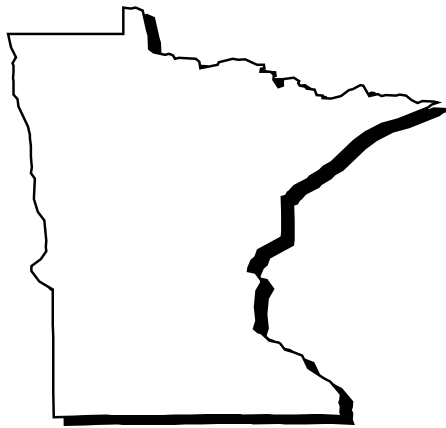


# **SIOUX VALLEY HEALTH PLAN OF MINNESOTA**

Large and Small Group  
Certificate Of Coverage



**Sioux Valley  
Health Plan**  
*of Minnesota*

PO Box 91110 • Sioux Falls, SD 57109-1110  
(605) 328-6800 • 1-800-752-5863

## **INTRODUCTION**

This Certificate describes the specific rights and responsibilities of the Members, Group, and the Plan.

**NOTICE:** THIS DISCLOSURE IS REQUIRED BY MINNESOTA LAW.  
FOR LARGE GROUPS, THIS CERTIFICATE OF COVERAGE IS EXPECTED TO RETURN, ON AVERAGE, 86% OF THE PREMIUM DOLLAR FOR HEALTH CARE. THE LOWEST PERCENTAGE PERMITTED BY STATE LAW FOR THIS CERTIFICATE OF COVERAGE IS 65% FOR LARGE GROUPS.  
FOR SMALL GROUPS, THIS CERTIFICATE OF COVERAGE IS EXPECTED TO RETURN, ON AVERAGE, 82.5% OF THE PREMIUM DOLLAR FOR HEALTH CARE. THE LOWEST PERCENTAGE PERMITTED BY STATE LAW FOR THIS CERTIFICATE OF COVERAGE IS 75% FOR SMALL GROUPS.

## **IMPORTANT CONSUMER INFORMATION AND MEMBER BILL OF RIGHTS**

### **CONSUMER INFORMATION**

- (1) **COVERED SERVICES:** Services provided by the Plan will receive the maximum coverage available if provided by participating Plan providers, or authorized by the Plan. This Certificate of Coverage fully defines what services are covered and describes procedures you must follow to obtain coverage.
- (2) **PROVIDERS:** Enrolling in the Plan does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of the Plan, you must choose among remaining Plan providers.
- (3) **REFERRALS:** All referrals to non-Plan providers and certain types of health care providers must be authorized by the Plan in order to receive the maximum coverage available. See Part III, Section B of this Certificate of Coverage.
- (4) **EMERGENCY SERVICES:** Emergency services from providers who are not affiliated with the Plan will receive the maximum coverage available only if proper procedures are followed. This Certificate of Coverage explains the procedures and benefits associated with emergency care from the Plan and Non-Plan providers.
- (5) **EXCLUSIONS:** Certain services or medical supplies are not covered. You should read this Certificate of Coverage for a detailed explanation of all exclusions.
- (6) **CONTINUATION:** You may convert to individual coverage or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in this Certificate of Coverage.
- (7) **CANCELLATION:** Your coverage may be canceled by you or the Plan only under certain conditions. This Certificate of Coverage describes all reasons for cancellation of coverage.
- (8) **NEWBORN COVERAGE:** A newborn infant is covered from birth. The Plan will not automatically know of the infant's birth or that you would like coverage under the Plan. You should notify the Plan of the infant's birth and that you would like coverage. If your contract requires an additional service charge for each dependent, the Plan is entitled to all service charges due from the time of the infant's birth until the time you notify the Plan of the birth. The Plan may withhold payment of any health benefits for the newborn infant until any service charges you owe are paid.
- (9) **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT:** Enrolling in the Plan does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

### **CONSUMER INFORMATION FOR COMPREHENSIVE SUPPLEMENTAL (OUT OF NETWORK) BENEFITS**

- (1) **COVERED SERVICES:** The comprehensive Out of Network benefit of the Plan covers similar services as the comprehensive health maintenance services, but at a different level of coverage. Copayments, deductibles, and maximum lifetime benefit restrictions may apply. Your contract describes the procedures for receiving coverage through the comprehensive Out of Network benefit.
- (2) **PROVIDERS:** To receive services through the comprehensive Out of Network benefit, you may go to providers of covered services who are not on the provider list supplied by the Plan and for whom you did not get a referral.

