AMENDMENT II TO
SIOUX VALLEY HEALTH PLAN
OF MINNESOTA

LARGE & SMALL
GROUP CERTIFICATE OF COVERAGE

The following is an amendment to your Sioux Valley Health Plan Group Certificate of Coverage dated May 2003. Please review this document carefully and keep it with your Certificate of Coverage for future reference. Deleted items have strike-through lines and new items are in red print. This Amendment is effective 04/01/06.

AMENDMENT #1	**Sioux Valley Health Plan Group Certificate of Coverage dated May 2003, pages 8-11, Part III, Sections A, B and C and Amendments #8-13, and #18 effective 01/01/04; are hereby deleted and replaced by the following:**

THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED

A. Preconditions for Coverage

Members shall be entitled to coverage for the Health Care Services listed in Paragraph D of this Part, "Covered Services," that is:

1. Medically Necessary and/or Preventive; and
2. Received from or provided under the orders or direction of a Participating Provider, or approved by the Plan. However, this specific condition does not apply for Emergency Conditions or Urgent Care in and out of the Service Area. In such cases, the services will be covered if they are provided by a Non-Participating Provider. Appropriate access for Primary Care Physicians, Mental Health/Substance Abuse Providers, and Hospital Provider sites is within *Thirty (30) miles* of a Member's city of residence. For other Participating Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within *sixty (60)* miles of a Member's city of residence. Appropriate access includes access to Participating Providers when the Member has traveled outside of the service area. If you are traveling within the service area where other Participating Providers are available, then you must use Participating Providers.

   Members who live outside of the Plan's service area must use the Plan's contracted network of participating providers as indicated on the *Member Welcome Letter* enclosed with their Member Identification Card. Members who live outside the Plan's service area will receive Identification Cards that display their network logo along with instructions on how to access this network. If Member chooses to go to a non-participating provider when access is available, claims will be paid at the out-of-network benefit level.

   Members are not required, but strongly encouraged, to select a Primary Care Physician and use that physician to coordinate their Health Care Services.

In addition, all Health Care Services are subject to:

1. the exclusions and limitations described in Part IV; and
2. any applicable Copay, Deductible, and Coinsurance amount as stated in the attached Summary of Plan Benefits.

The Plan's Health Services Department is available between the hours of 8:00am to 5:00pm Central Time, Monday through Friday, by calling the Plan's toll free number 1-800-805-7938 or (605)328-6807. After hours you may leave a message on the confidential voice mail of the Health Services Department and someone will return your call. The date of receipt for nonurgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it was received during normal business hours. All Utilization Management denials will be made by The Plan's Medical Director or a Provider and/or Practitioner of same or similar specialty.

B. Prior Authorization/Certification of Services

The member is ultimately responsible for obtaining prior authorization from the Health Services Department in order to receive In-Network coverage. However, information provided by the practitioner's office will also satisfy this requirement. Primary care physicians and any Participating Specialists have been given instructions on how to get the necessary authorizations for surgical procedures or hospitalizations you may need.

Prior authorization is the urgent or non-urgent authorization of a requested service prior to receiving the service. Prior authorization (or precertification/preservice decisions) is designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

The Plan determines approval for prior authorization based on appropriateness of care and service and existence of coverage. The Plan does not compensate practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Management decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

1. Services that Require Prior Authorization Include:

- Inpatient hospital admissions including admissions for medical, surgical, neonatal intensive care nursery, mental health and chemical dependency services;
- Partial Hospital Program (PHP)/Day Treatment for mental health and chemical dependency services;
- Selected Outpatient Surgeries;
- Home Health (excluding maternity home health visits), Hospice and Home IV therapy services;
- Durable Medical Equipment (rental or purchase retail price over $200);
- Acupuncture when requesting more than 12 sessions/visits.
- One-to-one water rehabilitative therapy;
- Skilled nursing and sub-acute care;
- Organ transplants;
- PET Scans;
- Referrals to Non-Participating Providers which are recommended by Participating Providers. Prior authorization is required for the purpose of receiving In-Network coverage only. If prior authorization is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out-of-Network coverage level. Prior authorization does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in Part III, Section A.

2. Prescription Drugs that Require Prior Authorization

To be covered by Sioux Valley Health Plan the following medications require prior authorization and a letter of medical necessity for a formulary exception. This can be in the form of written or verbal authorization. To request verbal authorization, you or your provider must contact the Health Services Department at 800-805-7938 between 8 a.m.-5 p.m. Monday through Friday. Fax a letter of Medical Necessity to Health Services at (605) 328-6813.

Prescription Drugs that Require Prior Authorization Include:

Oral Medications

- Zyox
- Testosterone Products
- Lamisil and Sporanox for fungal disease. A positive culture or KOH preparation is required for certification to receive coverage for one of these products.
- Proton Pump Inhibitors (Prevacid or generic omeprazole) after 90 day supply. For certification longer than 90 days, one of the following conditions must be present:
  1. Pathological hypersecretory conditions (e.g. ZE syndrome)
  2. Maintenance of recurrent esophageal or peptic ulcers
  3. Chronic unrelieved GERD. Unrelieved is defined as three months of effective treatment with a PPI followed by a month of treatment with an H2 antagonist during which symptoms recur
  4. Other conditions associated with peptic ulcer disease
     a. Chronic NSAID therapy in high-risk patients(history of a previous esophageal or gastric disorder)
     b. Chronic use of oral corticosteroids (>3 months)
     c. Other ulcerogenic drugs
     d. Cancer
     e. Concomitant use of anti-coagulants
  5. Other high-risk patients
     a. > 65 years of age
  6. Gastroduodenal Crohn’s
  7. Pancreatic enzymes for acute/chronic pancreatitis
  8. Barrett’s Esophagitis
  9. Chronic laryngopharangeal reflux as manifested by
     a. asthma
     b. chronic cough
     c. persistent sore throat
  10. Chronic use of Prograf or Cyclosporine
  11. Sioux Valley Health Plan does not consider Proton Pump Inhibitors medically necessary for uncomplicated heartburn greater than one (1) month duration with a frequency of at least twice a week that can be controlled by OTCs when there is not diagnosis of more complicated reflux disease such as erosive esophagitis and there are no symptoms of a more complicated GI problem.
      - Symptom complicated condition:
      - Trouble or pain swallowing food
      - Vomiting with blood
      - Bloody or black stools
      - Heartburn of >3 months duration
      - Heartburn with sweatiness and/or dizziness
      - Chest pain
      - Wheezing
      - Unexplained weight loss
      - Nausea or vomiting

- Stomach pain

Step Therapy

- Zetia
- Singulair
- Celebrex (30 pill limit per month supply)
- Antidepressent Therapy (SSRI and SNRI)

Injectable and High Cost Medications

- The following medications (injectable and high cost medications) listed must be obtained from Curascript by calling (888) 773-7376. If these medications are obtained from a retail pharmacy or physician office without certification by Sioux Valley Health Plan Health Services Department the member will be responsible for the full cost of the medication.

