits in connection with a mastectomy and then elects breast reconstruction in connection with the mastectomy. Coverage will include (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

F. Eligible Expenses

Eligible expenses are the *reasonable and customary amounts* that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this *Plan*. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Accidental Injuries**. Services and supplies to treat *accidental injuries*.
2. **Acne**.
3. **Ambulance.** Benefits will be provided for licensed ground and air ambulance services used to transport you from the place where you are *injured* or stricken by *illness* to the nearest accredited general *hospital* with adequate facilities for treatment. Benefits are provided in the case that transport does not take place. Benefits will also be provided for inter-facility ambulance transport as deemed *medically necessary* and will pay as outlined in the Schedule of Medical Benefits.
4. **Anesthetics.**
5. **Bariatric/Obesity Surgery.** Bariatric surgery as described in the Bariatric Surgery Benefit section of this document.
6. **Behavioral.** Diagnosis and treatment of behavioral problems and learning disabilities and/or learning impairment including but not limited to ADD/ADHD.
7. **Birthing Centers.**
8. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing. Autologous (self-donated) blood processing costs are covered only for blood collected for a scheduled surgery or transfusion, including storage fees charged as a result of *physician* and/or *provider* cancellations which are beyond the *participant's* control.
9. **Breast Pumps**. Effective April 1, 2013, the purchase of a portable breast pump is covered under the preventive benefit once per birth, following a delivery as indicated in the Preventive Care Services section. Plan participants must purchase the breast pump within 12-months of the birth of the baby; and is allowed once per birth.
10. **Cancer Treatment.** Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
11. **Cardiac Rehabilitation.** *Outpatient* cardiac rehabilitation services when rehabilitation follows *Medicare* guidelines.
12. **Cataract Surgery.** Services and supplies associated with cataract surgery. Eyeglasses or contact lenses are available under the vision benefit.

12. **Chiropractic**. *Chiropractic services* including any necessary related diagnostic x-rays. Includes only services provided by a chiropractor.

13. **Circumcision**. Routine circumcisions are covered for up to one (1) year following birth. After the first year *medically necessary* circumcisions only.

14. **Cochlear Implants**. Cochlear implants and exams for their fitting for Plan participants who have been on the Plan since birth or at least 1 year. This benefit is subject to a lifetime benefit maximum limit of $35,000.

15. **Colonoscopy Screenings**.

16. **Compression Stockings**.

17. **Continuous Glucose Monitoring**. The following is covered as *medically necessary*:

    Intermittent Monitoring (up to 72 hours):

    - Intermittent monitoring of glucose levels in interstitial fluid may be considered *medically necessary* in patients with type I diabetes prior to insulin pump initiation to determine basal insulin levels; and
    - Intermittent monitoring of glucose levels in interstitial fluid may be considered *medically necessary* in patients with type I diabetes whose diabetes is poorly controlled despite current use of best practices. Poorly controlled diabetes includes the following clinical situations: unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, and recurrent diabetic ketoacidosis.

    Continuous Monitoring:

    - Patients with recurrent unexplained severe symptomatic hypoglycemia for whom hypoglycemia puts the patients or others at risk and for pregnant type I diabetics, when use of best practices does not resolve the recurrent hypoglycemia.

    Continuous Glucose Monitors are limited to one (1) device every three (3) *benefit years* per *participant* as *medically necessary*.

18. **Contraceptives**. Devices, injectables, and implantable contraceptives, including removal. Oral contraceptives are covered under the Prescription Drug Benefits section.

19. **Dental Injuries.** Dental services and supplies for repair of the sound natural teeth and any professional services rendered by a *physician*, Doctor of Dental Surgery or Doctor of Oral Surgery for treatment of a fractured jaw or other *accidental injury* to the sound natural teeth, or any other surgery treatment of the mouth or jaw but not the teeth, provided that the *injury* occurs while the individual is covered under this *Plan*. Such dental services shall only be treatment started within twelve (12) months immediately following the date of the *accidental injury*. *Hospital* expenses will be covered if necessary for dental treatment.

20. **Developmental Delay.** Includes services for testing, office visits, rehabilitation therapy, and consultations.

21. **Diabetic Self-Management Education.** *Participants* with diabetes are eligible for *outpatient* diabetes education, not to exceed the maximum as stated in the Schedule of Medical Benefits. *Outpatient* diabetes education shall include instruction in the basic skills of diabetes management through books, educational material, as well as individual or group consultation with a Certified Diabetes Educator, Nurse, or Dietitian.

    In order to be eligible for *outpatient* diabetes education, a *participant*:

    - Must receive a referral from a *physician*, and
    - The patient diabetes education program must provide written communication to the referring *physician*.

21. **Dietary Surveillance and Counseling.** Services for nutritional surveillance and counseling which may involve the assessment of the *participant's* overall nutritional status followed by the assignment

of individualized diet, counseling, and/or specialized nutrition therapies to treat an *illness* or condition. Services are limited to five (5) visits per *benefit year.*

22. **Durable Medical Equipment.** Rental of *durable medical equipment* if prescribed by a *physician.* The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment or, at the option of the *Plan*, the purchase of *medically necessary durable medical equipment* required for therapeutic use.

    No benefits are available for the replacement of any item of *durable medical equipment* or braces that have been used by a *participant* for less than five (5) years (whether or not the item being replaced was covered under this *Plan*). Benefits shall not exceed the cost of the standard, most economical *durable medical equipment* or brace that is consistent, according to generally accepted medical treatment practices, with the *participant's* condition. If the *participant* and his or her *provider* have chosen a more expensive *durable medical equipment* or brace item than is determined to be the standard and most economical by the *Plan*, the excess charge is solely the responsibility of the *participant*. *Medically necessary* repair, maintenance and replacement of items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications and repair costs that exceed the replacement cost of the item are not covered. Equipment items considered to be common household items are not covered.

23. **Enterostomal Therapy.**

24. **Family Planning**. Services for elective sterilizations, voluntary or therapeutic.

25. **Hearing Examinations**.

26. **Home Health Care.** Charges for *home health care* services and supplies provided by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.), when the services are *medically necessary* and do not constitute *custodial care*. No benefits shall be provided during any period of time in which the *participant* is receiving services for *hospice care*. Therapies provided in the home apply to the applicable therapy maximum as stated in the Schedule of Medical Benefits.

27. **Home Infusion Therapy.**

28. **Hospice Care**. The *Plan* will cover 100% of such services and supplies, but not to exceed the maximums as stated in the Schedule of Medical Benefits:

    - Medical care rendered by a *physician* of a contracting *hospice*.
    - Physical therapy, speech therapy and respiration therapy provided by certified or registered therapists.
    - Medical social services, psychological social assessment and counseling of a *participant* as part of a *hospice plan* of treatment provided by a social worker with a Master of Social Work (M.S.W.) degree. Benefits are limited to two (2) visits.
    - Individual and group counseling services, for immediate family members and the primary care giver, related to coping with the *participant's* condition.
    - Initial and follow-up dietary counseling sessions provided by a certified dietitian. This benefit is limited to three (3) dietary counseling sessions.
    - Continuous Crisis Care limited to two (2) occurrences of no more than four (4) days each within a three (3) month period. To qualify for Continuous Crisis Care, at least 50% (but in no case less than eight (8) hours) of the total number of continuous hours of care in any day must require *skilled nursing care*. Home health aide care may be used to augment the *skilled nursing care* as determined by the *participant's* condition.

- Medical and surgical supplies, *durable medical equipment*, and oxygen and its administration.
- Benefits are provided only for covered *hospice care* included in a *hospice care plan* of treatment that has been *pre-certified*. A *participant* must specifically request *hospice care* benefits and must meet the following conditions to be eligible for *hospice care* benefits:
  a. The attending or primary *physician* must certify that the *participant* is a *terminally ill* patient with a life expectancy of six (6) months or less.
  b. Services and supplies must be prescribed by the attending *physician* and included in a *hospice care plan* of treatment approved in advance. The *hospice care agency* must notify the *Third Party Administrator* within one (1) working day of any change in the *participant's* condition or plan of treatment that may affect the *participant's* eligibility for *hospice care* benefits.
  c. Palliative care, which controls pain and relieves symptoms but does not provide a cure, must be appropriate to the *participant's illness*.

29. **Hospital Care.** The medical services and supplies furnished by a *hospital* or *ambulatory surgical facility*. If private accommodations are used, any excess of the daily service charges over the semi-private rate will be the responsibility of the *participant*, unless private accommodations are *medically necessary* and prescribed by a *physician*.
    a. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services if *medically necessary* for dental procedures if, (a) the *participant* is under age eight (8) (b) is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office, or (c) the *participant* has a medical condition besides the dental condition needing treatment that the attending *provider* finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*. This benefit does not cover the *dentist's* services.
30. **Insulin Pumps**. Includes pump supplies.
31. **Intensive Care Unit.** Charges for an *intensive care unit* stay.
32. **Laboratory studies.**
33. **Mastectomy Bras and/or Camisoles.** Limited to four (4) per year per *participant*.
34. **Maternity.** Pregnancy and complications of pregnancy shall be covered as any other *illness* for the *employee* or spouse. Benefits include pre-and post-natal care, obstetrical delivery, cesarean section, miscarriage, and complications resulting from the pregnancy. There is no coverage of pregnancy for a dependent child. Expenses of a newborn child who was given birth by a covered dependent child of an *employee* are not covered under this *Plan*.

    Participants may call the St. Luke's Healthy Pregnancy Program (HPP) at the specified toll-free number (Magic Valley – (208) 737-2165 or Boise/Meridian/Wood River/All other – (208) 381-3230) upon confirmation of pregnancy. Notification of the pregnancy to the HPP should occur within the first trimester in order that the HPP may assist the *participant* with any special needs as soon as possible. If a *participant* notifies the HPP and participates in the HPP, the *participant* shall be eligible to receive a credit of up to $250 toward the *participant's* patient balance on their St. Luke's *hospital* bill.

    Group health plans generally may not, under Federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a *provider* obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

35. **Medical Supplies**. Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations. Supplies and dressing when *medically necessary* for surgical wounds, cancer, burns, or diabetic ulcers; colostomy bags and catheters; and surgical and orthopedic braces.

36. **Mental Disorders and/or Substance Abuse.** Services and supplies used in the treatment of *mental disorders* and *substance abuse*. Includes *medically necessary* group counseling.

    Regardless of any limitations on benefits for *mental disorders/substance abuse* treatment otherwise specified in the *Plan*, any aggregate *lifetime* limit, annual limit, financial requirement, *non-network* exclusion or treatment limitation on *mental disorders/substance abuse* benefits imposed by the *Plan* shall comply with Federal parity requirements, if applicable.

37. **Nursery Care.** Routine well newborn nursery care is care while the newborn is *hospital*-confined after birth and includes room, board and other normal care for which a *hospital* makes a charge. Newborn expenses incurred will be payable provided the newborn is enrolled as a dependent within sixty (60) days (day one is date of birth) of birth.

38. **Obesity.** Services include testing, diagnosis and bariatric surgery (as described under the Bariatric Surgery Benefit section of this document) as well as obesity counseling and screening for adults with a Body Mass Index of 30 or more.

39. **Orthotic Appliances.** Orthotics if prescribed by a podiatrist or orthopedist.

40. **Oxygen.** Oxygen, supplies, and administration.

41. **Physician Care.** The professional services of a *physician* for medical services.

42. **Pre-Admission Testing**. *Outpatient*, pre-surgery, x-ray, and laboratory services performed within a one (1)-week period immediately prior to *hospital* services or necessary to determine an admission for surgery performed on an *outpatient* basis, provided that the tests are ordered by the same *physician* that ordered the services.

43. **Prenatal Testing**. Services for prenatal diagnosis or congenital disorders by the fetus by means of screening and diagnostic procedures will be provided the same as for any other condition during your covered pregnancy.

44. **Preventive Care.** Benefits will be provided for routine preventive care including, but not limited to, the services listed in Appendix A of this *Plan* document.

    Additional preventive care shall be provided as required by applicable law if provided by a *network*/participating *provider*. A current listing of recommended preventive care services can be accessed at **www.HealthCare.gov/center/regulations/prevention.html**.

45. **Prosthetic Devices.** Initial artificial limbs, eyes, and breast prosthesis, including service and repair of an artificial limb, eye or breast prosthesis, but not replacement of such items unless specifically approved by the *Plan Administrator* before the purchase or provision thereof, and the attending *physician* indicates *medical necessity* due to a change in the body condition and the artificial limb or eye cannot be repaired or made serviceable.

