

St. Luke's

New Hire
Packet

Treasure Valley

Benefit Plan Year

April 1, 2009 - March 31, 2010

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Group Health Plan Premiums Table

Medical Plans (Non-Tobacco User & Tobacco User)

All rates listed are deducted from each paycheck on a pre-tax basis & are effective April 1, 2009.

Type of Plan Preferred Premium Pricing (Non-Tobacco User)	Full Time Rates 72-80 hours per pay period	Part-Time Level III Rates 56-71 hours per pay period	Part-Time Level II Rates 32-55 hours per pay period
CHOICE			
Self only:	\$ 38.25	\$ 57.50	\$ 78.00
1 Child:	\$ 120.75	\$ 138.75	\$ 156.50
Spouse:	\$ 145.50	\$ 165.50	\$ 185.50
2+ Children:	\$ 209.50	\$ 227.50	\$ 245.50
Spouse + 1 Child:	\$ 222.50	\$ 242.00	\$ 260.25
Spouse + Children:	\$ 230.75	\$ 250.50	\$ 270.25
EPO			
Self only:	\$ 14.75	\$ 27.00	\$ 41.50
1 Child:	\$ 92.25	\$ 105.75	\$ 120.25
Spouse:	\$ 104.50	\$ 119.50	\$ 134.50
2+ Children:	\$ 126.50	\$ 140.25	\$ 154.00
Spouse + 1 Child:	\$ 135.50	\$ 150.25	\$ 165.00
Spouse + Children:	\$ 141.50	\$ 157.25	\$ 172.75
Dual Employee	\$ 73.25	\$ 80.50	\$ 88.00
CATASTROPHIC			
Self only:	\$ 11.75	\$ 20.00	\$ 30.75
1 Child:	\$ 49.00	\$ 56.25	\$ 63.75
Spouse:	\$ 55.25	\$ 63.75	\$ 72.00
2+ Children:	\$ 72.50	\$ 79.50	\$ 86.75
Spouse + 1 Child:	\$ 76.25	\$ 83.75	\$ 91.50
Spouse + Children:	\$ 85.00	\$ 93.25	\$ 101.75
Type of Plan Non-Preferred Premium Pricing (Tobacco User)	Full Time Rates 72-80 hours per pay period	Part-Time Level III Rates 56-71 hours per pay period	Part-Time Level II Rates 32-55 hours per pay period
CHOICE			
Self only:	\$ 48.25	\$ 67.50	\$ 88.00
1 Child:	\$ 130.75	\$ 148.75	\$ 166.50
Spouse:	\$ 155.50	\$ 175.50	\$ 195.50
2 + Children:	\$ 219.50	\$ 237.50	\$ 255.50
Spouse + 1 Child:	\$ 232.50	\$ 252.00	\$ 270.25
Spouse + Children:	\$ 240.75	\$ 260.50	\$ 280.25
EPO			
Self only:	\$ 24.75	\$ 37.00	\$ 51.50
1 Child:	\$ 102.25	\$ 115.75	\$ 130.25
Spouse:	\$ 114.50	\$ 129.50	\$ 144.50
2 + Children:	\$ 136.50	\$ 150.25	\$ 164.00
Spouse + 1 Child:	\$ 145.50	\$ 160.25	\$ 175.00
Spouse + Children:	\$ 151.50	\$ 167.25	\$ 182.75
Dual Employee:	\$ 83.25	\$ 90.50	\$ 98.00
CATASTROPHIC			
Self only:	\$ 21.75	\$ 30.00	\$ 40.75
1 Child:	\$ 59.00	\$ 66.25	\$ 73.75
Spouse:	\$ 65.25	\$ 73.75	\$ 82.00
2 + Children:	\$ 82.50	\$ 89.50	\$ 96.75
Spouse + 1 Child:	\$ 86.25	\$ 93.75	\$ 101.50
Spouse + Children:	\$ 95.00	\$ 103.25	\$ 111.75

Group Health Plan Premiums Table

Dental, Orthodontics & Vision Plans

All rates listed are deducted from each paycheck on a pre-tax basis and are effective April 1, 2009.

Type of Plan	Full Time Rates 72-80 hours per pay period	Part-Time Level III Rates 56-71 hours per pay period	Part-Time Level II Rates 32-55 hours per pay period
INCENTIVE DENTAL			
Self only:	\$ 2.00	\$ 4.00	\$ 6.00
1 Child:	\$ 9.25	\$ 10.00	\$ 10.85
Spouse:	\$ 11.50	\$ 12.50	\$ 13.45
2 + Children:	\$ 22.00	\$ 23.35	\$ 24.40
Spouse + 1 Child:	\$ 23.25	\$ 24.60	\$ 25.75
Spouse + Children:	\$ 25.50	\$ 27.00	\$ 28.30
DENTAL/ORTHODONTICS			
Self only:	\$ 3.25	\$ 5.00	\$ 7.50
1 Child:	\$ 11.25	\$ 12.65	\$ 14.00
Spouse:	\$ 13.50	\$ 15.15	\$ 16.85
2 + Children:	\$ 24.00	\$ 24.45	\$ 25.40
Spouse + 1 Child:	\$ 25.00	\$ 25.45	\$ 26.50
Spouse + Children:	\$ 27.00	\$ 27.65	\$ 28.70
VISION			
Self only:	\$ 1.25	\$ 1.50	\$ 1.75
1 Child:	\$ 2.15	\$ 2.50	\$ 2.94
Spouse:	\$ 2.85	\$ 3.30	\$ 3.85
2 + Children:	\$ 3.10	\$ 3.65	\$ 4.13
Spouse + 1 Child:	\$ 3.50	\$ 4.15	\$ 4.75
Spouse + Children:	\$ 4.25	\$ 5.05	\$ 5.75



MEDICAL PLAN COVERAGE OPTIONS

Effective July 1, 2009

CHOICE		EPO PLAN		CATASTROPHIC
Yearly Deductible: Per Person Per Family	\$600 \$1,200	\$400 \$800	\$1300 \$2600	
Lifetime Maximum	\$1,000,000	\$1,000,000	\$1,000,000	
Out-of-Pocket Maximum (after deductible is met) ¹	\$2,000 per individual	\$1,500 per individual	\$2,500 per individual	
Accidental Benefit ²	Deductible Waived	Deductible Waived	Deductible Applies	
Utilization Review	Yes - Pre-Certification	Yes - Pre-Certification	Yes - Pre-Certification	
PREVENTIVE CARE SERVICES				
CHOICE	EPO PLAN			CATASTROPHIC
	SELECT Network PCPs	EPO Preferred	Traditional	Out-of-Network ⁵
Annual Well Baby*** (ages birth to 24 months)	100% of \$1000	80% of \$1400	70% of \$1400	60% of \$1400
Child Annual Immunizations (ages 2 to 18)	100% of \$225	80% of \$250	70% of \$250	60% of \$250
Child Annual Physical****	100% of \$125	80% of \$150	70% of \$150	60% of \$150
Adult Annual Physical****	100% of \$300	80% of \$500	70% of \$500	60% of \$500
***Physician Services and Facility Services combined will not go over the maximum for preventive care services.				
PROVIDER SERVICES (PCPs ³ AND SPECIALISTS)				
CHOICE	EPO PLAN			CATASTROPHIC
	SELECT Network PCPs	EPO Preferred	Traditional	Out-of-Network
Office Visits	80%	80%	70%	60%
Home and Hospital Visits	80%	80%	70%	60%
HOSPITAL AND FACILITY OTHER SERVICES				
CHOICE	EPO PLAN			CATASTROPHIC
	EPO Network ICHN Facilities ⁴	Out-of-Network		
Inpatient and Outpatient Services	St. Luke's Facility: 80% of Maximum Allowance All Other Facilities: 60% of Maximum Allowance (Subject to balance billing)	80% of Maximum Allowance	60% of Maximum Allowance (Subject to balance billing)	St. Luke's Facility: 80% of Maximum Allowance All Other Facilities: 60% of Maximum Allowance (Subject to balance billing)

CHOICE			EPO PLAN		CATASTROPHIC																														
Durable Medical Equipment: (after deductible is met)	80% of Maximum Allowance	EPO Preferred	80% of Maximum Allowance	Out-of-Network 60% of Maximum Allowance (Subject to balance billing)	80% of Maximum Allowance																														
Chiropractic Services (after deductible is met)	Contracting Provider: 80% of Maximum Allowance Non-Contracting Provider⁴: 50% of Maximum Allowance \$600 plan year maximum																																		
Prescription Drug Benefit *Please note: If you do not purchase your prescription at a RxAmerica participating pharmacy, you will have to pay cash and submit a claim to them for reimbursement. This will not apply to your deductible or out-of-pocket maximum.	<table> <tr> <th></th><th colspan="2">Purchased at St. Luke's Pharmacy</th><th colspan="3">RxAmerica Participating Pharmacy*</th></tr> <tr> <td>Generic/Preferred:</td><td>\$ 5.00</td><td>20%</td><td>\$ 7.50</td><td>25%</td><td></td></tr> <tr> <td>Single Source Brand Name:</td><td>\$15.00</td><td>20%</td><td>\$20.00</td><td>25%</td><td></td></tr> <tr> <td>Multi-Source Brand Name:</td><td>\$20.00</td><td>20%</td><td>\$25.00</td><td>25%</td><td></td></tr> <tr> <td>Supply Maximum</td><td>90-day</td><td></td><td>15-day</td><td></td><td></td></tr> </table> <p>\$200 copay for drugs that cost \$1000 or more for a 30-day supply</p>						Purchased at St. Luke's Pharmacy		RxAmerica Participating Pharmacy*			Generic/Preferred:	\$ 5.00	20%	\$ 7.50	25%		Single Source Brand Name:	\$15.00	20%	\$20.00	25%		Multi-Source Brand Name:	\$20.00	20%	\$25.00	25%		Supply Maximum	90-day		15-day		
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Supply Maximum	90-day		15-day																																
Mental Health and Substance Abuse (after deductible is met):	<p>Inpatient 80%: 8 days per plan year</p> <p>Outpatient 50%: 20 visits per plan year</p> <p>Intensive Outpatient Program 80%: one time. Generally consists of 12-16 weeks of 2-3 hour treatment 4 days per week for 8 weeks then, 1 day per week for remaining weeks in program plus one year follow-up program.</p>																																		

- 1. Out-Of-Pocket Maximum:** For those non-emergency services provided at a non-St. Luke's facility (non-ICHN facility, if in the EPO Plan), or by a non-contracting provider (EPO plan only), the plan will only pay 60%, even if the participant has met their out-of-pocket maximum.
- 2. Accidental Benefit:** In the event of an accident, the covered individual's deductible is waived, if indicated above.
- 3. Primary Care Physician (PCP):** means family practice, internal medicine, obstetrics/gynecology and pediatrics.
- 4. ICHN:** Idaho Community Health Network, Inc. A list of these facilities is provided in this booklet. Services provided at all other facilities will be paid at the 60% benefit level, even if the out-of-pocket maximum has been met.
- 5. Non-Contracting (Out-of Network):** Providers who do not contract with SELECT, IPN or St. Luke's.
Special Note: Specific to all three medical plans, out-of-network and non-contracting providers may be subject to balance billing. To ensure you receive the highest level of benefit available to you, please make sure all service providers are contracting (or in-network) before receiving services (including all lab and other services your provider may order on your behalf).

Dental/Orthodontics/Vision Plan Options

All rates listed are deducted from each paycheck on a pre-tax basis and are effective April 1, 2009.

