



# 2025 Large Group Health Plans

**51+ Employees**



**St Luke's<sup>TM</sup>**  
**+ Health Plan**





We're the only Idaho-based health plan connecting health care and health coverage into **a seamless experience that reduces barriers and costs.**



# Oh, so affordable.

## **\$0 benefits\*, including:**

- Primary care office visits
- Preventive care
- Professional maternity care
- Obstetrics and gynecology (OBGYN) office visits
- Mental health
- Oncology office visits
- Medical eye exams
- Preventive prescription drugs
- Preferred generic drugs on most plans
- St. Luke's On-Demand Virtual Care visits

## **Comprehensive coverage, including:**

- St. Luke's Lifestyle Medicine Program

## **No limits on several services, including:**

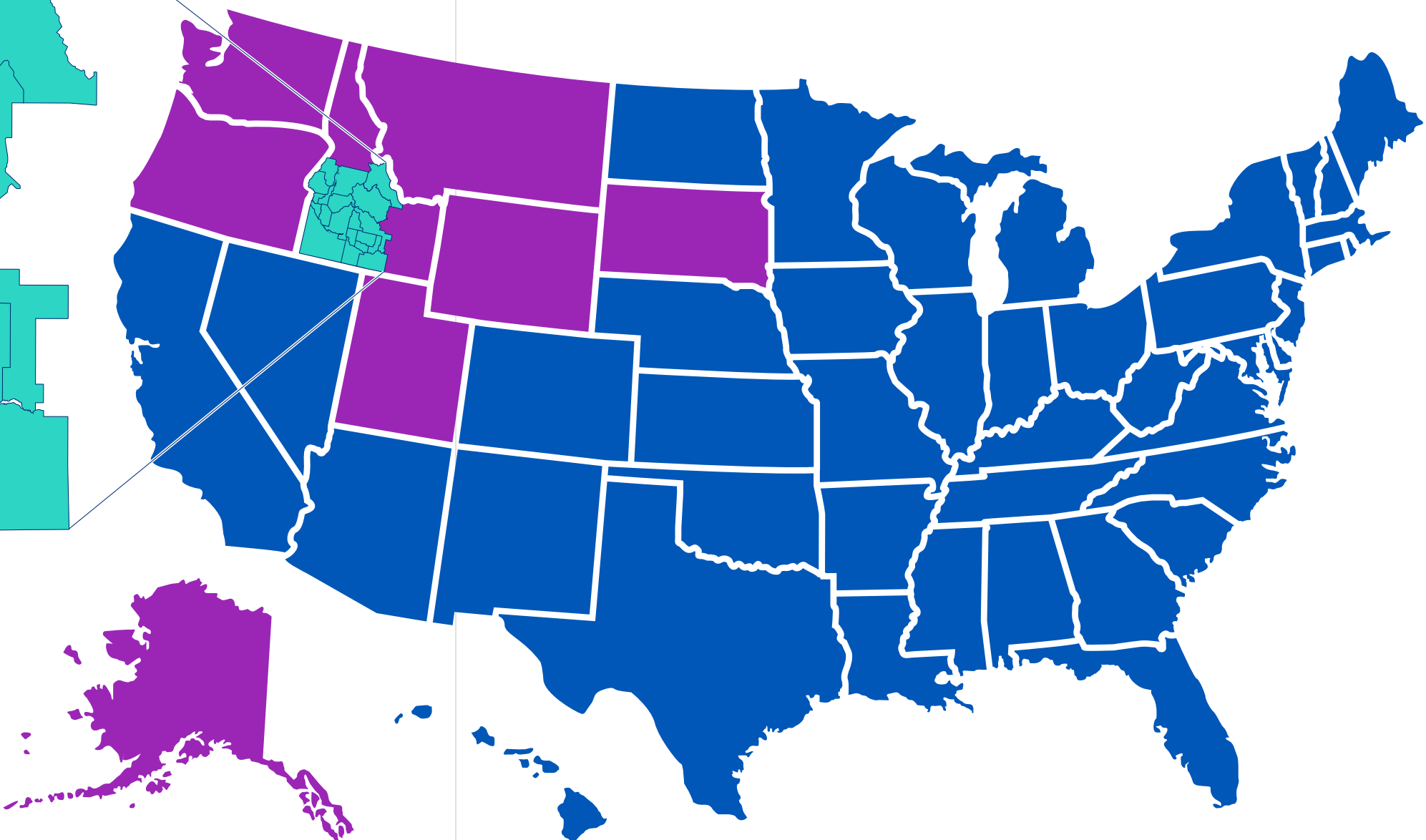
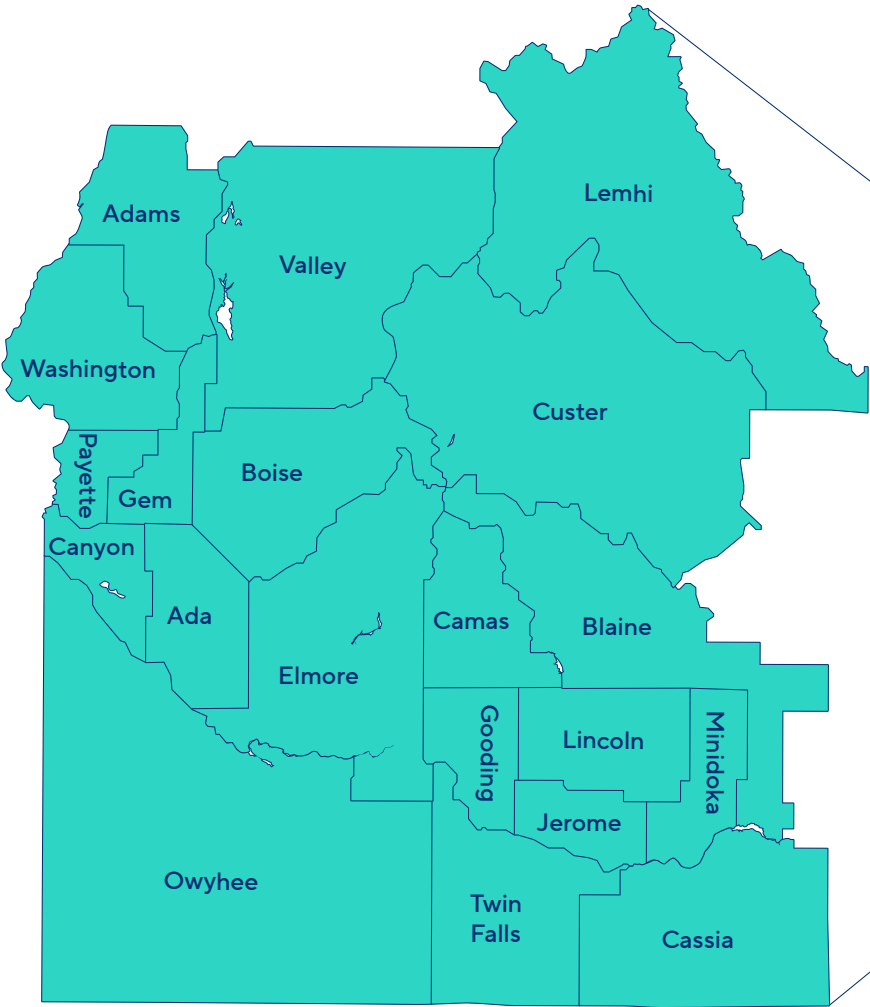
- Behavioral health visits
- Diagnostic lab and X-ray services

