Master Policy

St. Luke's Health Plan

Small Group Health Care Benefits

Effective January 1, 2027
stlukeshealthplan.org

In the event there is a discrepancy between the information provided during the enrollment period and the contents of this certificate of coverage, the contents herein shall prevail.

St Luke's HEALTH PLAN

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Important Information for Members about St. Luke's Health Plan

Welcome to St. Luke's Health Plan! The health care benefits described in this Master Policy are available to individuals and their families by [Group] the "Group and St. Luke's Health Plan, Inc., an Idaho not-for-profit corporation focused on delivering uncomplicated care and affordable coverage to its Members. St. Luke's Health Plan, Inc. is a wholly owned subsidiary of St. Luke's Health System, which has been caring for Idahoans since 1902.

St. Luke's Health Plan is an Idaho licensed insurance company regulated by the Idaho Department of Insurance under the laws and rules of the State of Idaho. This Master Policy Agreement ("Agreement") sets forth the terms under which health care coverage will be provided under the Plan, including the rights and responsibilities of the contracting parties, the requirements for enrollment and eligibility, as well as the health care benefits, also called Medical Benefits, to which those enrolled under this Agreement are entitled.

This Agreement is made between the Group, St. Luke's Health Plan and the individual designated herein as the Member. In consideration of timely payment of premium, St. Luke's Health Plan agrees to provide the Medical Benefits as described in this Agreement subject to certain terms and conditions contained herein. This Agreement, including the endorsements and attached papers, if any, constitute the entire Master Policy. No change in this Agreement shall be valid until approved by the President or Chief Medical Officer of St. Luke's Health Plan. No one, including the Group, insurance agent, producer, or broker has the authority to change this Agreement or waive any of its provisions. If you are not satisfied with this Agreement for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 10 days after receipt.

St. Luke's Health Plan Members are entitled to receive Medical Benefits while this Agreement is in effect, and Members, and their Dependents, if applicable, are properly enrolled with and recognized by St. Luke's Health Plan. Members do not have any permanent or vested interest in any Medical Benefits under the Plan. Benefits may change as this Agreement is renewed or modified from year to year. Unless otherwise expressly stated in this Agreement, all Medical Benefits end when the Agreement ends. The Agreement begins on the effective date specified by the Group and terminates at the end of that Plan Year. However, the Member's coverage is guaranteed renewable to the extent required by state or federal law.

St. Luke's Health Plan, in collaboration with the Group, establishes reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of Medical Benefits. Members are subject to these administrative practices when receiving Medical Benefits, but they do not change the express provisions of this Agreement.

St. Luke's Health Plan has created a Member Services Advisory Panel to provide Member review of input on certain elements, such as Grievances and cost sharing elements. Members may be eligible to participate in this panel. Participants are selected to represent geographic, demographic and product diversity.

If interested, please send the participation request in writing to:

Attn: Member Services Advisory Panel
P.O. Box 1739
Boise, ID 83702-5809

Medical Benefits are not assignable or transferable. Any attempted assignment or transfer by any eligible individual of the right to receive payment under the Plan will be invalid unless approved in advance in writing by St. Luke's Health Plan.
Any notice that St. Luke's Health Plan is required to send by mail under this Agreement will be sufficient if mailed to the Member at the address appearing in the Plan records. Notice to Dependents will be sufficient if provided to the Member. Any notice to St. Luke's Health Plan will be sufficient if mailed to the principal office of St. Luke's Health Plan. All required notices must be sent by at least first-class mail. Additionally, the Plan may provide written notice indicating where you can locate other documents on our website, along with an option to receive a paper copy free of charge.

St. Luke's Health Plan will not discriminate against any eligible Individuals based on race, sex, religion, national origin, or any other basis forbidden by law. St. Luke's Health Plan will not terminate any eligible individual because of his or her health status or the healthcare needs of the eligible individual or because he or she exercised any right under St. Luke's Health Plan's complaint resolution system.

If Members have questions about their Medical Benefits, call Member Services at (833) 840-3600, or visit stlukeshealthplan.org. Member Services can also provide Members with a Provider Directory and information about In-Network Providers, such as the name, address, phone number, professional qualifications, specialty, medical school attended, residency completed, and board certification status. The Provider Directory also includes information about receiving care after business hours. St. Luke's Health Plan offers assistance in languages other than English by calling (833) 840-3600. St. Luke's offers assistance for Members with hearing impairments by calling 711.

If you have knowledge of fraud, waste, abuse, discrimination or other violations of laws or regulations, call St. Luke's Health Plan's Compliance Line anytime at 866-291-4324. Calls to the Compliance Line are answered by a third party not affiliated with St. Luke's Health Plan and reports can be made anonymously. All reports are treated as confidential and will be investigated fully.

St. Luke's Health Plan employees often respond to inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the Medical Benefits provided by the Plan.

- In the event of a discrepancy between information given by a St. Luke's Health Plan employee, St. Luke's Health Plan vendor, agent, broker, producer, or any other apparent or actual representative of St. Luke's Health Plan, and the written terms of this Agreement, the terms of this Agreement will control.
- Any changes or modifications to Medical Benefits must be provided in writing and signed by the President, or Chief Medical Officer of St. Luke's Health Plan.
- Administrative errors will not invalidate Medical Benefits otherwise in force or give rise to rights or benefits not otherwise provided for by the Plan.

Capitalized words used in this Agreement shall be defined as set forth in the Definitions Section herein, unless otherwise defined in the text of this Agreement.

Again, welcome. We thank you for the opportunity to assist you with your health care coverage needs.

Matthew Wolff
President, St. Luke's Health Plan

Contacting St. Luke's Health Plan

To reach St. Luke's Health Plan Member Services Members should use the number printed on their ID card or contact by mail, fax or online:

Mail: St. Luke's Health Plan
Member Services Department
PO Box 1739
Boise, ID 83702
Phone: (833) 840-3600
Fax: (833) 840-1209
Medical Prior Authorization: (833) 840-1222
Pharmacy Department Customer Service: (833) 975-1281
Pharmacy Department Fax Number: (833) 850-0172
TTY: 711
Website: stlukeshealthplan.org

Member Services' business hours are Monday through Friday, 8 a.m. to 5 p.m. Mountain Time (MT). The office is closed on the following holidays: New Year's Day, President's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after, Christmas Eve and Christmas Day. If the holiday falls on a Saturday, the office is closed on the preceding Friday; if the holiday falls on Sunday, the office is closed the following Monday.

Members can access Medical Benefit information or their specific Claim and enrollment status anytime at stlukeshealthplan.org or by calling the Member Services at (833) 840-3600.

St. Luke's Health Plan does not discriminate against any individual based on race, religion, color, gender, gender identity, sex, sexual orientation, age, national origin, disability, veteran status or any other status or condition protected by law.
St. Luke's Health Plan provides free aid and services to people with disabilities to communicate effectively with us, including:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

St. Luke's Health Plan provides free language services to people whose primary language is not English, including qualified interpreters or information written in other languages.

If you need help in a language other than English, please call St. Luke's Health Plan at (833) 840-3600.

Spanish	Farsi
Si necesita ayuda en [Español], llame a St. Luke's Health Plan al (833) 840-3600. Este es un servicio gratis.	اگر به زبان [فارسی] نیاز به کمک دارید، با «طرح سلامت St. Luke به شماره (833) 840-3600 تماس بگیرید. این خدمات رایگان است.
Arabic	**Nepali**
إذا كنت تحتاج إلى المساعدة في [العربية]، الرجاء الاتصال بـ St. Luke's Health Plan على رقم (833) 840-3600 هذه خدمة مجانية.	तपाईंलाई [नेपाली] मा मद्दत चाहिन्छ भने St. Luke's Health Plan लाई (833) 840-3600 मा फोन गर्नुहोस्। यो एउटा नि: शुल्क सेवा हो।
Kiswahili (Swahili)	**Kirundi**
Ikiwa unahitaji usaidizi katika [Kiswahili], pigia St. Luke's Health Plan kwa (833) 840-3600. Huduma hii hailipiswhi.	Mu gihe woba ukeneye ubufasha mu [kirundi], hamagara St. Luke's Health Plan kuri (833) 840-3600. Bikorwa k'ubuntu.
Russian	**Burmese**
Если вам нужна помощь на [русском], позвоните в клинику Святого Луки по номеру (833) 840-3600. Это бесплатная услуга.	[မြန်မာ] ဘာသာစကားအကူအညီရယူလိုပါက St. Luke's Health Plan ၊ ဖုန်း- (833) 840-3600 သို့ ခေါ်ဆိုပါ။ ၎င်းသည် အခမဲ့ဝန်ဆောင်မှုဖြစ်ပါသည်။
Ukrainian	**Romanian**
Якщо вам потрібна допомога [українською], зателефонуйте до клініки Святого Луки за номером (833) 840-3600. Це безкоштовна послуга.	Dacă aveți nevoie de ajutor în [română], sunați la St. Luke's Health Plan la numărul (833) 840-3600. Acesta este un serviciu gratuit.
Japanese	**French**
[日本語]でのサポートが必要な場合、St. Luke's Health Plan (833) 840-3600 までお電話ください。これは無料サービスです。	Si vous avez besoin d'aide en [français] , veuillez appeler St. Luke's Health Plan en composant le (833) 840-3600. Ce service est proposé gratuitement.
Chinese	**Vietnamese**
如果您需要 [简体中文] 方面的帮助，请致电 (833) 840-3600 与 St. Luke's Health Plan 联系。此项服务免费。	Nếu quý vị cần hỗ trợ bằng [tiếng Việt], hãy gọi St. Luke's Health Plan qua số (833) 840-3600. Đây là dịch vụ miễn phí.
	Korean
	[한국어]로 도움이 필요한 경우, (833) 840-3600번으로 St. Luke's Health Plan에게 전화하십시오. 본 서비스는 무료로 제공됩니다.

Notice of Privacy Practices

St. Luke's Health Plan is committed to protecting the privacy of personal, financial, and health information. Members can find detailed information on our privacy practices on our website at stlukeshealthplan.org or by calling (833) 840-3600.

How to Obtain Health Services

Member ID Card

The Member's ID card identifies them as a Plan Member and contains important information about their coverage and Benefits. Members should present their ID card each time they receive care. If a Member loses their ID card, they may order a new one either by contacting Member Services at (833) 840-3600 or logging into stlukeshealthplan.org. Under no circumstances should a Member give their ID card to another person for their use.

Choosing a Provider

Members are entitled to seek covered Medical Benefit services from any Provider that they choose. However, to receive the highest level of Medical Benefit coverage, Members must receive care from an in-network or wrap network Provider. Information about the St. Luke's Health Network or our nationwide network, including which Providers are in these networks can be found here:

Networks	Network Status	State/Area	Website
St. Luke's Health Network	In-Network	Idaho Counties: Ada, Adams, Blaine, Boise, Camas, Canyon, Cassia, Custer, Elmore, Gem, Gooding, Jerome, Lemhi, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, and Washington	stlukeshealthplan.org/find-a-doctor
Nationwide Network	Wrap Network	Idaho Counties not served by St. Luke's Health Network, and all other states nationwide	stlukeshealthplan.org/find-a-doctor

Additionally, please be aware that Providers who are not part of the St. Luke's Health Network, or nationwide network are permitted to Balance Bill, which could result in you incurring out-of-network costs.

Continuity of Care

When Members are receiving certain types of In-Network Care, and the treating In-Network Provider leaves the network, they may qualify as a Continuing Care Patient and benefit from certain protections. For Continuing Care Patients, St. Luke's Health Plan must provide them notice that the treating In-Network Provider has left the network and an opportunity to elect to receive continued transitional care from that treating Provider. The Member's election to receive continued transitional care from the treating Provider will last until the earlier of 90 days from the date they received notice that the Provider was leaving the network or the date when they are no longer in need of continuing care. Continuity of care protections do not apply to Provider terminations if the termination is based on the Provider's failure to meet applicable quality standards or for fraud.

A Member is a Continuing Care Patient if they are: (1) undergoing active treatment for a chronic or acute medical condition from a Provider; (2) undergoing a course of institutional or inpatient care from a Provider; (3) scheduled to undergo non-elective surgery performed by a Provider (including postoperative care for such a surgery); (4) pregnant and undergoing a

course of treatment for pregnancy by a Provider; or (5) determined to be terminally ill and receiving treatment for such illness from a Provider.

If the Member or their Dependent is a Continuing Care Patient of a departing Provider, St. Luke's Health Plan will provide them with 30 days' notice of the Provider's termination. However, if St. Luke's Health Plan does not receive adequate notice of a Provider's termination, St. Luke's Health Plan will notify them within 30 days of receiving notice that the Provider is no longer an In-Network Provider.

If the Member or their Dependent is a Continuing Care Patient and elect to receive continued transitional care from a departing Provider, St. Luke's Health Plan will continue to allow in-network benefits for the Provider until the completion of the care (not to exceed 90 days), or until the Member or their Dependent is transferred to another In-Network Provider or otherwise not in need of continued transitional care, whichever occurs first. However, if the Member is receiving maternity care and they are in the second or third trimester when their treating Provider leaves the network, they may elect to be treated as a Continuing Care Patient through the first postpartum visit. During the period in which the Plan is required to continue to provide them in-network benefits, the departing Provider is not permitted to bill them for the difference between the billed charges and the Allowed Amount (also known as Balance Billing).

In all cases, to receive continued transitional care from a Provider terminated as an In-Network Provider, the Provider must not have been terminated for failure to meet applicable quality standards or for fraud.

Services Received Outside of the U.S.

Members who are traveling outside of the United States and require treatment for an injury or medical care defined as Emergency Services or Urgent Care in this Agreement, any payments they make for such medical services may be reimbursed, provided each of the following guidelines are met:

- The medical services were paid for at the time they were received.
- Upon returning to the United States, they submit an itemized statement of services that includes diagnosis, and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
- Charges submitted are for Emergency Services or Urgent Care as defined in this Agreement.

Eligible services will be priced according to Usual, Customary, and Reasonable (UCR) allowances and in-network benefit levels.

Utilization Management

Utilization Management

St. Luke's Health Plan engages in various elements of Utilization Management to help assure that the right health care is provided, at the right time, in the right setting. Utilization Management includes the evaluation of medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. This is detailed in the Concurrent Review and Case Management sections below. Nurses and/or physicians review and evaluate requests for medical services to ensure that the medical services are appropriate for the Member's condition. The sections below detail other requirements and information about Utilization Management and how it may benefit Members.

Benefit Determination Timeframes

St. Luke's Health Plan shall make benefit determinations in accordance with applicable state and federal law, including the Affordable Care Act and implementing regulations.

If additional information is required, St. Luke's Health Plan will notify the Provider or Member and allow a reasonable timeframe for submission consistent with applicable law.

Benefit Determination Timeframes	
Type of Review	**Determination Timeframe**
Pre-Service Requests	Determinations will be made as expeditiously as the Member's health condition requires, but no later than information received date/time plus two (2) business days.
Urgent Pre-Service Requests	Determinations will be made as soon as possible, taking into account the urgency of the request, but no later than information received date/time plus two (2) business days and not to exceed three (3) calendar days.
Concurrent Care Requests	Determinations will be made within three (3) calendar dates of receipt of information
Post-Service Requests	Determinations will be made within thirty (30) calendar days of received date.

Prior Authorization Requirements

St. Luke's Health Plan requires Prior Authorization for services specified in the Medical Benefit Prior Authorization List below.

When Prior Authorization is required and is not obtained, benefits for such services may be denied or reduced, even if the services are determined to be Medically Necessary. Failure to obtain Prior Authorization does not create coverage for services otherwise excluded under the Plan. Such determinations are subject to the Plan's internal and external review procedures.

Medical Benefit Prior Authorization List

Emergency Services or Urgent Care Services never require a Prior Authorization. For urgent or emergent needs, please go to the nearest available facility for treatment.

- Inpatient Admissions, including:
  - Behavioral/Mental Health
  - Chemical Dependency
  - Inpatient Rehabilitation
  - Long-Term Acute Care
  - Maternity: the attending physician does not have to obtain Prior Authorization from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery; this provision also applies for newborns.
  - Residential Treatment
  - Skilled Nursing
- Certain Durable Medical Equipment and Orthotic Devices and Prosthetic Appliances
- Certain Injectable, Infusion, and Specialty Medications
- Clinical Trials
- Cochlear Implants
- Genetic Testing
- Home Health, after 10 visits
- Hospice
- Non-Emergent Ambulance Transportation
- Organ and Bone Marrow Transplants, including travel reimbursement
- Physical, Occupational, and Speech Therapy, after 20 combined visits
- Reconstructive and Plastic Surgeries
- Services related to Dental Trauma covered under medical benefit
- Skin Substitutes

Maximizing Medical Benefits

St. Luke's Health Plan delivers care in its Service Area through a group of Providers known as the St. Luke's Health Network.

The Plan incentivizes Members to obtain care within the St. Luke's Health Network by giving them a higher level of coverage for services rendered by these Providers. If a Member or their Provider believe the necessary care is not available within the St. Luke's Health Network, they can ask St. Luke's Health Plan for a higher level of coverage. If the Plan does not give express permission for the higher level of coverage, a lower level of coverage will apply for all Providers who are not part of the St. Luke's Health Network. A lower level of coverage results in a higher Cost Share for the Member. To request a higher level of coverage with a non-St. Luke's Health Network Provider, Members should call (833) 840-3600.

Notification for Emergency Admissions

Under the Plan terms, the Member or their Provider need to provide notice of any Emergency Admission by calling (833) 840-1222 within two (2) business days after the admission, or as soon as possible, unless there are extenuating circumstances (as determined by the Plan terms). Contact information for the Plan is also listed on their ID card.

Concurrent Review and Discharge Planning and Coordination

All inpatient stays are subject to periodic clinical review ("Concurrent Review") to evaluate Medical Necessity of ongoing inpatient care. St. Luke's Health Plan will coordinate with the facility to ensure a safe discharge plan. If a Concurrent Review results in a determination that continued hospitalization or treatment in the facility is not Medically Necessary, further hospitalization or treatment in the facility will not be covered. St. Luke's Health Plan also assists with discharge planning and coordination for Members transferring from the hospital to home or another facility. Concurrent Review is conducted on the following admissions:

- Acute Care Admissions
- Behavioral/Mental Health
- Chemical Dependency
- Rehabilitation (Acute Inpatient Rehabilitation)
- Residential Treatment
- Skilled Nursing Facility and Long-Term Acute Care Admissions

Case Management

Case management, through a case manager, monitors patients who need assistance and support while exploring coordination and/or alternative types of appropriate care. The case manager consults with the patient, family, and attending Provider to develop an individualized plan of care that may include:

- Assisting in obtaining any necessary equipment and services.
- Contacting the family for assistance and support.
- Exploring alternative care options such as pain management without narcotics.
- Monitoring hospital or skilled nursing facility stays.
- Offering personal support to the patient.
- Providing guidance and information on available resources.

At times, the case manager may identify a customized treatment plan such as an alternative to hospitalization or other high cost care or to make more efficient use of St. Luke's Health Plan's Medical Benefits. Such a customized plan might include services involving expenses not usually covered or an exchange of benefits. The decision to provide alternative or customized benefits is at St. Luke's Health Plan's discretion. Member participation in Case Management, including any alternative or customized treatment plan, is voluntary. Members or their legal representative, the attending physician, and

St. Luke's Health Plan must all agree to any such treatment plan. Once agreement is reached, the specific Medically Necessary services stated in the treatment plan will be reimbursed, subject to all Plan terms and conditions.

Case management is a voluntary service. There are no reductions of Medical Benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their Providers.

Evaluation of New Technology

A Member or a Provider can ask St. Luke's Health Plan to cover a new technology. Our Medical Management team is committed to being informed about the latest evidence, and research regarding new tests, medications, treatments, and devices, as well as new ways to use current procedures, medications, and devices. The Chief Medical Officer leads the research and review of the new technology based on written medical literature, evidence-based studies, and information received from clinical experts in the field. New technologies are approved for coverage based on standards established by the St. Luke's Health Plan. Requests to cover a new technology are considered on a case-by-case basis, and new technologies are approved for coverage based on standards established by St. Luke's Health Plan.

Payment Provisions

Highlights of Plan Provisions

- Medical Benefit coverage is greatest, and Out-of-Pocket Costs are the least, when Members choose a St. Luke's Health Network Provider.
- The Deductible, Out-of-Pocket Maximum and Maximum Benefits are calculated on a Plan Year basis. Each January 1, those Plan Year maximums begin again.
- The Plan Year Deductible amount may include both Medical Benefits and Pharmacy Benefits, so Members don't have to meet two deductible amounts. However, please note certain Plans feature separate Medical and Pharmacy Benefit Deductibles.
- The payment for the Medical Benefit is based on the Allowed Amounts agreed upon by In-Network Providers.
- Only one (1) Copayment will apply per Provider, per Member, per day, for each applicable service category, regardless of the number of services rendered during that visit.
- A Prior Authorization is required only for those services listed on the Medical Benefit Prior Authorization List. Prior Authorization is NOT required for Emergency Services or Urgent Care Services.
- Services received from Providers in the Wrap Networks are paid based on the agreed-upon Allowed Amounts and apply to the Plan Year Medical/Pharmacy Deductible.
- Out-of-Network Providers are permitted to Balance Bill, meaning the Member may be responsible for the Provider's charges that exceed the Plan's Allowed Amount. An Out-of-Network Provider is one who does not participate in any of the networks listed above and is not considered a Recognized No Surprises Provider. (See No Surprises Act section below)
- The Plan relies on the Qualifying Payment Amount to determine cost-sharing for certain services rendered by a Recognized No Surprises Provider, certain non-Emergency Services furnished by Out-of-Network Providers at certain in-network facilities, and out-of-network air ambulances.
- Claims are processed according to the diagnoses and services billed by the Provider(s). The Plan is not responsible for disputes regarding the services billed. If the Member has concerns about the diagnoses or services billed, they are responsible for resolving those concerns directly with the rendering Provider.
- Out-of-Network Providers who render a service in an in-network facility may not bill the Member for more than their Plan's in-network Cost-Sharing amount. This applies to Emergency Services, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot Balance Bill and may not ask them to give up their protections. If they receive services not listed above in an in-network facility, the Out-

of-Network Provider cannot Balance Bill them, unless they give written consent and give up their protections against Balance Billing.