46. **Reconstructive Surgery.** Reconstructive surgery expenses which are deemed *medically necessary*:

    - When needed to correct damage caused by a birth defect *or illness* of a dependent child under this *Plan*;

- To correct damage caused by an *accidental injury*, or
- For breast reconstruction following a total or partial mastectomy, which was caused by disease, *illness* or *injury*, subject to the following:
    1) Reconstruction of the breast on which the mastectomy has been performed;
    2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    3) Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

47. **Rehabilitation Services**. Services include physical therapy, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis, including in home therapy.
48. **Sleep Disorders.** *Medically necessary* and *physician* ordered testing and treatment of sleep disorders. Includes surgery and continuous positive airway pressure (CPAP) machines.
49. **Skilled Nursing Facility.** Benefits for care in a licensed *skilled nursing facility* following a *hospital* stay for a non-occupational *injury* or *illness*, and provided such services are in lieu of *hospital* services. Services include those institutional services for which charges are made by the facility as a condition of occupancy on a regular daily or weekly basis. Any excess of the daily charges will be the responsibility of the *participant*. This benefit also provides for the cost of the following services and supplies:
    - Daily room and board; and
    - Medical services customarily provided by a *skilled nursing facility*, other than private duty or special nursing services and *physicians'* services.

    A *participant* is entitled to these *skilled nursing facility* benefits provided:

    - Services provided in a *skilled nursing facility* which charges for room and board;
    - Services provided in the *skilled nursing facility* begins within fourteen (14) days after a *hospital* stay of at least three (3) consecutive days;
    - The *hospital* and *skilled nursing facility* services both relate to the care and treatment of the same *injury* and *illness*; and
    - Use of the *skilled nursing facility* is prescribed by a *physician* for a condition requiring treatment by a *physician*.
50. **St. Luke's Healthy U CoPartner Program. Under the PPO Plan,** the initial Comprehensive Care Coordination and Planning visit through St. Luke's Healthy U CoPartner program will be covered at 100% and will not be subject to normal *Plan co-insurance* or *co-payments.* Any tests, treatment, or services provided during or after the Healthy U CoPartner initial visit will continue to be subject to applicable *Plan co-insurance* and *co-payment* provisions.
51. **Surgery**. Benefits for the treatment of *illnesses* and *injuries* including fractures and dislocations are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies.
52. **Temporomandibular Joint/Orthognathic Treatment.** Benefits for medical or dental services for treatment of temporomandibular joint disorders and orthognathic conditions.
53. **Transplants**. Transplants as described in the Transplant Program section of this document.
54. **Urgent Care.** The delivery of ambulatory medical care outside of a *hospital* emergency department on a walk-in basis without a scheduled appointment. Urgent care services will process as any other benefit and the coverage level will be subject to the applicable benefit.

55. **Wigs.** Charges associated with the initial purchase of a wig after chemotherapy.
56. **X-Rays and Imaging**. Diagnostic x-rays and imaging.

G. Expenses Not Covered

The *Plan* will not provide benefits for any services or supplies listed in the Expenses Not Covered section, regardless of *medical necessity* or recommendation of a *health care provider*. Items that are not listed as excluded will be considered based on *medical necessity*, standard of care, and medical appropriateness. The following list is intended to give you a general description of expenses for services and supplies not covered by the *Plan*. This list is not exhaustive.

1. **Abortion.** Services, supplies, care or treatment in connection with an elective abortion unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. Complications from a spontaneous or covered abortion as described above are covered, however complications from an elective abortion are not covered.
2. **Alcohol.** Services, supplies, care or treatment to a *participant* for an *injury* or *illness* which occurred as a result of that *participant's* illegal use of alcohol. The police or *hospital* report's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured *participants* other than the person illegally using alcohol and expenses will be covered for *substance abuse* treatment as specified in this *Plan*. This exclusion does not apply if the *injury* resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
3. **Alternative Medicine.** Including but not limited to acupuncture, massage therapy, hypnosis, holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.
4. **Clinical Trials.** Clinical Trials are generally not covered. However, a Clinical Trial that meets Federal and State criteria may be approved for coverage on a limited bases as dictated by Federal and State regulations. Services for an Approved Clinical Trial will only be covered to the extent required by federal or state law and only when the Member is:
    a. Eligible to participate in the trial according to the trial protocol; and
    b. The treatment is for cancer or another life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted); and
    c. Either:
        i. The referring health care professional is a Participating Provider and has concluded that the Member's participation in such trial would be appropriate; or
        ii. The Subscriber or Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate.
5. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered *participant* in the armed forces of a government.
6. **Before or After Eligibility.** Services, supplies, or accommodations provided prior to the *participant's* effective date or after the termination of coverage.
7. **Bone Marrow.** Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of an *illness*, except as otherwise specifically provided herein.
8. **Complications from a Non-Covered Service.** Care, services or treatment required as a result of complications from a treatment not covered under the *Plan* are not covered. Complications from a spontaneous or covered abortion as described above are covered, however complications from an elective abortion are not covered.
9. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except for newborn children or due to trauma or disease, done for aesthetic purposes and not to restore an impaired

function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent surgery related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*.

10. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; support groups, family counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling with *participant's* friends, *employer*, school counselor, or school teacher, except as specified herein.
11. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or *custodial care*.
12. **Dental Care.** Normal dental care benefits, including any dental and gum work except as otherwise specifically provided herein.
13. **Debarred Providers.** Services from Providers debarred by any state or federal health care program are not covered.
14. **Educational or Vocational Testing.** Services for any educational or vocational testing or training including but not limited to administrative, school and sport physicals.
15. **Excess Charges.** The part of an expense for care and treatment of an *injury* or *illness* that is in excess of the *reasonable and customary amount*.
16. **Exercise Programs.** Exercise programs, unless part of a *pre-certified* plan of treatment for cardiac rehabilitation.
17. **Experimental/Investigational or not Medically Necessary.** Care and treatment that is either *experimental/investigational* or not *medically necessary.* Services associated with an *Approved Clinical Trials will only* be covered to the extent required by federal or state law.
18. **Eye Care.** Radial keratotomy, LASIK, keratoplasty, or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, and visual therapy or training.
19. **Family Member.** Professional services performed by a person who ordinarily resides in the same household as the *participant* or is related to the *participant* as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
20. **Foot Care.** Any cosmetic foot care, including but not limited to, treatment of corns, calluses, bunions (except for surgical care) and toenails (except for surgical care of ingrown or diseased toenails). However, services associated with routine foot care for diabetes and peripheral vascular disease are covered.
21. **Foreign Travel.** Expenses for services received or supplies purchased outside the United States, if travel outside the United States is for the sole purpose of treatment.
22. **Gender.** Care, services, or treatment for transsexualism, gender dysphoria or sexual reassignment or change including drugs, medication, implants, hormone therapy or other surgical treatment, or psychiatric care or treatment.
23. **Government.** Services furnished by or for the U.S. government or any other government including services received in a Veteran's Administration Hospital, a Public Health Service Hospital, or any facility the U.S. Government or any of its agencies runs, except for:
    a. A service received by a *participant* due to a non-service connected disability, if a *participant* is a veteran and does not have a service-connected disability.

    This exclusion does not apply to *Medicaid* or if otherwise prohibited by law.

24. **Hair Loss.** Care and treatment for hair loss including wigs (except as specified herein), hair transplants or any drug that promises hair growth, whether or not prescribed by a *physician*, except as specifically provided herein

25. **Hearing Aids or similar Implantable Hearing Devices.** Charges for services or supplies in connection with hearing aids or implantable hearing devices. This exclusion does not apply to cochlear implants and exams for their fitting.

26. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an employee of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.

27. **Hospital Services**. *Hospital* services when hospitalization is primarily for diagnostic studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.

28. **Illegal Acts.** Charges for services received as a result of *injury* or *illness* caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the *injury* resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

29. **Illegal Drugs or Medications.** Services, supplies, care or treatment to a *participant* for *injury* or *illness* resulting from that *participant's* voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a *physician*. Expenses will be covered for injured *participants* other than the person using controlled substances and expenses will be covered for *substance abuse* treatment as specified in this *Plan*. This exclusion does not apply if the *injury* resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

30. **Immunizations**. Immunizations, vaccinations or other medications required for the purpose of travel outside of the United States.

31. **Impotence.** Care, treatment, services or supplies in connection with treatment for impotence

32. **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization. Any Assisted Reproductive Technology (ART) procedure including associated services and supplies.

33. **Maternity.** Care and treatment of pregnancy and complications of pregnancy for a dependent daughter only.

34. **Midwife Services**. – Excluded except in the case of a Certified Nurse Midwife working at a *medical care facility*.

35. **Milieu Therapy.** A treatment program based on manipulation of the *participant's* environment for their benefit.

36. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

37. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for non-*medical emergency* admissions on a Friday or a Saturday. This does not apply if surgery is performed within twenty-four (24) hours of admission.

38. **Non-Medical Expenses.** Expenses for preparing medical reports or itemized bills, services for telephone consultations, expenses for failure to keep a scheduled visit or appointment.

39. **Non-Prescription Medication**. Drugs and supplies not requiring a prescription order, including but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food

supplements, syringes, and bandages, Antabuse, Methadone, Minoxidil, or Rogaine hair preparations; special foods or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled “Caution: Limited by Federal Law to *Investigational* Use;” and prescription medications related to health care services which are not covered under this *Plan*.

40. **No Obligation to Pay.** Services for which there is no legal obligation to pay or charges which would not be made but for the existence of this benefit *Plan*.
41. **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a *physician*; or treatment, services or supplies when the *participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
42. **Nutritional Formula/Therapy.** Replacements or nutritional formulas, except when administered enterally due to impairment in digestion and absorption of an oral diet and is the primary source of caloric need or nutrition in a *participant*.
43. **Occupational**. Care and treatment of an *injury* or *illness* that is occupational; that is, arises from work for wage or profit including self-employment.
44. **Personal Comfort Items.** Expenses for services for personal hygiene, comfort, beautification or convenience items, even if deemed *medically necessary*, including, but not limited to, air conditioners, air purifiers, vaporizers, humidifiers, spas, hot tubs, whirlpool baths, waterbeds, swimming pools, physical fitness equipment or programs, heating pads, contour chairs, or therapeutic beds (not including certified, standard model *hospital* beds which will be paid as *durable medical equipment*), telephones, television, guest trays or meals, personal hygiene items or services, homemaker or housekeeping services, except by home health aides as ordered in a *hospice care plan*.
45. **Personal Injury Insurance.** Expenses in connection with an automobile accident for which benefits payable hereunder are or would be otherwise covered by mandatory *"no fault" automobile insurance* or any other similar type of personal *injury* insurance required by State or Federal law, without regard to whether or not the *participant* actually had such mandatory coverage. This exclusion does not apply if the injured person is a passenger in a non-family owned vehicle, or a pedestrian.
46. **Private Duty Nursing.** Charges in connection with care, treatment or services of a private duty nurse.
47. **Routine Care.** Charges for routine or periodic examinations, routine screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific *injury*, *illness* or pregnancy-related condition which is known or reasonably suspected, except as otherwise specifically provided herein.
48. **Self-Inflicted.** Expenses incurred as a result of intentionally self-inflicted *injury* or attempted suicide, unless the result of an underlying medical condition.
49. **Tobacco Cessation.** Supplies including smoking deterrent patches, over-the-counter drugs or medications are not covered under the medical benefits.

    Contact St. Luke’s at (208) 381-8400 for tobacco cessation resources or refer to the Prescription Drug Benefits section for more information regarding tobacco cessation coverage.
50. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
51. **Travel or Accommodations.** Travel expense whether or not recommended by a *physician*, or travel expenses incurred by a *physician* attending a *participant*, except as otherwise specifically provided herein.

52. **War.** Services provided a *participant* who suffers an *injury* while participating in war, (whether declared or undeclared), civil war, insurrection, rebellion or revolution, or to any act or condition incident to any of the foregoing.

53. **Weight Management.** Treatment for weight maintenance, gain or loss, including but not limited to, food, vitamin, dietary supplements, weight control and loss programs except for bariatric surgical coverage, as described herein.

54. **Workers' Compensation.** Expenses for any condition or disability sustained while engaged in an activity primarily for wage, profit or gain, which could entitle the *participant* to a benefit under Workers' Compensation or similar legislation, whether or not enrolled, if eligible.