Incentive Dental	Dental and Orthodontics																								
<p><u>Dental Only:</u></p> <p>Deductible: \$0.00</p> <p>Plan Payment Percentages: 70-80-90-100% Payment percentage graduates per year of coverage. Each covered individual must receive annual check up and cleaning to graduate to next payment percentage</p> <p><i>Class A</i> (Preventive) & <i>Class B</i> (Restorative): Yrs. of Coverage</p> <p><u>Important Note:</u> If this is your first year in this plan, coverage starts at 70% for Class A & Class B.</p> <p><i>Class C</i> (Prosthodontics): 50%</p> <p><i>Class D</i> (Orthodontics): Not Covered</p> <p>Annual Plan Maximum per covered individual: \$1,200.00</p>	<p><u>Dental and Orthodontics:</u></p> <p>Deductible (waived for Class A & D services):</p> <p>Single: \$30.00 Two-Party: \$60.00 Family: \$90.00</p> <p>Dental Plan Payment Percentages:</p> <p><i>Class A</i> (Preventive): 100% <i>Class B</i> (Restorative): 80% <i>Class C</i> (Prosthodontics): 50% <i>Class D</i> (Orthodontics): 50%</p> <p>Lifetime Orthodontics Maximum: \$1,000.00</p> <p><u>Important Orthodontics Note:</u> There is a one year waiting period from your effective date before this benefit begins.</p> <p>Annual Plan Maximum per covered individual: \$1,200.00</p>																								
Vision Plan																									
<p><u>Vision - What the plan will pay:</u></p> <table><tr><td>Vision Exam:</td><td>\$60.00 maximum</td><td>Each Contact Lens:</td><td></td></tr><tr><td>Frames:</td><td>\$70.00</td><td>Medically Necessary:</td><td>\$105.00</td></tr><tr><td colspan="2">(limited to one pair every 24 months from prior date of service)</td><td>In Lieu of Eyeglasses</td><td></td></tr><tr><td>Single Vision Lens:</td><td>\$21.00</td><td>Single Vision:</td><td>\$36.00</td></tr><tr><td>Each Bifocal Lens:</td><td>\$35.00</td><td>Bifocal:</td><td>\$46.00</td></tr><tr><td>Each Trifocal Lens:</td><td>\$45.00</td><td>Each Lenticular Lens:</td><td>\$85.00</td></tr></table>		Vision Exam:	\$60.00 maximum	Each Contact Lens:		Frames:	\$70.00	Medically Necessary:	\$105.00	(limited to one pair every 24 months from prior date of service)		In Lieu of Eyeglasses		Single Vision Lens:	\$21.00	Single Vision:	\$36.00	Each Bifocal Lens:	\$35.00	Bifocal:	\$46.00	Each Trifocal Lens:	\$45.00	Each Lenticular Lens:	\$85.00
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Important Information Regarding Group Health Plans

All Employees Need to Know the Following Regarding Initial Enrollment in St. Luke's Group Health Plans and Mid -Year Changes

Enrolling in St. Luke's Group Health Plans

**PLEASE
NOTE
DEADLINE**

Employees may enroll in one of the three medical plans and/or one of the two dental plans within 30 days of their hire date, or transfer to a “benefits eligible” position date (date of hire/transfer is day one). The only other time to enroll in St. Luke's Group Health Plan is if you have a qualified change in status or when St. Luke's authorizes an Open Enrollment. The following events are among those that qualify as a qualified change in status and you will need to request the “Mid-Year Changes” packet from the Benefits Department:

- COBRA coverage is exhausted (i.e. 18 months)
- Non-COBRA coverage is terminated due to loss of eligibility of coverage (including due to divorce, spouse's death, spouse's termination of employment, or spouse's reduction in work hours)
- Spouse's employer contributions for insurance coverage were terminated
- Birth, adoption, placement for adoption, or marriage (must be legally married, as determined in accordance with the laws of the State of Idaho)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) no longer allows health underwriting for late enrollees; therefore, it is very important to elect coverage for yourself and your eligible dependents when the opportunity is available to you. Please see the table for these important opportunities and requirements. This is not an exhaustive list, just some common scenarios. Please call the Benefits Department to see if your situation qualifies.

Mid-Year Changes

In order to enroll or drop yourself and your eligible dependents in St. Luke's Group Health Plan, a qualified change in status must have occurred within the last 60 days (date of qualifying event is day one). When making changes to your Group Health Plan, please complete the enrollment form with all the names of individuals you want covered. The new enrollment form will REPLACE any form we currently have on file.

St. Luke's Group Health Plan

Mid-Year Changes

Change in Status:	Deadline to Enroll:	Effective Date of Coverage:
Birth	60 days from date of birth (birth date is day one)	Date of Birth (all insurance premiums will be collected back to date of birth)
Adoption or Placement for Adoption	60 days from official placement or adoption date (court ordered date is day one)	Adoption Placement Date (must submit court order documents with enrollment forms and insurance premiums will be collected back to date of adoption placement)
Marriage (legal, not common law)	60 days from official marriage (date of marriage is day one)	First day of the month following receipt of all required forms in the Benefits Dept (must submit copy of marriage license with enrollment forms)
Loss of Other Coverage (must be an involuntary loss)	60 days from the date other coverage ended (coverage term date is day one)	First day of the month following receipt of all required forms in the Benefits Dept (must submit Verification of Medical Coverage Ending form with enrollment form - available on intranet or from Benefits Dept)
Divorce	60 days from official divorce date (official divorce date is day one)	Coverage terminates retro active back to divorce date. Applicable premium adjustments occur the first day of the month following receipt of all required forms in the Benefits Dept (must submit copy of court ordered final divorce decree with enrollment forms) Note: Premiums are adjusted only if paperwork is received within 60 days of divorce. If received after 60 days, premium cannot change until April 1st of the following year.
Gaining other coverage due to new spouse, new job, etc.	60 days from the date other coverage begins (effective date of coverage is day one)	First day of the month following receipt of all required forms in the Benefits Dept (must submit Verification of Medical Coverage form with enrollment form - this form is available on intranet or from Benefits Dept)

Note: For individuals becoming effective on the plan during a special enrollment period, due to a qualified change in status, a 12-month pre-existing condition period will apply from the effective date of coverage. The 12-month pre-existing condition period may be reduced by the period of creditable coverage under a previous plan. The employee must attach a "Certificate of Creditable Coverage," provided by the previous employer plan (or individual coverage plan), to the enrollment form when requesting enrollment. "Creditable coverage" will be applied to our 12-month exclusion period, and RBA will provide written notification to the employee of the remaining pre-existing condition period.

Pre-Existing Condition Exclusion & Special Enrollment Rights Notice

1. 1st Pre-existing Condition Exclusion Notification required by HIPAA

Notice of Pre-existing Condition Exclusion:

This plan imposes a pre-existing condition exclusion for those who enroll in the Group Health Plan due to a "qualified change in status or Open Enrollment" only. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 60 days (day one is the day of the event) following birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you enroll during a St. Luke's designated open enrollment) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to St. Luke's Regional Medical Center, Benefits Department, 190 E. Bannock, Boise ID 83712 or call 381-3074.

2. Notice of Special Enrollment Rights required by HIPAA

Notice of Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days (day one is the day of the event) following the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). For this special enrollment to apply, an employee or dependent of an employee must be eligible for coverage in the plan, and must have had coverage under another group health plan (or through health insurance) at the time coverage under the plan was previously offered and waived. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 60 days (day one is the day of the event) following the qualifying event. To request special enrollment or obtain more information, contact St. Luke's Regional Medical Center, Benefits Department, 190 E. Bannock, Boise ID 83712 or call 381-3074.

Important Reminders

- (1) **Divorce:** If an employee, whose spouse is covered on St. Luke's Group Health Plan, becomes divorced during a plan year, it is the employee's responsibility to complete a new Group Health Plan Enrollment Form to drop the former spouse off the plan. A copy of the official divorce decree must be attached to the enrollment form. Coverage for the ex-spouse ends retroactively back to the divorce date. If the divorced employee does not notify the Benefits Department of the status change within 60 days of the divorce, payroll deductions will continue for the spouse who essentially has no coverage.

For example: Flo Nightingale's divorce was official April 15, 2009. Because she neglected to submit a Group Health Plan Enrollment Form until November 15, 2009 (more than 60 days after the divorce), her two-party group health premiums continue to be deducted from her paycheck. The "two-party" premiums change to "single" effective April 1, 2010. Her spouse's coverage, however, terminates retroactive to the divorce date, April 15, 2009. Therefore, any claims submitted after the divorce date by the former spouse must be repaid, or COBRA elected and COBRA premiums paid from April 15, 2009.

- (2) **Children Ages 19 to 23:** If an employee has coverage on a child who is no longer an eligible dependent (19 years or older and no longer a full-time student or gets married) or turns 23 years of age, the employee must notify the Benefits Department so that your payroll deductions can be adjusted. The child will be offered COBRA through RBA and/or Delta Dental or you may choose an individual plan in the open market. Again, it is the employee's responsibility to complete the appropriate forms so that these offers can be initiated and premiums adjusted.

For example: Sue Smith's 22-year-old son officially graduated college on May 15, 2009. Because she neglected to complete a Verification of Full-Time Student Status form and didn't complete a new Group Health Plan Enrollment Form until November 15, 2009, her two-party group health premiums continued to be deducted from her paycheck. The "two-party" premiums changed to "single" effective April 1, 2010. Her son's coverage, however, terminates retro active to the end of the month in which he graduated (May 31, 2009). Therefore, any claims submitted for the son, after May 31st, must be repaid, or COBRA elected and COBRA premiums paid from June 1, 2009.

- (3) **Making Enrollment Changes:** Whenever you make changes to your group health insurance enrollment, the new enrollment form will replace any existing enrollment form completed before. Therefore, complete the enrollment form with all persons for whom you want to continue coverage - not just those individuals you want to add.
- (4) **Changing Employment Status (Full Time, PTLIII, PTLII, Flex):** Changing from one "benefits eligible" status to another (i.e., part-time level three to part-time level two or from full-time to part-time level two) does not constitute a qualified "change in status". In order to be considered a qualified event, you must transfer from a non-benefits eligible status (flex or temporary) to a benefits eligible status (part-time level two, three or full-time).
- (5) **Termination of Health Insurance:** Medical, dental, vision and prescription drug benefits will end the last day of the month in which an employee separates from employment. Federal "COBRA" laws provide employees and dependents under the age of 65 the option to continue coverage for 18 months by paying the total premium. RBA will send the information regarding this conversion option after your last day of coverage ends. You have 60 days from the last day of coverage to make a decision regarding continuation. This is not a grace period, but a time when reinstatement may be achieved by paying applicable premiums.

Maintenance of Group Health Benefits

What is a Maintenance of Benefits?

In the event that you or other family members are entitled to benefits for covered expenses under more than one health plan or under an automobile insurance plan, the benefits under all plans will be coordinated to ensure that you are paid no more than the expenses which you have incurred. St. Luke's is a "maintenance of benefits plan" and under no circumstances will you be reimbursed for more than you would have been reimbursed had you not had other insurance coverage. The Plan sets forth in detail all of the rules regarding coordination of benefits.