- (3) **REFERRALS:** A referral from the Plan for services covered by the comprehensive Out of Network benefit is not required to receive coverage. However, if a referral is requested from the Plan you may be eligible for the same services, from the same provider at a lower cost to you (or at the In Network level), as a benefit under your comprehensive health maintenance services. See Part III, B of this Certificate of Coverage for specific referral details.
- (4) **PRIOR AUTHORIZATION:** You are not required to get prior authorization from the Plan before using Out of Network benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. See Part III, B of your comprehensive Out of Network benefit agreement for specific information about prior authorization.
- (5) **EXCLUSIONS:** Coverage of Out of Network benefits is limited to those services specified in your evidence of coverage. Part IV, a list to related services which are excluded from coverage and clarifies any limitations imposed on coverage of the services.
- (6) **CONTINUATION:** Your comprehensive health maintenance services contract provides for continuation and conversion rights under certain circumstances. If you continue your coverage as an individual under your group contract, the comprehensive Out of Network benefits will also continue. If you convert to an individual plan, Out of Network benefits may not be available. Your continuation and conversion rights are explained fully in this Certificate of Coverage.
- (7) **DISCONTINUATION:** Your comprehensive Out of Network benefits are an addition to your comprehensive health maintenance coverage. Changes in your contract may result in the discontinuation of one or more of your Out of Network benefits. Please read all amendments to your contract carefully.

### **MEMBER RESPONSIBILITIES**

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) is responsible for cooperating with those providing health care services to the Member, and shall have the following responsibilities:

- (1) Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- (2) Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- (3) Members are responsible for following all access and availability procedures.
- (4) Members are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State law requires that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
- (5) Members are responsible to notify the Plan of an emergency admission as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.
- (6) Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.
- (7) Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating, to the degree possible, in understanding their health care problems and developing mutually agreed-upon treatment goals.
- (8) Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- (9) Members are responsible for notifying the Plan within thirty (30) days at 1-800-752-5863 if they change their name, address, or telephone number. Also, if Members get married or acquire a dependent they must inform us of their change in status.
- (10) Members are responsible for notifying the Plan of any changes of eligibility that may affect their Membership or access to services.

## **MEMBER BILL OF RIGHTS**

- (1) Members have the right to available and accessible services including Emergency Services, as defined in this Certificate of Coverage, twenty-four (24) hours a day and seven (7) days a week;
- (2) Members have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;
- (3) Members have the right to refuse treatment, and the right to privacy of medical and financial records maintained by Sioux Valley Health Plan of Minnesota (“the Plan”) and its health care providers, in accordance with existing law;
- (4) Members have the right to file a grievance with the Plan and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the Plan or its health care providers;
- (5) Members have the right to a grace period of thirty-one (31) days for the payment of each service charge for individual coverage falling due after the first premium during which period coverage shall continue in force;
- (6) Medicare Members have the right to voluntarily disenroll from the Plan and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law;
- (7) Medicare Members have the right to a clear description of nursing home and home care benefits covered by the Plan;
- (8) Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sex or sources of payment for care;
- (9) Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity;
- (10) Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy;
- (11) Members have the right to select a Primary Care Physician (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP;
- (12) Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Minnesota law;
- (13) Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about the Plan’s clinical guidelines and protocols;
- (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. Members also have the right to participate with practitioners in decision making regarding their treatment planning;
- (15) Members have the right to give informed consent before the start of any procedure or treatment;
- (16) When Members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician who is able to communicate with the Member;
- (17) Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read;
- (18) Members have the right to appeal any decision regarding medical necessity made by the Plan and its providers; and
- (19) Members have the right to disenroll from the Plan.
- (20) Members have the right to make recommendations regarding the Plan’s Member’s rights and responsibilities policies.

**ACCESS TO RECORDS AND CONFIDENTIALITY**

The Plan complies with the state (Minnesota Statute 144.335) and federal laws governing the confidentiality and use of protected health information and medical records. As part of this Contract, we are authorized to have access to and use protected health information held by any health care provider who delivers health care services to you for current treatment or medical emergencies. Prior written authorization will be requested for the release of medical records from a provider for payment or other healthcare operations including, but not limited to: claims processing, including claims we make for reimbursement or subrogation; quality of care assessment and improvement; accreditation; credentialing; case management; disease management; underwriting; premium rating; claims experience reporting to your employer or other health plan sponsor (only upon certification by your employer or plan sponsor of the compliance of plan documents with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)); the evaluation of potential or actual claims against us; auditing and legal services.