SECTION V—ST. LUKE'S HEALTY U PROGRAM

A. What is Healthy U?

Healthy U is St. Luke's wellness program for employees and spouses. Healthy U incentives are just one component of the Healthy U program. If you and or your spouse, (if you enroll your spouse in the Plan) successfully achieve specified targets, you can reduce the annual cost of your coverage in the Plan. The Healthy U Program is administered by St. Luke's. The terms and conditions of the wellness program are described in other documents, and therefore those documents are incorporated herein by reference.

B. Special Rules for Claims and Appeals Relating to Incentives under the St. Luke's Healthy U Program

With respect to all claims and appeals relating to eligibility, contributions or other plan administrative matters, the Plan Administrator shall have the sole authority, discretion and responsibility to interpret and apply the terms of the Plan and to determine all factual and legal questions under the Plan. All determinations, interpretations, rules, and decisions by the Plan Administrator shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Program.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to any denied claim.

C. BEST U

BEST U is a weight management program designed to provide a healthy, comprehensive approach to weight loss. BEST U is only available to employees and spouses covered under this *Plan* who meet the enrollment criteria and complete the program requirements as follows:

1. Complete the BEST U program by attending the Orientation class, 2 individual sessions with the Registered Dietitian, 3 core classes and 9 different group classes within 6 months of starting;
2. Agree to monitor and share nutrition and physical activity tracking at least 80% of the time for the length of the program;
3. Start the program with a BMI ≥33;

The *Plan* will cover at 100% to participants who complete the requirements of the BEST U program are as follows:

1. Orientation session
2. 2 individual (30 minutes) sessions with a Registered Dietitian
3. 3 core classes: Behavior, Exercise and Nutrition are mandatory for program completion
4. 9 additional group classes
    a. You choose topics of interest, but classes may not be repeated for completion credit!
5. Nutrition and Physical Activity Tracking
6. Unlimited access to BEST U online resources

SECTION VI—HEALTH CARE MANAGEMENT PROGRAM

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3. *Hospital* services for dental procedures
4. Restorative dental services following *accidental injury* to sound natural teeth
5. Home intravenous therapy
6. Home health services
7. Hospice services
8. Growth hormone therapy
9. Cardiac rehabilitation
10. Breast cancer genetic testing -- BRCA testing using BRAC Analysis, BRAC Analysis Rearrangement Test (BART)
11. Chemotherapy and radiation treatment
12. The following services when expected purchase price is in excess of $2,500
    i. Rental or purchase of *durable medical equipment* including repair, maintenance and replacement
    ii. Prosthetic appliances
    iii. Orthotic devices

The following *inpatient* and *outpatient* surgical procedures (not including office surgeries) must be *pre-certified* or reimbursement from the *Plan* will be reduced by 50% up to a maximum of $500 for resulting claims (if a facility claim applies the penalty will be applied to the facility claim).

- Bariatric surgery (surgical treatment of obesity) which meets the criteria for coverage outlined in Section X (BARIATRIC SURGERY BENEFIT).
- Cochlear Implants
- Eyelid Surgery
- Gastric reflux procedures, except EGD
- Hysterectomy
- Invasive treatment of lower extremity veins
- Nasal and sinus procedures
- Orthognathic and TMJ surgery
- Plastic and reconstructive surgery
- Spinal surgery
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)

The following service must be *pre-certified* or the service will not be covered by the *Plan*.

- Non-emergent ambulance transfers

If a *hospital* confinement extends beyond the certified number of days, the benefits otherwise payable by the *Plan* beyond the certified number of days will be reduced to 0% of the *maximum allowance* for the *eligible expenses* incurred unless both of the following conditions are met:

- The extension is *medically necessary*; and
- *Pre-certification* for the extension is obtained.

Note* While observation, regardless of the length of the observation, doesn't require *pre-certification*, services may be subject to *medical necessity* reviews. If a claim is found to not be *medically necessary*, the charges will be denied. If an observation claim denies for lack of *medical necessity* and the claim is re-billed as an *inpatient* charge and the *inpatient* charge is determined to be *medically necessary*, then the *pre-certification* penalty will not apply to the re-billed claim.

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits payments are subject to the eligibility and other coverage restrictions and limitations of the *Plan*.

C. How the Program Works.

Pre-certification. Before a *participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending *physician*, certify the care as appropriate for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the *participant*. Contact the utilization review administrator SelectHealth at (800) 442-5305**at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered *employee*
- The name, *employee* identification number and address of the covered *employee*
- The name of the *employer*
- The name and telephone number of the attending *physician*
- The name of the *medical care facility*, proposed date of admission, and proposed length of stay (in patient, out patient or observation stays)
- The proposed medical services with appropriate diagnosis and procedure codes
- The proposed rendering of listed medical services

If there is an **emergency** admission to the *medical care facility* the patient, patient's family member, *medical care facility* or attending *physician* must contact SelectHealth at 800-538-5038 **within forty-eight (48) hours** of the first business day after the admission.

The Healthcare Management Program will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the *Plan*.**

D. Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **the *Plan's* payment will be reduced by 50% up to a maximum reduction of $500 for any resulting claims or facility claims when applicable.** Amounts assessed under this penalty will not go towards satisfaction of your *deductible* or *out-of-pocket maximum*.

E. Special Rules Regarding Maternity and Newborns

In compliance with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), maternity care and nursery care at birth are not subject to *pre-certification* for the following minimum lengths of stay after delivery: forty-eight (48) hours for a vaginal birth and ninety-six (96) hours for a cesarean section birth. *Pre-certification* is recommended, however, because if the length of stay for either the mother or newborn is in excess of the forty-eight (48) or ninety-six (96) hours, as applicable, and the excess days are NOT *pre-certified*, the unapproved days will be subject to the penalty.

If the mother is admitted to the *hospital* during pregnancy for any reason other than delivery, she or her *health care provider* must obtain *pre-certification* for the *hospital* admission.

F. Care Management

The *Plan* may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

A care manager consults with the patient, the family and the attending *physician* in order to develop a plan of care for the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring *hospital* or *skilled nursing facility*;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Care Management occurs when this alternate benefit will be beneficial to both the patient and the *Plan*.

The care manager will coordinate and implement the Care Management program by providing guidance and information on available resources and suggesting the most appropriate care plan. Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*.

Note: Care Management is a voluntary service. There are no reductions of benefits or penalties if the patient chooses not to participate.

Each care plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

G. Concurrent Review and Discharge Planning

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are parts of the Healthcare Management Program. The utilization review administrator will monitor the *participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, medical care facilities and *participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

SECTION VII—VALUE BASED BENEFITS

To encourage members to receive appropriate treatment for their conditions and to adhere to medication regimens, the Plan covers the following services with no cost share under the PPO Plan:

Members who have been diagnosed as a diabetic:

a. Two office visits
b. One retinal exam
c. One LDL cholesterol test
d. One Urinary micro albumin test

In addition to the above benefit, members receive the following Benefit under the PPO Plan:
Members age 18 and older with diabetes who have completed all 4 items above within the past 12 months will receive the following services with no cost share:

a. Glucometer
b. Test strips
c. Lancets

Members under the age of 18 with diabetes who have completed two office visits within the past 12 months will receive the following services with no cost share:

a. Glucometer
b. Test strips
c. Lancets

SECTION VIII—TRANSPLANT PROGRAM

similar criteria, and must not be affiliated in any way with the *physician* who will be performing the actual surgery.

D. **Transplant Exclusions**

The following transplant-related expenses are not covered by the *Plan*:

1. When the recipient is not an eligible *participant*.
2. When the organ or tissue is sold rather than donated to the recipient.
3. That are covered or funded by governmental, foundation or charitable grants or programs.
4. For any mechanical or *artificial organ*.

SECTION IX—ST. LUKE'S CENTER FOR SPINE WELLNESS (CSW) PROGRAM

A. What the Program Offers

St. Luke's Center for Spine Wellness (CSW) offers a program that presents incentives to *participants* to try conservative, evidence-based treatment for lower back pain. The goal is to ensure evidence-based, systemized care is delivered, with appropriate referrals made to physical therapy, *chiropractic services*, social workers, mental health *providers*, and when needed surgical referrals. The St. Luke's Center for Spine Wellness is located in Boise, Idaho:

Center for Spine Wellness – Boise
703 Americana Blvd., Suite 130
Boise, Idaho

To schedule an appointment, call (208) 333-BACK (2225)

B. Benefit to those in the PPO Plan only

To access enhanced benefits for treatment of lower back pain, a *participant* must have an initial evaluation performed at the CSW. The initial evaluation will be covered at 100%, and the *deductible* will be waived. All *participants* must go to the CSW for the initial evaluation. Follow-up care for *participants* who reside outside of the Treasure Valley may be coordinated with BrightPath *providers* in the *participant's* local community.

Medical services referred by the CSW will be covered at the benefit specified in the Schedule of Medical Benefits. To qualify for the enhanced benefit, services must be performed by the *provider* specified in the referral and must be a covered benefit of the *Plan*.

Medical services not specifically referred by the CSW or performed by a *provider* other than the *provider* referred by CSW will not qualify for the enhanced benefits for lower back pain and will be covered at the applicable standard benefit. Non-covered services will not be covered, even if referred by the CSW.

Surgical services will be covered at the applicable standard benefit.

If a *participant* is non-compliant with the treatment program developed by the CSW, the *participant* will be released from the program for non-compliance and will no longer be eligible for the enhanced benefit. Non-compliance may include missed appointments. The *participant* can contact the CSW for re-enrollment in the program.

Pre-certification and *medical necessity* provisions will apply if otherwise required by the *Plan*.

SECTION X—BARIATRIC SURGERY BENEFIT

A. Bariatric Surgery Benefit

80% of *in-network* allowable charges, subject to *deductible*, for the following:

1. Professional and facility fees for the surgical procedure; and
2. Related services (for example: cardiovascular studies, sleep apnea testing, pre-op psych evaluation, etc.).

B. Criteria for Surgery

1. Body Mass Index (BMI) of forty (40) or higher, or BMI of at least thirty-five (35) with one (1) or more co-morbidities.

   Co-morbidities include, but are not limited to, diabetes mellitus, obstructive sleep apnea, asthma, coronary obstructive pulmonary disorder (COPD), dyslipidemia, coronary artery disease, congestive heart failure, severe degenerative joint disease of weight bearing joints, and hypertension.

2. Must be age eighteen (18) years or older, or have documented completion of bone growth.

C. Benefit Eligibility Requirements

1. *Employee* must be continuously employed for three (3) years with St. Luke's. Dependents are eligible provided the *employee* meets the years of employment requirement; and
2. Has not received coverage for any type of Bariatric Surgery under the St. Luke's Health System Employee Health Care Plan previously; and
3. Services must be coordinated by a St. Luke's Bariatric Surgery Program provider; and
4. Procedure must be performed at St. Luke's by an American Society for Metabolic and Bariatric Surgery (ASMBS) Center of Excellence surgeon.

SECTION XI—VISION CARE BENEFITS

The vision care benefits are administered by VSP. Vision care benefits apply when vision care charges are incurred by a *participant* for services that are recommended and approved by an ophthalmologist, optometrist, or optician. *Eligible expenses* must be incurred in their entirety while a *participant* is covered under this *Plan*. *Eligible expenses* shall be considered to have been incurred on the date the *participant* receives the services for which the charge is made.

A. Benefit Payment

Benefit payment for a *participant* will be made as described in the Schedule of Vision Benefits.

B. Vision Care Charges

Vision care charges are the *usual and reasonable* charges for the vision care services and supplies shown in the Schedule of Vision Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Vision Benefits for each vision care service or supply.

C. Eligible Expenses

1. Vision examination regardless of its *medical necessity*, including but not limited to the following services:
    a. A case history;
    b. External examination of the eye and adnexa;
    c. Ophthalmoscopic examination;
    d. Determination of refractive status;
    e. Binocular balance testing;
    f. Tonometry test for glaucoma, when indicated;
    g. Gross visual fields, when indicated;
    h. Color vision testing, when indicated;
    i. Summary finding; and
    j. Recommendations, including the prescribing of corrective lenses.
2. Prescribed Lenses and Frames including directly related *provider* services:
    a. Facial measurements and determination of interpupillary distance;
    b. Assistance in selection of frames;
    c. Procurement of lenses as prescribed;
    d. Verification of lenses as prescribed; and
    e. Follow-up care for a reasonable period of time for fitting and adjustment and maintenance of comfort and efficiency.