When you or your enrolled family members have other group medical and/or dental/vision coverage in addition to St. Luke's coverage (through your spouse's employer, for example), St. Luke's plan pays benefits depending on whether it is primary (pays first) or secondary (pays second). The rules used to determine which coverage is primary and should pay first are as follows:

1. The coverage that has no coordination requirement is primary.
2. The coverage covering the patient as an employee is primary.
3. The coverage covering the patient as a dependent spouse is secondary.
4. The coverage of the parent whose date of birth is earlier in the calendar year is primary for dependent children. If the parents have the same date of birth, the coverage that has been in force the longest is primary.
5. When parents are divorced or legally separated, the coverage of the parent who has custody of dependent children is primary, unless there is a court decree directing the noncustodial parent to maintain health coverage.
6. If you or your enrolled family member is injured and another party is partially or totally at fault, the insurance company of that party has the primary responsibility to pay your medical expenses to the extent their insured is at fault. If these payments do not cover your expenses, you can apply for benefits in accordance with your St. Luke's coverage.

When St. Luke's plan is primary, it pays benefits first without regard to whether or not you have other coverage. After you receive your St. Luke's plan benefits, you may then submit a claim to your second plan.

When St. Luke's plan is secondary, it will pay benefits so that the total combined reimbursement from your primary plan and the St. Luke's plan equals the St. Luke's plan's maximum benefits paid, and works as follows:

1. St. Luke's plan calculates how much it would have paid with the other coverage. Any applicable deductibles and coinsurance will be taken into account.
2. If the other plan's benefits are the same or more than this amount, St. Luke's plan will pay nothing.
3. If the other plan pays less than this amount, St. Luke's plan will pay the difference. Benefits from both plans combined will equal the amount normally paid by the St. Luke's plan.

Electing the Medical Plan That is Right for You

Each medical plan pays benefits for covered medical expenses. After you have satisfied a deductible, St. Luke's will pay or otherwise satisfy a percentage (coinsurance) of the maximum allowance for most covered services. The remaining percentage (coinsurance) is your share of the cost. If you have services provided by a non-contracting (or out-of-network) provider, you may also have to pay the provider for the amount above the maximum allowance, which is referred to as balance billing. Therefore, if you want to ensure that you are paying the lowest amount possible, please choose a "contracting" provider from the applicable provider directory enclosed with your annual enrollment material, and confirm with RBA that the provider is still a contracting provider before you receive services.

Once you have met your plan's out-of-pocket maximum, St. Luke's Group Health Plan will pay 100% of covered eligible expenses up to the maximum allowable charges (unless otherwise stated) for the remainder of the plan year.

Please refer to the *Group Health Plan Premiums Table* for each of the three medical plans described below, and the *Medical Plan Coverage Options table* for a side-by-side comparison of the three plans which includes deductible and out-of-pocket maximum information.

The following describes the three medical plans:

CHOICE Plan: This plan provides the enrollee with maximum choice of physicians and non-facility providers. The physician services coinsurance after you meet the deductible is 80% of the maximum allowance. Other coinsurance amounts under the CHOICE Plan are specified in the *Medical Plan Coverage Options Table*. As a contracting provider with Idaho Physicians Network (IPN) or St. Luke's, the provider has agreed not to "balance bill" you for amounts greater than the maximum allowance. If your provider does not contract with IPN or St. Luke's, they may "balance bill" you for charges above the maximum allowance. Please refer to the enclosed provider directory for a list of current contracting providers for this plan.

In addition, for services provided by St. Luke's, you must use a St. Luke's facility to receive the best level of benefits. That is, for non-emergency services, the enrollee must have services provided at St. Luke's or a St. Luke's owned facility, in order to receive the 80/20 percent coinsurance level. Services provided at all other facilities will be processed at the 60/40 percent coinsurance level, even if the plan participant has met their out-of-pocket maximum. For additional details, please refer to the *St. Luke's Facilities* section.

CATASTROPHIC Plan: The CATASTROPHIC Plan provides maximum choice of physicians and uses St. Luke's owned facilities for services in order to receive the 80/20 percent coinsurance level. While the premiums are lower, the amounts you are responsible for, such as deductibles and out-of-pocket maximums are higher than the other two plans. In addition, preventive care benefits are reduced for enrollees in this plan. This plan is for those employees who truly want the "insurance coverage" this plan provides, in the event they experience a catastrophic injury or illness. As a contracting provider with IPN or St. Luke's, the provider has agreed not to "balance bill" you for amounts greater than the maximum allowance. If your provider does not contract with IPN or St. Luke's, they may "balance bill" you for charges above the maximum allowance. Please refer to the enclosed provider directory for a list of current contracting providers for this plan.

EPO Plan: St. Luke's EPO plan is unique in that it offers four levels of benefits to Plan enrollees. The EPO Plan pays benefits for covered services received from both in-network and out-of-network providers giving you the freedom to choose your own health care provider. The EPO Plan offers three levels of benefits for in-network providers (SELECT, EPO Preferred and Traditional) and a fourth level for out-of-network providers.

The SELECT Network is made up of Primary Care Physicians and Specialists that work closely with St. Luke's. This group is committed to providing their St. Luke's employee/patients with affordable, high quality, coordinated care. The physicians in this network have contractually agreed to reduce the total cost of services provided. By contract, the SELECT Network providers must give 90 days written notice to terminate from the network. However, providers may be terminated from the network due to unforeseen circumstances; therefore, we encourage employees to check with Riverside Benefit Administrators, Inc. (RBA) prior to receiving services to confirm that their provider is still part of the SELECT Network.

Specific to provider services, you receive the highest benefit level by seeking services from the SELECT Network of Primary Care Physicians in the first section. The second level of benefits is for services received from providers in the EPO Preferred Providers/Specialists section. The third level of benefits is for services received from providers in the Traditional Network. The fourth level or out-of-network benefits is for services received from providers who have not contracted with the networks. This is your out-of-network benefit and you will pay the highest coinsurance amounts and may be responsible for additional out-of-pocket expenses, including balance billing.

It is your responsibility to make sure you know what level of benefits your provider's claims will be processed under before you receive services from that provider.

EPO Plan Definitions

Following are definitions to help you better understand this plan:

EPO Plan: The Exclusive Provider Organization Plan allows St. Luke's to provide different coinsurance levels in the benefit plan design and receive reduced rates from those providers contracted through SELECT Network .

Billed Charges: This is the amount that a contracting or non-contracting provider will charge for services provided and the full amount that will be sent to RBA by your provider for claims processing. The payment made will be based on the St. Luke's plan design and the provider's contractual agreement with RBA.

Allowable Charges (also referred to as maximum allowance, or maximum allowable): This is the dollar amount that contracting providers agree to accept for the services provided or the amount the claim will be processed for non-contracting providers. As a contracting provider, they contractually agree to "write-off" the difference between Billed Charges and the "allowable charges." The coinsurance paid by St. Luke's plan is based on allowable charges. For example, if the provider contractually agrees to reduce reimbursement by 10% (and assuming the patient has met their deductible), a claim would be processed as follows:

		<u>St. Luke's Plan Pays</u>	<u>Patient Pays</u>
Billed Charges	\$100.00		
Less Contractual Adjustment (written-off)	\$ 10.00		
Allowable Charges	\$ 90.00		
Coinsurance (80%/20%)		\$72.00	\$18.00

Balance Billing: This is the dollar amount that is the difference between the billed charges and the allowable charges. If you see a contracting provider, the provider has agreed to "write off" this difference. However, if you see a non-contracting provider, you will be responsible for this amount.

In the previous example, you would be "balance billed" for the initial \$10.00 that would have been "written-off" by a contracting provider. In addition, you are responsible for a higher coinsurance amount because the provider is out-of-network. Claims for services from a non-contracting (or out-of-network) provider, would be processed as follows:

	<u>St. Luke's Plan Pays</u>	<u>Patient Pays</u>
Billed Charges	\$100.00	
Less amount "not allowed" for payment	\$ 10.00	
Allowable Charges	\$ 90.00	
Coinsurance (60%/40%)	\$54.00	\$36.00
Non-contracting provider may balance bill patient for this amount		\$10.00

SELECT Medical Network of Idaho (SELECT Network): St. Luke's has designed its EPO Plan to encourage plan participants to receive services from SELECT Network providers, by offering to pay a higher coinsurance. This benefits the patient (receives a reduced allowable charge and high quality of care), the employer (receives a reduced allowable charge), and the physician (receives more patients and direct payment through the higher coinsurance).

EPO Preferred: The EPO Preferred includes SELECT Specialists and ICHN facilities. Services provided by these specialists will be processed at the second-tier level of benefits. Please confirm the contracting status of your provider, before receiving services. Please refer to the enclosed EPO Plan Provider Directory (EPO Preferred section) for a list of these providers.

Traditional Network: A medical provider in the Idaho Physician's Network (IPN) has entered into a contract with IPN, agreed to accept a set allowed amount, and has agreed not to balance bill participants. IPN includes Primary Care Physicians, Specialists and other providers (chiropractors, mental health, etc.) who contract with IPN. Please refer to the enclosed EPO Plan Provider Directory (Traditional section) for a list of these providers.

Primary Care Physician (PCP): Primary care physician means family practice, internal medicine, obstetrics/gynecology and pediatric physicians.

ICHN Facilities: Idaho Community Health Network, Inc. For a list of these facilities, please refer to the *Idaho Community Health Network, Inc.* page of this booklet. For non-emergency facility services, EPO Plan participants will need to have services provided at an ICHN facility in order to have claims processed at the highest coinsurance level. Non-emergency services provided at a non-ICHN facility will be processed at 60% coinsurance level, even if the out-of-pocket maximum has been met.

Out-of-Network Providers: These include Primary Care Physicians, Specialists, facilities and other providers (chiropractors, mental health, etc.) that do not contract with SELECT, IPN, or St. Luke's, or are by St. Luke's plan design not an in-network provider. Claims associated with services from providers in this group will be at the lowest coinsurance level. In addition, any amount billed above the maximum allowable may be subject to balance billing, and claims will continue to pay at the out-of-network coinsurance level, even if the out-of-pocket maximum has been met.

EPO Plan Provisions

Now that we have defined terms specific to the EPO Plan, the remainder of this section is devoted to explaining how claims will be processed depending upon which medical providers you use and the contracting network of the provider(s). The order of explanation coincides with the *Medical Plan Coverage Options* table.

Preventive Care Services

- 1st Tier: Claims billed for preventive care services by a SELECT Network Primary Care Physician (PCP) will be processed at 100% up to the indicated annual maximum for preventive care service.

Mammograms and/or wellness lab charges billed by an ICHN provider will be processed to pay at 100%, and will accumulate toward the annual maximums. If these services are billed by a Non-ICHN facility, the claim will be processed at 60% and you may be subject to Balance Billing.

- 2nd Tier: Claims billed for preventive care services by an EPO Preferred provider will be processed at 80% up to the indicated annual maximum for preventive care service.

Mammograms and/or wellness lab charges billed by an ICHN provider will be processed to pay at 100%, and will accumulate toward the annual maximums. If these services are billed by a Non-ICHN facility, the claim will be processed at 60% and you may be subject to Balance Billing.

- 3rd Tier: Claims billed for preventive care services by a Traditional provider will be processed at 70% of the indicated annual maximum for preventive care service.

Mammograms and/or wellness lab charges billed by an ICHN provider will be processed to pay at 100%, and will accumulate toward the annual maximums. If these services are billed by a Non-ICHN facility, the claim will be processed at 60% and you may be subject to balance billing.

- 4th Tier: Claims billed for preventive care services provided by an Out-of-Network (non-contracted) provider will be processed at 60% of the indicated annual maximum for preventive care service. In addition, you may be subject to balance billing for services provided by an out-of-network provider.

Mammograms and/or wellness lab charges billed by an ICHN provider will be processed to pay at 100%, and will accumulate toward the annual maximums. If these services are billed by a Non-ICHN facility, the claim will be processed at 60% and you may be subject to Balance Billing.