		Medical Claim Deductible and Coinsurance	Pharmacy Copay	Requires Prior-Authoriza-tion	Coverage Rules
SHORT NAME	**CATEGORY**				
ADVATE	HEMOPHILIA	x			Medical Necessity Criteria Apply
ALDURAZYME	MUCOPOLYSACCHARIDOSIS	x			
ALPHANATE	HEMOPHILIA	x			Medical Necessity Criteria Apply
ALPHANINE	HEMOPHILIA	x			Medical Necessity Criteria Apply
AMEVIVE	PSORIASIS	x			Medical Necessity Criteria Apply
ANTAGON	INFERTILITY				100% Copay
ANZEMET INJECTION	ANTI-EMETIC	x			
ARANESP	ANEMIA		x		Medical Necessity Criteria Apply
AUTOPLEX	HEMOPHILIA	x			Medical Necessity Criteria Apply
AVONEX	MULTIPLE SCLEROSIS		x		Medical Necessity Criteria Apply
BAYGAM	IMMUNE DEFICIENCY	x			
BAYHEP B	HEPATITIS		x		
BEBULIN	HEMOPHILIA	x			Medical Necessity Criteria Apply
BENEFIX	HEMOPHILIA	x			Medical Necessity Criteria Apply
BOTOX	MIGRAINE, CEREBRAL PALSY	x			Medical Necessity Criteria Apply
BRAVELLE	INFERTILITY				100% Copay
CALCIJEX		x			
CEREZYME	GAUCHER'S DISEASE	x			Medical Necessity Criteria Apply
CETROTIDE	INFERTILITY				100% Copay
COPAXONE	MULTIPLE SCLEROSIS		x		Medical Necessity Criteria Apply
COPEGUS	HEPATITIS C		x		Medical Necessity Criteria Apply
CYTOGAM	IMMUNE DEFICIENCY	x			
DESFERAL	SICKLE CELL ANEMIA	x			
ENBREL	RHEUMATOID ARTHRITIS/PSORIASIS		x		Medical Necessity Criteria Apply
EPOGEN	CHRONIC RENAL DISEASE		x		Medical Necessity Criteria Apply
FABRAZYME	FABRY DISEASE	x			Medical Necessity Criteria Apply
FACTREL	INFERTILITY				100% Copay
FEIBA	HEMOPHILIA	x			Medical Necessity Criteria Apply
FERTINEX	INFERTILITY				100% Copay
FOLLISTIM	Follitropin Beta, Recomb				100% Copay
FOLLISTIM	INFERTILITY				100% Copay

FORTEO	OSTEOPOROSIS		x	x	Limited to 2 years only
FUZEON	HIV	x			Medical Necessity Criteria Apply
GAMIMUNE	IMMUNE DEFICIENCY/IVIG	x			
GAMIMUNE N	IMMUNE DEFICIENCY/IVIG	x			
GAMMAGARD	IMMUNE DEFICIENCY/IVIG	x			
GAMMAR-P	IMMUNE DEFICIENCY/IVIG	x			
GAMUNEX	IMMUNE DEFICIENCY/IVIG	x			
GONAL-F	INFERTILITY				100% Copay
GONAL-F RFF	INFERTILITY				100% Copay
HELIXATE	HEMOPHILIA	x			Medical Necessity Criteria Apply
HEMOFIL	HEMOPHILIA	x			Medical Necessity Criteria Apply
HUMATE-P	HEMOPHILIA	x			Medical Necessity Criteria Apply
HUMATROPE	GROWTH HORMONE DEFICIENCY	x			Medical Necessity Criteria Apply
HUMIRA	RHEUMATOID ARTHRITIS		x		Medical Necessity Criteria Apply
INFERGEN	HEPATITIS C	x			
INTRON A	ONCOLOGY		x		
IVEEGAM	IMMUNE DEFICIENCY	x			
KINERET	RHEUMATOID ARTHRITIS		x		Medical Necessity Criteria Apply
KOATE-DVI	HEMOPHILIA	x			Medical Necessity Criteria Apply
KOGENATE	HEMOPHILIA	x			Medical Necessity Criteria Apply
LEUPROLIDE	ONCOLOGY - GENERIC	x			
LUPRON	ONCOLOGY	x			
MONARC-M	HEMOPHILIA	x			Medical Necessity Criteria Apply
MONOCLATE-P	HEMOPHILIA	x			Medical Necessity Criteria Apply
MONONINE	HEMOPHILIA	x			Medical Necessity Criteria Apply
MYOBLOC	NEUROLOGIC	x			Medical Necessity Criteria Apply
NEULASTA	NEUTROPENIA		x		Medical Necessity Criteria Apply
NEUMEGA	CHEMO SUPPORTIVE	x			
NEUPOGEN	NEUTROPENIA		x		Medical Necessity Criteria Apply
NOVAREL	INFERTILITY				100% Copay
NOVOSEVEN	HEMOPHILIA	x			Medical Necessity Criteria Apply
NUTROPIN/AQ	GROWTH HORMONE DEFICIENCY	x			Medical Necessity Criteria Apply
OVIDREL	INFERTILITY				100% Copay
PANGLOBULIN	IMMUNE DEFICIENCY/IVIG	x			
PANGLOBULIN/	IMMUNE DEFICIENCY/IVIG	x			