\*Deductibles might apply for high-deductible health plans.

Nationwide network access.

Members and dependents that live, work or travel outside the St. Luke's Health Plan areas of coverage have nationwide care.

To find in-network care, scan the QR code below or search for doctors at [stlukeshealthplan.org/find-a-doctor](https://stlukeshealthplan.org/find-a-doctor).



St. Luke's Health Partners	Regional
7,100+ doctors and specialists available across the primary coverage area, including both St. Luke's and independent practitioners.	National
	Extended regional and national networks offer in-network care for members when and where they need it.

 St. Luke's Health Partners

 Regional Network

 National Network



# When doctors and insurance work together, patients win.

You have the flexibility to design a health benefits package by selecting the right combination of medical and pharmacy benefits that offers your employees comprehensive care while maintaining cost efficiency. Below, we've outlined key choices and features that will help guide your decision-making process:

## Medical benefits.

Choosing the right medical plan is essential for offering the right care for your group. We offer a range of options to fit different needs, including:

- Traditional plans: Provide comprehensive medical coverage with benefit options, including \$0 copays, coinsurance and deductible choices.
- Split Rx plans: Separate pharmacy benefits from medical coverage, allowing for greater flexibility in managing prescription drug costs. These plans helps optimize savings while ensuring access to essential medications.
- High deductible health plan (HDHP): A budget-friendly plan that works with Health Savings Accounts (HSAs), offering potential tax savings and lower premiums.

## Pharmacy benefits.

In addition to your medical benefits, select from three flexible pharmacy benefit options to suit your needs:

- Rx Core option: A lower-cost pharmacy plan that provides essential coverage at a more affordable rate.
- Rx Maximum Copay option: A balanced plan that includes a set maximum amount you will pay for any tier, helping manage costs effectively.
- Rx Copay option: A fixed copay plan for predictable out-of-pocket costs.

All plans are paired with our \$0 benefits. You can explore each of these options on the following pages to find the best match for your group.

# Coverage in all the right places.

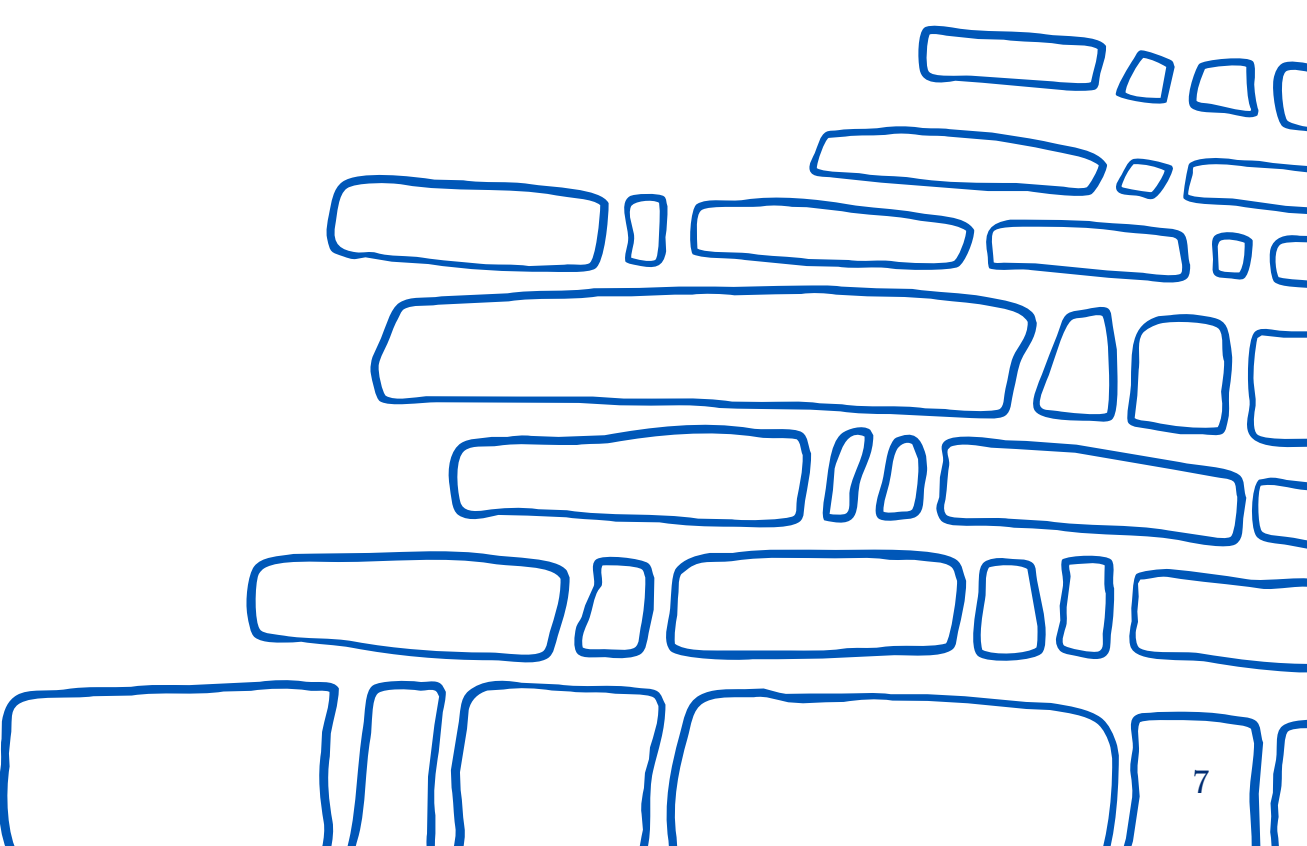
## Delta Dental of Idaho.