Please Note: Provider Services and Facility Services combined will not go over the maximum for preventive services.

Provider Services

- 1st Tier: Claims billed for non-preventive care physician services by a SELECT Network Primary Care Physician (PCP) will be processed at 90% of the allowable charges after the deductible has been met.
- 2nd Tier: Claims billed for non-preventive care physician services by an EPO Preferred provider will be processed at 80% of the allowable charges after the deductible has been met.
- 3rd Tier: Claims billed for non-preventive care physician services by a Traditional provider will be processed at 70% of the allowable charges after the deductible has been met.

- 4th Tier: Claims billed for non-preventive care services by an Out-of-Network provider will be processed at 60% of the allowable charges after the deductible has been met. In addition, you may be subject to balance billing for services provided by an out-of-network provider and claims will continue to pay at the out-of-network coinsurance level, even if the out-of-pocket maximum has been met.

Hospital and Other Services

- 1st Tier: Claims billed for hospital and other services by an ICHN Facility will be processed at 80% of allowable charges after the deductible has been met.
- 2nd Tier: Non-emergency claims billed for hospital and other services by an out-of-network (non-ICHN facility) will be processed at 60% of allowable charges after the deductible has been met. If the facility or provider is non-contracting, claims may be subject to balance billing. Claims will continue to pay at the out-of-network coinsurance level, even if the out-of-pocket maximum has been met.

Durable Medical Equipment (DME)

Durable Medical Equipment needs will receive the highest level of benefit when purchased through an IPN contracting provider. If you use a DME provider that contracts with IPN, your DME claims will be processed at the 80% coinsurance level, after your deductible has been met. If, however, you use a DME provider that does not contract with IPN, your DME claims will be processed at the 60% coinsurance level and you may be subject to balance billing and claims will continue to pay at the out-of-network coinsurance level, even if the out-of-pocket maximum has been met.

Additional Information about the EPO Plan

- (1) For emergency services or services related to an accident where the plan participant does not have the option to choose a facility, claims will be processed at the 80% coinsurance level. However, if a participant is admitted to, or receiving services from, a non-ICHN facility and the participant is deemed medically safe to be transferred to an ICHN facility, claims will be paid at the 60% level if the participant chooses to stay at the non-ICHN facility. All non-emergency facility services must be performed at an ICHN facility to receive the 80% benefit level.
- (2) For services not provided at a St. Luke's facility (for example: mental health services and dialysis), claims will be processed at the 80% coinsurance level for services received from a provider who contracts with IPN. If services are received from a non-contracting facility, the claim will be processed at 60% and may be subject to balance billing and claims will continue to pay at the out-of-network coinsurance level, even if the out-of-pocket maximum has been met. Services not provided at St. Luke's may change at any time, so be sure to confirm coverage with RBA prior to receiving services.
- (3) You do not have to designate a primary care physician on your enrollment form. Your coinsurance level will be applied by RBA based on the provider providing services. In addition, referrals are not required to obtain services.
- (4) Please refer to the enclosed St. Luke's EPO Plan Provider Directory for a listing of providers in SELECT Network, EPO Preferred, and the Traditional Network. NOTE: Not all Nurse Practitioners (NP) and Physician Assistants (PA) may be listed, but may be covered under the listed physician's practice. The coinsurance amounts for these mid-level providers will be the same as the coinsurance applied to their supervising physician.

EPO Plan and Wellness Requirements

The High Cost of Health Care

Keep more money in your wallet by taking a closer look at your health.

Individual health risk factors like high blood pressure, elevated blood sugar, being overweight and carrying fat around your middle can increase your risk of disease. This costs you time, emotional stress and money.

The Personal Wellness Profile (PWP) and health screening are FREE tools to help you identify your health risks. Education and resources are also provided so you can prevent costly health problems before they occur.

Take advantage of this benefit to improve your health and your bottom line!

EPO Plan Annual Requirements

The EPO plan has two unique Wellness requirements. If you choose this medical plan, you are agreeing to complete the Personal Wellness Profile (PWP) and participate in a health screening clinic **within 30 days of your hire date**. If you select the Choice or Catastrophic medical plan, you may still participate in these opportunities to take control of your health!

1. St. Luke's Personal Wellness Profile (PWP) is an electronic questionnaire and report that helps you understand your current health status, identifies risk factors for disease, and highlights areas for improvement. **Instructions for completing the PWP are provided on the next page.**

2. Health screening is an important step in preventing disease. It ensures that common, sometimes serious, health conditions are detected and treated. At your screening clinic, Wellness staff will perform biometric measures such as blood pressure, height, weight, waist and hip circumferences, as well as a fasting blood sugar (glucose) test. Screening clinic dates, times and locations will be posted on *Inside St. Luke's*.

- At work, log onto *Inside St. Luke's* and click on [Classes/Events/Education](#), then choose [St. Luke' Learning Center](#) and follow the directions.
- From home, open your internet browser and type <http://sumtotal.slrnc.org/> in the address bar.

The PWP and screening are confidential assessments of your health status. The information provided to you is not medical advice or a diagnosis. You are encouraged to share the findings with your health care provider and use them as a guide to achieve and maintain optimum health.

If you are identified at elevated risk for certain health conditions (i.e., pre-diabetes or hypertension), you will receive notification from a nurse educator on behalf of St. Luke's. The nurse can answer your questions, provide self-care information, help you find a physician and serve as a resource to you in managing a chronic condition or disease state.

Again, you may choose any medical plan offered by St. Luke's. Regardless of your selection, you may participate in the PWP and health screening tests. However, if you select the EPO plan, you are making a commitment to complete both these requirements.

Please note: Employees who select the EPO medical plan and do not comply with both requirements, will forfeit their eligibility to enroll in the EPO plan in 2010.

St. Luke's Personal Wellness Profile (PWP) Guide

You can complete the PWP from your home computer or any other computer that has access to the Internet. If you need assistance, please contact Mary Poell at 381-4294. **Deadline for completion: 30 days within your hire date.**

Instructions:

Step 1: From home, open your Internet browser and type www.stlukesonline.org/pwp in the address bar.

At work, log onto *Inside St. Luke's* and click on [Employee Health & Wellness](#), then click on the [2009 Personal Wellness Profile](#) link at the top of the page.

Step 2: Read the Terms of Use and click to continue.

Step 3: Enter your Employee ID# (no leading 0's) and password. Your password is **well** (lower case letters) and **the last 5 digits of your social security number** (i.e., 123-45-6789). For example, well56789. Press the button to begin.

Step 4: Enter required fields (last and first name, email address, department and work extension) and press .

Step 5: Enter your age, gender, frame size, height and weight and press (upper right side of screen).

Step 6: The questionnaire is divided into ten sections. Once you complete a section, press the button. This saves your answers up to that point. To return to a section, press the button. You have 30 minutes per page to complete the questions.

Step 7: When you complete the final section, press the button. This takes you to your Personal Report, including information and action steps for optimizing your health. Your PWP is **not complete until you press the finish button!**

Step 8: Review your report online or press the button at the bottom of the page. We recommend that you save a copy of the Personal Report for your records.

Prescription Drug Benefit

St. Luke's continues to update the prescription drug benefit to provide you the most cost effective and affordable benefit possible. The benefits are as follows:

1. We have a three tier coinsurance for drugs purchased through a St. Luke's Employee Outpatient Pharmacy - generic, single source brand name and multisource brand name drugs. Multi source brand name drugs are those drugs only available as brand names, but which have several competitors in the same class that are also brand names and/or those with generic alternatives. This design encourages the use of the lowest cost equivalent products. Maintenance prescriptions obtained from a St. Luke's Pharmacy may be filled for up to a 90-day supply. There is a 30-day limit on drugs you receive for the first time. The following is the schedule:

Generic/preferred:	\$ 5 plus 20%
Single Source Brand Name:	\$15 plus 20%
Multi Source Brand Name:	\$20 plus 20%

2. We contract with RxAmerica to provide you with community pharmacy access for prescriptions you must obtain when the Employee Outpatient Pharmacy and Meridian Retail Pharmacy are closed. You should have a prescription drug card which, when presented at a network pharmacy, will allow you to purchase up to a 15-day supply of medication. For purchases made at a network retail pharmacy, you will pay the following:

Generic/preferred:	\$7.50 plus 25%
Single Source Brand Name:	\$20 plus 25%
Multi Source Brand Name:	\$25 plus 25%

For a current list of pharmacies in the RxAmerica network, go online to RxAmerica.com or to *Inside St. Luke's*, click on Human Resources then RxAmerica. Please remember the most cost effective prescription drugs are available through one of St. Luke's pharmacies. The second most cost effective prescription drugs are available through a RxAmerica retail network provider, as RxAmerica has negotiated additional discounts for St. Luke's and its covered members through its retail pharmacy network. Purchases made through a RxAmerica retail network provider lower the overall cost to you and to St. Luke's.

If you purchase your 15-day supply of prescription drugs from a retail pharmacy that is not in the RxAmerica Network, you will have to pay full cash price for your purchase and submit a RxAmerica claim form and a receipt to RxAmerica. RxAmerica will reimburse you for St. Luke's portion of the prescription drug benefit, if applicable. Claim forms are available at all HR offices, in the back of the Meridian and Boise cafeterias, on *Inside St. Luke's* and online at RXAmerica.com.

3. For any drug that has a cost of \$1000 or more for a 30-day supply, a \$200 member copay will be applied.

Definitions:

Generic: Non-brand name prescription drug

Preferred: Specified brand name prescription drug within a drug class that provides the most cost-effective treatment option

Single source brand name: Brand name drug available from only 1 manufacturer

Multi source brand name drug: Brand name drug with 1 or more drugs with same ingredient(s) or with competitors in the same therapeutic class and/or with generic equivalents

The following Question and Answer Section illustrates several ways you can reduce your drugs costs:

Question #1: How much can I save by using generic drugs?

Generally, the first company to obtain FDA approval is also given 18 months exclusive marketing rights to the product. In this case, for the first 18 months cost savings are 5-10%. When multiple companies obtain FDA approval at the same time, cost savings can be as much or more than 50%. Employee's save two ways, first by reducing the copay from \$15 or \$20 per prescription to \$5, and secondly the coinsurance is 20% of a lower cost.

Question #2: What is an example of a Preferred drug and how does this impact your share of the cost?

Aciphex, Protonix and Prevacid are drugs used to treat ulcers, heartburn, and gastroesophageal reflux. They are all brand name drugs with no generic alternatives. Prevacid is the St. Luke's preferred product. Preferred products have a copay of \$5 plus 20% of the drug cost whereas non-preferred products cost \$20 plus 20% of the drug cost.

Question #3: What if your physician prescribes a brand name prescription drug for which there is no generic equivalent, it is not on the preferred list, and it is medically necessary that you take this particular drug?

This product is a single source, brand name prescription drug and cannot be purchased by St. Luke's pharmacy at a favorable rate, therefore your cost share will be at the \$15 plus 20% coinsurance.

Question #4: What if you have to take the non-preferred drug because you cannot tolerate the side effects caused by the preferred listed drug?

This product is a multi source brand name prescription drug and cannot be purchased by St. Luke's pharmacy at a favorable rate, therefore your cost share will be at the \$20 plus 20% co-insurance.

Question #5: Are there other ways to reduce my drug costs? What about tablet splitting?

(1) Some medications are available in "scored" tablets or have characteristics that allow them to be easily split. Many tablets, especially controlled or sustained release products should NOT be cut or crushed. Tablet splitters are available in the outpatient pharmacy. The pharmacy staff can answer your questions about cutting your particular medications. For more information to see if your prescription qualifies for this money saving option, contact the outpatient pharmacy in Boise at 381-4353, Meridian at 706-5252 or Wood River at 727-8300.