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SECTION XII—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The *prescription drug* benefits program is separate from the medical benefits even though it is also administered by SelectHealth. This program allows you to use your SelectHealth *prescription drug* card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions.

If you purchase your *prescription drug*s from a non-participating *pharmacy*, you will have to pay the full price of the prescription and then submit a claim for reimbursement. Reimbursement will be according to the *network* price, so your total out-of-pocket cost may likely be greater than the *co-payment* and/or *co-insurance* you would have paid if you had used a *network pharmacy*.

Claims for reimbursement of *prescription drug*s are to be submitted to SelectHealth at:

SelectHealth
Pharmacy Services
P.O. Box 30192
Salt Lake City, Utah 84130-0192

B. Co-Payments and Co-Insurance

The *co-payment* and/or *co-insurance* is applied to each covered *pharmacy prescription drug* charge and is shown in the Schedule of Prescription Drug Benefits.

For *employees* working in the Treasure Valley and their covered dependents, any one prescription purchased through a St. Luke's Employee Outpatient Pharmacy is limited to a ninety (90) day supply. Any one prescription purchased through a SelectHealth participating *pharmacy* is limited to a fifteen (15) day supply.

The maximum quantity limit for retail prescriptions is a ninety (90) day supply for *employees* who work outside the Treasure Valley and their covered dependents.

All Specialty Medications must be filled through a St. Luke's Outpatient Pharmacy or through the Intermountain Home Delivery Pharmacy unless otherwise approved in writing in advance by SelectHealth.

For specialty *prescription drug*s under the PPO Plan, the *participant* will pay a $200 maximum *co-payment* per thirty (30) day supply. If a ninety (90) day supply is allowed, the *co-payment* will be $600 (3 times $200).

C. Percentages Payable

The percentage payable amount is applied to Brand Formulary and Brand Non-Formulary for each covered *pharmacy* drug charge and is shown in the Schedule of Prescription Drug Benefits. This amount is not an *eligible expense* under the medical *Plan*.

D. Maintenance Drugs

For newly prescribed maintenance drugs, a thirty (30) day supply will be covered. Once it is determined that a *prescription drug* can be tolerated, a ninety (90) day supply will be covered. Established maintenance drug prescriptions are covered based on the limitations stipulated in the Schedule of Prescription Drug Benefits.

E. Covered Prescription Drugs

1. All drugs prescribed by a *physician* that require a prescription either by Federal or state law, excluding any drugs stated as not covered under this *Plan.*
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Insulin and other diabetic supplies when prescribed by a *physician.*
4. Oral Contraceptives.
5. Medically certified prescriptions for drugs to treat erectile dysfunction will be covered to nine (9) doses per thirty (30) days or whatever the established current standard. The *Plan* will only pay for the preferred drug(s) in this drug class (e.g. Levitra).
6. Under the PPO Plan, tobacco/smoking cessation coverage is limited to a one hundred and eighty-two (182)-day supply per *plan year* and will be covered at no cost to the member. Smoking cessation drugs eligible for coverage are listed on the Preferred Drug List maintained by the *Plan Administrator.*

F. Limits to Prescription Drug Benefits

This benefit applies only when a *participant* incurs a covered *prescription drug* charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a *physician.* Refills are allowed after 80% of the last refill has been used for a 30-day supply, and 50% for a 10-day supply.
2. Refills up to one year from the date of order by a *physician.*

Refer to the Preferred Drug List Maintained by the *Plan Administrator* for additional exclusions and limitations.

G. Expenses Not Covered

This benefit will not cover a charge for any of the following:

1. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
2. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed except for certain immunizations administered at the pharmacy.
3. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
4. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
5. **Experimental/Investigational.** *Experimental/investigational* drugs and medicines, even though a charge is made to the *participant.* A drug or medicine labeled: "Caution - limited by Federal law to *investigational* use".

6. **FDA.** Any drug not approved by the Food and Drug Administration.
7. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
8. **Immunization.** Immunization agents or biological sera.
9. **Infertility.** A charge for infertility medication.
10. **Injectable Supplies.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than for insulin).
11. **Inpatient medication.** A drug or medicine that is to be taken by the *participant*, in whole or in part, while *hospital* confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
12. **Medical Exclusions.** A charge excluded under Medical Plan Expenses Not Covered section.
13. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, State or Federal programs.
14. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
15. **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
16. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.
17. Charges incurred for *prescription drugs* excluded from coverage by St. Luke's Pharmacy and Therapeutics Committee and PBM Committee will not be covered. Changes to the exclusion list may occur at any time during the *plan year* as so determined by either committee.

Please refer to the Preferred Drug List maintained by the *Plan Administrator* for additional exclusions and limitations.

S CTI — TAL BENEF S

The Dental *Claims Administrator* is Delta Dental. All dental benefits are administered by Delta Dental. Contact Delta Dental at (208) 489-3580 or visit www.deltadental.com for information related to dental benefits.

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Claims Administrator pertaining to payment for dental c

10. **Orthodontia or Orthodontic Treatment** shall mean the means of active orthodontic appliances in order to correc of the teeth).

11. **Predetermination of Benefits** shall mean a *Dentist* Rep satisfactory to the Dental *Claims Administrator* that:
    a. itemizes the dental procedures required for the
    b. lists the charges for each procedure; and
    c. must be accompanied by supporting preoperat diagnostic materials reasonably required by th

B. Schedule of Dental Benefits

The dental benefits of this *Plan* shall be provided when a Dental Plan Coverage Option is specifically elected by the covered *participant* and when *eligible expenses* specifically described in this section are incurred for services rendered to a *participant* after 12:00 a.m. on the first day of such *participant*'s participation under the *Plan* and before 11:59 p.m. of the last day of such *participant*'s participation under the *Plan* as follows:

1. For full dentures or partial dentures, the date the final impression is taken;
2. For fixed bridges, crowns, inlays or onlays, on the date the teeth are first prepared;
3. For root canal therapy, on the latter of the date the pulp chamber is opened or the date canals are explored to the apex;
4. For periodontal surgery, on the date the surgery is actually performed;
5. For all other services other than orthodontic services, on the date the service is performed;
6. For orthodontic services, on the date any bands or other appliances are first inserted.

Dental benefits are payable for the *maximum allowance* actually incurred by or on behalf of a *participant* for the following services and supplies when deemed necessary by a licensed *dentist* for the treatment and/or prevention of dental *injury* and disease. Dental *eligible expenses* incurred from a contracting *dentist* shall be covered at the rates as set forth under the Dental Eligible Expenses section and the Schedule of Dental Benefits. Dental *eligible expenses* incurred from a non-contracting *dentist* shall be covered at the rates as set forth under the Dental *eligible expenses* and the Schedule of Dental Benefits but only up to the *maximum allowance*, and are subject to *balance billing*.

Dental Benefit Deductibles

The *deductible*s for types II and III services are set forth in the Schedule of Dental Benefits. For purposes of determining the family *deductible* amount, such family *deductible* amount shall be deemed to be satisfied if one or a combination of family members, singly or in the aggregate, meets the *deductible* amount.

Maximum Benefits (per individual)

Annual Maximum per *participant* when treatment is rendered by a participating Delta Dental PPO contracting *dentist*	$1,200
Annual Maximum per *participant* when treatment is rendered by a non-PPO contracting *dentist*	$1,000
Lifetime Orthodontia Maximum per *participant* under Dental Plan Option II	$1,000

C. Dental Eligible Expenses

The following is a listing of dental *eligible expenses* covered under the *Plan*. These benefits will be covered as set forth in the Schedule of Dental Benefits, provided such charges are not in excess of the *maximum allowance* per *participant*:

Type I – Preventive & Diagnostic Services

The following is a list of dental *eligible expenses* payable without needing to satisfy the dental *deductible*.

1. Oral examination – limited to one examination every six (6) months;
2. Emergency oral examination for trauma, acute infection, or acute pain;
3. Complete mouth survey or panoramic X-ray – limited to one (1) time every five (5) years (includes bitewings and 10 to 14 periapical x-rays);

4. Individual periapical X-rays, but not to exceed the *maximum allowance* and limited to the expense of a complete mouth series;
5. Occlusal and Extraoral x-rays – limited to twice every twelve (12) months;
6. Bitewing x-rays – limited to once every twelve (12) months;
7. Dental prophylaxis – limited to once every six (6) months;
8. Fluoride treatments – limited to two (2) applications every twelve (12) months and limited to *Participant*s who are dependent children under age nineteen (19);
9. Topical fluoride therapy treatment – allowed twice in twelve (12) months following periodontal surgery for *participants* age nineteen (19) and over;
10. Topical application of sealants per tooth – limited to permanent, posterior, un-restored dentition. Also limited to one (1) time per posterior tooth every two (2) years, under age nineteen (19);
11. Space maintainers – limited to *Participants* who are dependent children under age fourteen (14). Includes all adjustments made within six (6) months of installation.

D. Type II – Basic Benefits

The following is a list of dental *eligible expenses* payable after the *deductible* is satisfied, if applicable, at the rates set forth in the Schedule of Dental Benefits, up to the *maximum allowance*. Refer to the expenses entitled "Restorative" in the Schedule of Dental Benefits for *deductible* information.

1. Palliative treatment – paid as a separate benefit only if no other service is rendered during the visit (except x-rays, exam, and/or any treatment specific to diagnose the emergency condition);
2. Amalgam/resin-composite restorations – posterior restoration surfaces will be combined on same-tooth surfaces; same tooth restoration is covered once in two (2) year period. Posterior resin-composite restorations will be monitored for replacement of Amalgams;
3. Inlay restoration is not fully covered and benefit is paid to the corresponding filing code, with the remaining amount being the *participant*'s responsibility;
4. Silicate and composite restorations;
5. Biopsy of soft or hard oral tissue;
6. Simple extractions;
7. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue;
8. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of tooth (extraction of tooth, partial bony impaction);
9. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction);
10. Impaction that requires incision of overlying tissue, elevation flap, removal of bone, sectioning of tooth for removal, and/or presents unusual difficulties and circumstances;
11. Root recovery;
12. Excision of pericoronal tissues;
13. Tooth reimplantation;

14. Alveoloplasty and alveolectomy - not separately payable if performed on the same date as extraction;
15. Removal of exostosis;
16. Frenectomy (frenulectomy);
17. Excision of hyperplastic tissue;
18. Incision and drainage;
19. Oral Surgery - Removal of teeth and surgical extractions. Treatment of minor pathological conditions;
20. General anesthesia – first thirty (30) minutes covered in conjunction with Oral Surgery;
21. Intravenous Sedation – first thirty (30) minutes covered in conjunction with Oral Surgery;
22. Occlusal adjustment – covered when performed on an emergency basis with no other submitted, routine procedures;
23. Pulpotomy – covered on primary teeth only;
24. Root canal therapy – twenty-four (24) month limit for retreatment;
25. Apicoectomy and retrograde filling – twenty-four (24) month limit for retreatment;
26. Hemisection;
27. Scaling and root planing (periodontal therapy) – Each quadrant of the mouth, limited to once every two (2) years; with at least four (4) or more teeth with four (4) mm pocket depths per quadrant;
28. Periodontal maintenance – limited to once in a six (6) month period. To be eligible, at least six (6) months must have elapsed since the last periodontal therapy or prophylaxis was performed. To be covered, periodontal therapy must be in the patient's immediate history and is defined as any of the following procedures: gingivectomy, mucogingival surgery, osseous surgery, osseous grafts, scaling and root planing; this means some form of periodontal therapy had to be performed or the periodontal maintenance will not be fully covered;
29. Periodontic surgical procedures for treatment of the issues supporting the teeth are covered once every three (3) years, per quadrant of the mouth. Services covered include subgingival curettage, gingivectomy, osseous surgery and mucogingival surgery'
30. Repairs to full dentures – limited to repairs or adjustments allowed once per arch within twenty-four (24) months;
31. Recementation of all prosthetics;
32. Repairs to partial dentures – limited to repairs or adjustments allowed once per arch within twenty-four (24) months;
33. Repairs to bridges - to repairs or adjustments allowed once per arch within twenty-four (24)months;
34. Repairs to crowns – allowed once per prosthetic within twenty-four (24)months;
35. Denture adjustments – one adjustment allowed in a twelve (12) month period and only if performed more than six (6) months after the insertion of the denture.