## TABLE OF CONTENTS

<b>I.</b>	<b>DEFINITIONS .....</b>	<b>1</b>
<b>II.</b>	<b>ENROLLMENT .....</b>	<b>5</b>
	A. When to Enroll .....	5
	B. How to Enroll .....	5
	C. When Coverage Begins .....	5
	D. Eligibility Requirements for Dependents .....	5
	E. When to Enroll Dependents .....	6
	F. How to Enroll Dependents .....	6
	G. When Dependent Coverage Begins .....	6
	H. Special Enrollment for Individuals Losing Other Coverage .....	7
<b>III.</b>	<b>COVERED SERVICES .....</b>	<b>8</b>
	A. Preconditions for Coverage .....	8
	B. Prior Authorization .....	8
	C. Levels of Coverage .....	10
	D. Covered Services .....	11
<b>IV.</b>	<b>LIMITED &amp; NON-COVERED SERVICES .....</b>	<b>19</b>
	A. General Exclusions .....	19
	B. Drug Exclusions .....	21
	C. Pre-Existing Conditions .....	22
	D. Services Covered by Other Payers .....	22
	E. Services and Payments That Are the Responsibility of Member .....	23
	F. Special Situations Affecting Coverage .....	23
<b>V.</b>	<b>CONTINUITY OF CARE .....</b>	<b>24</b>
	A. Provider Contract Termination .....	24
	B. Provider Terminated for Cause .....	24
	C. Change of Provider .....	24
	D. Provider Agreement .....	24
	E. Coverage of Services .....	24
<b>VI.</b>	<b>HOW SERVICES ARE PAID FOR BY THE PLAN .....</b>	<b>25</b>
	A. The Process for Reimbursement of Charges by Participating Providers .....	25
	B. The Process for Reimbursement of Charges by Non-Participating Providers .....	25
<b>VII.</b>	<b>COMPLAINT AND APPEAL PROCEDURES .....</b>	<b>26</b>
	A. Types of Denials .....	26
	B. Types of Appeals .....	26
	C. Definitions .....	26
	D. Complaint & Medical Review Determination Process .....	26
	E. Appeal Process .....	27
	F. External Complaint Procedures .....	28
<b>VIII.</b>	<b>HOW COVERAGE ENDS .....</b>	<b>29</b>
	A. Termination by the Subscriber .....	29
	B. Termination of Member Coverage .....	29
	C. Notice of Termination of Coverage .....	29
	D. Member Appeal of Termination .....	29
<b>IX.</b>	<b>OPTIONS AFTER COVERAGE ENDS .....</b>	<b>30</b>
	A. Qualifying Events .....	30
	B. Continuation of Coverage for Survivors .....	34
	C. Disabled Member .....	34
	D. Replacement of Coverage and Confined Members .....	34
	E. Conversion of Coverage .....	34

<b>X.</b>	<b>COORDINATION OF BENEFITS .....</b>	<b>36</b>
A.	Applicability .....	36
B.	Definitions (for COB Purposes Only) .....	36
C.	Order of Benefit Determination Rules .....	37
D.	Calculation of Benefits, Secondary Plan .....	38
E.	Coordination of Benefits with Medicare .....	38
F.	Members with End Stage Renal Disease (ESRD) .....	39
<b>XI.</b>	<b>SUBROGATION &amp; RIGHT OF REIMBURSEMENT .....</b>	<b>40</b>
A.	Plan's Rights of Subrogation .....	40
B.	Plan's Right to Reduction and Reimbursement .....	40
C.	Member's Responsibility .....	40
D.	Limitations .....	40
E.	Notice to Plan of Subrogation Claim Required .....	41
<b>XII.</b>	<b>REIMBURSEMENT METHODOLOGY .....</b>	<b>42</b>
A.	Physician Reimbursement .....	42
B.	Hospital Reimbursement .....	42
<b>XIII.</b>	<b>SERVICE AREA .....</b>	<b>43</b>

**ATTACHMENT I      SUMMARY OF PLAN BENEFITS**

**ATTACHMENT II     DRUG EXCLUSION LIST**

## INDEX TO TERM DEFINITIONS

Definitions of terms used in this contract are incorporated into the text. Following is an index to the page on which each term is defined.

Ambulatory Surgical Center .....	1
Authorization (Certification) .....	1
Brand Name Drug .....	1
Calendar Year .....	1
Chemotherapy .....	1
Coinsurance .....	1
Copay .....	1
Covered Services .....	1
Creditable Coverage .....	1
Deductible .....	1
Dependent .....	1
Dependent Child .....	1
Drug Exclusion .....	1
Drug Supply .....	2
Eligible Dependent .....	2
Eligible Employee .....	2
Emergency or Emergency Condition .....	2
Emergency Care .....	2
ESRD .....	2
Experimental or Investigational Services .....	2
Formulary .....	2
Open .....	2
Closed .....	2
3-Tier .....	2
Formulary Brand-Name Drug .....	2
Generic Drug .....	2
Group .....	2
Group Member .....	2
Handicapped Dependent .....	2
Health Care Services .....	2
Hospital .....	3
Hospitalization .....	3
Large Employer Group .....	3
Maintenance Drug List .....	3
Medically Necessary .....	3
Member .....	3
Mental Health and Chemical Dependency Services .....	3
Non-Covered Services .....	3
Non-Formulary Brand-Name Drug .....	3
Non-Participating Pharmacy .....	3
Non-Participating Provider .....	3
Nursing Services .....	3
Open Enrollment .....	3
Over-the-Counter Drug .....	3
Participating Pharmacy .....	3
Participating Provider .....	3
Physician .....	3
Practitioner .....	3
Pre-Existing Condition .....	3
Prenatal Care Services .....	4
Prescription Drug Product .....	4
Preventive .....	4
Primary Care Physician .....	4
Prior Authorization .....	4