- Continuity of Care may apply when their Provider becomes out-of-network in the middle of their course of care. See "Continuity of Care" under How to Obtain Health Services section of this document for more information.

Benefit Year

The Deductible, Out-of-Pocket Maximum, and Medical Benefit Maximums are calculated on a Plan Year basis. These Plan Year maximums will reset to their full amounts on each subsequent January 1st.

Certain benefits, as specifically outlined in the Schedule of Benefits, may be subject to a separate Lifetime Maximum Benefit per Member and do not renew on a Plan Year basis.

If this plan renews or is modified mid-Plan Year, the previously satisfied Deductibles, Out-of-Pocket Maximums, and Medical Benefit Maximums will be credited toward the renewed or modified plan.

Plan Year Medical/Pharmacy Deductible

The Plan Year Medical/Pharmacy Deductible is the amount the Member or their family must pay each Plan Year before St. Luke's Health Plan will pay for covered Medical Benefit/Pharmacy Benefit services. Once the Plan Year Medical/Pharmacy Deductible is satisfied, Coinsurance amounts as noted in the Benefits Outline of Coverage apply. Until then, the amount due to a Provider is their responsibility.

This Plan offers a Maximum Plan Deductible, which means each individual must meet no more than the maximum Plan Year Medical/Pharmacy Deductible amount specified for an individual policy. A family must meet no more than the maximum Plan Year Medical/Pharmacy Deductible amount specified for the family's policy, regardless of the family's size. If the family meets its maximum Plan Year Medical/Pharmacy Deductible, then the Plan will pay for covered services for all covered individuals in the family, regardless of whether each individual has met his or her individual maximum Plan Year Medical/Pharmacy Deductible.

Split Pharmacy Deductible plans include separate prescription benefit deductions from the Plan Year Medical/Pharmacy Deductible and applies specifically to prescription drug costs. Once met, the plan will begin covering prescription medications according to the coinsurance or copay amounts outlined in your Benefits Outline of Coverage. Until the Split Pharmacy Deductible is satisfied, you are responsible for the full cost of covered prescriptions. The Maximum Plan Deductible ensures that an individual will not pay more than the specified individual deductible, and a family will not exceed the family deductible, regardless of family size. Once the family deductible is met, the plan will cover all eligible services, including prescriptions, for every family member.

Payments for the following do **not** apply toward the Plan Year Medical/Pharmacy Deductible:

- Charges for non-covered services and treatment.
- Charges for services that are denied as not Medically Necessary.
- Charges that exceed the Usual, Customary and Reasonable (UCR) amount for out-of-network Medical Benefits, as determined by St. Luke's Health Plan.
- Charges that exceed any applicable Medical Benefit maximum.
- Charges for Claims denied for lack of Prior Authorization.
- Copayments.
- In-Network preventive care.
- Amounts paid by pharmaceutical company when the drug is managed under a copay accumulator program.

Plan Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum amount the Member or their family will be required to pay in a Plan Year for covered Medical Benefit services. Once a Dependent has reached the individual Out-of-Pocket Maximum, they will not be assessed any additional financial responsibility. Also, the family will be required to pay no more than the stated family maximum, regardless of family size.

Payments for the following do not apply toward the Plan Year Out-of-Pocket Maximum:

- Charges of non-covered services and treatment.
- Charges for services that are denied as not Medically Necessary.
- Charges that exceed the Usual, Customary and Reasonable (UCR) amount for Out-of-Network services, as determined by St. Luke's Health Plan.
- Charges that exceed any applicable Medical Benefit maximum.
- Charges for Claims denied for lack of Prior Authorization.
- Charges for services paid by St. Luke's Health Plan at 100%.
- Amounts paid by pharmaceutical company when the drug is managed under a copay accumulator program.

Be aware, in many circumstances Out-of-Network Providers can bill the Member for the difference between the amount charged by the Provider and the amount allowed by St. Luke's Health Plan, sometimes referred to as Balance Billing. These fees do not apply to Member's Out-of-Pocket Maximum.

Summary of Benefit Limits

Medical Benefit Limits	
Breast Pumps	1 Breast Pump Per Pregnancy
Chiropractic Care	18 Visits Per Year
Hearing Aids/Appliances	2 Hearing Aids Every 3 Years* **Hearing aids are covered for dependent children up to age 26.*
Home Health	10 visits, then Prior Authorization is Required
Organ Transplants Transportation and lodging for covered organ transplants	$10,000 Per Year
Physical Therapy, Occupational Therapy, and Speech Therapy	20 Combined Visits, then Prior Authorization is Required
Respite Care	10 Days Per Year
Skilled Nursing Facility	30 Days Per Year
Vision Care – ***Pediatrics Only***	1 Vision Exam and 1 Pair Lenses/Frame Per Year
Wigs	1 Wig Per Year, up to $150

Medical Benefits

All Medical Benefits are subject to Plan exclusions and limits. Applicable Deductibles, Coinsurance, and Copayments, including those for inpatient, outpatient, and office visit services, apply. See Payment Provisions, Benefits Outline of Coverage and Plan Exclusions and Limitations for more details, as well as Plan Definitions.

Coverage is provided only when all these conditions are met:

- The service or supply is listed as a covered Medical Benefit.

- Specific Medical Benefit limits or maximums are not exhausted or exceeded.
- All Prior Authorization and Medical Benefit requirements are met (see Prior Authorization Requirements for details).
- Member is eligible for coverage and enrolled in this plan at the time the service or supply is received.
- The service or supply is considered Medically Necessary for a covered medical condition, as defined.

Allergy Care

Medical Benefits include allergy tests, injections, and serums, though serum is covered only when received and administered within the Provider's office.

Ambulance Services

Prior Authorization for non-emergent ambulance transportation is required. The Plan covers Medically Necessary licensed ambulance transportation when the following conditions apply:

- The transportation is to the nearest available health care facility where Medically Necessary services can be provided.
- Other forms of transportation would likely endanger their health.

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

Transportation for personal or convenience reasons is deemed not to be Medically Necessary.

Anesthesia

Medical Benefits for anesthesia are covered when required for certain procedures or surgeries.

Applied Behavior Analysis (ABA)

This Medical Benefit will provide coverage for behavioral interventions based on the principles of Applied Behavior Analysis (ABA). ABA therapy programs incorporate behavior modification, training, and education.

This Medical Benefit will cover the five components of ABA:

- Direct clinical treatment
- Initial assessment
- Program development
- Supervision of the Providers of direct service
- Treatment planning

Coverage will be provided for Medically Necessary services to develop, maintain, and/or restore the functioning of an individual. Duplicate services, Provider training and group classes are not covered.

ABA Covered Providers

ABA services are provided by a state certified behavior health facility that has ABA services overseen by a BCBA- or BCBA-D (defined below) or provided directly by them as independent practitioners. Qualified network Providers can be located using the St. Luke's Health Plan Provider search at stlukeshealthplan.org, by selecting "other facilities" and then "Applied Behavior Analysis Facility."

- **Board Certified Behavior Analyst® (BCBA® (graduate level), BCBA-D™ (doctoral level)** – The BCBA and BCBA-D are independent practitioners who also may work as employees or independent contractors for an organization. The BCBA conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in

unfamiliar situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to conduct ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board-Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

- **Board Certified Assistant Behavior Analyst® (BCaBA®)** – The BCaBA conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of Applied Behavior Analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to conduct interventions and supervise behavioral technicians once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA. Governmental entities, third-party insurance plans and others utilizing BCaBAs must require this supervision.
- **Registered Behavior Technician™ (RBT™) or Therapy Assistant (TA)** – The RBT/TA is a paraprofessional who practices under the close, ongoing supervision of a BCBA or BCaBA ("Designated therapy supervisor"). The RBT/TA is primarily responsible for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor. The RBT/TA may also collect data and conduct certain types of assessments (.e.g., stimulus preference assessments). The RBT/TA does not design intervention or assessment plans. It is the responsibility of the therapy supervisor to determine which tasks an RBT/TA may perform as a function of his or her training, experience, and competence. The therapy supervisor is ultimately responsible for the work performed by the RBT/TA and bills for their services.

The following services are not covered:

- Providers accompanying children or family members to health care appointments are not part of the direct provision of ABA services.
- Services by more than one program manager for each child/family (program development, treatment planning, supervision).
- Training of therapy assistants and family members (as distinct from supervision).
- Parent training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient.
- Services provided in a home school, or public/private school environment that are part of a child's schooling as distinct from specific ABA treatment services (e.g., acting as the "Teacher's Aide," or helping a child with homework).

Biofeedback Services

Biofeedback is a training program designed to develop one's ability to control the involuntary nervous system and is covered when determined to be Medically Necessary. Biofeedback equipment is not covered.

Blood Transfusions/Donation

Autologous blood donations are those in which the blood being transfused was donated by the patient during surgery. Blood transfusions are the replacement of blood or one of its components, depending on the condition being treated. Coverage for either is provided when ordered by their physician.

Chemical Dependency

Prior Authorization is required for all Inpatient Chemical Dependency treatment. Chemical Dependency treatment for abuse of substances (e.g., alcohol or other drugs) must be Medically Necessary and provided at the least restrictive level. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other Medically Necessary goals must be established as determined by the Provider.

Care may be received at a hospital, a Chemical Dependency facility, and/or received through residential treatment programs, partial hospital programs and Intensive Outpatient Programs or through group or individual outpatient services.

The following are not covered:

- Alcoholics Anonymous or other similar Chemical Dependency programs or support groups.
- Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior.
- Court-ordered or other assessments to determine the Medical Necessity of court-ordered treatments.
- Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no Medical Necessity exists.
- Custodial care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite.
- Emergency patrol services.
- Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program.
- Information or referral services.
- Information schools.
- Long-term or custodial care.
- Nonsubstance related disorders.
- Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs.
- Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required.

Chiropractic Care

Chiropractic services are covered when Medically Necessary and performed within the scope of the Provider's license. These services include manipulation and adjustment of the spine and extremities, aimed at diagnosing and treating musculoskeletal conditions to alleviate pain, improve mobility and restore functionality.

Clinical Trials

Prior Authorization is required for all Clinical Trials. This Medical Benefit covers routine patient costs if they choose to participate in an approved clinical trial, as outlined below. Services such as those identified as Experimental and/or Investigational in the clinical trial are not covered. Refer to "Costs Not Covered" below for details.

An approved clinical trial must meet all the following requirements:

- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted. The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes.
- The clinical trial intervention must be intended for a condition covered by the Plan.

The approved clinical trial must be classed as one of the following:

- A federally funded or federally approved trial.
- A clinical trial conducted under a U.S. Food and Drug Administration (FDA) investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects.

- The clinical trial must provide a thorough informed consent document to the Member, and this document must be signed by them.
- All applicable Plan limitations for coverage of Out-of-Network Care along with all applicable Plan requirements for precertification, registration, and referrals will apply to any costs associated with their participation in the trial. St. Luke's Health Plan may require them, if they are a qualified Member, to use an In-Network Provider participating in a clinical trial if the Provider will accept them as a participant. As a Member participating in an approved clinical trial conducted outside the state of the Member's residence, they will be covered if the Plan otherwise provides Out-of-Network coverage for routine patient costs.
- A "qualified Member" is a Member or beneficiary who is eligible, according to the trial protocol, to participate in the approved clinical trial for the treatment of disease and either:
  - The referring health care professional is a participating Provider and has concluded that the Member's or beneficiary's participation in the clinical trial would be appropriate; or
  - The Member or beneficiary provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Costs associated with clinical trial participation may be covered as follows:

Costs Covered:

- Routine Patient Costs defined as follows:
  - Items or services that are typically provided under the Plan if they are not enrolled in a clinical trial (e.g., Office Visit levels for PCP and Specialist, other Office Visit Related Service costs).
  - Items, services, or tests that are required to safely provide the investigational intervention to include clinically appropriate monitoring of the effects of the intervention.
  - Medically Necessary diagnosis and treatment for conditions are medical complications resulting from their participation in the clinical trial.

Costs Not Covered:

- Investigational items, services, tests, or devices that are the object of the clinical trial.
- Interventions, services, tests, or devices provided by the trial sponsor without charge.
- Data collection or record keeping costs that would not be required absent the clinical trial; this exclusion extends to any activity (e.g., imaging, lab tests, biopsies) necessary only to satisfy the data collection needs of the trial.
- Services or interventions clearly not consistent with widely accepted and established standards of care for their particular diagnosis.
- Interventions associated with treatment for conditions not covered by the Plan.

Clinically Administered Medications

Prior Authorization is required for certain medications, gene therapy, and immunotherapy. Most medications received in a Provider's office or facility are covered by their Medical Benefits.

This Medical Benefit covers the administration of medications, including but not limited to, intravenous, subcutaneous, epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, CAR-T cell therapy, pain management, parenteral nutrition, and immune globulin. In some cases, medications administered or infused in a clinic setting may be covered by the pharmacy benefit. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more. Nursing visits associated with infusion therapy are covered under the Home Health Care Medical Benefit, regardless of whether the patient is homebound.

Some clinician administered medications will be covered by the Pharmacy Benefit.

Dental Pediatric (Important Disclosure)

This Policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact the insurance agent, a stand-alone dental insurance Provider or Your Health Idaho if the Member wishes to purchase a stand-alone pediatric dental care product.

Dental Trauma

Prior Authorization is required for services related to dental trauma covered under medical benefit. Not intended as dental coverage, this Medical Benefit coverage is provided for repair of sound natural teeth and/or implants of sound natural teeth, and repair of the jawbone or supporting tissues, due to accidental injury. All services related to the repair must be completed within 24 months of the date of the injury. Any services received after 24 months have elapsed, or after they become disenrolled from the Plan regardless of whether 24 months have elapsed or not, are not covered. Anesthesia related to the accidental injury is covered within 24 months of the date of injury.

Injury due to biting or chewing is not covered and is not considered an accidental injury. For the purposes of this coverage, a “sound natural tooth” is a tooth that is (i) free of active or chronic clinical decay, (ii) contains at least fifty percent (50%) bony structure, (iii) is functional in the arch, and (iv) has not been excessively weakened by multiple dental procedures.

Dental, oral surgery or orthodontic related services are not covered, such as (but not limited to) those listed below, unless accident related or otherwise specifically covered by the Plan:

- Care of the teeth or dental structures.
- Dental X-rays.
- Extractions of teeth impacted or otherwise (except as covered under St. Luke’s Health Plan).
- Orthodontia.
- Procedures in preparation for dental implants, except as covered under the Dental Trauma Medical Benefits.
- Services to correct malposition of teeth.
- Tooth damage due to biting or chewing.

Diabetic Education and Diabetic Nutrition Education

Diabetic education regarding nutrition and insulin management of diabetes is covered. The education may take place in classes through approved diabetic courses or as individual instruction.

Participants with diabetes are eligible for outpatient diabetes education, not to exceed the maximum as stated in the Outline of Coverage.

Outpatient diabetes education shall include instruction in the basic skills of diabetes management through books, educational material, as well as individual or group consultation with a Certified Diabetes Educator, Nurse, or Dietitian.

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

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

Diagnostic Services

The Plan provides coverage for Medically Necessary diagnostic laboratory and radiology services when ordered by a qualified healthcare provider. These services are billed separately from office visits and may incur additional charges. Covered diagnostic services include, but are not limited to:

- Cardiovascular tests (e.g., cardiac catheterization, echocardiograms).
- Imaging services (e.g., CT scans, MRIs, PET scans).
- Pathology and laboratory testing.
- Other radiology services as required for diagnostic purposes.

The plan also covers sleep studies, including both in-lab and home sleep studies, when Medically Necessary and ordered by a qualified healthcare provider. These services are subject to separate billing and may require a copayment and coinsurance, depending on the specific service.

Dialysis

Medical Benefits are provided for kidney dialysis treatment, including medications and supplies used during the treatment.

Durable Medical Equipment (DME) and Supplies

Prior Authorization is required for certain DME. Equipment and supplies ordered by a health care Provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, or crutches. DME may be rented or purchased (at St. Luke's Health Plan's discretion) and the total cost for rental must not exceed the purchase price. After thirteen (13) months of rental, the Member claims ownership of the rental DME item. Repair or replacement is only covered when needed due to normal use, a change in the patient's physical condition or the growth of a child. Duplicate items are not covered. When more than one option exists, Medical Benefits will be limited to the least expensive model or item appropriate to treat the patient's covered condition.

The following items are covered under the plan when Medically Necessary and ordered by a qualified healthcare provider. Coverage details include:

- **Breast Pumps:** Medical benefits include electric, hospital-grade, or manual breast pumps, breast milk storage bags, as well as replacements for associated parts such as tubing, power adapters, breast shields, caps for breast pump bottles, polycarbonate bottles, and locking rings. The Plan provides coverage for a maximum of one breast pump per pregnancy, inclusive of any coverage required under the Affordable Care Act.
- **Diabetic Monitoring Equipment:** Coverage includes the initial cost of an insulin pump, related pump supplies, and other diabetic equipment as determined by the Plan. Diabetic supplies, such as insulin, syringes, needles, lancets, blood glucose meters, blood glucose test strips, and continuous glucose monitoring supplies, are covered under the Pharmacy Benefit.
- **Medical Supplies:** The plan covers medical supplies needed for the treatment or care of a Medically Necessary covered condition, as ordered by a healthcare provider. This includes, but is not limited to, compression garments, mastectomy supplies, and ostomy supplies. Over-the-counter items are excluded from coverage.
- **Oral Appliances for Sleep Apnea:** Oral appliances used for the treatment of sleep apnea are covered when Medically Necessary.
- **Orthopedic Appliances/Braces:** Coverage includes orthopedic appliances and braces used to support abnormal joints, reduce pressure on joints during healing, or correct abnormal spinal curves.
- **Prosthetic Devices:** External prosthetic devices, which are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect, are covered under medical benefits.
- **Wigs:** Wigs are covered if Medically Necessary following chemotherapy or radiation therapy. Prior Authorization is required for coverage. One (1) wig covered per Plan Year up to $150 value.

All covered items must be ordered by a qualified healthcare provider and meet the medical necessity criteria set forth by the plan.

Surgically implanted devices may be covered under the appropriate surgical Medical Benefit and are not considered DME. Medical Benefits for durable medical equipment are determined by the type of device and its intended use, and not by the entity that provides or bills for the device.

The following are not covered:

- Biofeedback equipment.
- Equipment or supplies whose primary purpose is preventing illness or injury.
- Exercise equipment.
- Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient.
- Items used outside the home primarily for sports/recreational activities.
- Oral appliances, except to treat obstructive sleep apnea.
- Over-the-counter items (except Medically Necessary crutches, walkers, standard wheelchairs, diabetic supplies, medications, and ostomy supplies are covered).
- Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers, or personal hygiene items.
- Phototherapy devices related to seasonal affective disorder.
- Supportive equipment/environmental adaptive items including, but not limited to, handrails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
- The following medical equipment/supplies: standard car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters).

Emergency Services and Urgent Care

The Plan covers Emergency Department visits (including pre-stabilization, post-stabilization, certain Ancillary Services) and Urgent Care visits to evaluate an urgent condition at In-Network and Out-of-Network facilities.

Emergency (or emergent) means the sudden and acute onset of a symptom(s), including severe pain, which would lead a person, acting reasonably, to believe a health condition exists that requires immediate medical attention and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Examples of **emergent** conditions include severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gunshot wounds, automobile accidents, and pain or bleeding during pregnancy.

In the case of an emergency, home or away, seek the most immediate care available. If the Member require Out-of-Network services after their condition is stabilized, the Member must obtain permission from the from St. Luke's Health Plan in order to receive their highest level of benefits. For additional information, see the *No Surprises Act* section.

Urgent care is for non-life-threatening conditions that still require prompt medical attention, but not as immediately critical as emergency care. Examples of **urgent** conditions include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting. While these conditions, and more, are not emergencies, they still need timely evaluation and treatment to prevent them from worsening.

Essential Health Benefits

Essential Health Benefits means those categories of benefits identified in section 1302(b) of the Affordable Care Act (see Plan Definitions section.). In addition, the following services are also considered Essential Health Benefits by the Plan and are covered:

- Breastfeeding Support
- Growth Hormone Therapy

- Enterostomal Therapy
- Home IV Therapy
- Postnatal Care
- Respiratory Therapy
- Well Baby Visits and Care

Family Planning

Voluntary sterilization procedures and Food and Drug Administration-approved birth control methods are covered. Female sterilization is covered under the Affordable Care Act (ACA), while male sterilization is covered but not under ACA provisions. FDA-approved birth control methods, including select oral contraceptives, patches, and rings, are covered under the Pharmacy Benefit. Over-the-counter birth control products are not covered, except for those required by the Patient Protection and Affordable Care Act (ACA).

The Plan covers prescription contraception intended to last six (6) months, in accordance with Idaho State Law.

The following are not covered:

- Sterilization reversal.
- Services or supplies for the treatment of sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation. However, medications for erectile dysfunction may be covered under the Pharmacy Benefit; please refer to the Prescription Drug List (PDL) to determine coverage.

Foot Orthotics

Custom-designed foot orthotics, when prescribed by a physician and required for all normal, daily activities, are covered by the Plan.