E. **Type III – Major Benefits**

The following is a list of dental *eligible expenses* payable after the *deductible* is satisfied, if applicable, at 50% of charges provided not in excess of the *maximum allowance*. Refer to the expenses entitled "Prosthodontics" in the Schedule of Dental Benefits for *deductible* information. All benefits for the services listed in this subsection (c) include an allowance for all temporary restorations and appliances and for one year follow-up care:

1. Night Guards – limited to one appliance every twenty-four (24) months.
2. Crown build-up – substructures are only a benefit when necessary to retain a cast restoration due to extensive loss of tooth structure from decay or fracture and are subject to a twenty-four (24)month time limitation.
3. Tissue conditioning – limited to repairs or adjustments allowed twice per arch within thirty-six (36) months.
4. Crowns and Onlays (whether they are gold, porcelain, gold substitute castings or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of tooth decay). Crowns, stainless steel crowns, onlays or laminate veneers on the same teeth are covered, only if, more than seven (7) years have elapsed since the last placement; for dependent children under age twelve (12), benefits are limited to composite or stainless steel crown. If a tooth can be restored with a material such as amalgam or composite resin but another type of restoration is selected by the patient and *dentist*, *eligible expense* will be limited to the cost of amalgam or composite.
5. Post and core; substructures are only a benefit when necessary to retain a cast restoration due to extensive loss of tooth structure from decay or fracture and are subject to a twenty-four (24) month time limitation.
6. Full dentures – includes all adjustments within six months of installation. Replacement of a denture is covered only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for immediate or customized dentures.
7. Partial dentures – includes all clasps and rests, all teeth, and all adjustments within six (6) months of installation. Replacement of a partial denture with another denture or fixed bridgework is eligible for benefits only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for precision or semi-precision attachments.
8. Relining dentures – limited to relining done more than six (6) months after the initial insertion, and not more than one time in any twenty-four (24)-consecutive-month period except for immediate dentures; which can be relined once after a three (3) month of the initial insertion and not more than one time in any twenty-four (24)months from last date performed.
9. Fixed bridges – Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than seven (7) years old and cannot be repaired.
10. Maryland bridge – Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than seven (7) years old and cannot be repaired.
11. Implants – Each tooth has a onetime benefit for the implant body, abutment and prosthesis up to $900 within the *Plan* designs annual maximum. Replacement of the prosthesis (crown or bridge) is covered once in a seven (7) year period for ages nineteen (19) years and over.

F. Type IV – Orthodontic Services

The following services are only covered under Dental Plan Option II as set forth in the Schedule of Dental Benefits:

Orthodontia or Orthodontic Treatment means the movement of teeth through bone or means of active orthodontic appliances in order to correct a patient's malocclusion (misalignment of teeth). Benefits are only available after the *participant* has been continuously enrolled in the Dental Plan Option II for twelve (12) months.

G. Dental Exclusions and Limitations

Coverage for the following services is excluded under the *Plan*:

1. Those expenses not included in the list of dental *eligible expenses*; or that are not *medically necessary* for the care of a *participant*'s dental condition; or that do not have uniform professional endorsement; or that are *experimental* and/or *investigational* in nature;
2. For cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam, silicate or composite fillings);
3. For replacement of an existing crown, inlay or onlay that was installed within the immediately preceding seven (7) years or replacement of an existing crown, inlay or onlay that can be repaired;
4. For appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion;
5. For partial or full removable denture or fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the immediately preceding seven (7) years;
6. For orthodontic services and supplies unless otherwise specifically set forth in the list of dental covered services and provided for under Dental Plan Option II;
7. For replacement of lost or stolen appliances;
8. Tooth transplantation;
9. Periodontal splinting procedures;
10. For any procedure, services or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible;
11. For any procedure, service or supply required directly or indirectly to treat a muscular, neural, orthopedic or skeletal disorder, dysfunction or disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome;
12. For orthognathic surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw;
13. General anesthesia and/or Intravenous Sedation in conjunction with Periodontal Surgery;
14. For temporary dental services. Charges for temporary services are considered an integral part of final dental service and are not separately payable;
15. For any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by the Dental *Claims Administrator*;

16. For myofunctional therapy, biofeedback procedures, precision or semi-precision attachments, denture duplications, oral hygiene instructions, treatment of jaw fractures; charges for acid etching;
17. In excess of *maximum allowance*;
18. For *hospital inpatient* services or *outpatient services* for extraction of teeth or other dental procedures;
19. Not prescribed by or upon the direction of a *dentist* or other recognized provider;
20. Provided for work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any Workers' Compensation, Employer's Liability Law, or Occupational Diseases Law, even if the *participant* does not claim those benefits;
21. Provided or paid for by any Federal governmental entity or unit except when payment under this *Plan* is required by Federal law, or provided or paid for by any State or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this *Plan*; or
22. For which payment has been made under *Medicare* Part A or would have been made if the *participant* had applied for such payment except when payment under this *Plan* is expressly required by law; or
23. For which payment has been made under *Medicare* Part B except when payment under this *Plan* is required by Federal law;
24. Provided for any condition, *accidental injury*, disease or *illness* suffered as a result of any act of war or any war, declared or undeclared;
25. For services intended mainly to improve appearance except for services necessary to treat an *accidental injury*, infection or other disease of the involved part;
26. Rendered prior to the *participant's* effective date of coverage for dental benefits;
27. For personal hygiene, comfort, beautification or convenience items even if prescribed by a *dentist*, including but not limited to, air conditioners, air purifiers, humidifiers, or athletic mouth guards;
28. For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a *dentist*;
29. For the treatment of *injuries* sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation;
30. For treatment or other health care of any *participant* in connection with an *illness*, disease, *accidental injury* or other condition which would otherwise entitle the *participant* to services under this *Plan*, if and to the extent those benefits are payable to or due the *participant* under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar policy of insurance, contract or underwriting plan;
31. In the event the Dental *Claims Administrator* for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated *provider*, *participant*, and the *participant's* heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the *participant* or his or her estate for such services, supplies, drugs or other charges so provided by Dental *Claims Administrator* in connection with such *illness*, disease, *accidental injury* or other condition;

32. Any services or supplies for which a *participant* would not have legal obligation to pay in the absence of coverage under this *Plan*; or for which no charge or a different charge is usually made in the absence of coverage;
33. Claims submitted more than twelve (12) months after the date the service is rendered;
34. Diagnostic casts; or
35. Pulp cap (direct or indirect) – inclusive with the fee for restoration.

H. **Predetermination of Benefits**

A *participant's dentist* should submit a Predetermination of Benefits to the Dental *Claims Administrator* prior to treating the *participant* for any of the following procedures:

1. crowns,
2. implants,
3. bridgework,
4. laminate veneers,
5. full or partial dentures,
6. periodontal surgery, or
7. surgical removal of impacted teeth.

A Predetermination of Benefits must be accompanied by supportive preoperative x-rays and any other appropriate diagnostic materials requested by the Dental *Claims Administrator* or its dental consultants.

The Dental *Claims Administrator* will notify the *participant* and his or her *dentist* of the benefits available based upon the Predetermination of Benefits. In determining the amount of benefits available, the Dental *Claims Administrator* shall consider whether alternate procedures would accomplish a professional satisfactory result. If the charges or fees for the treatment chosen by the *participant* and his or her *dentist* exceed the charges or fees for the treatment that the Dental *Claims Administrator* has determined will accomplish a professionally satisfactory result, the Dental *Claims Administrator* will only provide benefits based on the charges or fees for such less costly treatment. A Predetermination of Benefits is valid for three (3) months from the date it is issued. After three (3) months a Predetermination of Benefits should be resubmitted for a new Predetermination of Benefits before treatment begins.

If a *participant* submits a claim for completed treatment that includes services in the above-listed categories or Class III services, and benefits have not been predetermined by the Dental *Claims Administrator*, the claim will be reviewed in the same manner as if it were submitted for a Predetermination of Benefits. The Dental *Claims Administrator* shall consider whether alternate procedures would have accomplished a professionally satisfactory result. If the *participant* and his or her *dentist* have chosen a more expensive method of treatment than is determined professionally satisfactory to the Dental *Claims Administrator*, the excess charge will be solely the responsibility of the *participant*.

SECTION XIV—CLAIMS AND APPEALS

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decide the Appeal and, if the Appeal is denied, provide *notice* to the *claimant* within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the *Plan's* procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days. If you have any questions regarding this procedure, please contact the *Third Party Administrator*.

In addition to italicized terms defined in the *Plan* document, this section uses the following defined terms:

A. Administrative Consistency

The *Third Party Administrator* will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of the Plan and that its provisions have been applied consistently with respect to similarly situated Claimants.

B. Definitions

Adverse Benefit Determination

Any of the following: a Rescission of coverage or a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under SelectHealth Healthcare Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

Appeal

Review by **the *Third Party Administrator*** of an Adverse Benefit Determination or the negative outcome of a Pre-Service Inquiry.

Assignment of Benefits

Form under which a *provider* obtains the right to direct reimbursement from the *Plan* for services rendered by the *provider*.

Authorized Representative

Someone you have designated to represent you in the Claims or Appeals process. To designate an authorized representative a *claimant* must provide written authorization on a form provided by the *Plan*, and clearly indicate on the form the nature and extent of the authorization. However, where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Benefit Determination

The decision by the *Third Party Administrator* regarding the acceptance or denial of a claim for Benefits.

Claimant

A claimant is any *participant* or beneficiary making a claim for benefits. Claimants may file claims themselves or may act through an *authorized representative*. In this document, the words "you" and "your" are used interchangeably with claimant.

Concurrent Care Decision

Decisions by the *Third Party Administrator* regarding coverage of an ongoing course of treatment that has been approved in advance.

External Final

A review by an outside entity, at no cost to the Member, of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Third Party Administrator* at completion of the *Third Party Administrator* 's internal appeals procedures; or an *adverse benefit determination* for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule contained in the appeals regulations.

Independent Review Organization

An Independent Review Organization is an entity that performs independent external reviews of *adverse benefit determination*s and *final internal adverse benefit determinations*

Notice/Notify/Notification

The terms notice, notify or notification refer to the delivery or furnishing of information to a *claimant* as required by Federal law.

Post-Service Appeal

A request to change an a*dverse benefit determination* for services you have already received.

Post-Service Claim

A post-service claim is any claim for a benefit under the *Plan* related to care or treatment that the *participant* or beneficiary has already received.

Pre-Service Appeal

A request to change an *adverse benefit determination* on a Pre-Service Claim.

Pre-Service Claim

A Pre-Service claim is any claim that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan*. For example, a request for *pre-certification* under the Health Care Management Program is a Pre-Service claim.

Urgent Care Claim

An urgent care claim is any claim for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *Pre-Service claims.*

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information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of Benefits to allow you to Appeal and obtain a determination before the Benefit is reduced or terminates.

E. **Filing Post-Service Claims**

In order to file a *post-service claim*, you or your *authorized representative* must submit the claim in writing on a form pre-approved by the *Third Party Administrator*. All claims must be received by the *Third Party Administrator* within a twelve (12) month period from the date of the expense and must include the following information:

1. the *participant's* name, Social Security number and address;
2. patient's name, Social Security number and address if different from the *participant's*;
3. *provider's* name, tax identification number, address, degree and signature;
4. date(s) of service;
5. diagnosis;
6. procedure codes (describes the treatment or services rendered);
7. *assignment of benefits*, signed (if payment is to be made to the *provider*);
8. release of information statement, signed;
9. coordination of benefits (COB) information if another plan is the primary payor; and
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*.

Send complete information:

for medical and pharmacy Claims to :

SelectHealth
5381 Green Street
Murray, UT 84123

for dental Claims to:

Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701

for vision Claims to:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

How to Make a Pre-Service Inquiry.

Pre-Service Inquiries should be directed to SelectHealth Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038. A Pre-Service Inquiry is not a claim for Benefits.

F. Status of Benefit Verifications

Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not claims for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular claim will be paid. Benefits are determined by the *Third Party Administrator* at the time a formal claim for benefits is submitted according to the procedures outlined above.