Provider .....	4
Provider Participation .....	4
Reasonable Costs .....	4
Service Area .....	4
Service Charge .....	4
Small Employer Group .....	4
Spouse .....	4
Subscriber .....	4
Survivor .....	4
This Contract or The Contract .....	4
The Plan .....	4
This State .....	4
Usual, Customary and Reasonable .....	4
Utilization Review .....	4

## PART I DEFINITIONS

The following terms shall have the following meanings when used in this document:

**“Ambulatory Surgical Center”** means a lawfully operated, public or private establishment that:

- a. has an organized staff of Practitioners;
- b. has permanent facilities that are equipped and operated mostly for performing surgery;
- c. has continuous Practitioner’s services and Nursing Services when a patient is in the facility; and
- d. Do not have services for an overnight stay.

**“Authorization (Certification)”** The process of notifying and getting approval from Sioux Valley Health Plan of Minnesota before you proceed with an elective (non-emergency) medical procedure.

**“Brand Name Drug”** means a drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

**“Calendar Year”** means a period of one year which starts on January 1st and ends December 31st.

**“Chemotherapy”** means prescription drugs for cancer treatment and Medically Necessary services associated with the administration of the drug.

**“Coinsurance”** means the percentage of charges to be paid by a Member for Covered Services at the time such services are rendered. Coinsurance is calculated on the discounted provider charge. A Member may be required to pay either a Copay or Coinsurance at the time services are rendered, but will not be required to pay both.

**“Copay”** means an amount that a Member must pay at the time the Member receives a Covered Service which is not fully prepaid. A Member may be required to pay either a Copay or Coinsurance at the time services are rendered, but will not be required to pay both. The amount charged as a copay is based on the provider allowed amount for that service per Minnesota Rule 4685.0801.

**“Covered Services”** mean those Medically Necessary and Preventive Health Care Services listed in Part III, to which Members are entitled under a Health Maintenance Contract when provided or authorized in accordance with Plan Policy.

**“Creditable Coverage”** means benefits or coverage provided under:

- a. Medicare or Medicaid;
- b. an employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan;
- c. an individual health insurance policy;

- d. Chapter 55 of Title 10, United States Code which provides coverage for medical and dental care for Members and their dependents and former Members of the uniformed services (CHAMPUS);
- e. a medical care program of the Indian Health Service or of a tribal organization;
- f. a state health benefits risk pool;
- g. a federal employee health plan (FEHBP);
- h. a public health plan;
- i. a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504)(e));
- j. a college plan;
- k. the Minnesota Comprehensive Health Association;
- l. a self-insured health plan;
- m. the Minnesota Care program;
- n. a plan provided under Section 43A.316 (public employee insurance plan), 43A.17 (Minnesota employees plan) or 471.617 (a local government plan) of the Minnesota statutes;
- o. a health care network cooperative under Chapter 62R or by a health provider cooperative under Section 62R.17 of the Minnesota statutes; or
- p. a plan similar to any of the above plans provided in the State of Minnesota or in another state as determined by the Minnesota Commissioner of Health.

**“Deductible”** means the amount as specified in the Summary of Plan Benefits that a Member must pay at the time Covered Services are received before the Plan will pay for such Covered Services. The deductible is calculated on a calendar year basis.

**“Dependent”** means the Spouse and any Dependent Child of a Subscriber.

**“Dependent Child”** means

- a. the Subscriber’s biological child (including a child born out of wedlock), from the date of birth;
- b. a child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement;
- c. a stepchild of the Subscriber;
- d. a foster child or any other child for whom the Subscriber has been granted legal custody; or
- e. a grandchild who is financially dependent on a grandparent who is a Subscriber and who resides with that grandparent continuously from birth.

**“Drug Exclusion”** means

- a. Sioux Valley Health Plan reserves the right to maintain a drug listing in which medications are specifically not available for coverage under benefit packages per Plan policy.
- b. Payment for this list of drugs will be the member’s responsibility in full. Members may request a formulary exception. If the request for a formulary exception is

denied, the decision may be appealed (see Part III C #32, *Exception to Formulary*).

**“Drug Supply”** means drugs are supplied for 30 days (or less, if prescribed) at one time, unless otherwise approved by the plan. Maintenance drugs may be dispensed in a 90-day supply, but the copay applies to each 30-day supply received.

**“Eligible Dependent”** means any “Dependent” who meets the specific eligible requirements of the Group’s health benefit plan(s).

**“Eligible Employee”** means any Group Member who meets the specific eligibility requirements of the Group’s health benefit plan(s).