General Anesthesia for Dental Care

Coverage is provided for general anesthesia and associated facility charges related to dental care provided to a Member if the Member is:

- Eight years of age or younger.
- Physically developmentally disabled.
- An individual with a medical condition that places him/her at undue risk, as determined by a physician. The procedure must be approved by the Member's physician.

Genetic Services

Prior Authorization is required for genetic testing. Genetic testing, counseling, interventions, therapy, and other genetic services are covered when determined to be an essential component of Medically Necessary care or treatment of a covered condition, or a Medically Necessary precursor to obtaining prompt treatment of a covered condition. If recommended by a Provider, genetic testing for breast cancer (BRCA) is covered under the Affordable Care Act.

Growth Hormone

Growth hormone treatment is covered under the Pharmacy Benefit when Medically Necessary. Treatments included within the Plan's Drug Formulary can be found within the Prescription Drug List (PDL).

Habilitative Services

Medical Benefits are provided for habilitative services when Medically Necessary and related to a Developmental Disability. These services must be recognized by the medical community as efficacious:

- For partial or full development.
- For keeping and learning age-appropriate skills and functioning within the individual's environment.
- To compensate for a progressive physical, cognitive, and emotional Illness.

Covered services include speech, occupational, physical and Aural Therapy services.

Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.

Hearing Exams, Aids/Appliances/Implants

Prior Authorization is required for cochlear implants. Hearing aids, auditory osseointegration (bone conduction) devices, cochlear implants, and examinations for or fitting of them are covered for dependent children up to age 26 when Medically Necessary. Costs for these device(s), repairs, and any other related services such as surgical implantation are all subject to the limit(s) noted within the Benefits Outline of Coverage for Hearing Aids/Appliances.

Home Health Care

Prior Authorization is required for home health care services, after 10 visits. Home health care is covered when prescribed by their physician. Medical Benefits are limited to intermittent visits by a licensed home health care agency.

For this Medical Benefit, a visit is a time-limited session or encounter with any of the following home health agency Providers:

- Licensed as a social worker - masters prepared.
- Licensed or registered physical, occupational or speech therapist (or an assistant working under the supervision of one of these Providers.
- Nursing services (RN, LPN).
- Registered dietician.

Private duty nursing, home health aide, shift or hourly care services, custodial care, maintenance care, housekeeping services, respite care and meal services are not covered for home health services.

This Medical Benefit is not intended to cover care in the home when St. Luke's Health Plan determines care in a skilled nursing facility, or a hospital is more cost-effective. Any charges for home health care that qualify under this Medical Benefit and under any other Medical Benefit of this Plan will be covered under the most appropriate Medical Benefit, as determined by St. Luke's Health Plan.

Hospice Care

Prior Authorization is required for Hospice care. Hospice care is covered when prescribed by their physician and s/he has determined that life expectancy is 6 months or less and a palliative, supportive care treatment approach has been chosen. Note: Patients are not required to discontinue treatment or “curative care” in order to access the hospice Medical Benefit. This Medical Benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

- **Intermittent in-home visits** are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day “on call” registered nurse. This Level of Care does not cover room and board while Member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient hospice care** is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient’s condition stabilizes.
- **Respite Care**

- **Continuous home care** is provided when a medical crisis occurs where the patient resides, and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock care.
- **Inpatient respite care** is available to provide the patient's caregiver a rest. This acknowledges that caring for a dying person can be difficult. Care for the patient is provided at an inpatient facility and includes room and board costs.

When provided within the above defined levels of care, additional covered expenses include:

- Approved medications and infusion therapies furnished and billed by an approved hospice agency.
- Durable Medical Equipment.
- Supplies required for palliative care.

If the patient exhausts the hospice Medical Benefit maximum, limited extensions may be granted if it is determined that the treatment is Medically Necessary. Any charges for hospice care that qualify under this Medical Benefit, and under any other Medical Benefit of this Plan, will be covered under the most appropriate Medical Benefit as determined by St. Luke's Health Plan.

The following are not covered:

- Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits.
- Financial or legal counseling services.
- Housekeeping or meal services.
- Services by the Member or their family or volunteers.
- Services not specifically listed as covered hospice services under St. Luke's Health Plan.
- Supportive equipment such as handrails or ramps.
- Transportation.

Hospital Inpatient Services

Hospital inpatient services could include admission to acute inpatient, chemical dependency, long term acute care, mental health, rehabilitation, and skilled nursing facilities for Medically Necessary care. Covered inpatient care includes room and board, operating room and anesthesia, radiology, lab, and pharmacy services furnished by and used while in the hospital. See the *Concurrent Review* section for additional details.

Hospital Outpatient Services

Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab, and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Hyperbaric Oxygen Therapy

Services administered by a licensed physician are covered when deemed Medically Necessary. Hyperbaric Oxygen Therapy may be covered for the treatment of certain serious medical conditions where increased oxygen delivered in a pressurized chamber can support healing or improve outcomes. Covered treatment reasons may include, but not limited to:

- Wound care.
- Carbon monoxide/chemical poisoning.
- Diving-related injuries.
- Progressive necrotizing infections.
- Severe anemia.

Infertility Diagnostic Services

Coverage is provided for the initial evaluation and diagnosis of infertility only. Examples of covered services for the initial diagnosis of infertility include endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count. Treatments and procedures for the purposes of producing a pregnancy are not covered, including artificial insemination, in vitro fertilization (IVF), and gamete intra-fallopian transplant (GIFT).

Lifestyle Medicine

Through this Plan the Member will have access to St Luke's Intensive Lifestyle Medicine program which aims to prevent, treat, and manage various chronic diseases. The program includes three shared medical appointments with a medical Provider as well as regular health coaching support across the duration of the program. Virtual classes are offered to support behavior change regarding physical activity, nutrition, restorative sleep, stress management, positive social connections, and avoidance of risky substances. Opportunities exist for in-person exercise as well as individual appointments with Registered Dietitian or Licensed Clinical Social Worker, if warranted. A referral from your provider is required for this program. Learn more by visiting stlukesonline.org/lifestylemed or sign up for a free information session by calling (208) 706-9710.

Maternity and Newborn Care

Prior Authorization may be required; the attending physician does not have to obtain Prior Authorization from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery; this provision also applies for newborns. Services related to pregnancy, including surrogacy, and childbirth and complications of pregnancy are covered when the Member is appropriately enrolled and recognized by the Plan as a Member and when the services are Medically Necessary. Diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. Childbirth preparation classes are covered. Services rendered by a licensed physician, advanced practice registered nurse practitioner (ARNP), certified nurse midwife, or licensed midwife are covered under the Medical Benefit; birthing in a home setting is not a covered benefit.

Coverage of newborns is provided when the child is appropriately enrolled as a Dependent on the Plan (see Eligibility and Enrollment sections for more details). Medical Benefits are subject to the newborn child's own Coinsurance and Deductible requirements.

Newborn care includes inpatient hospital services and professional care (including circumcision) performed during the initial period of hospitalization immediately following birth. Any services performed after the baby is discharged from the inpatient Level of Care are covered under the Medical Benefit applicable to the services billed and are not considered newborn care.

Circumcisions are covered up to 28 days following birth. Circumcisions performed after 28 days are covered when Medically Necessary as determined by St. Luke's Health Plan.

Newborns and Mothers' Health Protection Act of 1996 *This Act states that health plans may not restrict Medical Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or newborn earlier than these periods. In any case, St. Luke's Health Plan may not, under federal law, require that a Provider obtain authorization from the Plan or the insurance issuer or Third-Party Administrator for prescribing a length of stay not in excess of these periods.*

Mental Health Care

Medically Necessary mental health care at a hospital or treatment facility, Residential Treatment Center, Partial Hospitalization Program, Intensive Outpatient Program, and group or individual outpatient service is covered. Mental health care services must be Medically Necessary and provided at the least restrictive level of care. Facilities offering inpatient level of care must follow a medical model with physician and/or nursing staff on site 24 hours each day. A clear treatment

plan must be established on admission and include measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other Medically Necessary goals as determined by their Provider and the Plan's medical management.

Prior Authorization is required for inpatient admissions for mental health services. All inpatient admissions, including those for the treatment of mental health conditions, are reviewed by the Plan concurrently. See the Concurrent Review and Discharge Planning and Coordination section for more details.

Family counseling, psychological testing and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the St. Luke's Health Plan applies its terms uniformly and enforces parity between covered health care Medical Benefits and covered mental health and substance disorder Medical Benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact St. Luke's Health Plan.

Treatments for Autism Spectrum Disorder (ASD) includes evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an ASD by a licensed physician or a licensed psychologist who determines the care to be Medically Necessary, including but not limited to behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

Autism spectrum disorder treatments will be paid consistent with other mental health services (including applicable deductibles, copayments, or coinsurance), and not subject to any separate dollar limits or visit limits, and in parity with medical and surgical Medical Benefits. See the Applied Behavioral Analysis (ABA) section for information specific to ABA.

The following are not covered:

- Adventure-based and/or wilderness programs that focus primarily on education, socialization, or delinquency.
- Court-ordered assessments.
- Custodial care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite.
- Family therapy, in the absence of an approved mental health diagnosis.
- Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program.
- Marriage and couples counseling.
- Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories.
- Sensitivity training.
- Sexual dysfunctions and paraphilic disorders.
- Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs.

Nutritional and Dietary Formulas

Nutritional and dietary formulas are covered when Medically Necessary and prescribed by a Physician.

Coverage is limited to specialized nutritional formulas that are:

- Administered enterally (including oral administration or tube feeding) due to a documented medical condition that impairs the Member's ability to ingest, digest, absorb, or metabolize a normal diet; and
- Used as the primary or predominant source of nutrition for the Member; or

- Prescribed for a Member with a documented disorder of amino acid metabolism, urea cycle metabolism, or other inherited metabolic disorder, when the product is specifically formulated for treatment of that condition and used under the ongoing supervision of a Physician.

Specialized nutritional formulas may include elemental, semi-elemental, or other medically necessary formulas when required to treat the Member's medical condition.

Coverage does not include standard infant formula, over-the-counter nutritional supplements, or products used solely for convenience, general nutrition, or weight management, unless required to treat a covered medical condition as described above.

Nutritional Counseling

Nutritional counseling is covered for Members with medical conditions that require a special diet when rendered by a registered dietician or other licensed professional. Some examples of such medical conditions include coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria, and hyperlipidemias. Nutritional counseling for diabetes is covered under the Diabetic Education & Diabetic Nutrition Education Medical Benefit.

Oral Surgery

Oral surgery is covered under the Medical Benefit when a medical diagnosis is present. Oral Surgery required for a dental diagnosis such as periodontal disease is not covered. Examples of covered services include:

- The reduction or manipulation of fractures of facial bones.
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip, or tongue.
- Incision of accessory sinuses, mouth salivary glands or ducts.
- Extraction of teeth damaged due to radiation therapy that occurred while under the St. Luke's Health Plan.

Pharmacy Benefits

Prior Authorization is required for certain prescription drugs, please see *Prior Authorization of Prescription Medications* section below for more information. This section includes important information about how to use your Pharmacy Benefits. In addition to this Agreement, you can find information about your Pharmacy Benefits by doing any of the following:

- Logging in to your St. Luke's Health Plan account at stlukeshealthplan.org and use Pharmacy Tools; or
- Calling Member Services at (833) 975-1281.

To get the most from your Pharmacy Benefits, use an In-Network Pharmacy and present your ID card when filling a prescription. St. Luke's Health Plan has a national network including chain pharmacies and independent pharmacies. Members can find an In-Network Pharmacy at stlukeshealthplan.org.

If the Member uses an In-Network Pharmacy, without using your Pharmacy Benefit coverage at the time of pick-up, the Member must submit to a Prescription Reimbursement Form to the Plan with your itemized pharmacy receipt. If needed, contact Member Services to request this form. If the drug is covered, the Member will be reimbursed the Allowed Amount minus your Copay/Coinsurance and/or Deductible.

Continuous Glucose Monitors (CGMs), including associated sensors, transmitters, and receivers, are covered under the Pharmacy Benefit when prescribed by a licensed Provider and determined to be Medically Necessary.

There are Tiers (or levels) of covered prescriptions on the prescription drug list. This Pharmacy Benefit allows the Member to choose the medications that best meet your medical needs while encouraging the Member and your Provider to discuss treatment options and choose lower-Tier medications when therapeutically appropriate.

Medications on each Tier are selected by an expert panel of physicians and pharmacists and may change periodically. To determine which Tier a drug is assigned to, call Member Services or log in to your St. Luke's Health Plan account.

Prescription Drug List (PDL)

A Formulary is a list of medications covered by your health plan that the Prescription Drug list is a list containing the most commonly prescribed medications in your most common strengths and formulations. It is not a complete list of all medications covered by your formulary. Medications not included on the PDL may be covered at reduced benefits or not covered at all. For a printed copy of your PDL or information regarding medications not included on the PDL, contact Pharmacy Department Customer Services at (833) 975-1281. To view an electronic copy of the PDL or to search a complete list of medications covered by your formulary, visit stlukeshealthplan.org.

Recognizing that preventive services can lead to improved health by identifying and treating illnesses early, St. Luke's Health Plan does not require High Deductible Health Plan (HDHP) participants to meet their Plan Year Deductible prior to covering drugs in some drug categories. You will not have to meet your Plan Year Deductible before the Plan contributes to the cost of your prescription for medications listed in the categories below. You will be responsible for the corresponding tier cost-share for the medication prior to meeting your deductible. Coinsurance for these medications will apply to your deductible; however, copays do not apply to deductible. Refer to the Prescription Drug List for a list of medications in the following categories:

- Antidepressants
- Antiepileptics
- Antipsychotics
- Asthma and COPD
- Blood Thinners
- Brand Contraceptives
- Cardiovascular
- Cholesterol
- Diabetes (Insulin, Non-Insulin, and Test Strips)
- Osteoporosis

The Plan complies with the Idaho anticancer medications statute, Idaho Code 41-1854, requiring that oral, intravenous, and injectable anticancer medications are subject to the same plan design cost-sharing (coinsurance, copayment, and deductible). The plan may continue to apply different formulary, prior authorization, or other utilization controls to oral, intravenous, and injectable anticancer medications, as expressly allowed by the anticancer medication statute.

Filling Prescriptions

Copay/Coinsurance

The Member generally will be charged one Copay/Coinsurance per covered prescription up to a 30-day supply at an In-Network retail pharmacy. If your Provider prescribes a dose of a medication that is not available, the Member will be charged a Copay for each separate prescription needed of lessor strength of the drug to meet the strength prescribed.

Quantity and Supply

Prescriptions are subject to the Plan's quantity and day-supply limitations based upon FDA guidance or evidence-based literature. The most current information can be found by logging in to your St. Luke's Health Plan account.

Refills

Except for Schedule II controlled substances, refills are allowed after 80 percent of the last refill that has been used for a 30-day supply, 80 percent for a 31 to 100-day supply, and 50 percent for a 10-day supply.

A one-time early refill per year per Member will be granted for the purposes of vacation and an additional one-time early refill per year per Member will be granted due to a lost medication. This does not apply to controlled substances.

Manual Reimbursement
If the Member purchases their medication without using their ID card, they may submit a claim for consideration for reimbursement using a Prescription Reimbursement Form. Please note if the prescription was filled at a pharmacy that is Out-of-Network, the Member will not be reimbursed. Reimbursement will be according to the pharmacy network price. Manual refund requests must be received within 60 days of when the pharmacy dispensed the prescription.

Claims for reimbursement of prescription drugs are submitted to:

Mail: St. Luke's Health Plan, c/o Capital RX
Attn: Claims Dept.
9450 SW Gemini Dr., #87234
Beaverton, OR 97008

You can also email all documents for processing to dmr@cap-rx.com.

Generic Drug Substitution Requirement

If the Member purchases a brand-name drug when a generic substitution is required, they must pay the difference between the Allowed Amount for the Generic Drug and the Allowed Amount for the brand-name drug, plus your Copay/Coinsurance or Deductible. Some prescription medications are excluded from this requirement.

Maintenance Medications and Home Delivery

The Plan offers a maintenance/home delivery Pharmacy Benefit, allowing the Member to obtain up to a 100-day supply of certain medications through a designated pharmacy. Controlled substance prescription medications and medications designated as Specialty Medications in the Prescription Drug List (PDL) medications are not eligible for this benefit. This Pharmacy Benefit is available for maintenance prescription medications if the Member:

- Have been using the drug for at least one (1) month.
- Expect to continue using the drug for the next year.
- Have filled the prescription at least once within the past six months.

Please note that a Member may fill a medication with up to 100 days' supply at any St. Luke's Health Plan network pharmacy.

Prior Authorization of Prescription Medications

There are certain medications that require Prior Authorization. These medications are identified on the Prescription Drug List. The letters "PA" appears next to each medication that requires Prior Authorization. Prior Authorization is also required if the medication is prescribed in excess of Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found at the St. Luke's Health Plan website. To obtain Prior Authorization for these medications, please have your Provider call St. Luke's Health Plan Pharmacy Department Customer Service at (833) 975-1281.

If your Provider prescribes a medication that requires Prior Authorization, the Member should verify that Prior Authorization has been obtained before purchasing the medication. The Member can choose to buy these medications if they are not Pre-Authorized, but they will not be covered, and they will have to pay the full price for the medication.

Compounded medications containing at least one (1) prescription ingredient may be covered; however, some compounded medications may require Prior Authorization.

Step Therapy

Certain medications require the Member to have already tried an alternative medication preferred by the Plan. This process is called “step therapy.” The alternative medication is generally a more cost-effective therapy that does not compromise clinical quality. If your Provider feels that the alternative medication does not meet your needs, the Plan may cover the medication without step therapy if St. Luke’s Health Plan determines it is Medically Necessary. Medication samples may not be applicable to satisfying the step therapy requirement.

Prescription medications that require step therapy are identified on the Prescription Drug List. The letters “ST” appear next to each medication that requires step therapy.

Inappropriate Prescription Practices

In the interest of safety, St. Luke’s Health Plan reserves the right to not cover certain prescription medications. These medications include:

- Narcotic analgesics.
- Other addictive or potentially addictive medications.
- Medications prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.

These medications are not covered when they are prescribed:

- Outside the usual standard of care for the practitioner prescribing the drug.
- In a manner inconsistent with accepted medical practice.
- For indications that are Experimental and/or Investigational.

This exclusion is subject to review by the St. Luke’s Health Plan Pharmacy and Therapeutics Committee which includes review by a practicing clinician who is familiar with the drug and its appropriate use.

Pharmacy Benefit Abuse

St. Luke’s Health Plan may limit the availability and filling of any Prescription Drug that is susceptible to abuse. St. Luke’s Health Plan may require you to:

- Obtain prescriptions in limited dosages and supplies.
- Obtain prescriptions only from a specified Provider.
- Fill your prescriptions at a specified pharmacy.
- Participate in specified treatment for any underlying medical problem (such as a pain management program).
- Complete a drug treatment program.
- Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If the Member seeks to obtain medications in amounts in excess of what is Medically Necessary, such as making repeated Emergency Department/Urgent Care visits to obtain medications, St. Luke’s Health Plan may deny coverage of any medication susceptible to abuse.

St. Luke’s Health Plan may terminate the Member from coverage if they make an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain medications, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information.

Specialty Medications

Specialty medications must be filled at a designated pharmacy. Exceptions will be allowed for limited distribution medications required to be filled through a specific pharmacy. To see if your medication qualifies as a specialty medication, review the Prescription Drug List. Specialty medications are identified in the Prescription Drug List (PDL). Specialty medications are on either tier 5 or tier 6 of the formulary. For questions regarding specialty medications, contact the Pharmacy Department Customer Service at (833) 975-1281 or the St. Luke's Specialty Pharmacy at (208) 205-7779.

Dispense as Written (DAW)

In many cases one or more generic versions of a brand name drug are covered. If you request the brand name drug when a generic alternative is available, a Dispense as Written (DAW) penalty will be applied. This means you will pay the difference in cost between what the Plan would have paid for the generic drug and the cost of the brand name drug. Some prescription drugs are excluded from the DAW penalty.

Smart Co-pay Program

The Smart Co-pay program takes advantage of assistance received from manufacturers on some high-cost medications. This program ensures both the Member and the Plan pay the lowest cost on many of the most expensive medications.

Under the Smart Co-pay program, the manufacturer will pay all or a portion of a Member's Copayment or Coinsurance through the manufacturer's assistance program. When manufacturer assistance is available on select prescription medications, a Member's Copayment or Coinsurance amount may reflect up to the maximum value of any manufacturer assistance. The amount paid by the manufacturer does not apply towards the Member's outstanding Deductible or Out-of-Pocket Maximum. St. Luke's Health Plan will help coordinate these assistance programs for the Member.

If Copayment or Coinsurance assistance is provided directly to a Member in the form of reimbursements from the manufacturer, the Member must report the amount received to the Plan to ensure the correct amounts are applied towards the Member's Deductible and Out-of-Pocket Maximum.

Exceptions Process

If the Provider believes that a Member requires a certain drug that is not on your formulary, they should not be subject to step therapy, or exceeds a quantity limit, they may request an exception through the Pharmacy Prior Authorization process at (833) 975-1281.

Prescriptions Dispensed in a Provider's Office

Prescriptions dispensed in a Provider's office are not covered by the Pharmacy Benefit unless expressly approved by St. Luke's Health Plan.

Disclaimers

St. Luke's Health Plan refers to many of the medications in the Agreement by their respective trademarks. St. Luke's Health Plan does not own these trademarks. The manufacturer or supplier of each drug owns the drug's trademark. By listing these medications, St. Luke's Health Plan does not endorse or sponsor any drug, manufacturer, or supplier. Conversely, these manufacturers and suppliers do not endorse or sponsor any St. Luke's Health Plan service or Plan, nor are they affiliated with St. Luke's Health Plan.