G. Notification of Benefit Determinations

The *Third Party Administrator* will notify you or your *authorized representative* of its *benefit determinations* as follows:

Urgent care claims:

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claim. However, if the *Third Party Administrator* gives you *notice* of an incomplete claim, the *notice* will include a time period of not less than forty-eight (48) hours for you to respond with the requested specified information. The *Third Party Administrator* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of: receipt of the specified information, or the end of the period of time given you to provide the information. If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a *concurrent care decision*, *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but not later than twenty-four (24) hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least twenty-four (24) hours before the prescribed period of time expires or the prescribed number of treatments ends.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to *claimant* of Claim determination	**72 hours**
Insufficient information on the Claim, or failure to follow the *Plan's* procedure for filing a Claim:	
Notification to *claimant*, orally or in writing	**24 hours**
Response by *claimant*, orally or in writing	**48 hours**
Benefit determination, orally or in writing	**48 hours**
Notification of *adverse benefit determination* on Appeal	**72 hours**

Concurrent Care Claims

A concurrent care claim is a special type of Claim that arises if the *Third Party Administrator* informs a *claimant* that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the *Third Party Administrator* must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to *Plan* amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to ***claimant*** of benefit reduction	**Sufficiently prior to scheduled termination of course of treatment to allow *claimant* to appeal**
Notification to *claimant* of rescission	**30 days**
Notification of determination on Appeal of an Urgent *Concurrent Care Claims*	**72 hours (provided *claimant* files Appeal more than 24 hours prior to scheduled termination of course of treatment)**
Notification of *adverse benefit determination* on Appeal for non-Urgent Claims	**As soon as feasible, but not more than 30 days**
Notification of *adverse benefit determination* on Appeal for Rescission Claims	**30 days**

Other Pre-service claims:

Notice of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim. However, this period may be extended one time by the *Third Party Administrator* for up to an additional fifteen (15) days if the *Third Party Administrator* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the *Third Party Administrator* expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the *notice* of extension will specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the *notice* to provide the specified information.

Notice of an *adverse benefit determination* regarding a *concurrent care decision* will be provided sufficiently in advance of any termination or reduction of benefits to allow you to appeal and obtain a determination before the benefit is reduced or terminates.

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receipt of the claim. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination.*

In the case of a Post-Service Claim, the following timetable applies:

Notification to *claimant* of *adverse benefit determination*	**30 days**
Extension due to matters beyond the control of the *Plan*	**15 days**
Extension due to insufficient information on the Claim	**15 days**
Response by *claimant* following notice of insufficient information	**45 days**
Notification of *adverse benefit determination* on Appeal	**30 days per appeal**

H. Notification of Adverse Benefit Determination

If a Claim is denied in whole or in part, the denial is considered to be an *adverse benefit determination.* Except with *urgent care claims*, when the *notification* may be oral followed by written or electronic *notification* within three (3) days of the oral *notification*, the *Plan Administrator* shall provide written or electronic *notification* of the *adverse benefit determination.* The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. Identification of the claim, including date of service, name of *provider*, claim amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request;
2. the specific reason(s) for the *adverse benefit determination*, including the denial codes and its corresponding meaning, and the *Plan's* standard, if any, used in denying the claim;
3. reference to the specific *Plan* provisions on which the determination was based;
4. a description of any additional information or material needed from you to complete the claim and an explanation of why such material or information is necessary;
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental or investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request;
7. if an *urgent care claim* was denied, a description of the expedited review process applicable to the claim;
8. a description of the *Plan's* review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under *ERISA* §502(a) with respect to any claim denied after an appeal; and

9. information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable Federal law to assist individuals with the internal claims and appeals and external review process.

I. Appeals

General Procedures

You may appeal any *adverse benefit determination* to the *Third Party Administrator*. As the delegated claims review fiduciary under the Plan, the *Third Party Administrator* will conduct a full and fair review of your Appeal. When a *claimant* receives *notification* of an *adverse benefit determination*, the *claimant* generally has one hundred eighty (**180**) days following receipt of the *notification* in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the *claimant* must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the *claimant* must file the Appeal within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the Claim.

The *Third Party Administrator* will conduct a full and fair review of all benefit appeals, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, including your claim file. You will also have the opportunity to submit to the *Third Party Administrator* written comments, documents, records and other information relating to your claim for benefits. You may also present evidence and testimony should you choose to do so; however a formal hearing may not be allowed. The *Third Party Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the *benefit determination*;
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with *Plan* documents and *Plan* provisions have been applied consistently with respect to all *claimants*; or
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit.

The period of time within which a *benefit determination* on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before SelectHealth issues its *final* internal *adverse benefit determination* based on any new or additional evidence or rationale, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate SelectHealth will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither

Post-service claims:

Appeals of *post-service claims* will be decided by the *Third Party Administrator* within a reasonable period of time, but not later than thirty (30) days after the *Plan Administrator* receives the appeal. The *Third Party Administrator's* decision will be provided to you in writing.

K. Notification of Appeal Denials

If your appeal is denied, the *Plan Administrator's* written *notification* will include:

1. Identification of the claim, including date of service, name of *provider*, claim amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request;
2. the specific reason(s) for the *adverse benefit determination*, including the denial codes and its corresponding meaning, and the *Plan's* standard, if any, used in denying the claim;
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based;
4. A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim. You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
6. if the denied appeal was based on a *medical necessity*, *experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
7. a statement describing any additional appeal procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under *ERISA* §502(a); and
8. information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable Federal law to assist individuals with the internal claims and appeals and external review process.

Notification of the decision on an *urgent care claim* may be provided orally, but a follow-up written *notification* will be provided no later than three (3) days after the oral *notice*.

L. Second Level Appeal

In addition to the Claims and Appeals Procedures described above, the *Plan* permits voluntary dispute resolution procedures. If a *claimant* agrees to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The *Plan* will not assert that a *claimant* has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the *Third Party Administrator*. A *claimant* may elect a voluntary appeal after receipt of a *final* internal *adverse benefit determination*.

The *Third Party Administrator* will provide to the *claimant*, at no cost and upon request, sufficient information about the voluntary appeal to enable the *claimant* to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the *claimant*'s rights to any other benefits under the *Plan*; will list the rules of the appeal; state the *claimant*'s right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the *claimant* as part of the voluntary level of appeal, and the *claimant* will be told this.

M. **Optional Internal Third Level Appeal for medical and pharmacy claims**

If you are dissatisfied with the decision under the Second Level Appeal for medical or pharmacy Claims, you may request further consideration of your appeal. Such a request must be made in writing to SelectHealth within 60 days of the date you are notified of the decision under the Second Level Appeal. SelectHealth will notify you of the result of the Third Level Appeal in writing within 30 days of the date you requested the review.

Electing to have the optional internal Third Level Appeal does not prevent you from pursuing an External Review. However, if you choose to pursue a voluntary External Review, you may not pursue the optional internal third level appeal later.

N. **External Review Rights**

If your final appeal for a claim is denied, you will be *notified* in writing that your claim may be eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. You must complete all mandatory levels of the internal claims and appeal procedure before you can request a voluntary external review.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the *Plan* document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the *Third Party Administrator*, and the *Plan*.

O. **External Review for Medical and Pharmacy Claims**

The External Review process is available for medical and pharmacy claims only where the *final* internal *adverse benefit determination* is denied on the basis of (1) a medical judgment (which includes but is not limited to, *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is *experimental* or *investigational*, or (3) a rescission of coverage. If your appeal is denied, you or your *authorized representative* may request further review by an *independent review organization* (IRO). This request for external review must be made, in writing, within 180 days of the date you are notified of an *adverse benefit determination* or final internal *adverse benefit determination*. This external review is mandatory, i.e., you are required to undertake this external review before you may pursue civil action under Section 502(a) of *ERISA*.

"External Review" means a review of an *adverse benefit determination*, including a *final internal adverse benefit determination* under applicable State or Federal external review procedures.

Within five (5) business days following the date of receipt of the external review request, SelectHealth will complete a preliminary review of the request to determine whether:

a. The *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided;

b. The *adverse benefit determination* or the final internal *adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health *Plan* (e.g., worker classification or similar determination);

c. The *claimant* has exhausted the *Plan's* internal appeal process; or

d. The *claimant* has provided all the information and forms required to process an external review.

SelectHealth will notify the *claimant* within **one (1) business day** of completion of its preliminary review if:

a. the request is complete but not eligible for external review, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272));

b. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for external review within the four-month filing period, or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later.

NOTE: If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the external review process, and no external review may be taken.

If the request is complete and eligible, the *Plan Administrator* will assign the request to an IRO. Once that assignment is made, the following procedure will apply:

a. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the *Plan*.

b. The assigned IRO will timely notify the *claimant* in writing of the request's eligibility and acceptance for external review. This *notice* will include a statement that the *claimant* may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the *notice* additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

c. Within five (5) business days after the date of assignment of the IRO, the *Plan* must provide to the assigned IRO the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the external review. If the *Plan* fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. Within one (1) business day after making the decision, the IRO must notify the *claimant* and the *Plan*.

d. Upon receipt of any information submitted by the *claimant*, the assigned IRO must within one (1) business day forward the information to SelectHealth. Upon receipt of any such information, SelectHealth may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the external review. Reconsideration by SelectHealth must not delay the external review. The external review terminated as a result of the reconsideration only if SelectHealth decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment.

Within one (1) business day after making such a decision, SelectHealth must provide written *notice* of its decision to the *claimant* and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the *notice* from the *Plan*.

e. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

    i. The *claimant's* medical records;

    ii. The attending health care professional's recommendation;

    iii. Reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating *provider*;

    iv. The terms of the *claimant's Plan* to ensure that the IRO's decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law;

    v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

    vi. Any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law; and

    vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available.

f. The assigned IRO must provide written *notice* of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the *notice* of final external review decision to the *claimant* and the *Plan*.

g. The assigned IRO's decision *notice* will contain:

    i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the *health care provider*, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);

    ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

    iii. The references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

    iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

    v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health *Plan* or to the *claimant*;

    vi. A statement that judicial review may be available to the *claimant*; and

    vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

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SECTION XV—MAINTENANCE OF BENEFITS

A. Maintenance of the Benefit Plans

Maintenance of benefits sets out rules for the order of payment of *eligible expenses* when two or more plans, including *Medicare*, are paying. When a *participant* is covered by this *Plan* and another plan, the plans will coordinate benefits when a claim is received.

Maintenance of Benefits

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary plan will pay up to its own plan formula minus the amount paid by the primary plan.

B. Benefit Plan

This provision will coordinate the medical and dental or vision benefits of a benefit plan. The term benefit plan means this *Plan* or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Group practice and other group prepayment plans.
3. Federal government plans or programs. This includes but is not limited to, *Medicare* and Tricare.
4. Other plans required or provided by law. This does not include *Medicaid* or any benefit plan like it that, by its terms, does not allow coordination.
5. *No Fault auto insurance*, by whatever name it is called, when not prohibited by law.

C. Allowable Charge

For a charge to be allowable it must be a *reasonable and customary amount* and at least part of it must be covered under this *Plan.*

In the case of HMO (Health Maintenance Organization) or other *network* only plans: This *Plan* will not consider any charges in excess of what an HMO or *network provider* has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *participant* does not use an HMO or *network provider*, this *Plan* will not consider as an allowable charge any charge that would have been covered by the HMO or *network* plan had the *participant* used the services of an HMO or *network provider.*

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

D. Automobile Limitations

When medical payments are available under vehicle insurance, the *Plan* shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

E. Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the allowable charge:
    a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

    b. The benefits of a benefit plan which covers a person as an employee who is neither laid off or retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off or retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    c. The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a *COBRA* beneficiary.

    d. When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
        1) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

        2) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

    e. When a child's parents are divorced or legally separated, these rules will apply:
        1) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

        2) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

        3) This rule will be in place of items (1) and (2) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

        4) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

        5) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of allowable charges when paying secondary.

3. *Medicare* will pay primary, secondary or last to the extent stated in Federal law. When *Medicare* is to be the primary payer, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make reasonable assumptions based on published *Medicare* fee schedules.
4. If a *participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first and this *Plan* will pay second.
5. The *Plan* will pay primary to Tricare and a State child health plan to the extent required by Federal law.

F. Claims Determination Period

Benefits will be coordinated on a *benefit year* basis. This is called the claims determination period.

G. Right to Receive or Release Necessary Information

To make this provision work, this *Plan* may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or *notice* to any other person. A *participant* will give this *Plan* the information it asks for about other plans and their payment of allowable charges.

H. Facility of Payment

This *Plan* may repay other plans for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

I. Right of Recovery

This *Plan* may pay benefits that should be paid by another benefit plan. In this case this *Plan* may recover the amount paid from the other benefit plan or the *participant*. That repayment will count as a valid payment under the other benefit plan.