(2) Studies show that direct-to-consumer prescription drug advertising is a significant factor in the increased utilization of expensive drugs. Sometimes “newer” isn’t necessarily “better,” but usually it is more expensive. You can help keep costs down by continuing to discuss brand name versus generic prescription drug options with your physician. For example, when asking your physician if it would be appropriate to prescribe the allergy relieving prescription drug you saw advertised on television, also ask if there is a generic equivalent, or a less expensive alternative drug, that might provide the same relief as the more expensive advertised drug. You could save money AND get the relief you are seeking!

Question #6: Which drugs are currently on the St. Luke's preferred drug list? Will more be added?

Drug classes are reviewed regularly to determine which drug(s) would be appropriate for preferred status. This determination is made by considering the clinical advantages, disadvantages and cost to select the optimal product. For a listing of drugs on the preferred list and drugs excluded from coverage, please go to *Inside St. Luke's/Human Resources*.

Two Dental Plan Options and One Vision Plan

Dental/Orthodontics

The dental orthodontics plan offers complete dental coverage. There are 4 types of dental services on this plan and it reimburses based on the type of service that is provided. The provider network utilized for this plan is the Delta Dental network of providers. You may still see any provider you would like, however, if the provider is non-contracting, you may be responsible for the difference between the billed and allowed amounts (balance billing). You may access a list of participating providers at www.deltadentalid.com or click on the link on *Inside St. Luke's/Human Resources*. Please refer to the Dental Plan Options for details on the plan. Reminder: There is a one-year waiting period before you are eligible to receive reimbursement for orthodontia coverage.

Incentive Dental

The incentive dental plan offers complete dental coverage. The reimbursement is based on years of coverage for those services that are preventive and restorative. Orthodontics is not covered under this plan. The provider network utilized for this plan is the Delta Dental network of providers. You may still see any provider you would like, however, if the provider is non-contracting, you may be responsible for the difference between the billed and allowed amounts (balance billing). You may access a list of participating providers at www.deltadentalid.com or click on the link on *Inside St. Luke's/Human Resources*. Please refer to the Dental Plan Options for details on the plan.

Vision Plan

This plan is administered by Riverside Benefit Administrators, Inc. (RBA). There is not a provider network for the vision plan, so you may shop around for the best deal based on the coverage that is offered. Please refer to the Vision Plan table for information on the plan design.

St. Luke's Facilities

In order to receive the highest available benefit, St. Luke's Group Health Plan participants will need to select a St. Luke's facility for non-emergent care, (or ICHN facility for EPO plan participants). If the plan participant chooses to have non-emergency services provided at a non-St. Luke's facility (or non-ICHN facility for EPO Plan participants), the claims associated with those services will only be reimbursed at 60% of the maximum allowable (after the deductible has been met). In addition, plan participants may have to pay for charges above the maximum allowable.

This provision applies as follows:

- Choice or Catastrophic plan participants: Non-emergency services provided at non-St. Luke's facility within 50 miles of St. Luke's Boise, Magic Valley, Meridian, or Wood River facility will be paid at the 60% benefit level, even if the participant's maximum out-of-pocket is met for the plan year.
- EPO Plan participants: Non-emergency services provided at an ICHN facility (listed in this booklet) will be paid at the 80% benefit level. Non-emergency services provided at any other facility will be paid at 60%, even if the participant's maximum out-of-pocket is met for the plan year.

Important Note: Always contact RBA before you have a non-emergency service performed at a non-St. Luke's facility (or non-ICHN facility for EPO Plan participants).

In the event of an emergency, where the participant is taken to another hospital, the participant must be transferred to a St. Luke's facility (or ICHN facility, if enrolled in the EPO Plan) when it is medically safe and practical to do so (in the opinion of the utilization manager and the attending physician). Participants not transferred in this manner will be subject to the 60% benefit level.

For the few services not provided at a local St. Luke's facility, you will need to confirm with RBA, during the pre-certification review process, where you may have those services provided in order to receive the highest benefit level.

St. Luke's Magic Valley provides mental health services. Should you require an inpatient mental health stay, you will be eligible for the 25% St. Luke's Discount if you choose St. Luke's Magic Valley for these services.

Please note: Services not currently provided at St. Luke's may be added at any time. For example: mental and nervous disorders and dialysis are not currently provided at St. Luke's. It is your responsibility to confirm with RBA that a particular service or procedure is not provided at St. Luke's, before having the service provided at another facility.

Idaho Community Health Network, Inc. (ICHN)

COMPANY	CITY	STATE
Bear Lake Memorial Hospital	Montpelier	ID
Benewah Community Hospital	St. Maries	ID
Bingham Memorial Hospital	Blackfoot	ID
Bonner General Hospital	Sandpoint	ID
Boundary Community Hospital	Bonnors Ferry	ID
Caribou Memorial Hospital	Soda Springs	ID
Eastern Idaho Regional Medical Center	Idaho Falls	ID
Elmore Medical Center	Mountain Home	ID
Franklin County Medical Center	Preston	ID
Gooding County Memorial Hospital	Gooding	ID
Harms Memorial Hospital	American Falls	ID
Holy Rosary Medical Center	Ontario	OR
Idaho Elks Rehabilitation Hospital	Boise	ID
Kootenai Medical Center	Coeur d'Alene	ID
Lost Rivers Hospital	Arco	ID
Madison Memorial Hospital	Rexburg	ID
McCall Memorial Hospital	McCall	ID
Memorial Hospital, Weiser	Weiser	ID
Mercy Medical Center	Nampa	ID
Minidoka Memorial Hospital	Rupert	ID
Oneida County Hospital	Malad City	ID
Portneuf Medical Center	Pocatello	ID
Shoshone Medical Center	Kellogg	ID
St. Luke's Boise Medical Center	Boise	ID
St. Luke's Magic Valley Medical Center	Twin Falls	ID
St. Luke's Meridian Medical Center	Meridian	ID
St. Luke's Wood River Medical Center	Ketchum	ID
Syringa General Hospital	Grangeville	ID
Teton Valley Hospital	Driggs	ID
Walter Knox Memorial Hospital	Emmett	ID
West Valley Medical Center	Caldwell	ID

Important Legal Reminders

HIPAA Privacy & Security

St. Luke's is committed to protecting your medical information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy & Security Practices is available on Inside St. Luke's/Human Resources. Or, you may obtain a copy by contacting the Benefits Department at 381-3430.

C.O.B.R.A. Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may have the right to continue group health care coverage when specific events occur that would normally result in loss of coverage. It is the employee's responsibility to notify Human Resources when qualifying events occur so you can be issued your COBRA rights. Qualifying events include termination of employment, changing status so you no longer qualify for insurance benefits, a dependent reaches the age of 19 (or 23 if they are a full-time student), divorce, or a dependent gets married or is no longer eligible to be claimed as a dependent when you file your taxes.

Notice to St. Luke's Group Health Plan Participants regarding the Women's Health and Cancer Rights Act of 1998

On October 21, 1998, the Women's Health and Cancer Rights Act was enacted requiring health plans to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), to provide certain benefits for reconstructive surgery following a mastectomy. This notice is to inform you of such benefits and is intended to satisfy the requirements of ERISA section 713(b) as amended by the Women's Health and Cancer Rights Act of 1998.

In the event you receive benefits under St. Luke's Group Health Plan in connection with a mastectomy, the following services will also be covered under the Plan, as long as the decision for such services is made in consultation with your attending physician.

1. Reconstructive surgery of the breast on which the mastectomy has been performed.
2. Reconstructive surgery of the other breast in order to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications during all stages of the mastectomy, including lymphedemas.

If you receive the benefits described on this Notice, the Plan may not:

- A. Deny you eligibility, or continued eligibility to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the breast reconstruction requirements; nor
- B. Penalize or otherwise reduce or limit the reimbursement of an attending physician or other provider, or provide incentives (monetary or otherwise) to an attending physician or other provider to induce him or her to provide care in a manner that is inconsistent with the Women's Health and Cancer Rights Act of 1998.

Coverage for the reconstructive benefits under St. Luke's Group Health Plan will be subject to the same deductibles and coinsurance amounts as other covered expenses under the Plan.

If you have any questions regarding this Notice and/or benefits described in this Notice, please contact St. Luke's Benefits Department at 381-3392 during regular business hours.

25% Discount on Facility Fees Provided at a St. Luke's Facility

St. Luke's benefits eligible employees and their eligible dependents (flex employees and their dependents are not eligible), will be able to receive a 25% discount off the balance of the facility portion of their bill for services received at a St. Luke's facility.

Simply put, after insurance has paid, if there is still a balance due, the employee/dependent can receive 25% off the facility portion for services covered under their insurance plan.

Only facility services incurred on or after an employee's hire date or date an employee transfers to a benefits eligible status are eligible for the discount. This discount **excludes**: 1) Physician and/or Professional fees, 2) Outpatient prescriptions and 3) Non-covered services.

You do not need to be enrolled in St. Luke's Group Health plan to receive this benefit.

IMPORTANT! In order to be eligible for this benefit, please complete the Dependents Information section on-line. Please be sure to include all of your eligible dependents, if applicable. If you do not include all eligible dependents, Patient Financial Services will not have adequate information to process the 25% Discount.

Other Benefits Available at St. Luke's

Life Insurance/Accidental Death & Dismemberment Options

All benefit eligible employees are eligible for a basic term life insurance policy. Benefits are paid at one times your annual salary for 72-80 hour full-time employees. Double indemnity for accidental death. Reduced benefits available for part-time employees. St. Luke's pays the full cost of this coverage.

Full-time and Part-time employees may purchase supplemental coverage in increments of \$5,000, up to \$100,000 (health statement required on spouse for amounts greater than \$50,000).

Any changes to coverage after initial enrollment cannot be implemented until a health statement has been sent to and approved by ING.

Your dependent life insurance options are as follows:

Dependent Life

Insurance Options

Spouse

Available in \$5,000 increments, up to \$100,000

Children up to 19 (or 23 if FT student)

Choice of \$5,000 or \$10,000 in coverage

**Benefits reduce at age 70. See policy for specifics.*

Long-Term Disability (LTD) Option

All full-time and part-time level III employees are eligible for coverage under the St. Luke's Health System Long Term Disability plan. St. Luke's pays for the full cost of this benefit. Eligible employees are effective first of the month following 90 days of employment. This benefit provides 60% of base earnings after a 90 day waiting period (from day of disability) for own occupation disability. Maximum benefit per month is \$8000.

Employee Assistance Program (EAP)

St. Luke's provides EAP services to its employees through Reliant Behavioral Health (RBH). RBH offers confidential, short-term, professional counseling services for employees and family members.

Who is eligible for the EAP? St. Luke's benefits eligible employees and their eligible dependents, living in or outside of the home.

How much does EAP cost and what does the EAP provide?

1. **Counseling Services:** You and your family have access to confidential services at no cost to you, up to 8 face-to face counseling sessions for each new issue. Confidential counseling services are available for a variety of short-term issues, including family, relationship, work stress, anxiety and other challenges you face on a daily basis.
2. **Legal and Financial Services:** You have convenient access to legal and financial professionals by simply calling the EAP. Legal services include a free, half-hour consultation, by phone or in person, followed with a 25% discount in legal fees. Legal services are not provided for any employer related issues.

Financial Services provide free telephone consultations for financial issues. A 25 % discount is offered if a local/RBH contracting CPA is retained.