Oral health is a critical part of overall wellness. Our partnership with Delta Dental of Idaho allows you to purchase trusted dental services alongside your health plan. Plus, employees who have certain medical conditions, including cancer, diabetes, heart disease and pregnancy, qualify for enhanced dental benefits, like additional cleanings or fluoride treatments, to help combat oral health issues associated with these conditions.

## St. Luke's Air Ambulance.

Emergencies can happen when least expected, and air ambulance services can be a critical lifeline. Employees are eligible to receive an exclusive discount for an Air St. Luke's membership, which allows access to lifesaving transport when needed, giving peace of mind in any situation.\*

\*Area limitations apply.



# Traditional plans.

Traditional health plans offer a balance of affordability and comprehensive coverage. These plans combine copays and coinsurance to cover a wide range of health care services, including preventive care and wellness services, with a core set of \$0 benefits.

IN-NETWORK BENEFITS	TRADITIONAL 0	TRADITIONAL 750	TRADITIONAL 1000	TRADITIONAL 1500	TRADITIONAL 2000
Individual deductible	\$0	\$750	\$1,000	\$1,500	\$2,000
Family deductible	\$0	\$1,500	\$2,000	\$3,000	\$4,000
Individual annual out-of-pocket maximum	\$5,000	\$3,000	\$3,250	\$3,500	\$4,000
Family annual out-of-pocket maximum	\$10,000	\$6,000	\$6,500	\$7,000	\$8,000
In-network coinsurance*	35%	20%	20%	20%	20%
Out-of-network coinsurance*	50%	50%	50%	50%	50%
Emergency rooms	35% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent care visit	\$50	\$25	\$25	\$25	\$25
Hospital services	35% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Diagnostic X-ray and lab services	\$100	\$0	\$0	\$0	\$25
Specialist office visit	\$50	\$25	\$25	\$25	\$25
Physical, speech and occupational therapy	\$20	\$0	\$0	\$0	\$0
Chiropractic care	\$30	\$0	\$0	\$0	\$0
\$0 benefits**	\$0				
Rx benefit options	Select from Rx Core plan, Rx Max Copay plan or Rx Copay plan. See page 15.				

\*Coinsurance applies after meeting deductible for all plans.

\*\*\$0 benefits found on page 3.

TRADITIONAL 2500	TRADITIONAL 3000	TRADITIONAL 4000	TRADITIONAL 5000	TRADITIONAL 6000	TRADITIONAL 7000	TRADITIONAL 8000
\$2,500	\$3,000	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000
\$5,000	\$6,000	\$8,000	\$10,000	\$12,000	\$14,000	\$16,000
\$4,500	\$5,000	\$6,000	\$7,000	\$8,000	\$9,000	\$9,200
\$9,000	\$10,000	\$12,000	\$14,000	\$16,000	\$18,000	\$18,400
20%	20%	20%	20%	20%	20%	20%
50%	50%	50%	50%	50%	50%	50%
20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
\$25	\$50	\$50	\$50	\$50	\$50	\$50
20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
\$25	\$50	\$50	\$50	\$75	\$75	\$75
\$25	\$50	\$50	\$50	\$50	\$50	\$50
\$0	\$25	\$25	\$25	\$25	\$40	\$40
\$0	\$25	\$25	\$25	\$25	\$40	\$40
\$0						
Select from Rx Core plan, Rx Max Copay plan or Rx Copay plan. See page 15.						