Further, this *Plan* may pay benefits that are later found to be greater than the allowable charge. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid.

J. Exception to Medicaid

In accordance with *ERISA*, the *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through *Medicaid* when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *participant* under the *Plan*.

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SECTION XVIII—RESPONSIBILITIES FOR PLAN ADMINISTRATION

A. Plan Administrator

The St. Luke's Health System Employee Health Care Plan is the benefit *Plan* of St. Luke's Health System, Ltd., the *Plan Administrator*, also called the *Plan Sponsor*. It is to be administered by the *Plan Administrator* in accordance with the provisions of *ERISA*. An individual may be appointed by St. Luke's Health System, Ltd., to be *Plan Administrator* and serve at the convenience of the *employer*. If the *Plan Administrator* resigns, dies or is otherwise removed from the position, St. Luke's Health System, Ltd. shall appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* shall administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a *participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* will be final and binding on all interested parties.

Service of legal process may be made upon the *Plan Administrator*.

B. Duties of the Plan Administrator

1. To administer the *Plan* in accordance with its terms.
2. To interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes that may arise relative to a *participant's* rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*.
6. To appoint a *third party administrator* to pay claims.
7. To perform all necessary reporting as required by *ERISA*.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under *ERISA* Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. Plan Administrator Compensation

The *Plan Administrator* serves **without** compensation; however, all expenses for *Plan* administration, including compensation for hired services, will be paid by the *Plan*.

D. Fiduciary

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan* or has discretionary authority or responsibility in the administration of the *Plan*.

E. **Fiduciary Duties**

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the *employees* and their dependent(s), and defraying reasonable expenses of administering the *Plan*. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the *Plan* so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the *Plan* documents to the extent that they agree with *ERISA*.

F. **The Named Fiduciary**

A "named fiduciary" is the one named in the *Plan*. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the *Plan*. These other persons become fiduciaries themselves and are responsible for their acts under the *Plan*. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under *ERISA* in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of *ERISA*.

G. **Third Party Administrator is Not a Fiduciary**

A *Third Party Administrator* is not a fiduciary under the *Plan* by virtue of paying claims in accordance with the *Plan's* rules as established by the *Plan Administrator*.

SECTION XIX—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee and Dependent Coverage

Funding is derived from the funds of the *employer* and contributions made by the covered *employees.*

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction.

Benefits are paid directly from the *Plan* through the *Third Party Administrator.*

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or offer of employment.

C. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a *participant*, if it is requested, the amount of overpayment may be deducted from future benefits payable.

D. Amending and Terminating the Plan

If the *Plan* is terminated, the rights of the *participants* are limited to expenses incurred before termination.

The *employer* intends to maintain this *Plan* indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan* or the Trust agreement (if any).

E. Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this *Plan*, the *Plan* has the right to recover these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the *Plan* has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the *Plan* will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

F. Death or Incompetence

Any benefits otherwise payable to a *participant* following his or her death shall be paid to his or her surviving spouse or to his or her estate if there is no surviving spouse. If the *Plan Administrator* determines that any *participant* is incompetent by reason of physical or mental disability, the *Plan* may cause all benefit payments that thereafter become due to be made to another person for the *participant's* benefit. Payments made to another party because of the *participant's* death or incompetence shall completely discharge any obligation of the *Plan* and the *employer*.

SECTION XX—CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Participants in this *Plan* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (*ERISA*). *ERISA* specifies that all *participants* shall be entitled to:

1. Examine, without charge, at the *Plan Administrator's* office, all *Plan* documents and copies of all documents governing the *Plan*, including a copy of the latest annual report (form 5500 series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain copies of all *Plan* documents and other *Plan* information upon written request to the *Plan Administrator*. The *Plan Administrator* may make a reasonable charge for the copies.
3. Continue health care coverage for a *participant*, spouse, or other dependents if there is a loss of coverage under the *Plan* as a result of a qualifying event. *Employees* or dependents may have to pay for such coverage.
4. Review this summary plan description and the documents governing the *Plan* or the rules governing *COBRA* continuation coverage rights.
5. The *employee* or dependent should be provided a certificate of *creditable coverage*, free of charge, from the group health plan or health insurance issuer when coverage is lost under the *Plan*, when a person becomes entitled to elect *COBRA* continuation coverage, when *COBRA* continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to twenty-four (24) months after losing coverage.

If a *participant's* claim for a benefit is denied or ignored, in whole or in part, the *participant* has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under *ERISA*, there are steps a *participant* can take to enforce the above rights. For instance, if a *participant* requests a copy of *Plan* documents or the latest annual report from the *Plan* and does not receive them within thirty (30) days, he or she may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and to pay the *participant* up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If the *participant* has a claim for benefits which is denied or ignored, in whole or in part, the *participant* may file suit in State or Federal court.

In addition, if a *participant* disagrees with the *Plan's* decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in Federal court.

In addition to creating rights for *participants*, *ERISA* imposes obligations upon the individuals who are responsible for the operation of the *Plan*. The individuals who operate the *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of the *participants* and their beneficiaries. No one, including the *employer* or any other person, may fire a *participant* or otherwise discriminate against a *participant* in any way to prevent the *participant* from obtaining benefits under the *Plan* or from exercising his or her rights under *ERISA*.

If it should happen that the *Plan* fiduciaries misuse the *Plan's* money, or if a *participant* is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the *participant* is successful, the court may order the person sued to pay these costs and fees. If the *participant* loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the *participant* has any questions about the *Plan*, he or she should contact the *Plan Administrator*. If the *participant* has any questions about this statement or his or her rights under *ERISA* including *COBRA* or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that *participant* should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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Co-Payment

A *co-payment* is a specific fixed dollar amount a *participant* is required to pay and is typically payable to the *health care provider* each time services or supplies subject to a co-payment are rendered.

Cosmetic Dentistry

Dentally unnecessary procedures.

Creditable Coverage

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including *COBRA* continuation coverage), HMO membership, an individual health insurance policy, *Medicaid* or *Medicare* or public health plans.

Creditable coverage does not include coverage consisting solely of dental or vision benefits.

Creditable coverage does not include coverage that was in place before a significant break of coverage of sixty-three (63) days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second *COBRA* election period under the Trade Act, does not count.

Custodial Care

Care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible

A specified portion of the *eligible expenses* that must be incurred by a *participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment

Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an *illness* or *injury* and (d) is appropriate for use in the home.

Eligible Expenses

Medically necessary or preventive services or supplies that are covered under this *Plan*.

Employee

A person who is an active regular *employee* of the *employer*, regularly scheduled to work for the *employer* in an employee/*employer* relationship.

Employer

St. Luke’s Health System, Ltd., each Participating Employer, and any successor organization thereto.

Enrollment Date

The first day of coverage or, if there is a waiting period, the first day of the waiting period.

ERISA

Employee Retirement Income Security Act of 1974, as amended.

Experimental/Investigational

Services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval; or
3. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Extended Care Facility

Means any one of the following:

1. A facility owned and operated by a *hospital* or under a written contract with a *hospital*;
2. A distinct part of a *hospital*; or
3. A facility or distinct part of a facility that meets the requirements for approved operation under *Medicare*.

All of the following must be true; the facility must:

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b. It has a full-time administrator;

c. It maintains written records of services provided to the patient; and

d. The staff includes at least one Registered Nurse (R.N.) or nursing care by a Registered Nurse (R.N.) is available.

Home Health Care Plan

A home health care program prescribed in writing by a *participant's* attending *physician* for the care and treatment of the *participant's illness* in that *participant's* home. Such program includes a *physician*'s certification that, in the absence of that program, the *participant's* would require *inpatient* confinement in a *hospital* or *extended care facility*.

Hospice Care

Palliative, supportive, and other related care for a *terminally ill participant* provided by a public or private entity that is licensed or certified as a hospice by *Medicare* and by the State.

Hospice Care Agency

A public agency or private organization which provides or arranges for provision of hospice care to *terminally ill participants* under a written plan which is established and periodically reviewed by the *terminally ill participant's* attending *physician* and by the medical director and interdisciplinary team of the hospice and which meets the requirements of a hospice program as defined by *Medicare*.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Unit

A facility or separate *hospital*, that provides treatment under a *hospice care plan* and admits at least two unrelated persons who are expected to die within six (6) months.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an *inpatient* basis at the patient's expense and which fully meets these tests: it is accredited as a *hospital* by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by *Medicare* as a *hospital*; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of *physicians*; it continuously provides on the premises twenty-four (24)-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the State in which the facility operates.
- A facility operating primarily for the treatment of *substance abuse* if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients; has a *physician* in regular attendance; continuously provides twenty-four (24)-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance abuse*.

Illness

A bodily disorder, disease, physical sickness or *mental disorder*. *Illness* includes pregnancy, childbirth, miscarriage or complications of pregnancy.

Infertility

Incapable of producing offspring.

Injury

An accidental physical injury to the body caused by unexpected external means. All injuries sustained in any one accident shall be considered one injury.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

Refer to the Experimental/Investigational definition above.

Leave of Absence

A leave granted by *employer*, in accordance with the rules uniformly applied to all *employees*, for reasons of health or public service, or for reasons determined by *employer* to be in its best interests and as prescribed by applicable law.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime

A word that appears in this *Plan* in reference to benefit maximums and limitations. Lifetime is understood to mean the maximum accumulated amount that the *Plan* will pay for certain covered services (as allowed by the Affordable Care Act) during a *participant's* lifetime. This may include all amounts paid on behalf of the Member under any prior health benefit plans offered by the Plan Sponsor. If applicable, lifetime maximums are specified in your Schedule of Benefits.

Maximum Allowance

The maximum amount payable for a given service, supply, or procedure, as set forth in a *provider* or facility contract. In the event that the maximum amount payable for a service, supply, or procedure is not governed by a *provider* or facility contract, the maximum allowance is determined by the *Claims Administrator* based on factors including: pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); the *provider's* charges; the charges of *providers* with similar training and experience within the particular geographic area; *Medicare* reimbursement amounts; and/or the cost of rendering the *eligible expense*.

Medicaid

Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Care Facility

A *hospital*, a facility that treats one or more specific ailments or any type of *skilled nursing facility*.

Medical Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medical Plan Coverage Option

The coverage option a *participant* may choose under the *Plan* for medical coverage. The *deductible* amount, out-of-pocket expenses, and other specified items differ with each option as described in Exhibit A.

Medically Necessary (Medical Necessity)

Care and treatment is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or *provider* of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder

Any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity

A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the *participant*.

Network and/or Contracting Provider

With respect to the HealthSave Plan, a *provider* who has signed an agreement with *provider networks* as designated by the *Plan Administrator* pertaining to payment of *eligible expenses* rendered to *participant* who is enrolled in the HealthSave Plan. With respect to the PPO Plan Option, *network* or contracting *provider* means a *provider* who has signed a network agreement with BrightPath. For the purposes of *medically necessary* dental *eligible expenses*, *network* or contracting *provider* includes any *provider* that has a contract with Delta Dental.

Network Facility

With respect to *participants* enrolled in the HealthSave Plan Option, network facility means a St. Luke's Health System facility, or outside a fifty (50)-mile radius of a St. Luke's facility, a network facility means a BrightPath (within Idaho) or MultiPlan facility (in states other than Idaho). With respect to *participants* enrolled in the PPO Plan Option, network facility means a *BrightPath facility*, and as may be updated from time-to-time at the discretion of the *Plan Administrator*.

Network Provider

A *network facility* or *contracting provider*.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network

Services rendered by a non-participating *provider* within the designated *network* area.

Non-Network Facility

A facility that is not a *network facility*.

Out-of-Area

Area outside of the designated *network* area.

Out-of-Pocket Maximum

A *Plan's* limit on the amount a *participant* must pay out of their own pocket for medical expenses incurred during a *benefit year*. Out-of-pocket maximums accumulate on an individual, family, or combined basis. After a member reaches the out-of-pocket maximum, the *Plan* pays benefits at a higher rate. Please note: If a *non-network provider* is used, the *participant* will continue to pay at the out-of-network *co-insurance* level, even if the out-of-pocket maximum has been met, and *balance billing* may apply.

Outpatient

Refer to the Outpatient Care and/or Services definition below.

Outpatient Care and/or Services

Treatment including services, supplies and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory or X-ray facility, an *ambulatory surgical center*, or the patient's home.

Participant

Any *employee* or dependent who is covered under this *Plan*.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the State where he or she practices.