Pharmacy Coordination of Benefits

If the Member has other health insurance that is their primary coverage, Claims must be submitted first to their primary insurance carrier before being submitted to the Plan. In some circumstances, their secondary policy may pay a portion of their Out-of-Pocket expense. When they mail a secondary Claim to the Plan, they must include a Prescription Reimbursement Form and the pharmacy receipt for the Plan to process their Claim. In some circumstances, an Explanation of Benefits (EOB) from their primary carrier may also be required. Please see the *Manual Reimbursement* section above for details on how to submit the Prescription Reimbursement Form.

Pivio

Pivio - the complete health improvement program educates people on lifestyle drivers to reduce their risk of chronic diseases. Coupled with education and a support system, Pivio provides participants with tools to help identify barriers and influence sustainable behavioral change. A powerful lifestyle medicine program that spans over 12 weeks and consists of 18 group sessions. Group sessions are facilitated by Pivio trained facilitators. The skills and behavior change techniques learned during the 12-week program empower participants to continue their journey toward optimal health and maintain healthy lifestyles. For questions about Pivio information sessions or courses call (208) 706-9710 or visit stlukesonline.org/health-services/specialties/programs/the-pivio-program.

Podiatric Care

Coverage is provided for certain surgical podiatric services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Routine foot care, such as the treatment of corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet are not covered, except if a Member has peripheral vascular disease or diabetes.

Preventive Care

Coverage is provided by or under the supervision of your Provider, and includes all services required by the Affordable Care Act, including:

- Periodic Exams – for Adults and Children, including the specific diagnostic testing/screening and laboratory services as recommended by the US Preventive Services Task Force and the Health Resources and Services Administration.
- Immunizations – including adult, adolescent, and child. Immunizations include those as recommended by the Centers for Disease Control (CDC); those provided in a pharmacy are covered under the Pharmacy Benefit. (Travel and occupational immunizations are not covered.)
- Mammograms. This includes coverage for 3-D Mammography.
- Colonoscopies.
- Preventive medications through your pharmacy.
- Sigmoidoscopy.
- Fecal Occult Blood Tests.
- Pap Test.
- Prostate Cancer Screening (PSA).
- FIT-Fecal DNA – 1 per Plan Year.
- Additional Screenings and Counseling – including Obesity Screening and Counseling, Nutritional Counseling, Bone Density Screening.

Supplemental Breast Screening

In addition, for “High Risk Members” (as that term is defined immediately below) preventive care coverage includes one “Supplemental Breast Screening” per year. Supplemental Breast Screening means a Medically Necessary and clinically appropriate examination of the breast using either standard or abbreviated magnetic resonance imaging (“MRI”), contrast mammogram imaging, or, if such imaging is not possible, ultrasound if recommended by a treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

High Risk Member is identified in Idaho Code § 39-2301 to be a person who is believed to be at an increased risk of breast cancer due to:

- Personal history of atypical breast histologies.
- Personal history or family history of breast cancer.
- Genetic predisposition for breast cancer.

- Prior therapeutic thoracic radiation therapy.
- Lifetime risk of breast cancer of greater than twenty percent (20%) according to risk assessment tools based on family history.
- Extremely dense breast tissue based on breast composition categories of the breast imaging and reporting data system established by the American college of radiology.
- Heterogeneously dense breast tissue based on breast composition categories with any one (1) of the following risk factors:
  - Personal history of BRCA1 or BRCA2 gene mutations;
  - First-degree relative with a BRCA1 or BRCA2 gene mutation who has not undergone genetic testing;
  - Prior therapeutic thoracic radiation therapy from ten (10) to thirty (30) years of age; or
  - Personal history of Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one (1) of these syndromes.

Preventive care is provided at no cost share to the Member and does not include diagnostic treatment, lab, x-ray, follow-up care, or maintenance care of existing conditions or chronic disease.

For more information on the recommendations of the CDC, US Preventive Services Task Force, and the Health Resources and Services Administration, visit the following website: www.healthcare.gov.

Non-Medical Occupational Services

Physical examinations, reports, or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs are not covered.

Professional/Physician Services

This Medical Benefit applies to in-person, face-to-face office visits, and Telehealth. St. Luke's On-Demand Virtual Care visits are covered as a separate benefit as described in the St. Luke's On-Demand Virtual Care section below.

Scheduling and medical record documentation of these visits, as well as creation of a Claim, follows the same standard as in-person office visits. Members should review this with their Provider before receiving services to ensure their telephonic or e-visit meets the requirements above.

The following are not covered:

- Professional services provided by fax or email.
- Follow up phone calls from Provider for test results, referrals, prescription refills or reminders that occur within 7 days of an in-person office visit.
- Calls to nurse line or to obtain educational material. This service is offered via St. Luke's Health System to Members of the Health Plan free of charge.

Reconstructive, Corrective and Cosmetic Services

Prior Authorization is required for reconstructive/plastic procedures. Plastic and reconstructive services are covered when performed to correct or repair abnormal structures of the body caused by congenital defects, trauma, infection, tumors, disease, accidental injury, or prior surgery (if the prior surgery was or would be covered under the Plan). Specific criteria for coverage are as follows:

- Services performed to correct congenital defects of a child must be completed before the child's 18th birthday.
- In the case of accidental injury, services must be completed within 12 months of the initial injury.

Women's Health and Cancer Rights Act of 1998 *The federal law titled "Women's Health and Cancer Rights Act of 1998" states health plans that are providing medical and surgical Medical Benefits for mastectomy resulting from disease, illness or injury must also cover, for those affected Members:*

- Internal or external prostheses.
- Reconstruction of the breast on which the mastectomy was performed.
- Reconstruction of the other breast to produce a symmetrical appearance.
- Treatment of physical complications in all stages of post-mastectomy reconstruction, including lymphedema.

The following are not covered:

- Abdominoplasty/panniculectomy.
- Complications resulting from non-covered services.
- Cosmetic services, supplies, or surgery to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem (except for gender affirming surgery).
- Dermabrasion, chemical peels, or skin procedures to improve appearance or to remove scars or tattoos.

Rehabilitation Therapy

Prior Authorization is required for physical therapy, speech therapy, and occupational therapy, after 20 combined visits. Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy. Examples of such therapies include, but are not limited to, physical therapy, speech therapy and occupational therapy. The following conditions must be met:

- The services are rendered to restore and significantly improve function that was previously present but lost due to acute injury or illness.
- Services are not for palliative, recreational, relaxation or maintenance therapy purposes.
- Loss of function was not the result of a work-related injury.

Coverage for cardiac rehabilitation requires that the Member has experienced a cardiac event in the preceding twelve (12) month period, such as myocardial infarction, chronic stable angina, heart transplants or heart and lung transplants. Covered rehabilitation therapies include pulmonary rehabilitation and therapy for peripheral arterial disease.

The following are not covered: Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present. Non-Medically Necessary education is not covered.

Inpatient Rehabilitation

Prior Authorization is required for Inpatient Rehabilitation. Inpatient Rehabilitation must be furnished and billed by a rehabilitative unit of a hospital or by another approved rehabilitation facility. When rehabilitation follows acute care in a continuous inpatient stay, coverage starts on the day the care becomes primarily rehabilitative. Inpatient care includes room and board, services provided and billed by the inpatient facility, and therapies performed during the rehabilitative stay.

Outpatient Rehabilitation

Outpatient rehabilitation Medical Benefits are subject to the following provisions:

- Members must not be confined in a hospital or other medical facility.
- Services must be billed by a hospital, physician, physical, occupational or speech therapist.

Outpatient Rehabilitation is covered for a Medically Necessary condition when ordered by a Provider.

Once the Medical Benefits under this provision are exhausted, coverage may not be extended by using the Medical Benefits under any other provision, except when an exception is expressly granted by the Plan.

Second Opinions/Physical Examinations

After enrollment, St. Luke's Health Plan will have the right to request that the Member be examined by a mutually agreed upon Provider concerning a claim, a second opinion request, or a request for Prior Authorization. St. Luke's Health Plan will be responsible for paying for any such physical examination.

Skilled Nursing Facility

Prior Authorization is required for skilled nursing facility care. Medical Benefits include room and board and ancillary services. The care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome. Maintenance care and custodial care are not covered.

Skin and Soft Tissue Substitutes

Prior Authorization is required for skin and soft tissue substitutes. Skin substitute grafts, bioengineered skin products, dermal matrices, amniotic membrane products, collagen matrices, and cellular and tissue-based wound care products are covered when:

- Medically Necessary;
- Approved by the U.S. Food and Drug Administration (FDA) for the intended use;
- Used for the treatment of eligible conditions such as chronic non-healing wounds, burns, or reconstructive surgical procedures; and
- All applicable Plan clinical criteria and Prior Authorization requirements are met.

The following are not covered:

- Experimental, investigation, or non-FDA-approved materials for the intended use of wound care or soft tissue repair.
- Any application, reapplication, preparation, procurement, storage, or removal of the above products.
- Use of these products for cosmetic purposes, convenience, or for conditions that do not meet Plan Medical Necessity requirements.

St. Luke’s On-Demand Virtual Care

St. Luke’s On-Demand Virtual Care is a service available daily, if appropriate depending on their symptoms. St. Luke’s On-Demand visits are performed through online video. A video visit is scheduled and completed through their MyChart account. If the Member needs a MyChart account, they can visit mychart.slhs.org/mychart/signup or call 208-381-9000, and someone will help them. Please allow time to set up their account before scheduling a visit.

For additional information about St. Luke’s On-Demand Virtual Care, including common symptoms and conditions treated, please visit stlukesonline.org/mychart/on-demand-virtual-care.

Smart Co-pay Program (Medical)

The Smart Co-pay program takes advantage of assistance received from manufacturers on some high-cost medications. This program ensures both the Member and the Plan pay the lowest cost on many of the most expensive medications.

Under the Smart Co-pay program, the manufacturer will pay all or a portion of a Member’s Copayment or Coinsurance through the manufacturer’s assistance program. When manufacturer assistance is available on select prescription medications, a Member’s Copayment or Coinsurance amount may reflect up to the maximum value of any manufacturer

assistance. The amount paid by the manufacturer does not apply towards the Member's outstanding Deductible or Out-of-Pocket Maximum. St. Luke's Health Plan will help coordinate these assistance programs for you.

If Copayment or Coinsurance assistance is provided directly to a Member in the form of reimbursements from the manufacturer, the Member must report the amount received to the Plan to ensure the correct amounts are applied towards the Member's Deductible and Out-of-Pocket Maximum.

Termination of Pregnancy

Voluntary termination of pregnancy is not covered unless the life of the mother is endangered by the continued pregnancy, or the pregnancy is the result of rape or incest as defined in Idaho Code or an applicable court.

Tobacco Cessation Counseling

Services to treat this addiction, including classes, patches and other prescriptions are covered.

Transgender/Gender Affirming Services

Prior Authorization is required for gender affirming surgeries. These services are intended to provide treatment for patients with gender dysphoria. This assistance may include primary care, gynecologic and urologic care, reproductive options, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and gender affirming surgical treatments. Gender affirming surgical treatments are limited to Members aged 18 and older.

Transplants, Organ, and Bone Marrow

Prior Authorization is required for transplant surgeries and procedures and related travel and lodging expenses. Services directly related to organ transplants must be coordinated by their participating Provider. Proposed transplants will not be covered if considered experimental or investigational for the Member's condition. Prior Authorization approval for transplants is based on these criteria:

- A written recommendation with supporting documentation received from their Provider.
- The request for the transplant is based on medical necessity.
- The requested procedure and associated protocol are not considered experimental or investigational treatment for the Member's condition.
- The procedure is performed at a facility, and by a Provider, approved by St. Luke's Health Plan.
- Upon evaluation, the Member is accepted into the approved facility's transplant program and comply with all program requirements.

Please Note: *Corneal transplants are not considered an organ transplant and are covered under the medical-surgical Medical Benefit, and not under the transplant Medical Benefit.*

Prior Authorization Requests for transplants prior to evaluation can be sent to:

Email: customerservice@slhealthplan.org
U.S. mail addressed to:
St. Luke's Health Plan
Attn: Medical Management
PO Box 1739
Boise, ID 83702
Fax: (833) 840-3414

Recipient Services

Covered transplant recipient services include:

- Anti-rejection medications.
- Diagnostic tests and exams directly related to the transplant procedure and follow-up care.
- Inpatient facility fees and pharmaceutical fees incurred while an inpatient.
- Medical and surgical services directly related to the transplant procedure and follow-up care.
- Pharmaceuticals administered in an outpatient setting.

Donor Services

Donor expenses are covered if all criteria are met below:

- St. Luke's Health Plan approves the transplant procedure.
- The recipient is enrolled in this Plan.
- Expenses are for services directly related to the transplant procedure.
- The donor services are not covered under any other health plan or government program.

Covered donor expenses include:

- Donor typing, testing, and counseling.
- Donor organ selection, removal, storage, and transportation of the surgical/harvesting team and/or the donor organ or bone marrow.

When both the recipient and the donor are Members under the Plan, covered charges for all covered services and supplies received by both the donor and the recipient will be payable.

Please Note: *If the Member chooses to donate an organ or bone marrow, donor expenses are not covered under the Plan unless the recipient is also enrolled in the Plan. However, complications arising from the donation would be covered to the extent that they are not covered under the recipient's health plan*.

The transplant services listed below (Organ and Bone Marrow) are not covered:

- Animal-to-human transplants.
- Artificial or mechanical devices designed to permanently replace human organs.
- Complications arising from the donation procedure if the donor is not a Plan Member.
- Donor expenses for Member if they donate an organ or bone marrow, however, complications arising from the donation would be covered as any other illness to the extent they are not covered under the recipient's health plan.
- Transplants considered experimental and investigational, as defined by St. Luke's Health Plan.

Travel Expenses

Prior Authorization is required for transplant related travel and lodging expenses. Travel and lodging expenses for approved transplants and associated pre-transplant evaluations are available for the recipient and his/her guardian/caregiver and the donor. If authorized, travel expenses are paid up to a maximum of $10,000 per transplant episode if the recipient is required to travel 100 miles or more from his or her home zip code for the Medically Necessary services related to an approved transplant, or if the facility requires the patient to remain within a certain distance of the facility during the transplant process. The maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient, companion(s), and donor(s). Reimbursement will be limited to allowable expenses per Internal Revenue Service (IRS) allowable amounts.

Vision Care

Cataract Surgery

Medically Necessary cataract surgery is a covered service when performed by a licensed provider.

Medically Necessary Eye Exam

Medically Necessary eye exams for adults and children are covered when they are needed to diagnose, monitor, or treat a medical condition affecting the eyes or vision. Coverage applies only when the exam is for a medical reason, not for routine vision care.

Examples include, but are not limited to:

- Changes in vision (such as blurred or double vision).
- Chronic eye conditions, such as glaucoma, cataracts, or macular degeneration.
- Eye infections, inflammation, or pain.
- Eye complications related to other health conditions, such as diabetes or high blood pressure.

For Pediatric patients (ages 18 and younger) one (1) preventive vison exam is covered annually and includes:

- Binocular balance testing.
- Case history and recommendations.
- Examination of the outer and inner parts of the eye.
- Glaucoma screening.
- Refraction.
- Routine tests of color vision, peripheral vision, and intraocular pressure.

The following vision Medical Benefits are not covered:

- Non-prescription sunglasses or safety glasses.
- Preventive eye exams for adults.
- Radial keratotomy, Lasik, and any other refractive surgery, orthoptics, pleoptics, vision therapy, visual analysis therapy or training related to muscular imbalance of the eye, and optometric therapy.
- Services or supplies received principally for cosmetic purposes, other than contact lenses selected in place of eyeglasses (for pediatric patients).
- Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lenses.

For these pediatric patients, a contact lens exam to ensure proper fit of their contacts, and evaluating their vision with the contacts, is also covered.

Vision Hardware

For pediatric patients only (ages 18 and younger), the Plan covers vision hardware needed to correct refractory vision problems under the Durable Medical Equipment Benefit. Covered hardware for pediatric patients includes frames, lenses and contact lenses needed to treat or as a result of a medical condition.

- **Elective Contact Lenses** - Coverage is provided for elective contact lenses that are worn instead of glasses as a personal choice, versus a medical condition that prevents Member from wearing glasses.
- **Frames and Spectacle Lenses** - Several lens options are available under the Plan.

Additional vision hardware services (extras) including, but not limited to, scratch resistant coating, tinting, etc. are not covered.

Plan Exclusions and Limitations

In addition to limits and exclusions stated elsewhere in this Agreement, coverage is specifically excluded for each of the following items and any related services and charges:

GENERAL EXCLUSIONS

Any service not Medically Necessary for the diagnosis, treatment, or prevention of illness, or injury, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care Medical Benefit); services requiring Prior Authorization for which Prior Authorization is not obtained; care in a setting when another setting of care is more cost-effective or appropriate for the treatment; services in excess of the maximum number of units or days specified in the Policy; services, devices, or medications prescribed by or performed by a practitioner without appropriate licensure or training; services that are experimental, investigational or unproven; charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a Claim or administrative forms; services or supplies primarily for personal convenience or comfort, including but not limited to phones, televisions, guest services, deluxe or suite hospital rooms, air conditioners, diapers or hygiene items; private duty nursing; respite care, except as expressly covered by this Agreement; and transportation, except ambulance services to the nearest appropriate facility, if Medically Necessary and other forms of transportation would likely endanger the Member's health (emergent air ambulance services are reviewed retrospectively).

Amounts for services provided by In-Network Providers in excess of the Allowed Amount, although In-Network Providers are not permitted to bill the Member for the amount in excess of the Allowed Amount. For Out-of-Network Providers, unless provided for otherwise under the No Surprises Act, amounts charged in excess of the Usual, Customary and Reasonable (UCR) rate are not covered and the Member may be billed by the Provider for the amount in excess of UCR.

Services received before their effective date of coverage or after the coverage termination date; services related to complications arising from non-covered services, including those services that would not have been covered by St. Luke's Health Plan at the time the complication arose; services received outside the United States, except for services that qualify as Emergency Services or Urgent Care, in which case the Member may qualify to be repaid only under specific circumstances; services resulting from participation in declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience; services that are the result of any illness or injury incurred by the Member while the they are participating in the commission of a felony, unless the illness or injury is the result of domestic violence or a physical or mental health condition; treatment of any illness or injury arising out of an illegal act or occupation or participation in a felony; and autopsies.

Amounts for which the covered person has no obligation to pay, including (but not limited to) any charges by a facility owned or operated by the United States or any state or local government unless they are legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veterans Health Administration when the services are provided to them for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to the Member and they are not on active military duty); services for which they receive compensation or reimbursement through another contractual arrangement or Medical Benefit, other than employer-based disability payments; services for any condition, illness or injury that arises from or during the course of work for wages or profit that is covered by state insurance workers' compensation and federal act or similar law; services or supplies payable under a contract or insurance for uninsured or underinsured (UIM) coverage; services or supplies payable under insurance for motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage; services or supplies payable under insurance for commercial premises or homeowner's medical premise coverage or other similar type of contract or insurance; services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group; treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits; services provided by a Family Member (spouse, parent or child); services provided by clergy; and services provided by a staff member of a school.

Physical examinations, reports or related services or supplies for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind; school admission; school sports clearances; immigration; foreign travel; medical research; camps; government licensure; other reasons not related to medical needs; and court-ordered examinations or treatment of any kind, except when Medically Necessary.

Care provided by phone, fax, email, Internet, or Telemedicine, except as expressly covered under this Agreement; follow-up phone calls from Provider for test results, referrals, prescription refills or reminders that occur within seven (7) days of an in-person office visit; and calls to nurse line or to obtain educational material.

ALTERNATIVE MEDICINE

Services, treatments, procedures, supplies, or medications that are considered alternative, complementary, holistic, or non-traditional in nature are not covered under the Health Plan. This exclusion includes but is not limited to acupuncture; dry needling; massage therapy; hypnosis, holistic or homeopathic treatment; naturopathic services; and alternative or naturopathic drugs or supplements. These services and products are excluded regardless of provider type, diagnosis, or therapeutic intent.

CLINICAL TRIALS

Investigational items, services, tests, or devices that are the object of the clinical trial; interventions, services, tests, or devices provided by the trial sponsor without charge; data collection or recordkeeping costs that would not be required absent the clinical trial; any activity or service (e.g., imaging, lab tests, biopsies) necessary only to satisfy the data collection needs of the trial; services or interventions clearly not consistent with widely accepted and established standards of care; and interventions associated with treatment for conditions not covered by St. Luke's Health Plan.

DENTAL SERVICES

Dental, oral surgery or orthodontic related services (unless accident-related or otherwise specifically covered by St. Luke's Health Plan); care of the teeth or dental structures; tooth damage due to biting or chewing; dental X-rays; extractions of teeth, impacted or otherwise (except as covered under St. Luke's Health Plan); orthodontia treatment, appliances, or services; procedures in preparation for dental implants, except as covered under the Dental Trauma Medical Benefits; services to correct malposition of teeth; treatments for Temporomandibular Joint Dysfunction (TMJ)/Orthognathic Treatment; or dentures or related services.

DURABLE MEDICAL EQUIPMENT (DME)

Biofeedback equipment; equipment or supplies whose primary purpose is preventing illness or injury; exercise equipment; items not manufactured exclusively for the direct therapeutic treatment of an illness or injury; items used outside the home primarily for sports/recreational activities; oral appliances, except to treat obstructive sleep apnea; over-the-counter items (except Medically Necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies); personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items; phototherapy devices related to seasonal affective disorder; supportive equipment/environmental adaptive items including, but not limited to, handrails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle; standard car seats or strollers; push chairs; air filtration/purifier systems or supplies; water purifiers; allergenic mattresses; orthopedic or other special chairs; pillows; bed-wetting training equipment; corrective shoes; whirlpool baths; vaporizers; room humidifiers; hot tubs or other types of tubs; home UV or other light units (light boxes or specialized lamps or bulbs); home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters); repair or replacement of items not used in accordance with manufacturer's instructions or recommendations; or items lost or stolen.