PEGASYS	HEPATITIS C		x		Medical Necessity Criteria Apply
PERGONAL	INFERTILITY				100% Copay
POLYGAM	IMMUNE DEFICIENCY	x			
PREGNYL	INFERTILITY				100% Copay
PROCRIT	ANEMIA		x		Medical Necessity Criteria Apply
PROFASI	INFERTILITY				100% Copay
PROFILNINE	HEMOPHILIA	x			Medical Necessity Criteria Apply
PROGESTERONE	INFERTILITY				100% Copay
PROGESTERONE IN OIL	INFERTILITY				100% Copay
PROPLEX	HEMOPHILIA	x			Medical Necessity Criteria Apply
PULMOZYME	CYSTIC FIBROSIS		x		
RAPTIVA	PSORIASIS		x		Medical Necessity Criteria Apply
REBIF	MULTIPLE SCLEROSIS		x		Medical Necessity Criteria Apply
RECOMBINATE	HEMOPHILIA	x			Medical Necessity Criteria Apply
REFACTO	HEMOPHILIA	x			Medical Necessity Criteria Apply
REMICADE	CROHNS DISEASE	x			Medical Necessity Criteria Apply
REPRONEX	INFERTILITY				100% Copay
RIBASPHERE			x		
RIBAVIRIN	HEPATITIS C		x		
ROFERON-A	ONCOLOGY		x		
SAIZEN	GROWTH HORMONE DEFICIENCY	x			Medical Necessity Criteria Apply
SENSIPAR	HYPERPARATHYROIDISM		x	x	
SEROSTIM	HIV WASTING	x			Medical Necessity Criteria Apply
SYNAGIS	PALIVIZUMAB	x			Medical Necessity Criteria Apply
TARCEVA	ONCOLOGY - ANTINEOPLASTIC		x		
THALOMID	ONCOLOGY	x			
TOBI	PULMONARY INH/CF		x		
VENOGLOBULIN-S	IMMUNE DEFICIENCY/IVIG	x			
XOLAIR	ASTHMA	x		x	Medical Necessity Criteria Apply
ZAVESCA	GAUCHER'S DISEASE	x			Medical Necessity Criteria Apply
ZOFRAN INJECTION	CHEMO SUPPORTIVE/ANTI-EMETIC	x			
ZOLADEX	ONCOLOGY	x		x	
ZOMETA	ONCOLOGY NON CHEMO	x		x	Medical Necessity Criteria Apply

3. **Prior Authorization Process (Nonurgent Preservice) For Elective Inpatient Hospitalizations, Non Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests**

All requests for prior authorization are to be made by the member or physician's office at least *three (3) business days* prior to the scheduled admission or requested service. The Health Services Department will review the Member's medical request against standard criteria.

Determination of the appropriateness of an admission is based on standard review criteria and assessment of:

a. Patient medical information including:
   -diagnosis
   -medical history
   -presence of complications and/or co-morbidities;
b. Consultation with the treating physician, as appropriate;
c. Availability of resources and alternate modes of treatment; and
d. For admissions to facilities other than acute hospitals additional information may include but are not limited to the following:
   -history of present illness
   -patient treatment plan and goals
   -prognosis
   -staff qualifications
   -*twenty-four (24) hour* availability of staff.

You are ultimately responsible for obtaining prior authorization from the Health Services Department. However, information provided by the physician's office also satisfies this requirement.

The Health Services Department will review the Member profile information against standard criteria. A determination for elective inpatient or non urgent care will be made by the Health Services Department within *ten (10) business days* of receipt of the request. If the decision is made to authorize (certify) your request, the Health Services Department will assign an authorization number for the approved service and will notify the provider of the decision promptly by telephone. Written notification will be sent to you, your attending practitioner and those providers involved in the provision of the service within *ten (10) business days* of the receipt of the request.

If the decision is not to authorize your request, telephone notification will be made within *one (1) working day* to you , your practitioner and those providers involved in the provision of the service. Written notification will be sent to you, your practitioner and those providers involved in the provision of the service within *ten (10) business days* of the receipt of the request.

Lack of Necessary Information Received

If the Plan receives a request that fails to meet the procedure for prior authorization requests, the Plan will notify the Practitioner or Member of the failure and proper procedures to be followed as soon as possible but no later than *five (5) calendar days* after the date of the failure. Notification may be oral unless the Practitioner or Member request written notification. A decision on the request will be made within *ten (10) business days* of the original receipt of the request. If the necessary information is not received, the request will be denied.

If the Plan's determination is a denial, the Plan shall provide written notice in accordance with the *Written Notification Process for Denials* as outlined in section E. At this point, the Member can request an appeal of denial decisions. Refer to the "Member Complaint and Appeals Procedures" section for details.

4. **Prior Authorization for Urgent/Emergency (Urgent preservice) Medical and Behavioral Health Care and Pharmaceutical Requests**

"**Emergency**" or "**Emergency Condition**" means a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person.

An "**Urgent Care Situation"** is a situation with a degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24) hours*. Urgent care means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination:

1. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one

has been selected, and follows his or her instructions. A Member may always go directly to a participating urgent care or after hour's clinic. In determining whether a request is "urgent," the Plan shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. A Practitioner and/or Provider with knowledge of the Member's medical condition, who determines a request to be "urgent" shall be treated as an urgent care request.

Prior authorization (preservice) is NOT required for emergency conditions. However, the Plan must be notified as soon as reasonably possible and no later than *forty-eight (48) hours* after physically or mentally able to do so. Additionally, because of the inability to predict admission, obstetrical admissions shall be authorized when the pregnancy is confirmed. The exception is that of an elective C-section, which must be prior authorized as an elective admission.

For urgent care prior authorization, the determination will be made and provided to you, your practitioner, and those providers involved in the provision of the service via telephone by the Health Services Department as expeditiously as your medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. You, your practitioner and those providers involved in the provision of the service will receive written notification within *(three) 3 calendar days* of the telephone notification.

Lack of Necessary Information Received

If the Plan receives a request that fails to meet the procedure for prior authorization requests, the Plan will notify the Practitioner or Member of the failure and proper procedures to be followed as soon as possible but no later than *twenty-four (24) hours* after the date of the failure. Notification may be oral unless the Practitioner or Member request written notification. A decision on the request will be made within *twenty-four (24) hours* of the original receipt of the request. If the necessary information is not received, the request will be denied.

If the Plan's determination is a denial, the Plan shall provide written notice in accordance with the *Written Notification Process for Denials* as outlined in section E. At this point, the Member can request an appeal of denial decisions. Refer to the "Member Complaint and Appeals Procedures" for details.

C. Authorization of Concurrent Medical and Behavioral Health Care Requests

"Concurrent review" is utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting. It is utilized when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted. Additional stay days must meet the continued stay review criteria and, if acute level of care criteria is not met, a decision to authorize further treatment must be made at that time.

Authorization of the hospital or behavioral healthcare stays will terminate on the date the Member is to be discharged from the hospital or behavioral healthcare facility (as ordered by the attending physician). Hospital/facility days accumulated beyond ordered discharge date will not be authorized unless the continued stay criteria continues to be met. Charges by providers associated with these non-authorized days will be considered non-covered.

Sioux Valley Health Plan will continue treatment without liability to the Member until it notifies the Member of the decision, unless the treatment was not initially approved or authorized. Any reduction or termination by the Plan during the course of treatment before the end of the period or number treatments shall constitute a denial. For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number of treatments, the Plan shall make a determination and notify the Member or the Member's authorized representative, practitioner and those providers involved in the provision of the service by telephone of the determination as soon as possible taking into account the Member's medical condition but in no event more than *twenty-four (24) hours* after the date of the Plan's receipt of the request. The Plan shall provide written notification of an authorization to the Member, practitioner and those providers involved in the provision of the service within *three (3) calendar days* after the telephone notification. The Plan shall provide written notification of a denial to the Member, practitioner and those providers involved in the provision of the service sufficiently in advance (but no later than *three (3) calendar days* after the telephone notification) of the reduction or termination to allow the Member or, the Member's authorized representative to file an Appeal request to review the denial and obtain a determination with respect to that review before the benefit is reduced or terminated.