**“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.

**“Emergency Care”** means Health Care Services provided in the case of an Emergency Condition.

**“ESRD”** means the Federal End Stage Renal Dialysis program.

**“Experimental or Investigational Services”** means a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning safety, effectiveness, or effect on health outcomes. Sioux Valley Health Plan will make its determination of experimental, investigative, or unproven based on a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself:

- a. whether there is final approval from the appropriate government regulatory agency, if approval is required;
- b. whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer review journals, or the reports of clinical trial committees and other technology assessment bodies;
- c. whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers.

**“Formulary”** means a list which identifies those Prescription Drug Products which are preferred to the Plan for dispensing to Members when appropriate. This list is subject to yearly review and modifications. There are 3 types of formularies:

- **Open formulary** is a list of medications that are recommended by Express Scripts, Inc., on behalf of the Plan, to encourage physicians to prescribe appropriate medications. All drugs are covered as defined by the benefit package.
- **Closed formulary** is a list of certain medications that are covered and others that are not covered by the Plan. If a prescription is written for a medication that is not on the formulary list, the Member is responsible in full for the cost of the medication. If a Member or their provider feels that a certain drug is medically necessary for the condition, an appeals process is available. See *Part III C #32, “Exception to formulary”*.
- **3-Tier formulary** uses a copay structure that reduces your out-of-pocket costs when using generic drugs and formulary brand name drugs. When a prescription is filled, your copay will be at least one of the following:
  - **Tier 1:** Generic Drugs or lowest copay
  - **Tier 2:** Formulary Brand Name Drugs (higher copay)
  - **Tier 3:** Non-Formulary Brand Name Drugs (highest copay)

**“Formulary Brand-Name Drug”** means a drug identified on the Drug Formulary as a formulary drug. It is the prescription drug identified as the most economical choice for the member. This is the 2nd Tier Copay in a 3-Tier Formulary.

**“Generic Drug”** means a medication chemically equivalent to a Brand-name drug whose patent has expired.

**“The Group”** means the entity that sponsors this health maintenance agreement as permitted by Minnesota Law under which the Group Member is eligible and applied for this Contract.

**“Group Member”** means any employee, sole proprietor, partner, director, officer or Member of the Group.

**“Handicapped dependent”** is a person that is and continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap; and (2) chiefly dependent upon the policyholder for support and maintenance.

**“Health Care Services”** mean any procedures, diagnoses, facilities or supplies furnished to a human being for the evaluation, diagnosis or treatment of pregnancy, illness or injury.

**“Hospital”** means a place licensed or recognized as a general, rehabilitation, or psychiatric hospital by the proper authority of the state in which it is located.

The term **“Hospital”** specifically excludes rest homes, places which are primarily for the care of convalescents, nursing homes, skilled nursing facilities, intermediate care facilities, health resorts, clinics, doctor’s offices, private homes, ambulatory surgical centers, residential or transitional living centers, or similar facilities.

**“Hospitalization”** means a stay as an inpatient in a Hospital. Each “day” of hospitalization includes an overnight stay for which a charge is customarily made.

**“Large Group Employer”** means a person, firm, corporation, partnership, or association that employs an average of no fewer than 50 current employees on business days during the preceding calendar year and that employs at least 50 current employees on the first day of the plan year.

**“Maintenance Drug List”** means a list of drug products, typically used for chronic conditions and contraception, approved by the Health Plan, or if applicable, the Employer for dispensing in quantities or day supplies of 90 days. (A copay amount applies for each 30-day supply received.)

**“Medically Necessary”** means Health Care Services that are appropriate, in terms or type, frequency, level, setting, and duration, to the Member’s diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary care must:

- a. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and
- b. help restore or maintain the Members health; or
- c. prevent deterioration of the Member’s condition; or
- d. prevent the reasonably likely onset of a health problem or detect an incipient problem; and
- e. not considered experimental or investigative

**“Member”** means any individual who is covered by the Plan.

**“Mental Health and Chemical Dependency Services”** mean Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSMM), current edition.

**“Non-Covered Services”** mean Health Care Services that are not Covered Services.

**“Non-Formulary Brand-Name Drug”** means a Brand-Name drug not on the Plan’s formulary. This drug is provided at a higher cost share to the member. This is the 3rd Tier Copay in a 3-Tier Formulary.

**“Non-Participating Pharmacy”** means a pharmacy that does not have a contract with Express Scripts Inc., on behalf of Sioux Valley Health Plan of Minnesota. If a Sioux Valley Health Plan Member utilizes a Non-Participating Pharmacy, except in an emergency, the Member is responsible for the prescription drug cost in full.

**“Non-Participating Provider”** means that the Provider has not signed such a contract with the Plan.

**“Nursing Services”** mean Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person’s license, (2) authorized by a Practitioner, and (3) not a member of the enrollee’s immediate family.

**“Open Enrollment”** means a period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan.

**“Over-the-Counter Drug” (OTC)** a drug product that does not require a prescription order under federal or state law. The Plan does not cover any medications that can be obtained Over-the-Counter (except for tobacco cessation products as covered elsewhere in this certificate).