FAMILY PLANNING AND REPRODUCTIVE SERVICES

Abortion (voluntary termination of pregnancy) unless the life of the mother is endangered by the continued pregnancy, although complications of a non-covered abortion are covered; adoption expenses; birthing in a home setting; infertility

services or treatments to achieve pregnancy (regardless of the cause) including but not limited to artificial insemination, in vitro fertilization (IVF) or gamete intra-fallopian transplant (GIFT); reversal of sterilization; services or supplies for the treatment of sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia and premature ejaculation; however, medications for erectile dysfunction may be covered under the pharmacy benefit (please refer to the Prescription Drug List to determine coverage).

HOME HEALTH AND HOSPICE

When provided through home health benefits; custodial care; housekeeping or meal services; maintenance care; and shift or hourly care services. When provided through hospice care, custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits; financial or legal counseling services; housekeeping or meal services; services by the Member or their family or volunteers; services not specifically listed as covered hospice services under St. Luke's Health Plan; supportive equipment such as handrails or ramps; room and board while the Member reside in a skilled nursing facility, adult family home, or assisted living facility; and transportation.

MENTAL HEALTH AND REHABILITATION SERVICES

Benefits for counseling in the absence of illness or injury, including, but not limited to, premarital or marital counseling; family counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling with Member's friends, employer, school counselor, or school teacher, except as specified herein.

Alcoholics Anonymous or other similar Chemical Dependency programs or support groups; care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior; court-ordered or other assessments to determine the medical necessity of court-ordered treatments; court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing, or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists; custodial care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite; emergency patrol services; housing for individuals in a Partial Hospital Program or Intensive Outpatient Program; information or referral services; information schools; long-term or custodial care; non-substance related disorders; therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs, or other similar programs; and treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required.

Learning disabilities and related services, educational testing or associated training; special education for the developmentally disabled; day habilitation services designed to provide training, structured activities and specialized assistance to adults; chore services to assist with basic needs; vocational and custodial services; vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present; or for non-Medically Necessary education.

Providers accompanying children or family members to health care appointments that are not part of the direct provision of Applied Behavior Analysis (ABA) services; ABA services by more than one program manager for each child/family (program development, treatment planning, supervision); training of therapy assistants and family members (as distinct from supervision); parent/Provider training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient; and services provided in a home school, or public/private school environment that are part of a child's schooling as distinct from specific ABA treatment services (e.g., acting as the "Teacher's Aide," or helping a child with homework).

PHARMACY BENEFIT

Any medication not included in the St. Luke's Health Plan formulary; any over-the-counter products, except as expressly covered by this Agreement; anorectics (any drug used for the purpose of weight loss); any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order; diagnostic tests; medications labeled "Caution: Limited by federal law to investigational use" or that are otherwise Experimental or Investigational; medications used for cosmetic purposes, including but not limited to medications such as Botox, Minoxidil

(Rogaine), Tretinoin (Retin A, covered through age 25); FDA Approved High Dollar Non-Essential Medications (new drug formulations and derivatives of similar agents already marketed, or combinations of agents that provide no additional clinical benefit to the currently available medications); high dollar kits and non-FDA approved patches; fluoride, except as required under the Patient Protection and Affordable Care Act; immunological agents, biological sera, blood or blood plasma; infertility medications; with certain exceptions, medications that are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; non-legend medications other than insulin and certain over-the-counter medications required under the Patient Protection and Affordable Care Act or as otherwise determined to be Medically Necessary; non-systemic contraceptives , such as diaphragms, IUDs, and cervical caps which would be covered through the Medical Benefits; or condoms which are over the counter; nutritional supplements; prescriptions that an eligible individual is entitled to receive without charge from any workers' compensation laws; therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above; and vitamins, singly or in combination, except prenatal and federal legend vitamins to treat covered medical conditions, or as required by the Patient Protection and Affordable Care Act (PPACA); certain narcotic analgesics or other addictive or potentially addictive medications that St. Luke's Health Plan determines not to cover; medications prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question or for the practitioner prescribing the drug; serum for allergies not administered in a Provider's office; prescriptions dispensed in a Provider's office unless expressly approved by St. Luke's Health Plan; botanical or herbal medicines; FDA-approved medications, medications or other items for non- approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature; vitamin B-12 injections except to treat Vitamin B-12 deficiency; costs associated with expedited shipping of home delivery or specialty medications, if requested by a Member; delivery costs for medications that are delivered; and medications that are repackaged. Prescriptions billed with a DAW code of 3,4,5,6, and 9 are not covered unless clinical review ("Concurrent Review") deems them Medically Necessary.

PERSONAL CARE AND COSMETIC SERVICES

Services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem (except for gender affirming surgery), including reduction of adipose tissue, abdominoplasty/panniculectomy and liposuction; dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos; athletic training, bodybuilding, fitness training or related expenses; gym memberships (unless expressly set forth in this Agreement); prescription or nonprescription diets, nutritional and/or food supplements, vitamins, minerals or other dietary formulas or supplements, including weight loss shakes, unless expressly covered by this Agreement; exercise programs and equipment; bariatric surgery and other gastric restrictive procedures, or the revision or reversals of these procedures; services provided by a spa, health club or fitness center, except covered Medically Necessary services provided within the scope of the Provider's license; massage therapy, even as part of a physical therapy or chiropractic program; and routine foot care, except as covered by St. Luke's Health Plan if the Member has peripheral vascular disease or diabetes.

TEMPOROMANDIBULAR JOINT SERVICES

Services, supplies, or treatment for temporomandibular joint (TMJ) disorders or other disorders of the jaw joint and associated musculature; surgical and non-surgical treatment of TMJ, including joint manipulation, joint reconstruction, or joint replacement; orthognathic surgery, mandibular or maxillary osteotomy, jaw realignment, repositioning, or other surgical correction of the jaw; occlusal adjustments, bite analysis, bite correction, equilibration, or orthodontic services related to TMJ or jaw alignment; and dental services related to TMJ or orthognathic correction. This exclusion applies regardless of medical necessity and includes services intended to treat associated symptoms.

TRANSPLANT SERVICES

Animal-to-human transplants; artificial or mechanical devices designed to permanently replace human organs; complications arising from the donation procedure if the donor is not a Plan Member; donor expenses for the Member if they donate an organ or bone marrow, however, complications arising from the donation would be covered as any other

illness to the extent they are not covered under the recipient's health plan; and transplants considered experimental and investigational.

VISION CARE

Nonprescription sunglasses or safety glasses; radial keratotomy, Lasik or any other refractive surgery; orthoptics; pleoptics; vision therapy; visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy; services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses; adult vision care including routine eye exams and hardware; additional vision hardware services including, but not limited to, scratch resistant coating, tinting, and the like; and specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lenses.

WAR AND ARMED CONFLICT

Services, treatment, or supplies for illness, injury, or disability arising out of or related to:

- War, whether declared or undeclared;
- Acts of war;
- Armed conflict; or
- Service in the armed forces of any country.

This exclusion applies except to the extent coverage is required under applicable federal or state law.

Eligibility and Enrollment

The Group decides, in consultation with St. Luke's Health Plan, which categories of its employees, and their Dependents are eligible for Medical Benefits, and establishes the other eligibility requirements of the Plan. In order to be accepted for enrollment and continuing coverage under this Agreement, individuals must meet all applicable requirements set forth below and satisfy the requirements of their employer.

Discovery of false or misrepresented information will result in the complete nullification of coverage, and Member will be held financially responsible for any Medical Benefits paid. Examples of false or misrepresented information are failing to provide requested information, providing incorrect or incomplete information, enrolling an ineligible Dependent, and failing to comply with the Plan's requirements for eligibility. It is the Member's responsibility to notify their employer or St. Luke's Health Plan of all Dependent eligibility changes.

Service Area

Enrollment for coverage under this Agreement is solely available to Groups located in the Plan's Service Area. The Group is required to maintain permanent residency in the Service Area to continue to receive coverage under this Agreement.

How to Enroll

In order to be accepted for enrollment and continuing coverage under this Agreement, individuals must meet all applicable requirements set forth below and satisfy the requirements if the Plan. Members must establish and maintain eligibility for participation for the duration of enrollment.

Application for Enrollment

Unless separately agreed to in writing by St. Luke's Health Plan and the Group, Members enroll themselves and any Dependent(s) by completing, signing, and submitting an Application for coverage by the Group and any other required enrollment materials to St. Luke's Health Plan. Applicants will not be enrolled, or premiums accepted, until the completed

application information has been received and approved. St. Luke's Health Plan reserves the right to refuse enrollment to any person whose coverage under any contract for medical coverage issued by St. Luke's Health Plan has been terminated for cause.

Limitation on Enrollment

Subject to prior approval by the Idaho Department of Insurance, St. Luke's Health Plan may limit enrollment, establish quotas, or set priorities for acceptance of new applications if it determines that the Plan's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

Retirees are not eligible.

Open Enrollment

Once any applicable Employer Waiting Period is satisfied, Members may enroll themselves and their Dependent(s) in the Plan during the Initial Eligibility Period, under a Special Enrollment Right, or, if offered by the Group, during a Plan Year Open Enrollment. Open Enrollment is a defined period when Members are allowed to enroll or make changes to their health care Medical Benefit coverage. The Employer Waiting Period cannot exceed 90 days.

Special Enrollment Periods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives the Member Special Enrollment rights if they have a change in status or an involuntary loss of other coverage as described below.

Change in Status

If a Member's family grows during the Plan Year and your existing coverage does not include Dependents, they may be eligible for a Special Enrollment Period to enroll themselves and their Dependent in the Plan. Getting married or becoming a parent through marriage, birth, adoption, or by assuming responsibility for a child's care through placement for adoption or foster care or through a child support order (see also Dependents) are all qualifying life events resulting in a change of status. For any of these and other changes in status (as described below),the Member may request enrollment in the Plan as long as their request is made within 60 days of the qualifying life event. Likewise, if a Member experiences a change in status and becomes eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, the Member will have 60 days to enroll in the Plan.

In addition, a Special Enrollment Period is available if any of the following changes of status occurs:

- Loss of minimum essential coverage.
- Marriage, divorce, or legal separation.
- Death of the Member's spouse or Dependent.
- Birth, adoption, or accepting responsibility for a child through an adoption, court ordered guardianship, or foster care placement.
- Court ordered child health care coverage.
- A change in employment status, such as a switch between part-time and full-time.
- COBRA coverage ceases.
- A new and permanent move to the area.
- Changes in the Member's Dependent's age status or other factor affecting his or her eligibility.
- Change in the Member's eligibility to participate in a premium assistance program under Medicaid or CHIP.
- Changes in the Member's eligibility for advance payments of premium tax credit or eligibility for cost share reductions.

Any changes made in elections must be consistent with the change in status.

Involuntary Loss of Other Coverage

Members may enroll for coverage under the Plan outside of Open Enrollment when one of the following requirements are met:

- The Member waived coverage under the Plan at the time this coverage was previously offered because they were already covered under another plan (a waiver of health plan Medical Benefits is required at Open Enrollment or when they become eligible for enrollment in the Medical Benefit Plan; forms are available from St. Luke's Health Plan).
- The Member's coverage under the other health care plan was terminated as a result of:
  - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment).
- The Member, or their Dependent(s), were covered under Medicaid or CHIP but have since lost eligibility for either program.

St. Luke's Health Plan must receive a completed enrollment form within 30 days of the date their prior coverage ended. Coverage under the Plan will become effective on the first day of the month following loss of coverage.

Late Enrollment

Late enrollments are not accepted. An enrollment is late if it is not submitted within the time frame set forth in the sections Enrollment Period, Open Enrollment and Special Enrollment Periods.

Effective Date

Effective Date of Coverage

coverage begins on the effective date specified by St. Luke's Health Plan and terminates at the end of that year.

Effective Date of Coverage for Dependents

If a Member has one or more eligible Dependents on the date that they become covered under the St. Luke's Health Plan and they elect to enroll them, they will be covered on the date their coverage becomes effective. Only Dependents for which they have applied for enrollment and paid any required premiums will be covered.

Effective Date for Adding Dependents (Other than Newborn and Adopted Children)

Any Dependents added after their effective date of coverage will be covered on the date determined by the Group. The Member must submit an enrollment form to St. Luke's Health Plan for any such Dependent and pay any required premiums. St. Luke's Health Plan must receive the form within 31 days of the date the Dependent becomes eligible for coverage. If the Dependent is a newborn or newly adopted child, St. Luke's Health Plan must receive the form within 60 days of the date of birth or date of placement. If they do not notify St. Luke's Health Plan within 60 days, the Dependent will be considered a late enrollee. **Late enrollments are not accepted**.

Dependents

Dependent Eligibility

Unless further restricted by the Group, Dependents become eligible for health plan Medical Benefits on either the day the Member becomes eligible or the day they acquire their first Dependent, whichever is later. Dependents can be enrolled in the health plan only if the Member is also enrolled. Dependents include only the following:

- Lawful spouse.
- Domestic Partnership (same or opposite sex) who meets the criteria for eligibility (with a signed affidavit regarding eligibility of the Domestic Partnership; see Plan Definitions section.
- Member's (or their Domestic Partner's) natural child, adopted child, child placed with them for legal adoption, stepchild, legal guardianship, or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical or developmental disability on the date that the individual's coverage would otherwise terminate. Proof of such incapacity must be furnished to St. Luke's Health Plan within 31 days prior to the date the child reaches age 26. Thereafter, Members are required to resubmit proof of continued disability once per year.

Dependents do not include:

- A spouse who is legally separated or divorced unless coverage is required by court order or decree.
- A spouse, Domestic Partner or child living outside the United States or Canada.
- Any person who is on active duty in any armed forces of any country.
- Member or their spouse's natural child for whom they have given up rights through legal adoption.
- A parent of a Member, spouse, or Domestic Partner.
- The newborn child, spouse, or Domestic Partner of an enrolled Dependent child.

Dependents Acquired Through Marriage/Domestic Partnership

If a Member acquires a new Dependent through marriage or Domestic Partnership, they must update their application within 31 days after the start of the marriage or Domestic Partnership for coverage to be effective, or their new Dependent will not be able to enroll until the next Open Enrollment.

Coverage for their new Dependent will become effective on the first of the month following the date the marriage or Domestic Partnership is established.

Dependent Children

An enrollment form is required to enroll any Dependent child. Their Dependent will not be denied based on health status. Additional information may be required to establish a Dependent child's eligibility.

Natural Newborn Children

Nursery Care. Routine well newborn nursery care is care while the newborn is hospital-confined after birth and includes room, board and other normal care for which a hospital makes a charge. Newborn expenses incurred will be payable provided the newborn is enrolled as a dependent within sixty (60) days (day one is date of birth) of birth. If enrolled, coverage becomes effective on the date of birth. This provision does not apply to grandchildren of the Subscriber or Spouse/Domestic Partner.

Adopted Children Acquired

Any child under age 18 whom a Member legally adopts or who is Placed (as that term is defined below) with them for adoption is eligible on the date of Placement. If the child is Placed but not adopted, all Medical Benefits stop when the child is removed permanently from the Placement and the legal obligation of the adoptive parent terminates or the adoptive parent rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

If the enrollment form, with documentation to support legal adoption, is received within 60 days of placement, coverage becomes effective on the date of placement. If the date of placement is within 60 days of a newborn's date of birth, coverage becomes effective on the date of birth. St. Luke's Health Plan may request added information.

Children Acquired Through Legal Guardianship

If the enrollment form, with documentation to support legal guardianship, is received within 60 days of obtaining legal guardianship, Dependent coverage becomes effective on the date of the order. St. Luke's Health Plan may request added information.

Children Covered Under Qualified Medical Child Support Orders

If the enrollment form, with notification of the medical child support order (from the Member, the custodial parent or a state agency administering Medicaid) is received within 31 days of the order, coverage becomes effective on the date of the order. If received after 31 days, coverage becomes effective on the first of the month after St. Luke's Health Plan has the enrollment information. (See *Qualified Medical Child Support Orders* for more information.)

Continued Eligibility for a Child who is Disabled

Coverage may be extended beyond age 26 if the child is:

- Incapable of self-sustaining employment due to mental or physical disability on the date that the child's coverage would otherwise terminate.
- Depends primarily on the Member for support.

Contact the Group for details and enrollment forms. For continued eligibility of a child who is disabled, the enrollment form must be received within 31 days of the date the child reaches age 26. Thereafter, Members may be required to resubmit proof of continued disability up to once per year.

Proof may be defined as a copy of the state disability check for the current month. If a copy of the state disability check for the current month is not available, the Provider of care must complete a physician statement to confirm the following:

- Name of Dependent child.
- Dependent child's date of birth.
- Dependent child's Plan ID number.
- Date of onset of disabling condition.
- Description of disabling condition and functional limitations.
- Expected duration of disabling condition and prognosis.
- Signature of Provider.

The Member must also submit the following:

- Signed statement that they provide total support for this child.
- Dependent's social security number.
- Date information provided.

A child who is disabled will continue to be eligible for coverage until the Member fails to submit proof that dependence is due to disability, or if coverage terminates for them or the Dependent due to any of the reasons noted under *Termination of Coverage*.

Court-Ordered Dependent Coverage

When the Member or their lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in their family coverage according to the minimum extent required by applicable law.

Qualified Medical Child Support Orders

St. Luke's Health Plan will provide medical coverage to certain children (called alternate recipients) if directed by a Qualified Medical Child Support Order (QMCSO), including Medical Benefits for adopted children. Either the Member, the child's custodial parent, or a state agency administering Medicaid may submit notification of the QMCSO to the Plan.

A medical child support order:

- Is any decree, judgment, order (including approval of settlement agreement) or administrative notice from a state court or state agency with jurisdiction over the child's support.
- Recognizes the child as an alternate recipient for plan Medical Benefits.
- Provides for, based on a state domestic relations law (including a community property law), the child's support or health plan coverage.

A QMCSO is a medical child support order that is qualified under the Omnibus Budget Reconciliation Act of 1993. A medical child support order is qualified if it creates or recognizes the existence of an alternate recipient's right to receive Medical Benefits under the Plan and specifies this information as follows:

- Member's name and last known address.
- Each alternate recipient's name and address (or state official/agency name and address if the order provides).
- Reasonable description of coverage the alternate recipient is entitled to receive.
- Coverage effective date.
- How long the child is entitled to coverage.
- That St. Luke's Health Plan is subject to the order.

If the medical child support order is a QMCSO:

- St. Luke's Health Plan notifies the Member and the alternate recipient of the Plan's procedures and allows the alternate recipient to name a representative to receive copies of any QMCSO notices.
- Alternate recipient coverage begins on the first of the month after the QMCSO is received.
- If a Dependent premium is required, their specific authorization is not needed to establish the payroll deduction, which would be retroactive to the alternate recipient's coverage effective date.
- St. Luke's Health Plan pays In-Network Providers directly for covered services; when an alternate recipient, custodial parent, legal guardian, or Member pays a covered expense, St. Luke's Health Plan reimburses the person who paid the expense.

If the medical child support order is not a QMCSO, St. Luke's Health Plan will notify the Member and each alternate recipient of the specific reason it does not qualify, along with procedures for submitting a corrected medical child support order.

The enrollment form with the notification of the medical child support order needs to be received within 31 days of the order for coverage to become effective on the date of the order. If the enrollment information is received after 31 days of the order, coverage will become effective on the first of the month following the date the Plan receives the enrollment information for coverage.

Termination of Coverage

For participating Members, coverage ends at these events:

- Termination of the Agreement.
- Termination of the Agreement by the Group with or without cause, by providing St. Luke's Health with written notice of termination not less than 30 days before the proposed termination date.
- The Group fails to satisfy the minimum group participation and/or employer Premium contribution requirements of St. Luke's Health Plan.
- Non-payment of premiums.
- The Member no longer meet eligibility requirements for coverage (see *Eligibility and Enrollment*); coverage ends the last day of the month after the date they no longer meet the eligibility requirements.
- The Member performs an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Plan.
- The Group materially breaches this Agreement.
- St. Luke's Health Plan ceases to offer coverage in the market under which this coverage is issued.

For participating Dependents, coverage ends at these events:

- The date Member coverage ends for any reason.
- The last day for which any required Plan premiums are paid.
- The last day of the month in which the Member passes away.
- The Member and their spouse legally divorce (St. Luke's Health Plan must receive a copy of the decree); or a Domestic Partnership is dissolved or terminated.
- The last day of the month in which the Dependent child reaches age 26, unless disabled (see *Continued Eligibility for a Child who is Disabled*).

If St. Luke's Health Plan cancels or declines to renew a Member's policy, St. Luke's Health Plan will extend Medical Benefits for a pregnancy that commenced while the policy was in force and for which Medical Benefits would have been payable had the policy remained in force.

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of the premium by St. Luke's Health Plan or by any agent duly authorized by St. Luke's Health Plan to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy provided. However, if St. Luke's Health Plan or its authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by St. Luke's Health Plan or, lacking this approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless St. Luke's Health Plan has previously notified the insured in writing of its disapproval of such application.

The reinstated policy shall cover only losses resulting from accidental injuries sustained after the date of reinstatement and losses due to sicknesses that commence more than ten (10) days after the date of reinstatement. In all other respects, the insured and insurer shall have the same rights under the policy as were available before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied first to the outstanding premium due for the coverage period not previously paid but not be applied to any coverage period more than sixty (60) days prior to the date of reinstatement.