Urgent Concurrent Reviews

If the request to extend urgent concurrent review is not made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number or treatments, Sioux Valley Health Plan will treat it as an urgent prior authorization (preservice) decision and make the decision within *seventy-two (72) hours of receipt of the request*. For authorizations, the Plan will

notify you, your practitioner and those providers involved in the provision of service of the decision promptly by telephone. For denials, the Plan will notify you, your practitioner and those providers involved in the provision of the service via telephone as expeditiously as your medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. You, your practitioner and those providers involved in the provision of the service will receive written notification within *(three) 3 calendar days* of the telephone notification.

If the Plan's determination is a denial, the Plan shall provide written notice in accordance with the *Written Notification Process for Denials* as outlined in section E. At this point, the Member can request an appeal of denial decisions. Refer to the "Member Complaint and Appeals Procedures" for details.

D. Authorization of Retrospective (Postservice) Medical and Behavioral Health Care and Benefit Reviews

Retrospective review will be utilized by Sioux Valley Health Plan to review services that have already been utilized by the Member. The Plan will review the request and make the decision to approve or deny within *thirty (30) calendar days* of receipt of the request. For retrospective review *decisions*, Sioux Valley Health Plan will give written notification of the decision to the Member, practitioner and those providers involved in the provision of the service within *thirty (30) calendar days* of the request.

E. Written Notification Process for Denials

The written notifications for denials will include the following:

1. The specific reason for the denial in easily understandable language;
2. Reference to the specific plan provision, guideline, or protocol on which the determination was based and notification that the Member on request can have a copy of the actual plan provisions, guidelines, and protocols free of charge;
3. If applicable, a description of any additional material or information necessary for the Member to complete the request, including an explanation of why the material is necessary;
4. A description of the Plan's appeal procedures including how to obtain an expedited review if necessary and any time limits applicable to those procedures; and
5. Notification and instructions on how the practitioner can contact the physician or appropriate behavioral health (for behavioral health reviews) reviewer to discuss the determination.

F. Levels of Coverage

There are *two (2)* levels of coverage that are available, In-Network Coverage and Out-of-Network Coverage, which are both described below. As indicated in the Summary of Plan Benefits, for Out-of-Network Coverage, the Plan will pay a percentage of the Reasonable Cost after credit is given for payment of the applicable Copays, Deductibles, and Coinsurance, provided that the Plan determines that the billed charges are reasonable. If the Plan determines that the billed charges are not reasonable, the Plan will only pay a percentage of the Reasonable Costs. Percentage amounts are indicated on the Summary of Plan Benefits.

1. **In-Network Coverage**. In-Network Coverage means Covered Services that are either received:
   a. from a Participating Provider,
   b. in an Emergency Condition or an urgent care situation,
   c. when the Member does not have appropriate access to a Participating Provider, or
   d. when a Participating Provider has recommended, and the Plan has authorized the referral to, a Non-Participating Provider. Appropriate access for Participating Primary Care, Mental Health/Substance Abuse, and Hospital Providers is within *thirty (30) miles* of a Member's city of residence and for other Participating Providers it is within *sixty (60) miles* of a Member's city of residence. The following Health Care Services may be accessed through network or non-network providers and are covered at the in-network coverage level:
      i. the voluntary planning of the conception and bearing of children;
      ii. the diagnosis of infertility;
      iii. the testing and treatment of a sexually transmitted disease; and
      iv. the testing for AIDS or other HIV-related conditions.

2. **Out-of-Network Services**. Out-of-Network Services means Services that do not fit the definition of In-Network Coverage set forth above. All Out-of-Network services are subject to Reasonable Cost. Specifically, Out-of-Network Coverage means Covered Services that are received :
   a. from Non-Participating Providers when appropriate access to a Participating Provider is available;
   b. when the Plan has not authorized the referral to a Non-Participating Provider; or
   c. for a non-emergency or non-urgent care situation when services are received from a Non-Participating Provider.

Members who live outside of the Plan's service area must use the Plan's contracted network of participating providers as indicated on the *Member Welcome Letter* enclosed with their Member Identification Card. Members who live outside the Plan's service area will receive Identification Cards that display their network logo along with instructions on how to access this network. If Member chooses to go to a non-participating provider when access is available, claims will be paid at the out-of-network benefit level.

AMENDMENT #2	Sioux Valley Health Plan Group Certificate of Coverage dated May 2003, Pages 26-28, Part VII: Complaint and Appeal Procedures. This section is hereby deleted and replaced by the following:

MEMBER COMPLAINT AND APPEAL PROCEDURES

Sioux Valley Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Members, health care providers with knowledge of the Member's medical condition, authorized representative of the Member and/or an attorney may appeal any adverse decision by Sioux Valley Health Plan. The following types of denials will be considered for the appeals process.

A. Types of Denials:

1. Benefits Denial – a denial that is specifically excluded from the Member's benefits package and is not considered a medical necessity denial.
2. Medical Necessity Denial – a denial of care of services that could be considered a covered benefit depending on the circumstances. Examples:
   a. Experimental Treatments
   b. Cosmetic procedures
   c. Pharmaceutical Prior Authorizations
   d. Access to Out-of-Network Practitioners and Providers
   e. Continued care and services
3. Claims Denials – denials based on timely and accurate filing of claims and failure to request authorization of services.

B. Types of Appeals:

1. Appeal: A request to change any previous adverse decision made by Sioux Valley Health Plan. An appeal can be for a pre or post service request.

2. Expedited Appeal: A request to change a previous decision made by Sioux Valley Health Plan for an urgent care request.

3. External Appeal: An external appeal is a request for an independent, external review of the final determination made by Sioux Valley Health Plan through its internal appeals process.

C. Definitions

Complaint: An oral or written expression of dissatisfaction against the Plan which has been submitted by a complainant and which is not under litigation. It is the policy of Sioux Valley Health Plan to make reasonable efforts to resolve Member, practitioner and provider complaints. A process has been established for Members (or their designees), practitioners and providers to use when they are dissatisfied with the Plan, its practitioners or providers, or processes. Examples of complaints are the scope of coverage for health care services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a complaint.

Utilization Review: Means the evaluation of the necessity, appropriateness, and facilities used by a Member for the purpose of determining medical necessity of the service or admission.