# Split Rx plans.

The split medical and prescription deductible plans offer more control over health care costs by separating deductibles for medical services and prescription drugs. With a lower prescription deductible, members can access medication benefits more quickly.

IN-NETWORK BENEFITS	TRADITIONAL 1500/250 RX	TRADITIONAL 2000/250 RX	TRADITIONAL 2500/250 RX	TRADITIONAL 3000/500 RX
Individual deductible	\$1,500 Med./ \$250 Rx	\$2,000 Med./ \$250 Rx	\$2,500 Med./ \$250 Rx	\$3,000 Med./ \$500 Rx
Family deductible	\$3,000 Med./ \$500 Rx	\$4,000 Med./ \$500 Rx	\$5,000 Med./ \$500 Rx	\$6,000 Med./ \$1,000 Rx
Individual annual out-of-pocket maximum	\$3,500	\$4,000	\$4,500	\$5,000
Family annual out-of-pocket maximum	\$7,000	\$8,000	\$9,000	\$10,000
In-network coinsurance*	20%	20%	20%	20%
Out-of-network coinsurance*	50%	50%	50%	50%
Emergency rooms	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent care visit	\$25	\$25	\$25	\$50
Hospital services	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Diagnostic X-ray and lab services	\$0	\$25	\$25	\$50
Specialist office visit	\$25	\$25	\$25	\$50
Physical, speech and occupational therapy	\$0	\$0	\$0	\$25
Chiropractic care	\$0	\$0	\$0	\$25
\$0 benefits**	\$0			
Rx benefit options	Select from Rx Core plan, Rx Max Copay plan or Rx Copay plan. See page 15.			

\*Coinsurance applies after meeting deductible for all plans.  
\*\*\$0 benefits found on page 3.



TRADITIONAL 4000/500 RX	TRADITIONAL 5000/750 RX	TRADITIONAL 6000/750 RX	TRADITIONAL 7000/1000 RX	TRADITIONAL 8000/1000 RX
\$4,000 Med./ \$500 Rx	\$5,000 Med./ \$750 Rx	\$6,000 Med./ \$750 Rx	\$7,000 Med./ \$1,000 Rx	\$8,000 Med./ \$1,000 Rx
\$8,000 Med./ \$1,000 Rx	\$10,000 Med./ \$1,500 Rx	\$12,000 Med. / \$1,500 Rx	\$14,000 Med./ \$2,000 Rx	\$16,000 Med./ \$2,000 Rx
\$6,000	\$7,000	\$8,000	\$9,000	\$9,200
\$12,000	\$14,000	\$16,000	\$18,000	\$18,400
20%	20%	20%	20%	20%
50%	50%	50%	50%	50%
20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
\$50	\$50	\$50	\$50	\$50
20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
\$50	\$50	\$75	\$75	\$75
\$50	\$50	\$50	\$50	\$50
\$25	\$25	\$25	\$40	\$40
\$25	\$25	\$25	\$40	\$40
\$0				
Select from Rx Core plan, Rx Max Copay plan or Rx Copay plan. See page 15.				

# HDHP plans.

The HDHP plans offer a unique approach to managing health care costs with higher deductible and lower monthly premiums. Paired with an HSA, they provide a tax-advantaged way to save for medical expenses.

IN-NETWORK BENEFITS	HDHP 1650 AGGREGATE	HDHP 3300 EMBEDDED	HDHP 4000 EMBEDDED	HDHP 5000 EMBEDDED
Individual deductible	\$1,650	\$3,300	\$4,000	\$5,000
Family deductible	\$3,300	\$6,600	\$8,000	\$10,000
Individual annual out-of-pocket maximum	\$3,300	\$3,300	\$8,000	\$8,000
Family annual out-of-pocket maximum	\$6,600	\$6,600	\$16,000	\$16,000
In-network coinsurance*	20%	0%	20%	20%
Out-of-network coinsurance*	50%	50%	50%	50%
Emergency rooms	20% after deductible	\$0 after deductible	20% after deductible	20% after deductible
Urgent care visit				
Hospital services				
Diagnostic X-ray and lab services				
Specialist office visit				
Physical, speech and occupational therapy				
Chiropractic care				
\$0 benefits**	\$0			
Rx benefit options	Select from Rx Core plan, Rx Max Copay plan or Rx Copay plan. See page 15.			