Fraud or Misrepresentation

If a Member intentionally misrepresent material facts concerning insurability during enrollment, coverage for them and/or their Dependents may be terminated or rescinded during the two (2) year period after a Member enroll. In addition, coverage for the Member and/or their Dependents may also be terminated or rescinded at any time if a Member makes any material misrepresentation in connection with insurability. Please note, if coverage is terminated or rescinded as described above, the termination is retroactive to the Effective Date of coverage.

If a Member intentionally misrepresents material facts or commits fraud in connection with Benefits or Eligibility, coverage for the Member and/or their Dependents may be terminated or rescinded.

Premium

Premiums

The Group is responsible to pay the Premium to St. Luke's Health Plan within the timeframes indicated by the Plan. Subject to the provisions contained herein, the amount of Premiums will remain the same until the end of the term of this Agreement. However, the Plan may reasonably modify the Premium amount if federal or state law or regulations mandate that the Plan adjust Medical Benefits under the Agreement. Premiums are payable on the first day of each month.

If the Group fails to pay premiums as agreed, this Policy will terminate without notice at the end of the period for which the last premiums were paid. A payer financial institution's return of or refusal to honor a check or draft constitutes nonpayment of premiums. This Policy does not have a grace period; however, if the Group makes payment of the premiums within thirty (30) days after the due date, St. Luke's Health Plan will reinstate this Policy as of the due date. No benefits are available during this thirty (30)-day period unless all premiums are properly paid before expiration of the thirty (30)-day period. St. Luke's Health Plan reserves the right to apply ten percent (10%) annualized interest fee on any portion of the balance owed by the Group to St. Luke's Health Plan that remains unpaid thirty (30) days or more beyond the original due date.

Refund of Premium

St. Luke's Health Plan will refund any unused collected Premium. However, the Plan is entitled to offset from the refund any amount incurred from Claims paid before the policy was canceled.

Extension of Medical Benefits for Continuous Loss

Except for covered services related to a continuous loss that commenced while the Agreement was in force, all Medical Benefits under St. Luke's Health Plan terminate when the Agreement terminates. An extension of Medical Benefits related to a continuous loss applies to a single inpatient stay where the Member is admitted prior to the termination of the Agreement and their stay extends after the Agreement termination date, including any inpatient readmission that occurs within 30 days of their initial discharge. Such Medical Benefits are subject to limitations in the Agreement that have not exhausted as of the termination date, such as day or visit limitations or maximum dollar amounts allotted for Medical Benefits.

Claim and Appeal Procedures

Claim

A Claim means any request for a St. Luke's Health Plan Medical Benefit made by a Member (Claimant") or their Authorized Representative (an individual acting on behalf of the Claimant in obtaining or appealing a Medical Benefit Claim). The Authorized Representative must be designated as such in writing with an approved form signed by the Claimant (except for Urgent Care Medical Benefits or Urgent Care appeals). Once an Authorized Representative is selected, all information and notifications should be directed to that representative until the Claimant states otherwise.

Note: Rights conferred through Medical Benefits, other than the right to payment, are not assignable. As such, St. Luke's Health Plan does not consider an assignment of Medical Benefits to confer standing or any other rights afforded to the Member (or their beneficiary), except the right to payment of Medical Benefits. A Member (or their beneficiary) may assign or transfer payment rights to a Provider. A Provider cannot be designated as the Authorized Representative but can submit additional information to support the appeal.

How to File a Claim for Plan Medical Benefits

In most cases, In-Network Providers submit Claims, and there are no Claim forms for the Member to complete. If a Member receives a bill for services from a Provider because the Provider did not file a Claim, the Member should write their name, Member ID number and group number on the bill and send a copy to the Claim address on their ID card. (A group number can also be found the ID card.) Any bill submitted must contain:

- Provider name.
- Provider tax ID information.
- Specific date(s) of service.
- Diagnosis codes (ICD-10 codes) or description of the symptoms or a diagnosis.
- Specific medical procedure codes (CPT codes) or description of the medical service or procedure.
- Specific dental procedure codes (CDT codes) or description of the dental service or procedure.

It is best to submit charges as soon as reasonably possible. However, charges for covered services submitted to the Plan must be received within 12 months of the date the service was rendered or received, or sixty (60) calendar days after Provider first receives notice that the Plan is secondary, whichever is later. Claims will not be considered for Medical Benefits if received after these timeframes (see ID card for the St. Luke's Health Plan Claim address). Claim forms are available from the Plan by contacting Member Services. Claims submitted more than 12 months after the services were provided will be denied unless notice was given, or proof of loss was filed as soon as reasonably possible.

Adjustments or corrections to Claims can be made only if the supporting information is submitted to the Plan within 12 months after the Claim was first processed unless the additional information relating to the Claim was filed as soon as reasonably possible.

When St. Luke's Health Plan receives a notice of Claim from Member or their Provider, St. Luke's Health Plan will furnish the Member with any additional forms needed to process their Claim within 15 days of the receipt of the notice. If additional information is not requested within 15 days, Members can assume that no further information is needed from the Member to process their Claim.

Claim Types

- **Pre-service Claim** means any Claim for a Medical Benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent Claim** means any Claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated Medical Benefit.
- **Post-service Claim** means any Claim for a Medical Benefit that is not a Pre-Service Claim and is a request for payment or reimbursement for covered services already received.
- **Urgent Care Claim** means a Claim for medical care or treatment that, if normal pre-service standards are applied, would in the opinion of a physician with knowledge of the Claimant's medical condition:
  - Seriously jeopardize the Claimant's life, health, or ability to regain maximum function.
  - Subject the Claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

St. Luke's Health Plan will:

- Interpret and construe Plan provisions, as necessary.
- Reach factually supported conclusions.
- Make a full and fair review of each denied Claim, as amended.
- Make all Claim and appeal determinations to the extent permitted by this Agreement and applicable law.

Medical Benefit issues include questions regarding Medical Necessity, health care setting, level of care, experimental or investigational treatment, cost-sharing requirements, or other limits on otherwise covered Medical Benefits.

All Claims for Medical Benefits are subject to a full and fair review within a reasonable time appropriate to the medical circumstances. Payment of any Medical Benefits will be subject to the applicable Deductibles, Coinsurance, Copays and Medical Benefit maximums. St. Luke's Health Plan will notify the Claimant in writing of the decision regarding a Claim review.

It is important to note St. Luke's Health Plan itself holds the authority, responsibility, and discretion to deny Claims based on administrative issues such as questions of eligibility status for the Member, their spouse, and their Dependents; change in status; Special Enrollment; termination and continuation of coverage; and qualified medical child support orders. The same appeal process described below applies to administrative issues.

Written Notice and Payment of Claim for Loss

Written notice of Claim for a loss must be given to the Plan within twenty (20) days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notices can be sent to St. Luke's Health Plan at PO Box 1739, Boise ID 83702-5809, or given to any authorized agent of the St. Luke's Health Plan. Plan shall pay indemnitee immediately upon receipt of due written proof of loss.

Legal Action

Legal action may be brought to recover on this policy before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Adverse Medical Benefit Determination

An Adverse Medical Benefit determination means a denial, decrease or termination of a Medical Benefit. This includes a failure to provide or make payment (in whole or in part) for a Medical Benefit based on:

- A determination that a Medical Benefit is not covered by the Plan.
- A determination based on an individual's eligibility to participate in the Plan, or to receive Medical Benefits at time of service (these appeals are considered administrative and are managed by St. Luke's Health Plan, see Claim Procedure above).
- A determination that a service is experimental, investigational, or not Medically Necessary.
- A rescission of coverage (these appeals are considered administrative and are managed by St. Luke's Health Plan, see *Claim Procedure* above).

The different Claim types have specific times for approval, payment, or request for information or denial, as shown below:

Timetable for Adverse Medical Benefit Determinations for Claim Procedures			
Type of Review	**Notice of Incorrectly Filed Claim – Notice to Claimant**	**Notice of Incomplete Claim – Notice to Claimant**	**Initial Medical Benefit Determination by St. Luke's Health Plan**
Pre-Service Claim	2 days	Not required (may be part of extension notice)	Reasonable period = 15 days 15-day extension with notice to Claimant Reasonable period suspended up to 45 days on incomplete Claim
Concurrent Claim	n/a	n/a	In time to permit appeal and determination before treatment ends or is reduced
Post-Service Claim	n/a	Not required (may be part of extension notice)	Reasonable period = 30 days 15-day extension with notice to Claimant

			Reasonable period suspended up to 45 days on incomplete Claim
Urgent Care Claim	24 hours	24 hours	72 hours No extensions from Claimant

If the Member's Claim is denied wholly or in part, they will receive a written notice of Adverse Medical Benefit Determination:

- For a denial of a Pre-Service Claim, such notice will be in the form of a letter from St. Luke's Health Plan explaining the denial.
- For a denial of a Post-Service Claim, their Explanation of Benefits (EOB) will serve as their notice of Adverse Medical Benefit Determination.

Both the letter and the EOB will include information necessary to identify the Claim, such as the date of service, Provider name, amount billed, as well as the reason for the denial(s). Denial reasons include:

- Reference to the specific Plan provisions on which the determination is based.
- Reference to any internal Plan rule, guideline, protocol, or similar criterion relied upon in making the decision.
- For Pre-Service Claims, the standards for Medical Necessity relied upon making the Adverse Medical Benefit Determination (for example, an explanation of the scientific or clinical judgment used in making the decision) if applicable.

In addition to the above information, the notice of Adverse Medical Benefit Determination will include:

- A description of any additional material or information needed to support their Claim and an explanation of why it is needed, and
- A description of the available appeal process, as well as information about how to initiate the appeal process.

Facility of Payment

St. Luke's Health Plan may pay benefits under this Policy to the Member, directly to the Provider of services, or jointly to the Member and the Provider, as determined by the Plan and consistent with applicable law.

If payment cannot be made directly to the Member, payment may be made to the Member's legal representative, estate, or other party deemed by the Plan to be equitably entitled to such payment, in accordance with applicable law.

Any payment made in good faith by St. Luke's Health Plan shall fully discharge the Plan's obligation for the amount paid.

Appeals

Member Appeal Rights

St. Luke's Health Plan Members have the right to:

- Request an appeal if coverage of any health care service is denied, either wholly or in part. An appeal is an internal review of an Adverse Medical Benefit Determination. Members have **180 days** from the date of the Adverse Benefit Determination to file an appeal.
- Appoint a person of their choosing to represent them. This person is known as an Authorized Representative and can be, but does not have to be, an attorney.
- Reasonable access to, and copies of, all documents, records, and information relevant to their Claim and relied upon in making the Adverse Medical Benefit Determination. This information will be made available upon request at no cost.
- Submit written comments, documents, and other information relevant to their appeal.

- Obtain the title and qualifications of the person(s) who participated in the Adverse Medical Benefit Determination, if the determination was based on Medical Necessity, or if the Plan determined the services are/were experimental or investigational.
- Request an Expedited ("Fast Track") Appeal.
  - If their appeal situation is urgent, call the St. Luke's Health Plan Appeals Coordinator at (833) 353-0312.
  - Urgent is defined as a situation in which, in the opinion of a physician with knowledge of the Claimant's medical condition, the application of the time periods for making non-urgent appeal determinations could seriously jeopardize the Claimant's life, health, or ability to regain maximum function; or would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.
  - If the Plan determines the situation **is** urgent, the Plan will issue an appeal determination within **72 hours** of receiving the appeal request.
  - If the Plan determines the situation is **not** urgent, the Plan will issue a determination within the non-urgent appeal timeframe. Non-urgent appeal determination timeframes are as follows:
    - **30 days** if the services have not been rendered yet (pre-Service).
    - **60 days** if the services have already been rendered (post-Service).
  - The Member or their Authorized Representative will be notified by the Plan within **72 hours** if their request for an Expedited Appeal was denied.
  - Expedited Appeals are only available for services denied prior to being rendered (Pre-Service) or services that are ongoing (Concurrent). If the service has already been completed (Post-Service), an Expedited Appeal review will not be granted; the Plan will issue an appeal determination within the Post-Service appeal timeframe of **60 days.**

How to Request an Appeal

Appeal Request Forms are available by contacting Member Services. Use of this form is not required, but it is helpful in guiding Members to provide the information that is necessary and/or most helpful for us to render an appeal determination.

Appeals can be submitted in writing via mail, fax or email using the contact information below:

Medical Appeals
Mail: Attn: Appeals Coordinator
P.O. Box 1739
Boise, ID 83702-5809
Email: SLPlanAppeals@slhealthplan.org
Fax: (833) 840-1209
Phone: (833) 840-3600
Note: only urgent appeals can be submitted via telephone.

Pharmacy Appeals
Mail: St. Luke's Health Plan
Attn: Pharmacy Department
P.O. Box 1739
Boise, ID 83702-5809
Email: rx@slhealthplan.org
Fax: (833) 850-0172
Phone: (833) 975-1281
Note: only urgent appeals can be submitted via telephone

Internal Appeal Process

The Member or their Authorized Representative must file their appeal within **180 days** of the date on their Adverse Medical Benefit Determination notice (Internal Appeal). Non-urgent appeals must be submitted to the Plan in writing.

The Member or their Authorized Representative are encouraged to include comments, documents, records and/or other information that explains the reason they believe their Claim should be approved. St. Luke's Health Plan will send a letter acknowledging receipt of their appeal within five (5) calendar days.

Upon receipt by the Plan, an Appeals Coordinator will prepare the documents and any applicable documentation from the Agreement for review and discussion by the Plan's Appeal Committee or Chief Medical Officer. The individual who made the original Adverse Medical Benefit Determination will not be involved in the Internal Appeal Process. The Appeal Committee or Chief Medical Officer will review the information and make a recommendation to St. Luke's Health Plan to either uphold or overturn the original Adverse Medical Benefit Determination.

St. Luke's Health Plan will notify the Member in writing of the decision to either uphold the original denial or to overturn it within **30 calendar days** of Pre-Service Claims or **60 calendar days** of Post-Service Claims. If the determination is to uphold the original denial based on Medical Necessity, the letter will also include information on how to initiate the next level of appeal (External Review).

Health Claims External Review

Members are entitled to an External Review if the denial was based on medical judgment or rescission. Denials that do not involve rescission or medical judgment (i.e., denials that involve only contractual or legal interpretation without any use of medical judgment) are not eligible for External Review.

External Review requests can be submitted to the Plan using the same address, email address, or fax as an Internal Appeal request. The contact information is listed above under How to Request an Appeal. External Review requests can also be submitted directly to the Idaho Department of Insurance:

Idaho Department of Insurance
Attn: External Review
700 W. State St., 3rd Floor
Boise, ID 83702
https://doi.idaho.gov/consumers/health-insurance/external-review

For more information or to request an External Review Request Form, visit the Idaho Department of Insurance website at www.doi.idaho.gov, or call **(800) 721-3272**.

For **non-Urgent** Care:

- The Member or their Authorized Representative must first submit an Internal Appeal request and receive a final internal Adverse Medical Benefit Determination before they request External Review. Their request for External Review must be received within **120 days** of date indicated on their final internal Adverse Medical Benefit Determination.
- St. Luke's Health Plan will conduct a preliminary review to determine if the Claim is eligible for External Review within **(14) calendar days** of the receipt of a request. The Plan will send the Member notification if its decision within one business day thereafter.

For **Urgent** Care:

- The Member or their Authorized Representative can request an expedited External Review to occur at the *same time* as an Internal Appeal.
- St. Luke's Health Plan will conduct a preliminary review to determine if the Claim is eligible for External Review within **two (2) business days** of the receipt of the request. The Plan will send the Member notification of its decision within one business day thereafter.

This notice of decision of eligibility for External Review will include the following:

- If their request is found ineligible for External Review, the reason for its ineligibility.
- If their request is eligible for External Review but is not complete, a description of any additional information or materials required to complete their request.
- If their request is complete and eligible for External Review, contact information for the Independent Review Organization (IRO) assigned by the Idaho Department of Insurance, and details about their right to provide additional information.

If eligible for External Review, St. Luke's Health Plan will forward the Member's appeal, including all information and documentation considered in both the original denial and the Internal Appeal, as well as any additional documentation they submit, to the Idaho Department of Insurance within **five (5) business days** of determining the Claim is eligible for External Review.

The Idaho Department of Insurance will assign an Independent Review Organization (IRO) within **seven (7) business days** of the receipt. The IRO consists of independent physicians or other specialists that are not associated with St. Luke's Health Plan. If applicable, they will possess medical training specific to the services that are the subject of the appeal.

The IRO will notify the Member that their appeal has been received and will allow them at least **ten (10) business days** to submit any additional information to the IRO that they wish to be considered in reviewing their appeal. The IRO will review all information submitted, make a determination, and notify both the Member and St. Luke's Health Plan of the results within **forty-five (45) calendar days**. Decisions regarding Urgent Care Claims are made as expeditiously as the Member's health condition requires, but not later than **72 hours** after receipt of a request.

The decision made by the IRO is final and binding on both the Member and the Plan. This means if the Member requests an External Review, they will be bound by the IRO's decision and will not have any further review opportunity for the Plan's denial after the IRO issues its final decision. If the IRO overturns the original Adverse Medical Benefit Determination, the Appeals Coordinator will forward that decision to the appropriate party for Claim payment or, if a Pre-Service Claim, approval of the request for authorization.

Under Idaho law, the IRO is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

If the Member chooses not to use the External Review process and have exhausted the Claim and Internal Appeal procedures, they have the right to file a civil action. The civil action must be filed within **180 days** from the date of the written notice of St. Luke's Health Plan's final determination.

Grievance Procedure

A Grievance is an expression of dissatisfaction with any aspect of the care or service the Member received as a member of St. Luke's Health Plan, except for an Adverse Benefit Determination (ABD). ABDs are managed through the appeal process described above.

If a Member has a Grievance concerning any matter except an ABD, the Member or their Authorized Representative can submit it to St. Luke's Health Plan by mail, email, fax, or verbally by telephone. See below for contact information:

Grievances
Mail: St. Luke's Health Plan, Inc.
Attn: Grievances
PO Box 1739
Boise, ID 83702
Email: SLPlanAppeals@slhealthplan.org
Phone: (833) 840-3600
Fax: (833) 840-1209

All Grievances must include:

- Member name; address; telephone number.
- St. Luke's Health Plan Member number.
- The nature of the grievance.
- Why the Member is asking for reconsideration.
- Anything that they think will help their Grievance.

The Plan will issue a written response to the Member or to their Authorized Representative within **five (5) days** for urgent Grievances, and **30 days** for non-urgent Grievances, of receiving the Grievance. If additional information is needed, or there are extenuating circumstances, the Plan may extend the notification timeframe by up to **14 days**. The Member will be informed of any need for additional information as well as the reason for extension.

When a response is provided, it will contain the following information:

- The names, titles and qualifying credentials of the person or persons participating in the first level Grievance review process (the reviewers).
- A statement of the reviewers' understanding of the Member's Grievance and all pertinent facts.
- The reviewers' response in clear terms and the basis for the response.
- A reference to the evidence or documentation used as the basis for the response.
- Notice of their right to contact the Idaho Department of Insurance.

Independent Dispute Resolution

Per the protections of the No Surprises Act apply (see below), if the St. Luke's Health Plan and an Out-of-Network Provider or facility that rendered services cannot agree on how much the Provider or facility will be paid by St. Luke's Health Plan for an item or service, the dispute may be submitted by either St. Luke's Health Plan or the Provider to Independent Dispute Resolution (IDR).

Plan Members are not involved in the IDR process (though their medical information will be shared with the certified IDR entity). Regardless of what the certified IDR entity decides, the Member will not have any additional cost-sharing for the affected item or service under the Plan, as their Cost-Sharing is limited to the In-Network costs for that item or service.

To the extent that the Member has a dispute about any Adverse Medical Benefit Determination they received relating to the item or service, they can appeal that decision under St. Luke's Health Plan's Claim and Appeal Procedures.

Coordination of Benefits

When the Member or their Dependents have healthcare coverage under more than one health benefit plan, St. Luke's Health Plan will coordinate Medical Benefits with the other healthcare coverage according to the Coordination of Benefits (COB) rules issued by the Idaho Department of Insurance (see IDAPA 18.04.14.).

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **plan**. Applicable to this section only, **plan** is defined below.

The order of benefit determination rules governs the order in which each **plan** will pay a claim for benefits. The **plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **plan** may cover some expenses. The **plan** that pays after the **Primary plan** is the **Secondary**

plan. The **Secondary plan** may reduce the benefits it pays so that payments from all **plans** do not exceed 100% of the total **Allowable expense**.

Definitions (for this section only)

A. A **plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   1. A **plan** includes: Group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   2. A **plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
   3. Each contract for coverage under (1) or (2) is a separate **plan**. If a **plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **plan**.

B. This **plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other **plans**. Any other part of the contract providing health care benefits is separate from this **plan**. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules establishes whether this **plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **plan**.
   1. When this **plan** is primary, it determines payment for its benefits first before those of any other **plan** without considering any other **plan's** benefits. When this **plan** is secondary, it determines its benefits after those of another **plan** and may reduce the benefits it pays so that combination of all the applicable **plan** benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, which is covered at least in part by any **plan** covering the person. When a **plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any **plan** covering the person is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the **Plans** provides coverage for private hospital room expenses.
   2. If a person is covered by two or more **plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more **plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   4. If a person is covered by one **plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the Allowable Expense for all **plans**. However, if the Provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the **Secondary plan** to determine its benefits.

5. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **plan** provisions is not an Allowable Expense. Examples of these types of **plan** provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

E. Closed panel **plan** is a **plan** that provides health care benefits to covered persons in the form of services through a panel of Providers who are primarily employed by the **plan** and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Plan Year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **plan**.