Audit trails for complaints, appeals and denials are provided by the Plan's information system and an Access database which includes documentation of the complaint and/or appeal by date, service, procedure, and reason. The denial file includes documentation telephone notification, including the date; the name of the person spoken to; the Member; the service, procedure, or admission authorized (certified); and the date of the service, procedure, or admission denial and reason for denial. If the Plan indicates authorization by use of a number, the number must be called the "authorization (certification) number."

D. Complaint & Medical Review Determination Process

1. **Informal/Oral Complaints:**
   A complainant may orally submit a complaint to the Member Services Department . Member Services will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within *ten (10) business days* of receipt of the complaint, the Plan will provide a complaint form to the complainant, which must be completed and returned to the Member Services Department for further consideration. The Plan will assist the complainant in completing this form, or will

complete the form and mail it to the complainant for a signature, if the complainant asks for assistance.

At any time, the complainant may also file a complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 201-5100, or toll free 1-800-657-3916 or the Commission of Commerce regarding Supplemental (Out-of-Network) benefits at (651) 296-2488, or toll free at 1-800-657-3602.

2. **Formal/Written Complaint Process:**
A complainant can seek further review of a complaint not resolved through the formal process. The steps in this complaint and appeal process are outlined below.

a. Formal Complaint Review. You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the complaint, the reasons you believe you are entitled to benefits and any other supporting documents to:

Sioux Valley Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

We will notify the complainant within *ten (10) business days* that we received the written complaint, unless the complaint has been resolved to the complainant's satisfaction within those *ten (10) business days*.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your complaint.

We will review your complaint and notify you of our decision in accordance with the following timelines:

b. For PreService Claims (services for which prior approval by us is a requirement for coverage)

Urgent Request
If the service request is urgent, you or your practitioner may request an **expedited** review. Within *seventy-two (72) hours* of such request, a decision will be made via telephone to you, your practitioner and those providers involved in the provision of the service. You, your practitioner and those providers involved in the provision of the service will receive written notification within *three (3) calendar days* of the phone notification.

Non-Urgent Request
If the service request concerns non-urgent services, a written decision will be made to you, your practitioner and those providers involved in the provision of the service within *ten (10) business days* from the date the Plan receives your request. If the decision is not to authorize your request, telephone notification will be made within *one (1) working day* to you, your practitioner and those providers involved in the provision of the service.

c. PostService Claims.
A decision and written notification on your complaint will be made to you, your practitioner and those providers involved in the provision of the service within *thirty (30) calendar days* from the date the Plan receives your request. This time period may be extended if you agree.

All notifications described above will comply with applicable law.

E. Appeal Process.
NOTE: When, due to a medical reason, an initial determination is made not to cover a health care service prior to or during an ongoing service, an appeal must be submitted to the Plan within *180 days* following the written notice of initial determination.

1. Preservice Appeal (for utilization review for a medical determination).
If the Member or a Member's authorized representative appeals an adverse response, Members do not have the right to attend or have a representative attend the first level review, but Members are entitled to:

1. Send written comments, documents, records and other material relating to the request; and
2. Receive reasonable access to documents, records and other information relevant to the request, free of charge.

Full and thorough investigation of the substance of the appeal, including any aspects of clinical care, will be coordinated by the Complaint Coordinator. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the appeal. For medical necessity reviews only, a practitioner in the same or similar specialty that

typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal. The Plan will document the substance of the appeal and any actions taken.

When an initial determination is to deny your request, you or your authorized representative may submit a request for appeal. If the request concerns non-urgent services, a written decision on your complaint will be made to you and your practitioners and/or providers involved in the appeal within *thirty (30) calendar days* from the date the Plan receives your request.

In certain circumstances, this time period may be extended *fourteen (14) additional days*. In such cases the Plan will notify you in advance, of the reasons for the extension. Per NCQA guidelines, the member must voluntarily agree to this extension.

3. Expedited Appeal Process

An expedited appeal process is used when the condition is emergent or urgent in nature, as defined by the Certificate of Coverage.

An expedited review of a prior authorization (preservice) denial determination not to authorize must be utilized if the Member or practitioner acting on behalf of the Member believes that an expedited determination is warranted. This can be done by oral or written notification to the Plan. The Plan will accept all necessary information (electronic or by telephone) for review from the practitioner of care. A designated physician advisor will conduct the review and will be available to discuss the case with the attending practitioner on request. For medical necessity reviews only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

The determination will be made and provided to the Member and those practitioners and/or providers involved in the appeal via telephone by the Health Services Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those practitioners and/or providers involved in the appeal will receive written notification within *(three) 3 calendar days* of the telephone notification.

If the expedited review is a concurrent review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

4. Postservice appeal.

If after the first level of complaint review of a postservice claim, your request was denied, you or your authorized representative may submit a request for appeal either in writing or by telephone. Written requests should include any relevant documents, issues, comments and additional information as appropriate and be sent to:

Sioux Valley Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the telephone. Hearings and written reconsideration shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, practitioners, providers, or other persons as deemed necessary for a fair appraisal and resolution of the complaint. During your appeal, upon your request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

Full and thorough investigation of the substance of the appeal, including any aspects of clinical care, will be coordinated by the Complaint Coordinator. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the appeal. For medical necessity reviews only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal. The Plan will document the substance of the appeal and any actions taken.

We will review your appeal and written notice of the decision and all key findings will be given to the complainant within *thirty (30) calendar days* of the Member Services Department's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, written notice of the decision and all key findings will be given to the complainant within *forty-five (45) calendar days* of the Member Services Department's receipt of the complainant's written notice of appeal.

In certain circumstances, this time period may be extended *fourteen (14) additional days*. In such cases the Plan will notify you in advance, of the reasons for

the extension. Per NCQA guidelines, the member must voluntarily agree to this extension.

F. Written Notification Process for Appeals

The written decision for the Appeal reviews will contain the following information:

1. A complete summary of the review findings;
2. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
3. The specific reason for the decision in easily understandable language;
4. Reference to the evidence, benefit provision, guideline, and/or protocol used as the basis for the decision and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
5. The relationship between the Member's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision;
6. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
7. Notification and instructions on how the practitioner can contact the physician or appropriate behavioral health (for behavioral health reviews) reviewer to discuss the determination.
8. Notice of the Member's right to contact the Commissioner of Health either in writing or by calling (651) 201-5100 or toll free 1-800-657-3916 or the Commission of Commerce regarding supplemental benefits at (651) 296-2488 or toll free 1-800-657-3602.
9. Notice of the Member's right to initiate the external appeals process and the procedure for initiating the process. Final denial letters will contain information on the circumstances under which appeals are eligible for external review and information on how the Member can seek further information about these rights.
10. If the adverse determination is completely overturned, the decision notice must state the decision and the date.