3. **Identify Theft Services:** Identify theft services offer support and help plan the recovery process for restoring your identify and credit following an incident of theft.
4. **Personal Advantage:** The EAP includes Personal Advantage, a health and wellness focused website, with interactive self-care tools and information on work stress, parenting, relationships, personal growth, health, child & eldercare resources, maternity support and access to more than 50 online trainings.

How do I access the EAP?

Call 1-866-750-1327 to schedule a counseling appointment, access legal or financial services, ask questions and get information. You may also call for 24-hour crisis assistance.

How do I access the Personal Advantage website?

1. Go to www.reliantbh.com
2. Click on the Register button
3. Follow the Registration instructions. Your company name is SLHS.

Flexible Spending Accounts (FSA)

Please Note:

For new hires or eligible transfers, this benefit becomes effective the first day of the month following 90 days of employment.

Important!

**You must re-elect this benefit every Annual Enrollment.
This benefit does not “carry over” from year to year.**

Do you feel like you pay too much in taxes?

Can you predict how much you spend on dependent care each year?

Can you predict how much you spend on health care each year?

If you answered “yes” to any of the above, a Flexible Spending Account may be just the benefit for you!

Flexible Spending Accounts are designed to help you pay for certain health care and dependent care expenses using tax-free dollars. The dollars you put into these accounts are never taxed — not when they go into your account or when they come out as a reimbursement for eligible expenses.

St. Luke's offers two Flexible Spending Accounts (FSA) - the Health Care Account and the Dependent Care Assistance Account. If you contribute to an FSA, you put money into an account before taxes are deducted from your pay, thus lowering your taxable income. When you submit claims for eligible expenses, you withdraw tax-free dollars from your account(s).

As you consider whether the Health Care and/or Dependent Care Assistance Account is right for you, keep the following points in mind:

- The Health Care Account is for eligible health care out-of-pocket expenses: deductibles, co-payments, eligible expenses not covered under our medical plan.
- The Dependent Care Assistance Account is for dependent care expenses that allow you, or you and your spouse, to work. Special Note: The dependent care assistance account is not for dependent health care expenses.
- Each account is completely separate: You cannot, for example, use funds from the Dependent Care Assistance Account to pay for your children's medical expenses.
- “Use It or Lose it.” At the end of the Plan Year (April 1, 2009 through March 31, 2010), if there is any money left in your FSA that you have not submitted claims for services completed within the Plan Year, you will lose the unspent money.
- Elections are irrevocable unless you submit the appropriate paperwork to the Benefits Department within 60 days of a qualified change in status. Please note: The change you make to your FSA election must be consistent with the qualifying event. For example, if your qualifying event is the birth of a new baby, you can only increase (not decrease) the amount of your annual Health Care Account election. Another example: You cannot decrease the amount of your annual Health Care Account if your dependent turns age 23 in the plan year. The IRS assumes that you know your dependent will turn 23 years of age in the current plan year and will make your original election in accordance with this “foreseen” event.

Flexible Spending Account Plan - Eligible Expenses to Consider:

- (1) Over-the-counter (OTC) medicine and drugs used for medical care as defined by section 213(d) 1 of the CODE may now be eligible for reimbursement through a Flexible Spending Account.

Section 213(d) 1 defines "medical" care to include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of a disease, or the purpose of affecting any structure or function of the body. The item must be a medicine or drug. Items such as pain relievers, antacids, allergy and cold medicine are eligible expenses. However, general health items such as vitamins, food supplements, dietary aids and sundry items such as lotions, toothpaste, acne cream, cotton balls, latex gloves, diagnostic pregnancy test, condoms, etc. are not eligible expenses. That is, OTC items for prevention, diagnostic and general supplies, and "health and beauty aids" are not eligible FSA expenses.

The request for reimbursement must be accompanied by an itemized receipt that specifies the name of the medication (e.g. "Advil", "Tylenol," etc.), the name of the provider (e.g. St. Luke's, Walmart, etc.), cost of the item purchased and medical necessity. Also note that sales tax is not eligible for reimbursement.

- (2) You may elect to have your FSA reimbursements deposited directly into your savings or checking account. If you elect this option and submit the appropriate paperwork, automatic reimbursements are made twice a week, rather than every Friday.

Please refer to the sample Authorization for Direct Deposit of Reimbursement Claims.

You may elect direct deposit of your FSA reimbursement. If you do not check one of the boxes, you will automatically continue to receive reimbursement checks through the mail. Similarly, if you elect the direct deposit option, but do not complete and submit the required authorization form (or do not attach the required voided check or pre-printed deposit slip), you will automatically continue to receive reimbursement checks through the mail.

If you elected the direct deposit option last plan year, you do not need to re-elect direct deposit. However, please be sure to mark the box on the election form which states: "Please continue direct deposit with the information already on file."

For those who do not elect to have their reimbursements made through direct deposit, you will continue to receive a check. Checks will continue to be generated every Friday.

If you elect the direct deposit method, you will be notified of the amount deposited in your account as follows:

- (1) For the month(s) you submit claims for FSA reimbursement, Pinnacle Pension Services will send you a summary statement. The first week of the following month this summary will include annual election amount, year-to-date amount deducted (from your paycheck), year-to-date amount reimbursed, amount reimbursed for the month and the date the deposit was sent.
- (2) If you will be receiving a reimbursement that is less than the amount you have requested on your claim form, Pinnacle Pension Services may be contacting you by telephone to let you know the amount that will be reimbursed and the reason for the reduction.

If you have any questions about the direct deposit option, please feel free to contact Pinnacle Pension Services at 433-0030.

Flexible Spending Account Tax Savings for Dependent Care and/or Health Care

The following is an example to help you understand how enrolling in an FSA account(s) can save you tax dollars. Note: The following is an estimate for illustrative purposes only, you will need to talk to your tax advisor to determine the exact amount of tax savings available to you.

Assume:

Employee A and Employee B:

- Earn \$1760.00 per pay period
- Know they will spend \$2,600 for Dependent Care Expenses between April 1, 2009 through March 31, 2010.
- Know they will spend \$1000 for Health Care Expenses between April 1, 2009 and March 31, 2010.

Assume:

Employee A does not elect to cover his/her eligible expenses under a Flexible Spending Account(s).

Assume:

Employee B does elect to cover his/her eligible expenses under a Flexible Spending Account(s).

Account Annual Maximums:

Health Care Account: \$5,000
Dependent Care Assistance Account: \$5,000

Assume Pledge Per Short Plan Year:

Dependent Care: \$2,600 (\$100 per pay period)
Medical/Dental: \$1000 (\$38.46 per pay period)

	<u>Employee A</u> Without an FSA	<u>Employee B</u> With an FSA
Gross Pay:	\$1,760.00	\$1,760.00
Less FSA Deduction:	<u>-0-</u>	<u>- 138.46</u>
Taxable Income:	\$1,760.00	\$1,621.54
Taxes (30% + 7.65%):	<u>- 662.64</u>	<u>- 610.51</u>
Total Take Home Pay:	\$1,097.36	\$1,011.03
Medical Expense:	-38.46	0.00
Dep. Care Expense:	<u>-100.00</u>	<u>0.00</u>
Net Spendable Income:	\$ 958.90	\$1,011.03

Employee B: Increase in take-home pay per pay period: \$52.13

Employee B: Annual increase in take-home pay: \$1,355.38

Because employee "A" decided not to enroll in a FSA, all "known" expenses will have to be paid with after-tax dollars. Whereas, employee "B" had all "known" expenses elected under an FSA. Therefore, employee "B" actually has \$52.13 per pay period, or \$1,355.38 over the year to spend at the gift shop, the cafeteria, "Cafe 190", "Big Apple Deli," or any place else s/he so desires.

A health care FSA may only reimburse medical expenses as defined in IRC Section 213(d). Although this is the same medical definition used by individual taxpayers who take a deduction on their tax return for medical and dental expenses that exceed 7.5% of their adjusted gross income, the difference between an FSA and taking the deduction on your tax return depends on when the services are received for an FSA versus when you pay for services in order to itemize them as deductions on your taxes.

Health Flexible Spending Account (FSA) Reimbursements

A healthcare FSA reimburses expenses incurred for medical care as defined in IRC Code Section 213(d). This code section is written to assist individuals in determining allowable Schedule A income tax deductions. There are certain deductible expenses allowed under Section 213(d) that are not reimbursable through a health FSA. The following is a partial list of common medical expenses and how they are treated by an FSA.

Examples of expenses eligible for FSA reimbursement:

Acupuncture	Hearing devices and batteries	(including contraceptives)
Alcoholism treatment	Fees for licensed osteopaths	Psychiatric care
Ambulance service	Fertility treatments	Psychologist fees
Artificial limbs	Flu shots	Retarded persons' cost for special home
Artificial teeth	Handicapped persons' schools	Routine physicals and other non-diagnostic services or treatments
Birth control pills	Hospital bills	"Seeing-eye" dog and its upkeep
Birth prevention surgery	Immunizations	Special communication equipment for the deaf
Braces	Laboratory fees	Special education for the blind
Braille reading material	Laser eye surgery	Special plumbing for the handicapped
Care for mentally handicapped	Fee to retirement home for medical care	Sterilization fees
Chiropractors	Medical monitoring & testing devices	Surgical fees
Christian Science practitioners	Medical Services	Therapeutic care for drug and alcohol addiction
Co-Insurance payments	Norplant insertion or removal	Therapy treatments
Contact lenses	Nursing fees (including nurses' room and board when paid by taxpayer)	Transportation for medical services
Cosmetic surgery (as defined under IRC section 213 - medically necessary)	Obstetric expenses	Tuition at special schools for the handicapped
Crutches	Operations (as defined under IRC section 213)	Insulin
Deductibles	Orthodontia	Wheelchair
Dental fees (excludes cosmetic repairs)	Orthopedic shoes	Wigs (as defined under IRC section 213)
Dentures	Over-the-Counter (OTC) medicine and drugs	X-rays
Diagnostic fees	Oxygen	
Electrolysis (as defined under IRC section 213)	Physicians' fees	
Eyeglasses	Pregnancy tests	
Eye examinations	Prescribed medicine and drugs	
Fee for practical nurse		
Fees for healing services		

Examples of expenses not eligible for FSA reimbursement

Arch supports, kness & wrist braces (unless prescribed and medically necessary)	First aid supplies	Neck support pillows
Blood pressure machines (unless prescribed by a physician as medically necessary for constant monitoring of blood pressure due to a medical condition)	Fitness programs & health club dues	Rogaine
Breast pumps (unless underlying medical reason)	Hair transplant	Safety glasses
Chinese herbal treatments	Health club dues	Smoking cessation & smoking cessation drugs
Cosmetic surgery	Herbs	Sonicare toothbrushes & replacement brushes
Dental bleaching or any other teeth whitening	Humidifiers	Supplements
Electrolysis or hair removal	Insurance premiums of any kind	Tanning salons
	Laetrile, even if prescribed by a doctor, is <i>not</i> reimbursable	Tuition for Special schools (unless it is a special school to treat a specific condition like blindness, speech, etc.)
	Lamaze/childbirth classes	Vitamins
	Marijuana or other controlled substances	Weight loss programs & machines
	Marriage counseling	
	Massage therapy	
	Maternity clothes	

This list is not all-inclusive and may be subject to change based on IRS codes for eligible expenses. This list compiled from CCH Federal Tax Guide Reports.

Flexible Spending Accounts Worksheet

This is for your own calculations only - do not submit to Benefits.