**“Participating Pharmacy”** means a pharmacy that has contracted with Express Scripts Inc., on behalf of Sioux Valley Health Plan of Minnesota to deliver medical and/or outpatient prescription drug services to Members. The Participating Pharmacy may be a hospital, pharmacy or other facility that has contractually accepted the terms and conditions set forth by the Health Plan. Refer to the Sioux Valley Health Plan Participating Pharmacy Listing or Express Scripts website found on [www.siouxvalley.org](http://www.siouxvalley.org).

**“Participating Provider”** means that the Provider or someone on the Provider’s behalf has signed a contract with the Plan to provide services to Members.

**“Physician”** means an individual licensed to practice medicine or osteopathy.

**“Practitioner”** means any individual or group of individuals licensed to practice the healing arts in the state where care is provided, including Physicians and any other category of Practitioners with whom the Plan has determined to contract.

**“Pre-Existing Condition”** means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage or the first day of any waiting period if applicable. Pregnancy and genetic information are not considered Pre-Existing Conditions.

**“Prenatal care services”** means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

**“Prescription Drug Product”** means a medication, product or device approved by the Food and Drug Administration and dispensed under federal or state law only pursuant to a Prescription Order or Refill.

**“Preventive”** means Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.

**“Primary Care Physician”** (PCP) means a Participating Physician who is an internist, family practice physician, pediatrician, or obstetrician/gynecologist who is a Participating Provider and who has been chosen to be designated as a Primary Care Physician as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.

**“Prior Authorization”** means the urgent or non-urgent process of requesting a service or coverage of certain prescription drug products prior to receiving the service or product. It is designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

**“Provider”** means any Practitioner, group of Practitioners, hospital or any other institution or entity that furnishes Health Care Services and is licensed or otherwise authorized to render such services in the state where care is provided.

**“Provider Participation.”** All Providers are either “Participating” or “Non-Participating”:

**“Reasonable Costs”** mean those costs that do not exceed the lesser of: (1) negotiated schedules of payment developed by the Plan which are accepted as payment in full by Participating Providers within the Plan’s Service Area or (2) the prevailing marketplace charges.

**“Service Area”** means the geographic area as stated in Part XIII to this Contract.

**“Service Charge”** means the amount paid by the Group to the Plan on a monthly basis for coverage for Members under this Contract.

**“Small Employer Group”** means a person, firm, corporation, partnership, or association that employs an average of no fewer than 2 nor more than 50 current employees on business days during the preceding calendar

year and that employs at least two current employees on the first day of the plan year.

**“Spouse”** means an individual who is a Subscriber’s current lawful spouse under the laws of this State.

**“Subscriber”** means an Eligible Group Member who is enrolled in the Plan. A Subscriber is also a Member.

**“Survivor”** means a person who would be entitled to and is dependent upon economic support by an enrollee if that person were alive; including a spouse, child or children as defined by the Plan.

**“This Contract”** or **“The Contract”** means this Certificate of Coverage, including all attachments, the Group’s application, and the applications of the Subscribers, if any, and the Health Maintenance Contract.

**“The Plan”** defined as Sioux Valley Health Plan of Minnesota.

**“This State”** shall mean the State of Minnesota.

**“Usual, Customary and Reasonable”** (UCR) means the amount established by the commercially published database utilized by the Plan and adopted by the Plan administrator which commercial database provides published UCR fees for eligible expenses.

**“Utilization Review”** means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending health care professional, for the purpose of determining the medical necessity of the service or admission.

## PART II ENROLLMENT

### A. When to Enroll

To become a Subscriber, an Eligible Group Member must submit an enrollment application within the applicable Initial Enrollment Period or any Open Enrollment Period. The Initial Enrollment Period starts on the day the Group Member first becomes an Eligible Group Member, and ends thirty-one (31) days later. Open Enrollment is a period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan.

**Late entrant.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan. However, an eligible employee or dependent will not be considered a late entrant if:

1. the individual was covered under qualifying coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the Plan a certificate of termination of the qualifying coverage, due to loss of eligibility for that coverage, or proof of the termination of employer contributions toward that coverage, provided that the individual maintains continuous coverage and requests enrollment within 30 days of termination of qualifying coverage or termination of the employer's contribution toward that coverage.  
For purposes of this clause, loss of eligibility includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. For purposes of this clause, an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;
2. the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law Number 99-272, as amended, and any state continuation laws applicable to the employer or health carrier, provided that the individual maintains continuous coverage and requests enrollment within 30 days of the loss of coverage;
3. the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;
4. the individual is a new dependent child of an eligible employee;
5. the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or
6. a court has ordered that coverage be provided for a former spouse or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

### B. How to Enroll

Both the Group and Group Member are involved in the enrollment process.

#### The Group must:

1. submit a written request for coverage of the Group Member;
2. provide all information needed by the Plan to determine eligibility; and
3. agree to pay the required Service Charges on behalf of the Group Member.