G. External Complaint Procedures:

1. If your complaint is denied based on our medical necessity criteria, you have the right to request an external review upon receiving notice of our decision on your complaint. If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of the internal appeal process. However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the internal appeal process.
2. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (Commissioner of Commerce). This written request must be accompanied by a $25 filing fee payable to the Center for Health Dispute Resolution. This fee may be waived by the Commissioner in cases of financial hardship. The Plan must participate in this external review, and must pay the cost of the review which exceeds the $25 filing fee.
3. Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the complainant and to the Plan. Within *ten (10) business days*, the Member and the Plan must provide their reviewer with any information they wish to be considered. The Member (who may be assisted or represented by a person of their choice) and the Plan shall be given an opportunity to present their versions for the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
4. An external review must be made as soon as possible, but no later than *forty (40) calendar days* after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the Member, the Commissioner of Health or Commissioner of Commerce, and to the Plan.
5. The results of the external review are non-binding on the Member and binding on the Plan. The Plan may seek judicial review of the decision under certain circumstances.
6. Notification to Members about the independent, external appeal program includes a general communication to Members, at least annually, to announce the availability of the right to independent, external review.

AMENDMENT #3	Sioux Valley Health Plan Group Certificate of Coverage dated May 2003, Amendment #27 effective 01/01/04 "Attachment II: Drug Exclusion List" Second paragraph is revised as follows:

Exception to formulary. The health plan will use providers of the same or similar specialty to consider exception requests and promptly grant an exception to the drug formulary/list of excluded drugs, including exceptions for anti-psychotic and other mental health drugs, for a Member when the health care provider prescribing the drug indicates to the health plan company that:

(1) the formulary drug causes an adverse reaction in the patient;
(2) the formulary drug is contraindicated for the patient; or
(3) the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

AMENDMENT #4	Sioux Valley Health Plan Group Certificate of Coverage dated May 2003, Page iii "Member Bill of Rights" is revised as follows:

MEMBER BILL OF RIGHTS

(14) Members have the right to obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis in a way that is understandable from the practitioners responsible for coordinating their care, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with practitioners in decision making regarding their treatment planning;

(20) Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities; and

~~(20)~~(21) Members have the right to make recommendations regarding the Plan's Member's rights and responsibilities policies.

AMENDMENT #5	Sioux Valley Health Plan Group Certificate of Coverage dated May 2003, Amendment #27 effective 01/01/04; is hereby deleted and replaced by the following:

Excluded Drugs and Supplies

The following are specifically **EXCLUDED** from coverage under the plan unless mandated by State regulation or a formulary exception has been granted by the Plan or previous certification by the Plan was given:

- Drugs not listed in the Sioux Valley Health Plan Formulary, or drugs without certification of the plan or a formulary exception;
- Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and insulin syringes) that by federal or state law do not require a prescription order; any medication that is equivalent to an OTC medication; drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner and/or Provider certifies off-label use with a letter of medical necessity);
- Anorexia/Weight management drugs except when medically necessary to treat morbid obesity (Meridia, Xenical);
- Replacement of a prescription drug due to loss, damage, or theft;
- Outpatient Drugs dispensed in a Practitioner and/or Provider's office or non-retail pharmacy location;
- Experimental or Investigational drugs or drug usage if not recognized by the Food and Drug administration;
- Growth Hormone (except for medical necessity)
- B-12 Injections, except for pernicious anemia;
- Acne Medication for Members over ages thirty-five (35);
- Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multi-vitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances;

- Whole Blood and Blood Components Not Classified as Drugs, in the *United States Pharmacopoeia;*
- Drug Efficacy Study Implementation ("DESI") drugs;
- Drugs that may be received without charge under a federal, state, or local program;
- Drugs for cosmetic purposes, including baldness;
- Refills of any prescription older than one year; and
- Compound medications with no legend medication.

Drug Exclusion List

The following drugs (and their generic equivalent, if available) are excluded because they can be obtained without a prescription as an OTC (over-the-counter) medication or due to Health Plan prescription benefit coverage. However, you may always request a formulary exception or previous certification by the Plan for excluded drugs.

Avage
Caverject
Cialis
Claritin/D
DESI Drugs
Edex
Immunological Agents
Infertility Drugs (Refer to Injectable Program)
Legend Vitamins
Levitra
Muse
Pigmenting/Anti-pigmenting Agents
Prescription Vitamins
Propecia
Renova (over the age of 25)
Vaniqa

Excluded Drug	Over the Counter Alternative
Axid	OTC Axid AR
Claritin/-D	OTC Claritin/-D, Alavert, loratadine OTC
Clarinex/D	OTC Claritin/-D, Alavert, loratadine OTC
Lamisil Solution	OTC Lamisil AT Solution
Pepcid	OTC Pepcid AC
Prilosec	OTC Prilosec
Tagamet	OTC Tagament HB
Zantac	OTC Zantac 75 maximum strength

(Please note: OTC products are not a covered pharmacy benefit)

The following drugs (and their generic equivalent, if listed) are excluded because of Health Plan policy, as there are similar drugs in this category considered for coverage.

Excluded Drug	Formulary Alternative
Accolate	Singulair
Aciphex	generic omeprazole, Prevacid
Activella	Prempro, Premphase, FemHRT
Aerobid/-M	Flovent, Pulmicort
Alamast	Patanol
Allegra/-D	OTC products, Zyrtec/-D
Alocril	Patanol
Alomide	Patanol
Alora	generics, Climara, Estraderm, Vivelle, Esclim
Altrex	Patanol
Altoprev (Altocor)	generic lovastatin
Anaprox/DS (naproxen)	generic ibuprofen, naproxen sodium
Ansaid (flurbiprofen)	generic ibuprofen, naproxen sodium