B. (1) Except as provided in Paragraph (2), a **plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **plans** state that the complying **plan** is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base **plan** hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel **plan** to provide Out-of-Network benefits.

C. A **plan** may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other **plan**.

D. Each **plan** determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, Member, policyholder, or subscriber is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent; then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, Member, policyholder, or subscriber is the **Secondary plan** and the other **Plan** is the **Primary plan**.
2. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one **plan**, the order of benefits is determined as follows:
   a. For a Dependent child, whose parents are married or are living together, whether or not they have ever been married:
      i. The **plan** of the parent whose birthday falls earlier in the Plan Year is the **Primary plan**; or
      ii. If both parents have the same birthday, the **plan** that has covered the parent the longest is the **Primary plan.**
   b. For a Dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. This rule applies to **plan** years commencing after the **plan** is given notice of the court decree.
      ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits.
      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         1) The **plan** covering the Custodial Parent,

2) The **plan** covering the spouse of the Custodial Parent,
3) The **plan** covering the non-custodial parent; and then,
4) The **plan** covering the spouse of the non-custodial parent.

c. For a Dependent child covered under more than one **plan** of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Laid-off Employee. The **plan** that covers a person as an active employee, that is, an employee who is laid off, is the **Primary plan**. The **plan** covering that same person as a laid-off employee is the **Secondary plan**. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a laid-off employee. If the other **plan** does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Subsection D (1) above can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is also covered under another **plan**, the **plan** covering the person as an employee, Member, or subscriber, or covering the person as a Dependent of an employee, Member, or subscriber is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Subsection D (1) above can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, Member, policyholder, or subscriber, longer is the **Primary plan** and the **plan** that covered the person the shorter period of time is the **Secondary plan.**
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the **plans** meeting the definition of **plan** as stated in this Coordination of Benefits section. In addition, this **plan** will not pay more than it would have paid had it been the **Primary plan**.

Effect on the Medical Benefits of This Plan

A. **Standard Coordination of Benefits.** When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a Plan Year are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its **plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **plans** for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel **plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel **plan**, COB shall not apply between that **plan** and other Closed panel **plans**.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under **This plan** and other plans.

In administering these COB rules, St. Luke's Health Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other plans covering the person claiming benefits. St. Luke's Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give St. Luke's Health Plan any facts it needs to apply these COB rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under **This plan**. If it does, St. Luke's Health Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under **This plan**. St. Luke's Health Plan will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Timely Payment of Benefits

If the **plans** cannot agree on the order of benefits within **30 calendar days** after the **plans** have received all of the information needed to pay the Claim, the **plans** shall immediately pay the Claim in equal shares and determine their relative liabilities following payment, except that no **plan** shall be required to pay more than it would have paid had it been primary.

Right of Recovery

If the amount of the payments made by St. Luke's Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. As stated above, the term "payments made" includes the reasonable cash value of any benefits provided in the form of services.

Notice to Covered Persons

If the Member is covered by more than one health benefit **plan**, and they do not know which is their **Primary plan**, the Member or their Provider should contact any one of the health plans to verify which **plan** is primary. The health plan that they contact is responsible for working with the other **plan** to determine which is primary and should let the Member know within **thirty (30) calendar days.**

Questions about Coordination of Benefits? Contact Member Services at (833) 840-3600.

Prior Authorization when the St. Luke's Health Plan is Secondary

With the exception of the specific services listed in the Medical Benefit Prior Authorization List, Prior Authorization is not required if the **Plan** offered by St. Luke's Health Plan is their **Secondary plan.** St. Luke's Health Plan will honor a determination of Medical Necessity made by their **Primary plan**. This means that if their **Primary plan** determines a service to be Medically Necessary, the **Plan** offered by St. Luke's Health Plan will apply its normal benefit, subject to all of its other **Plan** provisions and exclusions. If their **Primary plan** determines a service is not Medically Necessary, coverage under the **Plan** offered by St. Luke's Health Plan will be denied. Benefits which are excluded by their **Primary plan** but payable under the **Plan** offered by St. Luke's Health Plan are subject to medical review by St. Luke's Health Plan.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

If a Member's coverage terminates under this group health plan, they may be eligible under COBRA to continue the same coverage they had when coverage ended, on a temporary self-pay basis. COBRA requires this continuation of coverage be made available to covered persons – called qualified beneficiaries under COBRA – on the occurrence of a qualifying event, described below.

Continuation of coverage under COBRA is not automatic; the Member must elect COBRA by completing and properly providing an enrollment form to their Plan Administrator. The Member must contact their Plan Administrator and apply for continuation of their group health plan coverage within 60 days of the termination of coverage. The Member will also be required to pay applicable contributions for themselves and/or their Dependent(s) directly to the Plan.

This Plan provides no greater COBRA rights other than what COBRA requires. Nothing in this Plan is intended to expand their rights beyond COBRA's requirements.

This section describes Member's COBRA coverage rights; contact the Plan Administrator for more information.

Who is a COBRA Qualified Beneficiary?

Employees and covered Dependents who participate in the Plan may be eligible for COBRA in the case of a qualifying event if they are also a qualified beneficiary. Qualified beneficiaries include:

- Employees enrolled in the Plan on or before the date of the event that causes them to lose that coverage (called the qualifying event).
- An employee's spouse enrolled in this Plan on the day before the qualifying event.
- The employees' Dependent children enrolled in this Plan on the day before the qualifying event.
- Dependent children born to, or placed for adoption with, the employee while the employee has COBRA coverage.
- Dependent children acquired through legal guardianship while the employee has COBRA coverage.
- Dependent children covered under medical child support orders while the employee has COBRA coverage.

Please note: Domestic Partners are not eligible for COBRA or other continuation of coverage.

A qualified beneficiary may choose to continue any one benefit, or all of the benefits that s/he was enrolled in prior to the qualifying event.

Certain qualified beneficiaries may have additional COBRA rights and possible tax credits if they are certified by the Department of Labor or state labor agencies as eligible under the Trade Adjustment Assistance Reform Act of 2002. (Contact the Plan Administrator for more details.)

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

- If employment terminates (voluntary or involuntary), the Member and their covered Dependents may continue coverage under this Plan for up to 18 months unless the cause is gross misconduct.
- If the Member's work hours are reduced, resulting in loss of group coverage, the Member and their covered Dependents may continue coverage under this Plan for up to 18 months.
- If the Member and their spouse legally divorce or are legally separated, their spouse and covered Dependent children may continue coverage under this Plan for up to 36 months.
- When the Member's covered Dependent child no longer meets the Plan's definition of Dependent child, the child may continue coverage under this Plan for up to 36 months.
- When the Member becomes Medicare eligible, their Medicare-ineligible covered Dependents may continue coverage under this Plan for up to 36 months.
- If the Member dies their spouse or covered Dependents may continue coverage under this Plan for up to 36 months.
- If the Member enters into uniformed service, they may elect to continue Plan coverage for up to 24 months (See also Military Leave under Other Continuation of Coverage section).

- If while covered under COBRA the Member (or a COBRA-eligible Dependent) become disabled, they may be eligible for a coverage extension. The 18-month COBRA coverage period may be extended another 11 months for a total of 29 months of COBRA coverage.

To qualify for this disability extension, the Member must:

- Meet the definition of disability under Title II or XVI of the Social Security Act at the time of the qualifying event or within the first 60 days of COBRA coverage.
- Provide the Plan Administrator with notice of the disability determination (from Social Security) on a date that is both within 60 days after the determination date and before the original 18-month coverage ends. If the beneficiary who is disabled is later determined by Social Security to no longer be disabled, the Plan Administrator must receive notice within 31 days of that determination date.

When COBRA Coverage Ends

COBRA coverage ends before the 18-, 29-, or 36-month period expires for any of these reasons:

- The Plan no longer provides group health coverage to any employees.
- The COBRA coverage. premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election)
- The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit.
- The qualified beneficiary enrolls in Medicare.
- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled, the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period.

Please note: Once COBRA coverage ends, it cannot be reinstated.

Contribution Payment Requirements

Members are required to pay any and all applicable contributions for themselves and their covered Dependents. They must pay the first contribution for continuation of coverage within 45 days of the date the Member elects COBRA coverage. Contributions consist of the full cost of coverage, plus 2% (a total of 102%).

If Members are eligible and receive a disability extension under Title II or XVI of the Social Security Act, their contribution will be 102% of the full cost of coverage.

If the cost for similarly situated active employees or Dependents changes, the COBRA coverage premium also changes (only once a year before the Plan Year begins).

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the month for which a complete payment was made. Payments need to be sent directly to St. Luke's Health Plan at P.O. Box 736221, Chicago, IL 60673-6221. If you have COBRA related questions, you may call (833) 840-3600 to speak with a Customer Service Representative.

Election Requirements

At the time of a qualifying event, such as termination of employment or reduction in hours, the qualified beneficiary must be notified of the right to continue coverage within 14 days of St. Luke's Health Plan receiving notice of the qualifying event from the Plan Administrator.

In the case of divorce, Legal Separation, or the ineligibility of a Dependent, the employee or qualified beneficiary is responsible for notifying the Plan Administrator within 61 days of the divorce, Legal Separation, or ineligibility of a Dependent. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 61 days.

What Coverage Must Be Offered When Electing COBRA?

The Plan is required to continue the following coverage for COBRA participants:

- **Identical coverage** – The qualified beneficiary must be offered the opportunity to continue the coverage received immediately before the qualifying event.
- **Independent rights** – Once a qualifying event occurs each qualified beneficiary has an independent right to elect continuation coverage. For example, if an employee and family are offered COBRA coverage, each individual can make an election. Although an active employee must be covered to cover a Dependent, it is possible to have COBRA coverage for a Dependent when the former employee does not elect to continue coverage.
- **Open Enrollment** – Qualified beneficiaries must be notified of any benefit or carrier changes at Open Enrollment and be given the opportunity to change coverage just like active employees. Qualified beneficiaries have the same rights as active employees during Open Enrollment to add or drop Family Members, change coverages, and change carriers, if available. However, if a qualified beneficiary adds a Family Member during Open Enrollment who was not previously covered, that added Family Member does not become a qualified beneficiary.
- **Modification of coverage** – If an employer modifies coverage for similarly situated active employees; the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers.

Other Continuation of Coverage

Leaves of Absence

Family Medical Leave Act of 1993 (FMLA) Leaves

The FMLA gives employees on FMLA leave the same rights and privileges as active employees. The FMLA allows an eligible employee to take 12 weeks of leave each year (during a rolling backward Plan Year) for the following reasons:

- The birth or adoption of the employee's child.
- Placement of a foster child in the employee's care.
- To care for the employee's spouse, parent, or child if suffering from a serious health condition.
- An employee's own disabling serious health condition.
- For qualifying exigencies arising out of the fact that the employee's spouse, parent or child is on active duty with the Armed Forces, including the National Guard or Reserves (Examples of "qualifying exigencies" include, but may not be limited to, short-notice deployment, military events and related activities, certain childcare and related activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and/or any other event that the employer and employee agree constitute a qualifying exigency).

The FMLA also allows an eligible employee to take 26 weeks of leave each year (during a rolling backward Plan Year) for the following reasons:

- For military caregiver leave, an employee may be allowed for up to 26 weeks of leave, per service member, per injury, to care for a Family Member who (1) is an current Member of the Armed Forces, Guard or Reserves; (2) who suffered a serious illness or injury or whose pre-existing illness or injury was aggravated in the line of duty while on active duty;

and (3) is undergoing medical treatment, recuperation, therapy, outpatient care, or has been placed on the temporary disability retirement list by the military. (Please note the Department of Labor (DOL) has established an order of familial priority for Family Members seeking this leave; the Group is within its rights to request information seeking proof and/or clarification of the relationship to the service member.).

If Members are granted an authorized leave of absence from work, they may choose to continue coverage under this group health plan during the approved leave time as long as they pay their required contribution. Since continuation of coverage under this provision is not extended automatically, please contact the Plan Administrator for more information. Any and all applicable monthly contributions must be paid directly to the Plan in accordance with the Agreement established before the leave. Failure to make the established monthly contribution may result in the termination of group health benefits. Eligible employees will receive information about the option of continuing their health benefits on a self-pay basis under COBRA.

If a Member's leave is a paid leave, the contribution costs will continue to come out of their paycheck as a deduction. If their leave is unpaid, they are responsible for paying their share of contribution directly.

If a Member loses coverage during their leave because they did not make the required contributions, they may enroll again within 31 days of returning to work. Their coverage will start on the first day of the month after they return to work and make any required contributions.

Military Leave

If a Member takes a military leave, for active duty or training, they will be covered under the Plan's health benefits as if they were an active employee, as long as they are in an active paid status.

If the Member's uniformed service lasts beyond their paid time or 31 days, whichever is longer, they may continue coverage under the self-pay option for approved leaves (as described in the COBRA section) according to their rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). While continued, coverage will be what was in force on the last day they worked as an active employee. However, if benefits decrease for others in the class, theirs will also decrease.

If the Member returns to active employment promptly after their military leave, in accordance with federal law, their medical and pharmacy coverage will be reinstated on the date they return to the active payroll. The Member must submit a written request for reinstatement within 90 days of their discharge from active military service, or one year following a hospitalization which continues after they are discharged from active military service.

All Leave of Absences

If a Member's coverage has been terminated, they must re-enroll within 31 days of returning to work in a benefit-eligible status. There is no automatic re-enrollment process. Contact the Plan Administrator for further questions.

Subrogation, Reimbursement, & Recovery

Payment of Claims When Another Person or Entity is Liable

When the Member or their Dependents suffer an illness or injury that is caused by another person or entity, regardless of whether the person or entity is also an insured under the Plan or any other insurance policy (hereinafter a "Recovery Party"), the Recovery Party or an insurer for the Recovery Party may be liable for damages or may be willing to pay money in settlement of a Claim. This Plan does not pay benefits or services that the Member or their Dependents receive for illnesses and injuries when the medical expenses are the responsibility of, or are paid by, a Recovery Party who has caused the

illness or injury or a Recovery Party's insurer. In situations where St. Luke's Health Plan determines that a Recovery Party may be liable for Member or their Dependent's medical expenses, St. Luke's Health Plan may nonetheless agree to conditionally pay the Claims relating to such expenses in advance pending a final determination of a) whether a Recovery Party or the Member is responsible for such expenses instead of the Plan; and/or b) the Claims are excluded from coverage under this Plan. Each Member agrees to reimburse St. Luke's Health Plan for such conditional payments when a final determination is made by St. Luke's Health Plan that it is not responsible for the payment of such Claims.

St. Luke's Health Plan's Recovery Rights

If St. Luke's Health Plan pays benefits under this Plan for an illness or injury and St. Luke's Health Plan determines that a Recovery Party is or may be responsible or liable for damages to the Member or their Dependents, St. Luke's Health Plan has the right to recover the benefits paid under this Plan and is subrogated to all and any of Member or their Dependent's rights to recover from the Recovery Party and to any money paid in settlement of a claim, but only up to the amount of the benefits provided by the Plan. St. Luke's Health Plan is entitled to reimbursement and/or recovery under this section from any judgment, award, and other types of recovery or settlement received by the Member, their Dependents and/or Member or their Dependent's representatives, regardless of whether the recovery is characterized as relating to medical expenses. St. Luke's Health Plan and the Plan is entitled to reimbursement even if the Member or their covered Dependent is not made whole or fully compensated by the recovery. The Member and their Dependents are required by this Plan, and agree, to promptly notify St. Luke's Health Plan when the terms of this section might apply. If the person for whom Plan benefits are paid is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this section regardless of whether the minor's representative has access to or control of the recovered funds. The provisions of this section are binding upon the Member and their Dependents and binding upon their and their Dependent's guardians, heirs, executors, assigns and other representatives.

Agreement by Members

As a condition to receiving benefits under the Plan, the Member and their Dependent(s) agree (a) that St. Luke's Health Plan is automatically subrogated to, and has a right to receive restitution from, any right of recovery the Member may have against a Recovery Party as the result of an accident, illness, injury, or other condition involving the Recovery Party (hereinafter "Recovery Event") that causes the Member or their Dependents to obtain Medical Benefits that are paid for by St. Luke's Health Plan; (b) that St. Luke's Health Plan is entitled to receive as restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any claim or potential claim that the Member or their Dependents have or could assert against a Recovery Party to the extent of all Benefits paid by St. Luke's Health Plan or payable in the future because of the Recovery Event; (c) not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of St. Luke's Health Plan's rights described in this section; (d) not to spend or otherwise disburse funds received under a settlement agreement or from an insurance company or other Recovery Party until such time as St. Luke's Health Plan has been paid or reimbursed for the amounts due to St. Luke's Health Plan under this section; (e) to cooperate with St. Luke's Health Plan to effectuate the terms of this section and to do whatever may be necessary to secure the recovery by St. Luke's Health Plan of the amounts it paid, including execution of all appropriate papers, furnishing of information and assistance; and (f) not to interfere with St. Luke's Health Plan's rights under this section and not to take any action that prejudices St. Luke's Health Plan's rights under this section, including settling a dispute with a Recovery Party without protecting St. Luke's Health Plan's rights under this section. If requested to do so by St. Luke's Health Plan, the Member and their Dependents must execute a written Recovery Agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If their Dependent is so injured or has such an illness, both the Member and their Dependent are required to execute the written Recovery Agreement. If the injured or ill person is a minor or legally incompetent, the written Recovery Agreement must be executed by the person's parent(s), managing conservator and/or guardian. If the Member or their Dependent has died, the Member or their Dependent's legal representative must execute the Recovery Agreement. The costs of any Plan benefits paid must be returned to St. Luke's Health Plan immediately in the event that St. Luke's Health Plan requests that a written Recovery Agreement be signed and there is a failure or refusal to execute the Recovery Agreement. St. Luke's Health Plan's rights, however, are not waived if St. Luke's Health Plan does not request a written Recovery Agreement under this section.

Constructive Trust and First Lien

Any funds the Member and/or their Dependents (or Member or their Dependent's agent or attorney) recover by way of settlement, judgment, or other award from a Recovery Party or from Member or their Dependent's own insurance due to a Recovery Event shall be held by the Member and/or their Dependents (or Member or their Dependent's agent or attorney) in a constructive trust for the benefit of St. Luke's Health Plan until St. Luke's Health Plan's rights under this section have been satisfied. St. Luke's Health Plan will have, and the Member and their Dependents grant, a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that the Member or their covered Dependents receive or are entitled to receive from any source, regardless of whether the Member or their covered Dependents receive a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. These first priority rights will not be reduced due to the Member or their covered Dependent's own negligence. The Member and/or their Dependents (or Member or their Dependent's agent or attorney) will be personally liable for the restitution amount required under this section to the extent that St. Luke's Health Plan does not recover that amount due to a failure by the Member and/or their Dependents (or Member or their Dependent's agent or attorney) to follow the required process.

Rights to Intervene and Sue

St. Luke's Health Plan shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a Recovery Party for purposes of asserting and collecting St. Luke's Health Plan's restitution and other interests described in this section. St. Luke's Health Plan shall have the right to bring a lawsuit against, or assert a counterclaim or crossclaim against, the Member (or their agent or attorney) for purposes of collecting restitution or other interests under this section, to enforce the constructive trust required by this section, and/or take any other action to collect funds from the Member. St. Luke's Health Plan is entitled to institute these actions in its own name or in Member or their Dependent's name or to join any action brought by the Member, their Dependents, or their representatives, with or without specific consent, and to participate in any judgment, award or settlement to the extent of St. Luke's Health Plan's interest. The Member and their Dependents must notify St. Luke's Health Plan before filing any suit or settling any claim so as to enable St. Luke's Health Plan to participate in the suit or settlement to protect and enforce St. Luke's Health Plan's rights under this subrogation provision. The Member and their Dependents agree to keep St. Luke's Health Plan fully informed and advised of all developments in any such suit or settlement negotiations. The amount that St. Luke's Health Plan is entitled to recover from the Member and their Dependents under this section is specifically unreduced by any attorney, legal or other fees and costs incurred by the Member or their Dependents in seeking recovery from a Recovery Party or a Recovery Party's insurer, except if St. Luke's Health Plan specifically agrees in writing to participate in these fees. If the Member or their Dependents fail to fully cooperate with St. Luke's Health Plan or its designated agents in asserting its rights under this section, St. Luke's Health Plan may reduce or deny coverage under the Plan and offset against any future Claims. Further, St. Luke's Health Plan may compromise with the Member or their Dependents on any issue involving subrogation/restitution in a way that includes the Member or their Dependents surrendering the right to receive further benefits under the Plan.

Excess Payment

St. Luke's Health Plan will have the right to recover any payment made in excess of the obligations of St. Luke's Health Plan under this Agreement. Such recoveries are limited to a time period of 12 months (or 24 months for a COB error) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by the Member or their Dependents. This right of recovery will apply to payments made to the Member, their Dependents, or Providers. If an excess payment is made by St. Luke's Health Plan to the Member, they agree to promptly refund the amount of the excess. St. Luke's Health Plan may, at its sole discretion, offset any future benefits against any overpayment. St. Luke's Health Plan may recover excess payment made to a Provider by withholding other amounts payable to the Provider from any plan under which St. Luke's Health Plan makes payment.

Your Rights and Protections Against Surprise Medical Bills (No Surprises Act)

What is Balance Billing (sometimes called Surprise Billing)?

When the Member sees a doctor or other health care Provider, they may owe certain Out-of-Pocket costs, such as a Copayment, Coinsurance, and/or a Deductible. The Member may have other costs or may be required to pay the entire bill if they see a Provider or visit a health care facility that is not in the St. Luke's Health Network or nationwide networks.