HEALTH CARE ACCOUNT:

You can contribute up to \$5,000 a year to the Health Care Account before taxes are deducted from your paycheck. Your contributions will be automatically deducted in equal amounts from each paycheck. Then, when you have a health care expense not covered by another plan, you can be reimbursed from your Health Care Account – tax free (refer to the previous page listing). *Please note: You cannot be reimbursed through your Health Care Account for any pre-tax health insurance premiums or for cosmetic surgery, except for the correction of a congenital birth defect.*

	Estimated Cost
Medical Deductibles:	\$ _____
Dental Deductibles:	\$ _____
Medical coinsurance:	\$ _____
Dental coinsurance:	\$ _____
Annual physical exam:	\$ _____
Eligible over-the-counter medicine and drugs:	\$ _____
Eyeglasses, contact lenses, and insurance:	\$ _____
Orthodontic expenses above the maximum paid by your plan:	\$ _____
Other: _____	\$ _____
_____	\$ _____
_____	\$ _____
	\$ _____ TOTAL

DEPENDENT CARE ASSISTANCE ACCOUNT:

The Dependent Care Assistance Account works much like the Health Care Account. You can contribute up to \$192.30 per payperiod to this account before taxes are deducted from your paycheck. To help you estimate your eligible dependent care expenses, look at the list below and fill in the expenses you will have. Your contributions will be automatically deducted in equal amounts from each paycheck. Then, when you have an eligible dependent care expense, you are reimbursed from your Dependent Care Assistance Account – tax free. Remember, these must be expenses you incur so that you – or you and your spouse – can work or so that your spouse can attend school full-time. **Do not include health care expenses in this account.**

	Estimated Cost
Qualified daycare center (child or adult):	\$ _____
Nursery school:	\$ _____
Before-school/after-school care:	\$ _____
Summer day camp:	\$ _____
Baby-sitter while you are at work:	\$ _____
Housekeeper whose duties include daycare:	\$ _____
Other: _____	\$ _____
_____	\$ _____
_____	\$ _____
	\$ _____ TOTAL



**EMPLOYEE/PARTICIPANT
FLEXIBLE SPENDING ACCOUNT
AUTHORIZATION FOR DIRECT DEPOSIT OF
REIMBURSEMENT CLAIMS**

Company Name: St. Luke's

Employee/Participant's Name: Hank A. Hart

Employee/Participant's SS #: 555-55-5555

I hereby authorize Pinnacle Pension Services, Inc. to initiate credit entries to my:

☒ Checking account

☐ Savings Account

Indicated below and the depository named below to credit the same to such account.

*An actual voided check must be attached.

Staple Voided Check Here

*The form cannot be processed without a voided check or a pre-printed
deposit slip (if you have elected a savings account).*

Bank account number: 123456789

Name of financial institution: Inland Ocean Bank

Branch location: Downtown

City: Boise State: Idaho

Bank ACH Transit Routing Number: 987654

This authorization will remain in full force and effect until Pinnacle Pension Services, Inc. has received written notification from me of its termination in such time and in such manner as to afford Pinnacle Pension Services, Inc. a reasonable opportunity to act upon it.

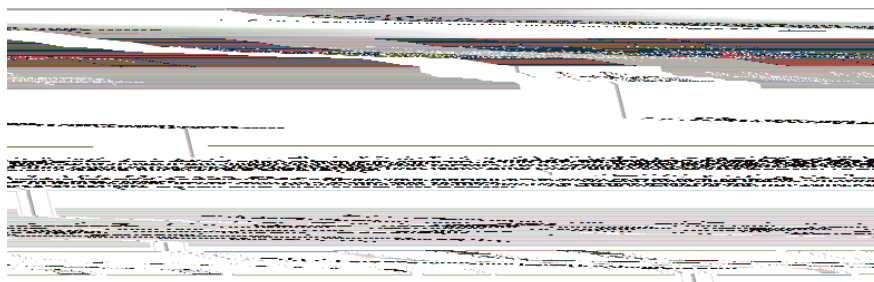
Signature of participant:  Date: 4/15/09

Pinnacle Pension Services has an on-line claims filing system. You will be able to monitor your FSA at www.MyFlexOnline.com.

- Social Security Number: Enter your nine-digit Social Security Number without dashes or slashes.
- Date of Birth: Enter your date of birth in a mm/dd/yyyy format.
- E-mail Address: Enter your e-mail address. This e-mail address will be used to facilitate the “Lost Password” function if needed.
 - Must begin with a letter or number.
 - Must contain only letters, numbers, and a single @, one or more periods, and may contain any of the following special characters: ! @ # \$ % ^ & * () _
 - Must contain at least one character before and after the “@”.
 - The string after the “@” must contain a period.
 - There must be at least one letter or number after the “@” and before the period.

Step 1 - Start Your Form

- Click on “Request Payment” tab in the top blue bar.
- This page will show several text boxes for you to fill in with information about each item you purchased.



Step 2 - Enter Each Item

- For the first item, select the “Claim Type” from the drop-down menu that matches your purchase, like “MEDFEE” for medical charges, or “RX” for prescriptions. Medical claims for your eligible dependents should be entered with the appropriate medical description. The “DEPCARE” claim type is only for things like daycare and babysitting for people who have Dependent Care FSAs.
- In the “Description” box, enter a brief description of the charge, like “surgery”, or “dental] copay”.
- Enter the total amount you are claiming in the “Amount” box. Do not include the dollar sign.
- In the “Dependent” box, enter the name of the person who needed the service.
- Once you have entered all the information, click “Add An Item”, located just below the form you filled in. The claim will show up at the bottom of the page.
- Repeat Step 2 for each item you purchased out-of-pocket.

Step 3 - Finish Your Form

- Once you have entered each item, scroll down the page, below the “Detailed Instructions” section, and you should see each item you have entered.
- If anything is entered incorrectly, just click the “Remove” link to the right of the item, and it will remove the item only.
- Click the blue “View Form” button at the bottom of the page, once each item is correct. The next page will show a list of each item, as well as a total.
- If all the information is correct, click the blue “Continue” button on the right side of the page, then on the next screen, click the blue “Print” button. Your form should print automatically!

Pay in Lieu of Benefits (PILB)

The pay in lieu of benefits plan is an **OPTIONAL** benefit election and designed to allow benefits eligible employees who have health insurance coverage under a non-St. Luke's health plan, to elect a higher rate of pay in lieu of certain benefits.

If you choose this option, you are agreeing to **FORFEIT** the following:

- Group Health Plan
- Paid Time Off (PTO)
- Extended Sick Leave (ESL)
- Long Term Disability (LTD)
- PTO Donations
- ESL Bonus
- Group Term Life & Supplemental Term Life Insurance
- Adoption Reimbursement

You will **RETAIN** (based on applicable eligibility and FTE Status) the following St. Luke's benefits:

- Retirement Program
- Flexible Spending Account (FSA)
- Tuition/Certification Reimbursement
- Employee Assistant Program (EAP)
- On-Site Child Care (Little Luke's)
- Leave of Absence Program
- E. E. Gilbertson Scholarship
- Workers' Compensation
- Unemployment Insurance
- Wellness & Tobacco Challenge
- All Voluntary Benefits
- Years of Service Awards
- Bereavement Pay

With PILB being an optional election, if you do not elect PILB, you will remain eligible for all applicable benefits based on your employment status. For example, if you do not want to enroll in St. Luke's Group Health Plan, you are not required to elect PILB.

For eligible employees electing pay in lieu of benefits, their base salary will be increased as follows:

Full-time:	(80 hours per pay period)	15%
PTLIII:	(56-79 hours per pay period)	12%
PTLII:	(32-55 hours per pay period)	9%

PILB Enrollment: Employees are only eligible to elect (or revoke) PILB within 30 days of their hire or transfer to a benefits-eligible status date, during the designated annual enrollment period, or within 60 days of a qualifying change in status. Reminder: If an employee revokes PILB during an annual enrollment period s/he will not be able to enroll in St. Luke's Group Health Plan until an "open enrollment" period, or (2) the employee experiences a qualifying change in status.

PILB elections will continue and are irrevocable until the employee revokes PILB during one of the periods described in the preceding paragraph.

Electing PILB:

Paid Time Off (PTO) Provisions

Once the pay in lieu of benefits plan is elected, the electing employee's regular PTO balance will be paid out at the employee's current base hourly rate (net of the PILB premium), and is taxed at the 28% statutory federal limit plus state and other applicable taxes. Thereafter, PTO will not accrue.

Vacation, holiday, and short-term illness days will be taken by the PILB participant without pay.

If an employee revokes PILB during annual enrollment or with a qualifying event, and they remain in a benefits eligible employment status, they will once again accrue PTO based on their years of service with St. Luke's.

Extended Sick Leave (ESL) Provisions

ESL balances will be frozen as of the elected PILB effective date. ESL cannot accrue nor be used while the employee is a PILB participant. Time off due to an employee's own injury or illness will be without pay. All leave of absence policies will apply (although applicable LOAs will start immediately following the last day worked due to the injury or illness).

If an employee revokes PILB during annual enrollment or with a qualifying event, and they remain in a benefits eligible employment status, they will once again accrue ESL and be eligible to use according to St. Luke's policies.

Voluntary Benefits

In an effort to continue to provide the highest level of benefits to you, we are offering Supplemental Insurance through AFLAC, MetLife, MedAmerica and MetLife Supplemental LTD. Your participation is voluntary, and you may choose which plans would most benefit you and your family.

As a convenience to employees who want to participate in any of the Voluntary Benefits, St. Luke's has agreed to take payroll deductions from employees and remit them to the elected vendor(s). Please appreciate that the program provides products offered by AFLAC, MetLife, MedAmerica and MetLife Supplemental LTD and is not an employee benefit plan sponsored by St. Luke's.

Accordingly, St. Luke's has no responsibility for the administration of the Program or for any benefits payable thereunder. St. Luke's does not guarantee that AFLAC, MetLife, MedAmerica or MetLife Supplemental LTD offer the lowest rates in any particular circumstance. All inquiries with respect to the plans should be directed to AFLAC at (208) 322-6610, MetLife at 1-800-GET-MET8 (1-800-438-6388), MetLife Supplemental LTD at (208) 375-7540 x106 and MedAmerica at (208) 467-4862.

Long Term Care offered by MedAmerica: Long Term Care Insurance provides a cash benefit to those needing convalescent care, whether at home, or in a nursing home. Most people think of this type of coverage when they think of the elderly. That is clearly one application. However, what you may not realize is that over 40% of convalescent care is for those under age 65 (due to disability illnesses, auto or sports injuries, etc.). Furthermore, health insurance does not cover any expenses associated with convalescent care. Thus, those who are disabled have to draw down on their pensions/savings in order to pay for their care. The result is the spouse loses their future retirement security because those dollars have been spent.

Simplicity Long Term Care Insurance from MedAmerica Insurance pays a monthly cash benefit to those who need home care or nursing home care, regardless of services used or amounts spent. An eligible policyholder can use the monthly cash benefit for care as they choose-whatever is needed from whomever you want, wherever you are, anywhere in the world-without policy restrictions or limitations.

With Simplicity, you can have coverage to fit your lifestyle, rather than change your lifestyle to fit the coverage. You select the amount of the monthly benefit, the payment terms, and whether certain policy features are desired (inflation protection, etc.).

MetLife Supplemental Long Term Disability (LTD) Plan: Did you know your current Long Term Disability coverage through St. Luke's provides up to 60% of your pre-disability earnings in the event you become disabled? If you qualify for the 60% LTD benefit, you will pay taxes on the up to 60% benefit you receive. Can your family maintain your current lifestyle on less than half of what you earn today? The new voluntary Supplemental Long Term Disability plan through MetLife allows you to protect a greater portion of your income in the event you become disabled. The MetLife Supplemental LTD plan includes a provision that allows up to 100% income replacement in the event that you incur a catastrophic disability.