#### The Group Member must:

1. complete and sign the Plan's enrollment application form, requesting coverage for the Group Member and any Dependents, and
2. provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

### C. When Coverage Begins

Coverage generally becomes effective on the first day of the month that follows the date that the Plan receives the Group's written request to cover Group Members.

If all the requirements for coverage are not met immediately, the effective date of coverage may be delayed. However, this delay may not exceed thirty-one (31) days from the date that all coverage requirements are met.

Health Care Services that are covered under an extension of benefits from a previous group health plan or other coverage arrangement will not be covered under this Contract until the extension under the prior plan ends.

### D. Eligibility Requirements for Dependents

The following Dependents are eligible for coverage ("dependent coverage"):

A Spouse is always eligible for coverage, subject to the limitations set forth below.

To be eligible for coverage, a Dependent Child or Handicapped Dependent must meet all the following requirements:

1. be unmarried;
2. receive more than half of his or her support from the Subscriber; and
3. be one of the following:
  - a. under nineteen (19) years old; or
  - b. under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis. The school's definition of "full-time student" shall be determining for the purposes of this Contract. A student who is unable to carry what the school

considers to be a full-time course load because of illness, injury or physical or mental disability as documented by a physician will be considered a full-time student for purposes of this Contract if the student's course load is sixty (60) percent of what the school considers to be a full-time course load; or

- c. a child incapable of 1) self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and 2) chiefly dependent upon the Member for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan by the Member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the Plan but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

**Exceptions.** If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Plan. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be disenrolled unless the Plan is provided satisfactory written evidence of any of the following:

1. the court or administrative order is no longer in effect;
2. the Dependent Child is or will be enrolled in comparable health coverage through an insurer which will take effect not later than the effective date of the disenrollment; or
3. the Group has eliminated family coverage for all of its Members.

**Limitations.** A Dependent shall not be covered under this contract if he or she is eligible to be a Subscriber, already covered as a Dependent of another Subscriber, or already covered as a Subscriber.

**Noncustodial Subscribers.** Whenever a Dependent Child receives coverage under the Plan through the noncustodial parent who is the Subscriber, the Plan shall do all of the following:

1. provide necessary information to the custodial parent in order for the Dependent Child to receive benefits under the coverage;
2. allow the custodial parent or Provider, with the custodial parent's approval, to submit claims for Covered Services without approval from the noncustodial parent; and
3. make payment on the submitted claims directly to the custodial parent or Provider.

#### **Qualified Medical Child Support Order (QMCSO) Provision**

A QMCSO is an order that creates the right of a Member's child to be enrolled under this Plan. If a QMCSO is issued,

this Plan will provide benefits to the child(ren) of a covered person regardless of whether the child(ren) reside with the covered person. In the event that a QMCSO is issued, each named child(ren) will be covered by this Plan in the same manner as any other Dependent child(ren) by this Plan.

When the Plan is in receipt of a medical child support order, the Plan will notify the Member and each child named in the order, whether or not it is a QMCSO. A QMCSO must contain the following information:

- Name and last known address of the Member and the child(ren) to be covered by the Plan.
- A description of the type of coverage to be provided by this Plan to each named child.
- The applicable period determined by the order.
- The plan determined by the order.

In order for the child's coverage to become effective as of the date of the court order issued, the Member must apply for coverage as defined previously in this section. Each named child may designate another person, such as a custodial guardian, to receive copies of explanation of benefits, checks, and other materials.

#### **E. When to Enroll Dependents**

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "Coverage from Birth," (Part II, Section G-3,) and "Children Placed for Adoption." (Part II, Section G-4) There is also an exception for Spouses; see "New Spouses" (Part II, Section G-5).

#### **F. How to Enroll Dependents**

A Subscriber must:

1. agree to make the required Service Charge, if any; and
2. complete and sign a written application form for coverage of the Dependent(s).

#### **G. When Dependent Coverage Begins**

1. General

If a Dependent is enrolled at the same time the Subscriber enrolls for coverage, the Dependent's effective date of coverage will be the same as the Subscriber's effective date.

2. Delayed Effective Date of Dependent Coverage  
Except for newborns (see "Coverage from Birth" (Part II, Section G-3 below), if, on the date dependent coverage becomes effective, the Dependent is hospitalized and covered under an extension of health benefits from a previous group health plan or other coverage arrangement, coverage under this Contract for Hospitalization shall not begin until the extension under the prior coverage ends.
3. Coverage from Birth  
If a Subscriber, or a Group Member who is eligible to be enrolled in the Plan, but has failed to enroll during a

previous enrollment period, has a child through birth, the child will become a covered Dependent from the date of birth, provided that coverage is applied for the child and that all the required service charge payments are made for the period from the time of birth forward are made.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, the Group Member shall be covered under this Contract from the date of birth, provided that coverage is applied for the mother and the required Service Charge payments are made.