Out-of-Network describes Providers and facilities that have not signed a contract with the St. Luke's Health Plan, or the networks used by St. Luke's Health Plan. Out-of-Network Providers may be permitted to bill the Member for the difference between what the St. Luke's Health Plan agreed to pay under the Plan and the full amount charged for a service. This is called Balance Billing. This amount is likely more than In-Network costs for the same service and might not count toward their Plan Year Out-of-Pocket limit.

Surprise Billing is an unexpected Balance Bill. This can happen when the Member cannot control who participates in their care, like when they have an emergency or when they schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

You Are Protected from Balance Billing for Emergency Services

If the Member has an emergency medical condition and get Emergency Services from an Out-of-Network Provider or facility, the most the Provider or facility may bill the Member is their Plan's In-Network cost-sharing amount (such as Copayments and Coinsurance). The Member cannot be Balance Billed for these Emergency Services. This includes services the Member may get after they are in stable condition, unless they give written consent and give up their protections not to be Balance Billed for these post-stabilization services.

You Are Protected from Balance Billing for Out-of-Network Providers at In-Network Facilities

When the Member get services from an In-Network hospital or ambulatory surgical center, certain Providers there may be out-of-network. In these cases, the most those Providers may bill the Member is their Plan's In-Network cost-sharing amount, unless they give written consent and give up their protections not to be Balance Billed for these post-stabilization services.

Certain Providers cannot ask the Member to waive their protections under the No Surprises Act. They include Providers of emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers cannot Balance Bill the Member and may not ask them to give up their protections not to be Balance Billed. If the Member has other services at these In-Network facilities, Out-of-Network Providers cannot balance bill them, unless the Member gave written consent and give up their protections.

You are never required to give up your protections from Balance billing. You also are not required to get care out of network. You can choose a Provider or facility in the St. Luke's Health Plan's network.

When balance billing is not allowed, you also have the following protections:

- Members are only responsible for paying their share of the cost (like the Copayments, Coinsurance, and Deductibles that they would pay if the Provider or facility was In-Network). The Plan will pay Out-of-Network Providers and facilities directly.
- The Plan generally must:
  - Cover Emergency Services without requiring the Member to get approval for services in advance (Prior Authorization).
  - Cover Emergency Services by Out-of-Network Providers.
  - Base what the Member owes the Provider or facility (cost-sharing) on what it would pay an In-Network Provider or facility and show that amount on their explanation of benefits.
  - Count any amount the Member pays for Emergency Services or out-of-network services toward their Deductible and Out-of-Pocket limit.

Visit www.cms.gov/nosurprises for more information about their rights under federal law.

The Idaho Department of Insurance has also published an overview of the No Surprises Act on its website at doi.idaho.gov/nosurprises.

If the Member believes they have been wrongly billed under their Plan, they may call (800) 985-3059 to contact federal authorities or (208) 334-4319 or consumeraffairs@doi.idaho.gov to reach the Consumer Affairs division of the Idaho Department of Insurance. If the medical service at issue was performed in a state with an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS), such as Maryland, Vermont, and Pennsylvania, they may call that applicable state Department of Insurance for more information about their rights under applicable state law.

Maryland:
Maryland Insurance Administration
200 Saint Paul Place, Suite 2700
Baltimore, Maryland 21202-2272
Phone: (410) 468-2000

Pennsylvania:
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120
Phone: (717) 787-7000

Vermont:
Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620-3101
Phone: (802) 828-3301

Plan Definitions

Adopted means a child for which a Member has legally assumed the parental rights and responsibilities.

Adverse Medical Benefit Determination means a denial, decrease or termination of a Medical Benefit. This includes a failure to provide or make payment (in whole or in part) for a Medical Benefit based on: a determination that a Medical Benefit is not covered by St. Luke's Health Plan; a determination based on an individual's eligibility to participate in St. Luke's Health Plan, or to receive plan Medical Benefits at time of service (these appeals are considered administrative and are handled by St. Luke's Health Plan, see *Claim Procedure* above); a determination that a service is experimental, investigational, or not Medically Necessary; and/or rescission of coverage (these appeals are considered administrative and are handled by St. Luke's Health Plan, see *Claim Procedure* above).

Agreement or Master Policy means the document that describes requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in the St. Luke's Health Plan.

Allowed Amount means the maximum amount considered for payment by St. Luke's Health Plan for a Medically Necessary covered service.

- Cost-sharing amounts for the following services are determined by the Qualifying Payment Amount (see related definition):
  - Emergency Services rendered by Out-of-Network Providers and facilities.
  - Certain non-Emergency Services furnished by Out-of-Network Providers at certain In-Network facilities.
  - Out-of-network air ambulances.
- The Member is responsible for paying the difference between the Plan's payment and the Provider's actual charges for services rendered by an Out-of-Network Provider who is not a covered Recognized No Surprises Provider.

Ancillary Services means services related to Emergency Services, such as radiology, anesthesiology, pathology, neonatology, laboratory, and specialty services needed to respond to unexpected complications (such as those delivered by a neonatologist or cardiologist) and also in situations where an In-Network Provider is not available at the In-Network facility to provide the services.

Applied Behavior Analysis (ABA) is a term describing principles, techniques and interventions used in assessment and treatment to increase behaviors that are helpful, reduce behaviors that are harmful and demonstrate that the interventions employed are responsible for the improvement of behavior in individuals with autism. ABA incorporates many techniques for understanding and changing behavior and may involve a multi-disciplinary approach to increase language and communication skills, improve attention, focus, social skills, and memory. ABA is flexible in that it can be adapted to meet the needs of each individual.

Aural Therapy is a service provided to both children and adults who have been diagnosed with hearing loss. Typically, Aural Therapy is an intervention that takes place following hearing aid fitting or cochlear implant hook-up. It involves working with the hearing-impaired individual providing the patient with strategies to better utilize his or her listening skills. Aural Therapy involves training the brain to process and understand auditory information, teaching how to monitor speech through listening, and learning to develop listening skills in each ear separately and integrated. Usually provided by a speech therapist.

Authorized Representative means an individual acting on your behalf or your beneficiary Claimant in obtaining or appealing a Medical Benefit Claim. The Authorized Representative must have a signed form (specified by St. Luke's Health Plan) by the Claimant except for Emergency or Urgent Care Medical Benefits or appeals. Once an Authorized Representative is selected, all information and notifications should be directed to that representative until the Claimant states otherwise.

Birthing Center means any freestanding licensed health facility, place, professional office, or institution, which is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located. It must:

- Have facilities for obstetrical delivery and short-term recovery after delivery.
- Provide care under the full-time supervision of a physician and either a registered nurse or a licensed nurse-midwife.
- Have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Chemical Dependency condition means a condition characterized by a physiological or psychological abuse/dependency of a controlled substance and/or alcohol that impairs or endangers your beneficiary's health. It must be listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions are either not considered Chemical Dependency Conditions or are covered under other Medical Benefits offered by the St. Luke's Health Plan (subject to all terms, limitations, and exclusions):

- Conditions related to Mental Health (see *Mental Health Condition definition*).

- Nicotine Related Disorders (see *Tobacco Cessation*, if applicable to the St. Luke's Health Plan).
- Nonsubstance related disorders.

Claim means any request for a St. Luke's Health Plan Medical Benefit made by the Member or their authorized representative. If the Member is making a Claim for Medical Benefits, they are a Claimant.

Coinsurance is an amount that is calculated based upon the Allowed Amount determined for the Medical Benefit and is shown as a percentage. This percentage of the Allowed Amount is what the Member is responsible to pay for the Medical Benefit. In some cases, they may also have to pay a Copayment.

Complications of Pregnancy means health problems that occur during pregnancy that can involve the mother's health, the baby's health, or both, and includes ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy abut are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but not false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Concurrent Claim means any Claim that is reconsidered after an initial approval for ongoing treatment and results in a reduced or terminated Medical Benefit.

Congenital Defect means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. A significant deviation is a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers, or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Copayment or Copay means a fixed dollar amount the Member pays to the Provider to receive Medically Necessary care. Copayment amounts do not apply toward their Plan Year Deductible, but they do apply toward their Plan Year Out-of-Pocket Maximum. If a Copayment is shown as "$0" or "no charge" this means they do not have to pay the Provider any Copayment.

Cost Share means the combined total amount which the Member pays. This includes copays, coinsurance, and covered charges that count towards their deductible.

Developmental Disabilities is an umbrella term that can include physical, cognitive, and intellectual disability that are apparent during childhood.

- Some Developmental Disabilities are largely physical, such as cerebral palsy or epilepsy.
- Some individuals may have a condition that includes a physical and intellectual disability, for example Down syndrome or fetal alcohol syndrome.
- Intellectual disability encompasses the "cognitive" part of this definition, that is, a disability that is broadly related to thought processes.
- Because intellectual and other Developmental Disabilities often co-occur, intellectual disability professionals often work with people who have both types of disabilities.

Domestic Partnership mean two (2) individuals, either opposite or same sex, who meet all the following criteria:

- Must be 18 or older.
- Must have an intimate, committed relationship of mutual caring that has existed for at least 12 months.
- Must be financially interdependent and share the same residence.

- Neither partner can be married or Legally Separated from any other person or involved in another Domestic Partner relationship.
- Partners must not be blood relatives of a degree of closeness that would prohibit marriage.
- The partners must complete during the enrollment process the Affidavit of Domestic Partnership (and be responsible for keeping a copy of the original and providing copies when requested by St. Luke's Health Plan).

Emergency Department (ED) is an emergency department of a hospital, or an Independent, Freestanding Emergency Department (or a hospital, with respect to services that are included in Emergency Services).

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

1. Jeopardy to the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child),
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the Emergency Department of a hospital or an Independent, Freestanding Emergency Department, including pre-stabilization services, post-stabilization services, and Ancillary Services to evaluate such an Emergency Medical Condition, and within the capabilities of the staff and facilities available at the hospital, to treat such an Emergency Medical Condition.

Pre-stabilization services provided after the patient is moved out of the Emergency Department (ED) and admitted to a hospital, post-stabilization services and Emergency Services provided at an Independent, Freestanding Emergency Department. Emergency Service are subject to the protections of the No Surprises Act.

Post-Stabilization services are also subject to the protections of the No Surprises Act, unless the patient is able to travel to an In-Network facility using non-medical transportation but elects to stay at the out-of-network facility.

Essential Health Benefits shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; Hospitalization; Maternity and Newborn Care; Mental Health and Substance Abuse Disorder Services, including Behavioral Health treatment; Prescription Medications; Rehabilitative and Habilitative Services and devices; Laboratory Services; Preventive and Wellness Services and Chronic Disease Management; and Pediatric Services, including Oral and Vision Care.

The determination of which Medical Benefits provided under St. Luke's Health Plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Idaho as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Family Member means a person who is a spouse, former spouse, child, stepchild, grandchild, parent, stepparent, grandparent, niece, nephew, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother, sister, brother-in-law, or sister-in-law, including adoptive relationships.

Fiduciary means a person who exercises discretionary authority or control over the management of a plan or its assets or has discretionary authority or responsibility in Plan administration.

First Responder User Fee is a charge to patients who were treated or evaluated by a First Responder Unit of a municipality or other government agency that responded to a 9-1-1 call for medical services.

In-Network Service Area is a geographical area in which healthcare services covered by this Agreement are performed by In-Network Providers.

In-Network Provider means a Provider who is contracted with the St. Luke's Health Network.

Wrap Network Provider means a Provider who is contracted with nationwide network.

In-Network Care is health care covered by this Agreement and provided by an In-Network Provider.

Independent, Freestanding Emergency Department is any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide Emergency Services, even if the facility is not licensed under the term, "Independent, Freestanding Emergency Department."

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Levels of Care related to Mental Health and Chemical Dependency Conditions:

- **Intensive Outpatient Programs** provide services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.
- **Inpatient Psychiatric Hospitalization Programs** provide around-the-clock psychiatric and nursing interventions in secure, State-licensed psychiatric facilities for individuals diagnosed with a mental health disorder. These facilities operate under the supervision of a licensed and Board eligible/certified psychiatrist who evaluates the patient within 24 hours of admission. Subsequent face-to-face visits with a psychiatrist or psychiatric ARNP occur at least once every 24 hours along with daily medication management. Treatment must follow a written plan of care and include psychosocial and substance abuse evaluations. Individual, group, and/or family therapy occurs daily. The focus of the program is stabilization of client's psychiatric symptoms through the use of assessment, medication management, evidenced-based treatment strategies, group and individual therapy, behavior management, and active family engagement/therapy.
- **Partial Hospitalization Programs** provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.
- **Mental Health Residential Treatment Program** provides around- the- clock behavioral health services that do not need the high level of physical security and psychiatric and nursing interventions that are available in an acute inpatient program. Care is medically monitored with on-site nursing and medical services. The focus of the program is an improvement of client's psychiatric symptoms through the use of assessment, evidenced-based treatment strategies, group and individual therapy, behavior management, medication management and active family engagement/therapy. Treatment must follow a written plan of care. The facility must be state licensed for residential treatment. Residential settings not meeting these criteria, such as group homes, halfway houses, or adult/child foster homes, are not considered to be Mental Health Residential Treatment Programs.
- **Chemical Dependency Rehabilitation/Residential Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Related Conditions. Care is medically monitored, with 24-hour medical and/or nursing availability. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

Lifetime is a reference to Medical Benefit maximums and limitations, understood to mean while covered under the St. Luke's Health Plan. Under no circumstances does Lifetime mean during their Lifetime.

Made Whole Doctrine is an equitable defense to the subrogation or reimbursement rights of a subrogated Plan or other party, requiring that before subrogation and/or reimbursement will be allowed, the Covered Person must be made whole for all of its damages.

Medical Group means a group or association of Providers, including hospital(s), listed in the Provider directory.

Medically Necessary describes a medical service or supply that meets all the following criteria:

- It is required for the treatment or diagnosis of a covered medical condition.
- It is the most appropriate supply or Level of Care that is essential for the diagnosis or treatment of the patient's covered medical condition.
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards.
- It is not furnished primarily for the convenience of the patient or Provider of services.
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

The fact that a service or supply is furnished, prescribed, or recommended by a physician or other Provider does not, of itself, make it Medically Necessary. A service or supply may be Medically Necessary in part only.

Member means any eligible, enrolled individual on the St. Luke's Health Plan.

Mental Health Condition means a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions, although considered mental health conditions under the DSM, are not included in the Mental Health Care Medical Benefit under the St. Luke's Health Plan, and are either excluded or are covered under other Medical Benefits offered by the St. Luke's Health Plan (subject to all terms, limitations, and exclusions):

- Conditions related to Substance Related and Addictive Disorders (see *Plan Definitions, Chemical Dependency*).
- Relational, family, and lifestyle stressors absent a primary psychiatric diagnosis.
- Sexual dysfunctions, personality disorders, paraphilic disorders.

Newborn is a child under 28 days of age.

No Surprises Act holds patients harmless from surprise medical bills and Prior Authorization requirements. See *Your Rights and Protections Against Surprise Medical Bills.* This act:

- Bans balance billing for Emergency Services.
- Requires that patient cost-sharing, such as copayments, co-insurance, or a deductible, for Emergency Services and certain non-Emergency Services provided by an Out-of-Network Provider at an in-network facility cannot be higher than if such services were provided by an In-Network Provider, and any cost-sharing obligation must be based on In-Network Provider rates.
- Prohibits out-of-network charges for items or services provided by an Out-of-Network Provider at an in-network facility unless certain notice and consent is given. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that Provider can bill the patient more than in-network cost-sharing rates.

Open Enrollment Period is a defined time when the Member is allowed to enroll themself and/or their Dependents for benefit coverage.

Out-of-Network Provider means a Provider who is not an In-Network Provider or Wrap Network Provider. For services received from Out-of-Network Providers (not covered under Recognized No Surprises Providers), the Member is responsible to pay the difference between St. Luke's Health Plan payment and the Provider's actual charges.

Out-of-Pocket Costs means the expenses for medical or prescription drug care that the Member pays and that are not paid for by the Plan or other insurance coverage or, in the case of certain pharmaceutical products, by the manufacturer. Out-of-pocket costs include Deductibles, Coinsurance, and Copayments for covered services.

Placed or Placement is defined as physical placement in the care of the adoptive subscriber or other Member, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive subscriber or other Member signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

Plan Year determines how a Member's Medical Benefits are calculated (on a Plan Year basis) and is listed in the Enrollment material. Out-of-Pocket Maximums, Limitations, and Deductibles calculated on a Plan Year basis start over each January 1st.

Plan Year Deductible or Deductible is the amount the Member or their family must pay each Plan Year before St. Luke's Health Plan will pay for covered Medical Benefit and Pharmacy Benefit services.

Post-Service Claim means any Claim for a St. Luke's Health Plan Medical Benefit that is not a Pre-Service Claim and is a request for payment or reimbursement for covered services already received.

Prior Authorization is the process of obtaining coverage determination from St. Luke's Health Plan before receiving inpatient and certain outpatient services, as specified in the component plans' Medical Benefit description booklets.

St. Luke's Health Plan delivers care in its Service Areas through a network of caring, engaged Providers. When the Member is able to receive their Medical Benefit from one of these In-Network Providers, except for specific services outlined in the Prior Authorization Section, Prior Authorizations are not required. As always, any Emergency Services or Urgent Care Services never require a Prior Authorization. Please go to the nearest facility able to treat you!

Pre-Service Claim means any Claim for a St. Luke's Health Plan Medical Benefit for which St. Luke's Health Plan requires approval before medical care is obtained.

Primary Care Provider (PCP) includes the following Provider types:

- Family Practice
- Family Practice with OB
- Internal Medicine
- General practice
- Pediatrics
- Nurse Practitioner – Family Practice
- Nurse Practitioner – Pediatrics
- Nurse Practitioner – Adult
- Nurse Practitioner – Women's Health
- Nurse Practitioner – Geriatric Medicine
- Geriatric Medicine
- Obstetrics & Gynecology
- Gynecology
- Physician Assistants – designated as PCP

Provider means any person, organization, health facility or institution licensed to deliver or furnish health care services.

Provider Directory is the listing of the Network Providers, hospitals, and other facilities that have agreed to provide covered services to the Member or their Dependents under the St. Luke's Health Plan.

Qualifying Payment Amount (QPA) means consumer cost-sharing amounts for Emergency Services provided by out-of-network emergency facilities and Out-of-Network Providers, certain non-Emergency Services furnished by Out-of-Network Providers at certain in-network facilities, and out-of-network air ambulances that must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act,
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law, or
- If neither of the above apply, the lesser amount of either the billed charge or the St. Luke's Health Plan's median contracted rate for such services.

Recognized No Surprises Provider is a Provider acting within the scope of his/her license that the No Surprises Act applies to and who: 1) St. Luke's Health Plan does not offer agreements to his/her category of Providers, or 2) agreements are offered but do not cover the particular Provider at issue or no written notice and consent was provided. This includes:

- Air Ambulance services
- Anesthesiologist services
- Assistant surgeon services
- Emergency services
- Hospital services
- Intensivist services
- Laboratory services
- Neonatology services
- Pathology services
- Radiology services
- Services of non-contracted Providers when rendering care within an in-network facility, except a primary surgeon for a non-emergent admission

If the Member receives any of the services listed above, then those Out-of-Network Providers cannot balance bill the Member, unless they are provided with written notice and give written consent to waive their protections against balance billing.

Service Area means the geographic areas outlined for each network as set forth in the How to Obtain Health Services section.

Special Enrollment means, under HIPAA, special mid-year enrollment rights that health plans must offer to those who experience a mid-year loss of other coverage or when there is a mid-year birth, adoption, or marriage.

Surrogacy means if the Member bears a child for another person, often for pay, either through artificial insemination or by carrying until birth another Member's surgically implanted fertilized egg.

Telehealth Services includes but is not limited to:

- **Telehealth Visit** means health care services conducted with technology that includes live audio and video communication between the Participant and a Provider in compliance with state and federal laws.
- **Scheduled Telephone Visit (STV)** means a telephonic visit initiated by patient and scheduled for a specific time with a designated Provider and not related to any previous visits within 7 days.

- **Electronic Visit (e-visit)** means a visit of non-urgent clinical information between a Provider and a patient conducted over a secure encrypted web portal. E-visits must be scheduled with a designated Provider and not be related to any visit within the last seven (7) days.
- **Remote Patient Monitoring** means the collection of physiological data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the Provider.
- **Videoconference Consultation** means the use of medical information exchanged from one site to another via electronic communications.

Temporomandibular Joint (TMJ) Disorders mean disorders that have one or more of the following characteristics:

- Pain in the musculature associated with the temporomandibular joint.
- Internal derangement of the temporomandibular joint.
- Arthritic problems with the temporomandibular joint.
- An abnormal range of motion or limited motion of the temporomandibular joint.

Urgent Care means services that are Medically Necessary and immediately required as a result of an unforeseen illness, injury or condition that is not an emergency, but it was not reasonable given the circumstances to wait for a routine appointment.

Urgent Care Claim means a Claim for medical care or treatment that, if normal pre-service standards are applied:

- Would seriously jeopardize the Claimant's life, health, or ability to regain maximum function.
- In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Usual, Customary and Reasonable (UCR) is the maximum amount that St. Luke's Health Plan will consider for a covered health care service received from an Out-of-Network Provider (outside of the Recognized No Surprises Providers), that is consistent with and based upon what Providers in a given particular geographic area charge for a same or similar medical procedure. Coinsurance, copayments, deductible, or non-covered services are applied against UCR amount as patient responsibility. The Provider can balance bill the Member the difference between St. Luke's Health Plan payment and Provider's actual charges.

In instances where a UCR amount cannot be established for a Covered Service, such as services billed under unlisted or miscellaneous procedure codes, including certain dialysis services, St. Luke's Health Plan will determine the Allowable Amount in accordance with its reimbursement policies, as published in the Provider Manual and as updated from time to time. The Allowable Amount determined under such policies will be used to calculate Member cost-sharing.