\*Coinsurance applies after meeting deductible for all plans.

\*\*\$0 benefits found on page 3.

HDHP 6000 EMBEDDED	HDHP 7000 EMBEDDED	HDHP 8000 EMBEDDED
\$6,000	\$7,000	\$8,000
\$12,000	\$14,000	\$16,000
\$8,000	\$8,000	\$8,000
\$16,000	\$16,000	\$16,000
20%	20%	0%
50%	50%	50%
20% after deductible	20% after deductible	\$0 after deductible
\$0		
Select from Rx Core plan, Rx Max Copay plan or Rx Copay plan. See page 15.		





# Prescription for success.

Pharmacy benefits are important for your team’s health. Our goal is to get what you need, when you need it, without worrying. Select a pharmacy benefit option that includes copay and coinsurance choices designed to meet the unique needs of your employees.

## Pharmacy benefits you can count on.

Take advantage of the only health plan in the state that partners with an Idaho-based specialty pharmacy stocked with medications for cancer, chronic conditions and advanced illnesses.

## Never miss a refill again.

Your employees can scratch one more errand off their to-do lists with our mail-order pharmacy. In just a few minutes, they can arrange medication deliveries directly to their doors. Your employees can also get up to a 100-day supply of certain medications through the mail or through a St. Luke's Retail Pharmacy or Medication Locker. That saves time and money. Some exceptions apply.

## \$0 copays.

Your team will have access to hundreds of prescription drugs offered at no out-of-pocket cost.\*

In addition to Affordable Care Act preventive medications offered at no cost, they'll pay \$0 for many generic medications in these classes:

- Antibiotics
- Asthma
- Blood pressure
- Blood thinner
- Cholesterol
- Depression
- Diabetes
- Thyroid

\*Deductibles may apply.

## Choose your pharmacy benefits.

	RX CORE PLAN	RX MAX COPAY PLAN	RX COPAY PLAN
<b>Affordable Care Act (ACA) Preventive Drugs</b>	\$0	\$0	\$0
<b>Tier 1: Preferred Generic</b>	\$0	\$0	\$0
<b>Tier 2: Non-preferred Generic</b>	\$10	\$10	\$10
<b>Tier 3: Preferred Brand</b>	35% after deductible	35% after deductible (max \$90 per drug)	\$20
<b>Tier 4: Non-preferred Brand</b>	50% after deductible	50% after deductible (max \$120 per drug)	\$30
<b>Tier 5: Preferred Specialty</b>	40% after deductible	40% after deductible (max \$200 per drug)	\$150

All costs are for a 30-day supply. Copay after deductible on HDHP plans.



# Healthy network. Healthy team.

## Skip prior authorization stress.

No more waiting games. With St. Luke's Health Plan, employees won't have to seek medical prior authorization or referrals for most in-network care.

## Get care without leaving home.

Carving out time for health can be a hassle. St. Luke's Health Plan makes accessing care when and where you need it even easier. We offer St. Luke's On-Demand Care for urgent care and other services and telehealth for regular checkups with your provider, so you can save gas money and precious time.





# Plan exclusions and limitations.

In addition to limits and exclusions stated elsewhere in the Policy, 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 injury or illness, 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 room, air conditioners, diapers or hygiene items; private duty nursing; respite care, except as expressly covered by the Policy; and transportation, except ambulance services to the nearest appropriate facility, if medically necessary and other forms of transportation would likely endanger your 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 your 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 the 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 injury or illness incurred by you while you are participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition; services related to injuries incurred while under the influence of a controlled substance and/or alcohol; 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 you are legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to you for a non- service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to you and you are not on active military duty); services for which you receive compensation or reimbursement through another contractual arrangement or Medical Benefit, other than employer-based disability payments, such as (but not limited to) surrogate pregnancy; 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, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, 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 in a school setting (such as early learning and K-12).

Physical examinations, reports or related services or supplies for the purpose of obtaining or maintaining employment, insurance, 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; and court ordered examinations or treatment of any kind, except when Medically Necessary.