Antara	generic gemfibrozil, Tricor
Arixtra	Lovenox, Fragmin, Heparin
Atacand/HCT	Avapro/Avalide, Diovan/HCT
Avinza	Generics, Oxycontin
Avita	generic tretinoin, Differin
Avodart	Proscar, Flomax, Uroxatral
Azmacort	Flovent, Pulmicort
Azelex	generic tretinoin, Differin
Azopt	Alphagan P, Cosopt, Trusopt
Beclovent	Flovent, Pulmicort
Beconase/AQ	Flonase, Nasacort/AQ, Nasonex
Benicar/HCT	Avapro/Avalide, Diovan/HCT
Betaseron	Avonex, Rebif, Copaxone
Betimol	Alphagan P, Cosopt, Trusopt
Biaxin	generic erythromycin, Zithromax, Ketek
Boniva	Fosamax, Actonel
Cardene SR	generic felodipine, nifedipine ER, Norvasc, Sular
Cataflam (diclofenac potassium)	generic ibuprofen, naproxen sodium
Ceclor CD	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Cedax	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Celexa	generic citalopram, fluoxetine, paroxetine,
Cenestin	Premarin
Cipro XR	generic ciprofloxacin, Avelox, Levaquin
ClimaraPro	Combipatch
Colazal	Asacol, Pentasa
Cozaar	Avapro/Avalide, Diovan/HCT
Cyclessa	generics, Ortho Tri-Cyclen Lo, Ortho Evra, Nuvaring
Didronel	Fosamax, Actonel
Dipentum	Asacol, Pentasa
Dynabac	generic erythromycin, clarithromycin, Zithromax, Ketek
DynaCirc/CR	generic felodipine, nifedipine ER, Norvasc, Sular
EC-Naprosyn (naproxen)	generic ibuprofen, naproxen sodium
Elestat	Patanol
Emadine	Patanol
Enablex	generic oxybutynin, Detrol/LA, Ditropan XL
Factive	generic ciprofloxacin, Avelox, Levaquin
Fempatch	generics, Climara, Estraderm, Vivelle,
Fexofenadine	OTC Claritin, Zyrtec
Flumadine	generic rimantadine, generic amantadine, Tamiflu

Fluoxetine 40mg strength	Use 2 x 20mg strength
FML Forte	Lotemax
Genotropin	Humatrope, Nutropin/AQ, Saizen
Geodon	Abilify, Risperdal, Seroquel, Zyprexa
Geref	Humatrope, Nutropin/AQ, Saizen
Helidac	Prevpac
Hyzaar	Avapro/Avalide, Diovan/HCT
Innohep	Lovenox, Fragmin, Heparin
Iopidine	Alphagan P, Cosopt, Trusopt
Iressa	Tarceva
Istalol	Alphagan P, Cosopt, Trusopt
Kadian	Generic morphine sulfate, Oxycontin
Kytril	Zofran
Lescol/XL	generic lovastatin, Lipitor, Zocor, Crestor
Lexxel	Tarka, Lotrel
Livostin	Patanol
Lorabid	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Lofibra	generic gemfibrozil, Tricor
Luvox	generic fluvoxamine
Lunesta	Ambien
Maxaquin	generic ciprofloxacin, Avelox, Levaquin
Menest	Premarin
Menostar	generics, Climara, Estraderm, Vivelle
Miacalcin	Actonel, Fosamax
Micardis/HCT	Avapro/Avalide, Diovan/HCT
MS Contin	generic morphine sulfate, Oxycontin
Nabi HB	Bayhep B
Naprelan (naproxen)	generic ibuprofen, naproxen sodium
Nasalide	Flonase, Nasacort/AQ, Nasonex
Nasarel	Flonase, Nasacort/AQ, Nasonex
Nexium	generic omeprazole, Prevacid
Norditropin	Humatrope, Nutropin/A/Q, Saizen
Noroxin	generic ciprofloxacin, Avelox, Levaquin
Optivar	Patanol
Oramorph SR	generic morphine sulfate, Oxycontin
Oxytrol	generic oxybutynin, Detrol/LA, Ditropan XL
Palladone	generic morphine sulfate, Oxycontin
PCE	generic erythromycin, Biaxin, Zithromax
Peg Intron-A	Pegasys
Plendil	generic felodipine, nifedipine ER, Norvasc, Sular
Pravachol	generic lovastatin, Lipitor, Zocor, Crestor

Pravigard PAC	generic lovastatin, Lipitor, Zocor, Crestor
Prefest	Prempro, Premphase, FemHRT
Prilosec	generic omeprazole, Prevacid
Protropin	Humatrope, Nutropin/A/Q, Saizen
Protonix	generic omeprazole, Prevacid
Prozac Weekly	generic fluoxetine, paraxetine, citalopram
QVAR	Flovent, Pulmicort
Rebetol	generic ribavirin, ribasphere, Copegus
Relenza	generic rimantadine, generic amantadine, Tamiflu
Risperdal M	Risperdal
Retin-A/micro	generic tretinoin, Differin
Rhinocort/AQ	Nasacort/AQ, Flonase, Nasonex
Rynatan	OTC Claritin-D, Zyrtec-D
Sanctura	generic oxybutynin, Detrol/LA, Ditropan XL
Sarafem	generic fluoxetine, paroxetine, citalopram
Seasonale	generics, Ortho Tri-Cyclen Lo, Ortho Evra, Nuvaring
Serzone	generic mirtazipine, generic bupropian, Effexor/XR, Wellbutrin SR/XL
Skelid	Actonel, Fosamax
Sonata	Ambien
Spectracef	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Suprax	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Symbyax	generic fluoxetine and Zyprexa
Tequin	generic ciprofloxacin, Avelox, Levaquin
Testim	Androgel, Androderm
Teveten/HCT	Avapro/Avalide, Diovan/HCT
Tev-tropin	Humatrope, Nutropin/A/Q, Saizen
Triglide	generic gemfibrozil, Tricor
Tri-Nasal	Flonase, Nasacort/AQ, Nasonex
Vanceril	Flovent, Pulmicort
Vantin	generic cefaclor ER, generic amox/pot clav, generic cefuroxime, Omnicef, Cefzil
Vesicare	generic oxybutynin, Detrol/LA, Ditropan/XL
Vexol	Lotemax
Zaditor	Patanol
Zegerid	generic omeprazole
Zorbtive	Humatrope, Nutropin/A/Q, Saizen
Zyflo	Singulair
Zyprexa Zydis	Zyprexa

The following drugs (and their generic equivalent, if listed) are excluded from medical coverage as there is no FDA approved indication for use of listed diagnosis.

Humira	No coverage for psoriasis diagnosis
Remicade	No coverage for psoriasis diagnosis

Quantity Limit List*
The following drugs do not require certification but have a quantity limit:

Amerge	9 tablets/month
Anzemet	1 tablets/month (not covered)
Axert	6 tablets/month
Diflucan	3 tablets/month
Frova	9 tablets/month
Imitrex	9 tablets/ 6 nasal spray or 1 kit for injections/month or 2 injections
Kytril	2 tablets/month (not covered)
Maxalt	6 tablets/month
Maxalt MLT	9 tablets/month
Migranal	4 ampules/spray/month
Relpax	12 tablets/month
Stadol Nasal Spray	2 spray bottles
Viagra	4 tablets/month
Zofran	12 tablets/month
Zomig	6 tablets for 2.5mg. and 3 tablets for 5mg./month
Zomig	6 ampules/spray/month
Zomig ZMT	6 tablets for 2.5 mg. and 3 tablets for 5 mg./month

*The Sioux Valley Health Plan policy is a 30-day prescription limit excluding maintenance medications. If you would like a complete listing or information about a specific drug please contact the Health Services Department at (800) 805-7938.