Physician

A physician or person acting within the scope of applicable State licensure/certification requirements and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Medicine (D.M.D), Doctor of Dental Surgery (D.D.S.), Denturist, Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Optometrist (O.D.), Optician, Durable Medical Equipment Supplier, Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychiatrist or Psychologist (Ph.D., Ed.D., Psy.D.), Master of Social Work (M.S.W.), Licensed Professional Counselor (L.P.C.), Audiologist, Physiotherapist, Occupational Therapist, Physician's Assistant, Nurse Practitioner, or Speech Language Pathologist.

Plan

St. Luke's Health System Employee Health Care Plan, which is a benefits plan for certain *employees* of St. Luke's Health System and is described in this document.

Plan Administrator

St. Luke's Health System, Ltd., which is the named fiduciary of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Sponsor

St. Luke's Health System, Ltd.

Plan Year

The twelve (12) month period beginning April 1 and ending March 31. Also see *benefit year*.

Pre-Certification (Pre-Certified)

An evaluation conducted by a *utilization review team* through the Health Care Management Program to determine the *medical necessity* and reasonableness of a *participant's* course of treatment.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under Federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Primary Care Provider

Family practice, internal medicine, obstetrics/gynecology, and pediatrics. All others are considered specialists under the PPO *Plan*.

Provider

A *hospital*, *skilled nursing facility*, urgent care facility, *ambulatory surgical facility*, *home health care agency*, *physician*, or other individual or organization which is duly licensed to provide medical or surgical services, supplies, and accommodations.

Reasonable and Customary/Usual Amount

A charge which is not higher than the usual charge made by the *provider* of the care or supply and does not exceed the usual charge made by most *providers* of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The *Plan* will reimburse the actual charge billed if it is less than the reasonable and customary amount.

The *Plan Administrator* has the discretionary authority to decide whether a charge is reasonable and customary.

Semi-Private Accommodations

A *hospital* or *extended care facility* room containing two or more beds for other than intensive care.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons convalescing from *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of *mental disorders*.
7. It is approved and licensed by *Medicare*.

This term also applies to charges incurred in a facility referring to itself as an *extended care facility*, convalescent nursing home, rehabilitation *hospital*, long-term acute care facility or any other similar nomenclature.

Specialized Treatment Facility

A specialized treatment facility, as the term relates to this *Plan*, includes *birthing centers*, *ambulatory surgical facilities*, *hospice care* facilities, *skilled nursing facilities*, *mental disorder* treatment facilities, *substance abuse* treatment facilities, rehabilitation facilities, and residential treatment facilities.

Substance Abuse

A behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with the *participant's* health, social or economic functioning. Includes services of a licensed *Physician*, Psychiatrist, Psychologist, Marriage, Family, and Child Counselor or Mental Health Counselor holding a license for such services and acting in accordance with that license.

Terminally Ill

A *physician* and the medical director of a hospice have certified in writing to the *Claims Administrator* that a *participant* has a life expectancy of six (6) months or less.

Third Party Administrator

SelectHealth has been hired as the Third Party Administrator by the *Plan Administrator* to perform claims processing and other specified administrative services in relation to the Medical *Plan*. SelectHealth also has been hired as the Third Party Administrator for *outpatient* retail and mail order *prescription drugs* including specialty drugs. SelectHealth is affiliated with Intermountain Healthcare, but is a separate company. SelectHealth's agreement with the Plan does not involve Intermountain Healthcare or any other affiliated Intermountain companies, or their officers or employees. Delta Dental has been hired as the independent Third Party Administrator for the Dental Plan, including eligibility and claims processing/status. VSP has been hired as the independent Third Party Administrator for the Vision Plan, including eligibility and claims processing/status. AmeriBen has been hired as the Third Party Administrator for COBRA administration.

The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a fiduciary of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Travel Network

The group of *providers* that has been selected by the *Plan Administrator* to provide covered services in states other than Idaho.

Total Disability (Totally Disabled)

In the case of a dependent child, the complete inability as a result of *injury* or *illness* to perform the normal activities of a person of like age and sex in good health.

Utilization Review Team

A group of medical care professionals selected by the Health Care Management Program to conduct *pre-certification* review, emergency admission review, continued stay review, discharge planning, patient consultation, and individual benefits management.

SECTION XXII—COMPLIANCE WITH HIPAA PRIVACY STA ARDS

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (as defined below).

A. Compliance with HIPAA Privacy Standards

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these *employees* are permitted to have such access subject to the following:

2. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
3. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training or accreditation of *health care providers*; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities; or population-based activities relating to improving health or reducing health care costs, protocol development and case management and care coordination. *Genetic information* will not be used or disclosed for underwriting purposes.
4. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this HIPAA Privacy section, "members of the *employer's* workforce" shall refer to all *employees* and other persons under the control of the *employer*.
    - a. **Updates Required.** The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    - b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the *Plan*.
    - c. **Resolution of Issues of Noncompliance.** In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

        i. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
        ii. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
        iii. Mitigating any harm caused by the breach, to the extent practicable; and
        iv. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

5. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to:
    a. Not use or further disclose the Protected Health Information other than as permitted or required by the *Plan* documents or as required by law;
    b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the *Plan*, agrees to the same restrictions and conditions that apply to the *employer* with respect to such information;
    c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*;
    d. Report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
    e. Make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the Privacy Standards;
    f. Make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
    g. Make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the Privacy Standards;
    h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the Privacy Standards;
    i. If feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
    j. Ensure the adequate separation between the *Plan* and members of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

6. The following members of St. Luke's Health System, Ltd.'s workforce are designated as authorized to receive Protected Health Information from St. Luke's Health System Employee Health Care Plan ("the *Plan*") in order to perform their duties with respect to the *Plan*:
    a. Director, Benefits/HRIS/Retirement Services
    b. Supervisor, Benefits
    c. Senior Benefits Analyst
    d. Information Technology staff as required by job duties
    e. HRIS staff as required by job duties
    f. Accounting staff as required by job duties
    g. Pharmacy staff as required by job duties
    h. Pharmacy Business Analyst
    i. Other designated individuals approved by the Director, Benefits/HRIS/Retirement Services

B. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the *employer* creates, maintains or transmits on behalf of the *Plan*. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

SECTION XXIII—GENERAL PLAN INFORMATION

A. Type of Administration

The *Plan* is a self-funded group health *Plan* and the claims administration is provided through a T*hird Party Administrator*. The funding for the benefits is derived from the funds of the *employer* and contributions made by covered *employees*. The *Plan* is not insured.

B. Employer

The *employer*'s legal name, address, telephone number, and Federal employer identification number are:

St. Luke's Health System, Ltd.
190 East Bannock Street
Boise, ID 83712
(208) 381-6180
TIN: 56-2570681

C. Plan Name

The name of the *Plan* is St. Luke's Health System Employee Health Care Plan.

D. Plan Number

501

E. Plan Year

The *plan year* is the twelve (12) month period beginning April 1 and ending March 31.

F. Plan Effective Date

April 1, 2014

G. Type of Plan

The *Plan* is commonly known as an *employee* welfare benefit plan. The *Plan* has been adopted to provide *participants* certain benefits as described in this document including Medical, Prescription, Dental and Vision benefits.

H. Plan Funding

The funding for this self-funded *Plan* is derived from the funds of the *employer* and contributions made by covered *employees*.

I. Plan Sponsor

The *employer* is the *Plan Sponsor.*

J. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address and telephone number of the *Plan Administrator* is:

St. Luke's Health System, Ltd.
190 East Bannock Street
Boise, ID 83712
(208) 381-6180

K. Named Fiduciary

St. Luke's Health System, Ltd.
190 East Bannock Street
Boise, ID 83712
(208) 381-6180

L. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* (TPA) to assist the *Plan Administrator* with claims adjudication. The TPA's name, address, and telephone number are:

For Medical and Pharmacy administration:
SelectHealth
P.O. Box 30192
Salt Lake City, Utah 84130-0192
(800) 538-5038

For Dental administration:
Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701
(208) 489-3580

For Vision administration:
VSP
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

For COBRA administration:
AmeriBen/IC Group (AmeriBen)
P.O. Box 7186
Boise, ID 83707
(208) 955-1435 or (866)847-9547

M. Legal Process

The names of the person designated as agent for service of legal process and the address where a processor may serve legal process upon the *Plan* are:

St. Luke's Health System, Ltd.
General Counsel
190 East Bannock Street
Boise, ID 83712

N. Employer's Right to Terminate

The *employer* reserves the right to amend or terminate this *Plan* at any time. A though the *employer* currently intends to continue this *Plan*, the *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *employer* will sign the documents with respect to such amendment or termination.

O. Adoption

St. Luke's Health System, Ltd. hereby adopts the provisions of this *Plan*, and its duly authorized officer has executed this *Plan* document and summary plan description effective the first day of April 2014.

By: Maureen O'Kee [illegible] Date: [illegible] 15

Title: VP & CHRO

Append A - VENTI C S RVICES

Effective April 1, 2014

Preventive Care Services	Adult Men	Adult Women	Pregnant Women	Children
Annual adult physic l exa ination				
Well-baby and well-child examinations				x
Well Women visits for reventative services				
Aortic aneurysm – abdominal ultrasound	x			
Alcohol misuse screening and behavioral counseling interventions				
Anemia (iron deficiency) screening			x	
Aspirin use for the prevention of cardiovascular disease				
Autism/Behavioral Health Screening				x
Bacteriuria (urinary tract infection) screening for asymptomatic women				
Blood pressure screening	x	x		x
Breast cancer screening (mammogram) for those age 40 and over				
BRCA (breast cancer susceptibility) mutation testing, genetic risk assessment and counseling – for women with family risk of breast and ovarian cancer		x		
Breast cancer chemoprevention counseling for women at increased risk				
Breastfeeding supplies and counseling to promote and support breastfeeding for pregnant or nursing women		x	x	
CBC Lab Test				
Cervical cancer screening (pap smear) eligible every 1-3 years between ages 21-30 per discretion of provider and every 3 years from age 30 to 65		x		
Chlamydial infection screenin				
Cholesterol (lipid disorders) screening	x	x		
Colorectal cancer screening eligible over age 50 once ever 5 10 ears				
Contraception methods, sterilization procedures, and patient education and counseling. Excludes abortifacient prescriptions		x		
Dental caries prevention fluoride supplements for children without sufficient fluoride in water source; requires a prescription				
Depression screening	x	x		

Preventive Care Services	Adult Men	Adult Women	Pregnant Women	Children
Depression screening (major depressive)				x
Developmental Child Screening				x
Diabetes screening (type 2) for adults with sustained high blood pressure	x	x		
Domestic and interpersonal violence screening and counseling for women		x	x	
EKG	x	x		
Folic acid supplementation – requires a prescription			x	
Gestational diabetes screening for women 24 to 28 weeks pregnant and at high risk of gestational diabetes			x	
Gonorrhea prophylactic eye medication for newborns				x
Gonorrhea screening		x		
Healthy diet behavioral counseling for adults with hyperlipidemia and other risk factors for cardiovascular and diet-related chronic disease (Limited to once per year)	x	x		
Hearing loss screening for newborns				x
Hemoglobinopathies (sickle cell disease) screening for newborns				x
Hepatitis B screening			x	
HIV screening	x	x	x	x
HPV (Human Papillomavirus DNA testing once every 3 years for women age 30 and older with normal cytology results		x		
Hypothyroidism (congenital) screening for newborns				x
Immunizations recommended by the Center for Disease Control & Prevention (CDC)	x	x		x
Iron supplementation for children age 6-12 months at increased risk				x
Lead Poisoning screening				x
Lipid Disorders for Children				x
Nutritional Counseling (up to 5 annual visits)	x	x	x	x
Obesity screening and counseling	x	x		x
Osteoporosis screening		x		
Pediatric Oral Health Screening				x
Phenylketonuria (PKU) screening for newborns				x
Prostatic specific antigen (PSA) screening eligible at age 50 or at the discretion of the provider based on evidence based on risk factors	x			
Rh(D) incompatibility screening			x	

Preventive Care Services	Adult Men	Adult Women	Pregnant Women	Children
Sexually transmitted infection (STI) prevention counseling	x	x		x
Syphilis screening		x		
Tobacco use counseling	x	x	x	
Visual acuity screening for children younger than age 5				

For more detailed information on these preventive services, including recommended ages, frequencies, and timelines for child and adolescent immunizations, you may refer to **www.healthcare.gov**. or ask your health care *provider*.