Care provided by phone, fax, e-mail, Internet or Telemedicine, except as expressly covered under the Policy; 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.

### 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); 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 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 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; 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); and 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

#### Maternity Care and Services

The \$0 copay for maternity care applies to all professional (physician) charges for both routine office visits and delivery. This also includes routine postpartum office visits. Maternity and newborn-related facility charges are not covered by the \$0 copay.

If you purchase St. Luke's Health Plan on the Your Health Idaho exchange:

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; 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), anorgasm and premature ejaculation.

If you purchase St. Luke's Health Plan off exchange:

Abortion (voluntary termination of pregnancy) unless the life of the mother is endangered by the continued pregnancy, or the pregnancy is the result of rape or incest, although complications of a non-covered abortion are covered; adoption expenses; 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), anorgasm and premature ejaculation.

### 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 you or your 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 you reside in a skilled nursing facility, adult family home, or assisted living facility; and transportation.

### MENTAL HEALTH AND REHABILITATION SERVICES

The \$0 copay for behavioral health applies to all professional (physician) charges for both outpatient and inpatient mental health care services. Facility charges for mental health services are not covered by the \$0 copay.

Marriage and couples counseling; family therapy, in the absence of an approved mental health diagnosis; nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories; sensitivity training; and treatment for sexual dysfunctions and paraphilic disorders.

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; 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 the Policy; 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; impotency medications, including but not limited to Viagra; infertility medications; medication which is 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 which 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 and implants, such as diaphragms, IUDs, cervical caps which would be covered through the Medical Benefits; or condoms which are over the counter; nutritional supplements; prescriptions which 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; compounded medications; 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; and vitamin B-12 injections except to treat Vitamin B-12 deficiency.

### 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 the Policy); prescription or non-prescription diets, nutritional and/or food supplements, vitamins, minerals or other dietary formulas or supplements, including weight loss shakes, unless expressly covered by the Policy; exercise programs and equipment; complications resulting from bariatric surgery performed internationally; and complications arising from bariatric surgery performed at non-ASMBS centers; services provided by a spa, health club or fitness center, except covered Medically Necessary services provided within the scope of the Provider's license; and routine foot care, except as covered by St. Luke's Health Plan if you have peripheral vascular disease or diabetes.

### GENDER AFFIRMING SERVICES

Services that are considered cosmetic (including but not limited to) abdominoplasty, blepharoplasty, breast augmentation, calf implants, cheek/ malar implants, chin augmentation (reshaping or enhancing the size of the chin), collagen injections, cryothyroid approximations (voice modification surgery), electrolysis (hair removal), face-lift, facial bone reduction, forehead lift, hair transplantation, laryngoplasty (reshaping of laryngeal framework/voice modification surgery), lip reductions/ enhancement (decreasing/increase lip size), liposuction, mastopexy (breast lift), neck tightening, pectoral implants, reduction thyroid chondroplasty (trachea shave), and rhinoplasty.

### 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 you if you 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.

### 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 record keeping 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.

### VISION CARE

Non-prescription 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 and Toric intraocular lenses.

These exclusions were last updated October 1, 2022.



# Let's do this.

We understand that every business is unique. When you meet with us, we'll take the time to understand your company and work together to find a plan that fits the needs of both you and your employees.

Call us at: **208-385-3777**

Email us at: **employers@slhealthplan.org**

Learn more at: **stlukeshealthplan.org**

INFORMATION	LOCATION
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Obtain primary, specialty, behavioral health and hospital services—including after-hours care	
Find urgent care	
Find regional and nationwide care options	
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Review covered benefits (included and excluded)	Learn more about health care and pharmacy benefits at <b>stlukeshealthplan.org/members/resources</b>
View prescription drug benefits	
Submit an appeal	Review your rights at <b>stlukeshealthplan.org/members/appeal</b>
Dispute a claims decision and review your right to external independent review	
Understand your rights and responsibilities	Review your rights at <b>stlukeshealthplan.org/members/rights</b>
Learn how to file a grievance	Review information at <b>stlukeshealthplan.org/faqs</b>
Learn more about preauthorization and utilization management	

Is St. Luke's  
Health Plan right  
for **your business?**

**St Luke's<sup>TM</sup>**  
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