Step Therapy Program

The step therapy program was developed to encourage the use of first-line alternatives before more expensive second-line medications are covered by the pharmacy benefit. If a member does not obtain the desired clinical effect or experiences side effects at one step, then the drug choice at another step may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by prospective (pre-service) review. You can request prospective (pre-service) review and/or certification by calling the Health Services Department at (800) 805-7938. The following step therapy programs are listed and their clinical criteria are as follows.

Zetia Step Therapy

1. If a member has tried one of the following drugs (may be brand or generic) or combination of drugs at the following dosage:

Generic (Brand)	Daily Dose
Atorvastatin (Lipitor)	≥40 mg
Fluvastatin (Lescol)	≥40 mg
Lescol XL	≥80 mg
Lovastatin (Mevacor; generics)	≥40 mg
Lovastatin ER (Altocor)	≥40 mg
Niacin ER/Lovastatin (Advicor)	≥2000 mg/40 mg
Pravastatin (Pravachol)	≥40 mg
Simvastatin (Zocor)	≥40 mg

2. The member has tried one of the drugs from the above list and cannot tolerate the side effects.
3. The member is taking or will be taking a medication that has drug interactions with a drug from the above listing.

4. Children or adolescents <17 years of age must have tried a drug from the above listing but not at the doses listed.
5. Members with severe renal impairment of creatinine clearance ≤30 mL/minute.
6. Homozygous familial hypercholesterolemia.
7. Homozygous familial sitosterolemia.
8. Pregnant women.
9. Active liver disease or unexplained persistent elevations of serum transaminases.

Singulair Step Therapy
1. Certification for Singulair is approved for members with Asthma.
2. For children < 5 years of age, exceptions can be made for Singulair certification.
3. For members with *allergic rhinitis,* Singulair is not covered.
4. Members with *chronic urticaria* should have tried one of the oral antihistamines (Zyrtec/D) or hydroxyzine.
5. Members with atopic dermatitis should have tried a prescription topical corticosteroid or a topical immunomodulator (Elidel, Protopic). If one of these drugs has been tried, then approve Singulair.
6. Infants with *acute respiratory syncytial virus (RSV) bronchiolitis*. Approve Singulair.

Celebrex Step Therapy
1. If a member has tried one (1) prescription strength NSAIDS (nonsteroidal anti-inflammatory) (may be generic or brand) for the current condition, then certification for a formulary single source COX-2 Inhibitor [(Celebrex (30 pill limit per month supply)] may be given at the 3rd tier copay.
2. Generic Naproxen 500mg. will be offered to all members at $0 copay.
3. Generic Ibuprofen 600mg and 800mg will be offered to all members for a generic copay.
4. Mobic will be offered at the 3rd tier copay but does not apply to the step therapy guidelines.
5. Exceptions for formulary coverage at a 2nd tier copay can be made for members that meet one of the following criteria:
    - Age ≥65
    - Past history of a GI bleed, perforation, obstruction.
    - Requires use of long-term (>1 month) oral corticosteroids therapy.
    - Currently taking warfarin (Coumadin® - DuPont Pharma) or dicumarol.
    - Diagnosis of rheumatoid arthritis.
6. Certification for formulary Celebrex (30 pill limit per month supply) may be given for patients with reduced platelets counts < 75,000.

Antidepressent (SSRI and SNRI) Step Therapy
1. One generic drug will be required before a brand name drug is authorized. Generic drugs will have to have been prescribed at an effective dose for a minimum of 30 days. Documentation of attempt and failure of a generic within the last 12 months will be considered as fulfilling this requirement. The daily effective doses are considered to be:
    - Fluxoetine 40 mg.
    - Paroxetine 20 mg.
    - Citalopram 40 mg.
    - Mirtazapine 30mg.
    - Bupropion sr 300mg.
    - Sertraline 150 mg. (when becomes generic)
2. Second tier drugs are Lexapro, Zoloft (until it becomes generic), Wellbutrin XL, Effexor, and Paxil CR.
3. Cymbalta will be third tier for all diagnoses.
4. Effexor will not be covered for the diagnosis of perimenopausal symptoms until one generic SSRI has been tried.

Antiemetic Step Therapy (Zofran, Aloxi, Anzemet)

This step therapy only applies to Members receiving Chemotherapy.
1. Zofran is the preferred drug for Level 1 and Level 2 Chemotherapy Agents.
2. Anzemet will be covered for these agents if Zofran fails.
3. Aloxi will not be covered for Level 1 and Level 2 agents without prior authorization.
4. Aloxi will be covered for agents in Level 3, 4, and 5. Prior authorization is not required.
5. Zofran is the only covered outpatient oral agent that a Member can obtain from a retail pharmacy.

Injectable Drug Program

Sioux Valley Health Plan uses *Curascript* for your injectable medication needs. *Curascript* will ship your drug and all the supplies you need for your injection directly to your home or physician's office within 24 to 48 hours after ordering. Also, your administration supplies (syringes, needles etc.) are free; you do not pay additional co-pays for them.

Curascript offers toll-free customer service available 24 hours a day, 365 days a year. Specially trained staff offers support services for you, your caregivers, and your physicians that include:

- Injectable drug order information;
- Consultation with an experienced, knowledgeable injectable drug pharmacist;
- Specially trained nurses available to answer questions about injectable drugs and disease states they treat.

Whether the injectable medications are administered at home or in a physician's office, there's no change in benefit coverage, only improved convenience, access, and service.

If you are a woman currently receiving an injectable medication for infertility another benefit has been offered to you by *Curascript.* If you use the *Curascript Specialty Care* program you will receive a discount on all your injectable medications.

To enroll in the *Curascript* program, call toll-free at *(888) 773-7376* and a customer service representative will ask the following information:

- **Your name and date of birth**
- **Your phone number and address**
- **The name of your injectable medication to be filled**
- **Your doctor's name and phone number**

The *Curascript* pharmacists will take care of your order and have it shipped to your chosen address within 24-48 hours after receiving the prescription from your physician. Prior to all shipments, a Specialty Care staff member will contact you to discuss your co-pay for your drug and arrange delivery.

Curascript will mail your physician a letter explaining the new program and how to send your prescriptions to *Curascript*. By participating in Specialty Care, you are automatically enrolled in a drug therapy management program. This program entitles you to receive the following benefits at no additional charge:

- Access to nurses and pharmacists 24 hours/day, 7 days/week for questions related to your injectable drug and the illness the drug is treating.
- Injectable drug refills reminders if you forget to call for your refill, and convenient refill process.
- Free delivery of your medication and supplies to your home, physician's office or designated location.

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