If you are a St. Luke's benefits eligible employee regularly scheduled to work more than 56 hours per pay period, you are eligible to purchase this supplemental coverage. Look for information on this valuable new program in the coming weeks!

Voluntary Benefits Brought to You by AFLAC **(208) 322-6610 or email: dmajors@rmci.net**

Some important features of AFLAC's Supplemental Insurance:

- Benefits paid directly to insured, unless assigned
- Pays regardless of other insurance
- Payroll rates may be continued when employment terminates
- Guaranteed - renewable for life
- Family or Individual coverage

Some of the plans available through payroll deduction:

Personal Accident Expense (Pre & Post Tax)

- 24-hour coverage for all insured for accident/injury
- Payments for Emergency doctor visits, follow-up or referral visits, hospitalization, specific injuries/treatments/surgeries, ambulance, appliances, physical therapy, annual wellness procedures and more
- Accidental death and dismemberment benefits are included

Personal Short Term Disability (Post Tax)

- Design a policy to meet your income replacement needs for accident and sickness.
- Provides both Accident and Sickness disability
- Monthly benefit amount/elimination periods designed specifically for you

Hospital Intensive Care (Pre Tax)

- Covers any Intensive Care Confinement - Coronary ICU, Neonatal ICU, etc.
- Daily benefit dollar amounts increase with number of days confined to ICU
- Organ transplant benefit
- Air and Ground ambulance benefit

Cancer Expense Protection (Pre Tax)

- Covers ALL types of cancer
- Internal cancer survivors can obtain coverage after 5 years of remission
- Benefits paid for annual wellness diagnostic tests, initial diagnosis of malignancy, hospitalization, radiation/chemotherapy, in-or-out patient surgery/anesthesia, blood/plasma, prosthesis, ambulance, travel/lodging, bone marrow transplantation, stem cell transplantation, home health care, NCI evaluation/consultation and more

Voluntary Benefits Brought to You by MetLife® **(1-800-GET-MET8)**

MetLife® Group Auto and Home/Personal Property Insurance

If you haven't shopped around for your auto and homeowner's coverage lately, you might consider requesting free premium quotes from MetLife® Auto and Home Insurance. With special group rates and other discounts for St. Luke's Regional Medical Center, you could save up to \$200 on your auto insurance alone.

To provide peace of mind for its customers, MetLife Auto & Home now includes identity theft resolution service, at no additional charge, on all its renters, condominium, and standard homeowners policies. The service is provided by IdentityTheft 911™, one of the nation's foremost providers of identity theft crisis resolution and education services.

MetLife Auto & Home customers whose policies have Identity Theft and Credit Protection simply call a toll-free claim number upon discovering something suspicious regarding their credit. A professional identity theft resolution representative assigned to the case will work one-on-one with customers to help them notify the appropriate authorities, track and monitor their credit files, and work with grantors of credit until their name and credit have been restored.

MetLaw® Premier Legal Plan

The Group Legal Plan made available by Hyatt Legal Plans, a MetLife Company, provides you with legal representation that's both cost-effective and convenient. Whether you are selling a home, preparing a will or dealing with an unexpected legal matter, the advice of an experienced attorney can be essential. With MetLaw, you will find a qualified attorney that won't break your budget.

Special Note: Elections made to Hyatt Group Legal Services Plan effective April 1, 2009 are irrevocable through March 31, 2010.

Veterinary Pet Insurance

Available plans cover medical treatments and surgeries for accidents and illnesses for your dog or cat - over 6,400 medical conditions ranging from minor problems such as ear infections and fleas, to major conditions such as broken bones, diabetes and cancer.

MetLife Auto & Home is a brand of Metropolitan Property and Casualty Insurance Company and its affiliates: Metropolitan Casualty Insurance Company, Metropolitan Direct Property and Casualty Insurance Company, Metropolitan Group Property and Casualty Insurance Company, Metropolitan General Insurance Company, and Metropolitan Lloyds Insurance Company of Texas, all with administrative home offices in Warwick, RI. Coverage, rates, and discounts are available in most states to those who qualify. Veterinary pet insurance policies are provided by Veterinary Pet Insurance Company (in California), Brea, CA, or National Casualty Company (in all other states), Madison, WI, an A+15 rated company. These companies are not affiliated with Metropolitan Life

ST. LUKE'S REGIONAL MEDICAL CENTER HEALTH AND WELFARE BENEFIT PLANS ADMINISTRATIVE INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:

St. Luke's Regional Medical Center
190 East Bannock
Boise, ID 83712
208-381-2222

2. Name, address, and telephone number of the Plan Administrator:

St. Luke's Health System
420 West Idaho
Boise, ID 83702
208-381-2222

3. Employer's federal tax identification number:

56-2570681

4. Plan Numbers

Health Care Plan – 501
Life Insurance Plan - 503
Long Term Disability Plan – 504
Health Care Flexible Spending Account – 505
Extended Sick Leave – 506

5. Plan years for fiscal record purposes:

Health Care Plan – April 1 through March 31
Life Insurance Plan – October 1 through September 30
Long Term Disability Plan – April 1 through March 31
Health Care Flexible Spending Account – April 1 through March 31
Extended Sick Leave Plan – June 1 through May 31

6. Type of Plans:

Health Care Plan: The Health Care Plan is a welfare plan providing medical, dental and vision benefits through an Internal Revenue Code section 125 cafeteria plan. The Health Care Plan is subject to the Employee Retirement Income Security Act (ERISA) of 1974, as amended and is intended to comply with all other applicable federal and state laws.

Life Insurance Plan: The Life Insurance Plan is a welfare plan providing life insurance benefits. The Life Insurance Plan is subject to ERISA, as amended and is intended to comply with all other applicable federal and state laws.

Long Term Disability Plan: The Long Term Disability Plan is a welfare plan providing disability benefits. The Long Term Disability Plan is subject to ERISA, as amended and is intended to comply with all other applicable federal and state laws.

Health Care Flexible Spending Account: The Health Care Flexible Spending Account is a welfare plan providing self funded medical reimbursements. Health Care Flexible Spending Account is subject to ERISA, as amended and is intended to comply with all other applicable federal and state laws.

Extended Sick Leave Plan:

The Extended Sick Leave Plan is a welfare plan providing short term disability benefits. The Extended Sick Leave Plan is subject to ERISA, as amended and is intended to comply with all other applicable federal and state laws.

7. Source of Contributions:

All of the plans are funded through employer contributions and/or employee before-tax and after-tax contributions.

8. Funding Medium and Administration:

Medical and Vision Care Plans: Self-funded medical and vision claims are paid for by St. Luke's Regional Medical Center out of its general assets. Medical and vision benefit payments are administered by:

Riverside Benefit Administrators, Inc.

P.O. Box 5679

Boise, ID 83705

(208) 333-1580

Dental Care Plan: Self-funded dental claims are paid for by St. Luke's Regional Medical Center out of its general assets. Dental benefit payments are administered by:

Delta Dental of Idaho

P.O. Box 2870

Boise, ID 83701

(208)489-3580

Life Insurance Plan: Group Term Life insurance premiums are paid for by St. Luke's Regional Medical Center out of its general assets. Life insurance benefits are provided through the purchase of insurance from:

Reliastar Life Insurance Company/ING

20 Washington Avenue South

Minneapolis, MN 55401

website: www.ingemployeebenefits-us.com.

Long Term Disability Plan: Self-funded long term disability benefits are paid for by St. Luke's Regional Medical Center out of its general assets. Long term disability benefits payments are administered by St. Luke's Regional Medical Center.

Health Care Flexible Spending Account: Self-funded Health Care Flexible Spending Account benefits are paid for by St. Luke's Regional Medical Center out of its general assets. Health Care Flexible Spending Account benefits payments are administered by:

Pinnacle Pension Services

3101 West Main St, Ste 100

Boise, ID 83702

208-433-0030

9. Type of Administration:

Administered by the Plan sponsor in accordance with summary plan descriptions, insurance contracts, administrative agreements and plan documents.

10. Agent for Service of Legal Process:

St. Luke's Regional Medical Center

VP Chief Legal Officer

190 East Bannock

Boise, ID 83712

208-381-2222

IMPORTANT BENEFITS CONTACTS

PLAN:

St. Luke's Benefits Staff

Julie Eng
engj@slrmc.org
381-1164

Dru Sewchok
sewchokd@slrmc.org
381-1108

Elizabeth Martin
martinel@slrmc.org
381-3430

Jessica Connor
connorj@slrmc.org
381-3074

Cathy Swigart
swigartc@slrmc.org
381-3392

Brenda Nelson
nelsonb@slrmc.org
381-3074

Sheri Boicourt
boicours@slrmc.org
381-3883

ADMINISTRATOR/SPECIALITY:

Department Director

Leave of Absences (LOA), all other benefits

LOAs: maternity, paternity, adoption, personal;
certification pre-payment

LOAs: medical, education

Tuition reimbursement, mid-year changes

Flexible Spending Accounts, life insurance, tuition
reimbursement and adoption reimbursement

General benefits

St. Luke's Benefits Plan Administrators

Group Health Plan

Medical & Vision

Riverside Benefit Administrators, Inc. (RBA)
www.rba-sl.com
208-333-1580
1-866-373-1526
For out-of-state: multiplan.com
(Go to "Provider Now & use client #3009)
or 1-800-672-2140

Dental & Orthodontics

Delta Dental
www.deltadentalid.com
208-489-3580
800-356-7586
Email: customerservice@deltadentalid.com

Prescription Drugs

St. Luke's Employee Outpatient Pharmacy
381-DRUG (3784)

RX America

www.rxamerica.com (must register to access)
1-800-770-8014

Employee Assistance Program (EAP) - Mental Health and Substance Abuse

Reliant Behavioral Health
www.reliantbh.com
1-866-750-1327

Flexible Spending Accounts (FSA)

Pinnacle Pension Services
flex@pinnaclepensionservices.com
208-433-0030

Life Insurance Benefits - Group term, AD&D and Supplemental Term Life

Reliastar Life Insurance Company/ING
20 Washington Avenue South
Minneapolis, MN 55401
website: www.ingemployeebenefits-us.com

Other Important Contacts

Call St. Luke's
381-1200

Employee Health & Wellness

EH&W Office

381-2667

Wellness Challenge Program

Terri Landa

Email: landat@slrmc.org

381-3491

Mary Poell

poellm@slrmc.org

706-5031

Retirement

Elaine Sodenkamp

Email: sodenkae@slrmc.org

381-7046

Becky Riddle

Email: riddleb@slrmc.org

381-2741

Sandy Aldrich

aldrichs@slrmc.org

381-2581

Little Luke's Child Care

Jeanne Hayden

haydenj@slrmc.org

381-4670

Long Term Disability (LTD) Program

Jeanne James

jamesj@slrmc.org

381-3040

Voluntary Benefits Vendors

MetLife

www.metlife.com

1-800-438-6388

AFLAC

1-800-992-3522

Dan Majors

322-6610

dmajors@rmci.net

Med America

www.locktonportal.com/den/stlukes

1-888-525-1148

MetLife Supplemental Long Term Disability

Cyndy Erickson

(208) 375-7540 x 106

cynthia.erickson@bankerslife.com

Health Care Idaho Credit Union

381-2099 (Boise)

706-5900 (Meridian)