In such situations, Dependent coverage is available for the Spouse if the Spouse is otherwise eligible for coverage, provided that coverage is applied for the Spouse and, if applicable, the Group Member and the required Service Charge payments are made.

#### 4. Adoption or Children Placed for Adoption

If a Subscriber or a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, adopts a child or has a child placed with him or her as a Dependent, that child will become covered as a Dependent from the date of placement for adoption, provided that coverage is applied for the child.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, the individual shall be covered from the date of placement for adoption, provided that coverage is applied for by Group Member and the required Service Charge payments are made.

If a child placed for adoption is hospitalized on the day that coverage would otherwise end, coverage will continue through the end of that hospital stay.

In such situations, Dependent coverage is available for the Spouse if the Spouse is otherwise eligible for coverage, provided that coverage is applied for the Spouse and, if applicable, the Group Member and the required Service Charge payments are made.

Coverage at the time of placement for adoption includes the necessary care and treatment of medical conditions existing prior to the date of placement.

For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child.

#### 5. New Spouses and Dependent Children

If a Subscriber or a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, gets married, his or her

Spouse and any of the Spouse's dependents who become Dependents of the Group Member as a result of the marriage will become covered as a Dependent from the first day of the calendar month beginning after the date coverage is applied for, provided that coverage is applied for the Spouse and/or the dependent children and, if applicable, the Group Member within thirty-one (31) days of the date of marriage and the required Service Charge payments are made.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, the individual shall be covered from the first day of the calendar month beginning after the date coverage is applied for, provided that coverage is applied for within thirty-one (31) days of the date of marriage and the required Service Charge payments are made.

### H. Special Enrollment for Individuals Losing Other Coverage

Any Eligible Group Member or Eligible Dependent of an Eligible Group Member who has failed to enroll in the Plan during a previous enrollment period and has lost prior coverage shall be able to enroll in the Plan within thirty (30) days after the date of exhaustion of the previous coverage provided that the following conditions are met:

1. The Eligible Group Member or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Eligible Group Member or Eligible Dependent;
2. The Eligible Group Member stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Group required such a statement at such time and provided the individual with notice of such a requirement at such time;
3. The Eligible Group Member's or Eligible Dependent's previous coverage:
  - a. was under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
  - b. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for coverage or employer contributions toward such coverage were terminated; and
4. Under the terms of the Plan, the Eligible Group Member requests enrollment in the Plan not later than thirty (30) days after the date of exhaustion or termination of coverage as described in number three (3) above.

## PART III COVERED SERVICES

### **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 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.

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

#### **B. Prior Authorization of Services**

Prior authorization is the urgent or non-urgent authorization of a requested service prior to receiving the service. Prior authorization (or precertification/pre-service 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.

Admission before the day of non-emergency surgery will not be authorized unless the early admission is medically necessary and specifically approved by the Plan. Coverage for hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

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 provider'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.

#### **1. Services that Require Prior Authorization Include:**

- Inpatient hospital admissions including admissions for medical, surgical, obstetric, mental health and chemical dependency services;
- Selected Outpatient Surgeries;
- Physician office site surgical center;
- 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.
- Rehabilitative services; including speech, occupational and physical therapy and one to one water therapy;
- Skilled nursing and sub-acute care;
- Organ transplants;
- Ambulance Services for non-emergency situations; and
- Referrals to Non-Participating Providers which are recommended by Participating Providers. Prior authorization is required for the purposes 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 the Sioux Valley Health Plan the following medications require prior authorization. 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:**

- Lamisil and Sporanox for nail fungus. A positive nail culture is required for authorization to receive coverage for one of these products.

##### **Injectable Medications:**

- Growth Hormone
- Serostim
- Hemophiliac/Hemostatics
- Lupron
- Lupron Depo

### **3. Prior Authorization Process For Elective Inpatient Hospitalizations, Non Urgent Care, Pharmaceutical Decisions and Behavioral Health**

All requests for prior authorization are to be made by the member or physician's office at least ten (10) business days prior to the scheduled admission or requested service. In the event that Health Care Services need to be provided within less than ten (10) business days, Members should contact the Health Services Department to request an expedited review. 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.

The Plan's Health Services Department is available between the hours of 8:00a.m. to 5:00p.m. Central Time, Monday through Friday, by calling the Plan's toll free number 1-800-805-7938 or (650)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. 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 including the collection of information. If the decision is not to certify your request, telephone notification will be made within 1 calendar day to you and your provider. The Health Services Department will assign an authorization/certification number for the approved service.

Upon request the Plan will provide the attending physician and or provider with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service.

If the Health Services Department is unable to make a decision *due to matters beyond its control*, it may extend the decision time frame once, for up to *fourteen (14) calendar days*. Within *ten (10) business days* of the request for authorization, Sioux Valley Health Plan must notify the Member or Member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the Health Services Department is unable to make a decision *due to lack of necessary information*, it must notify the Member or the Member's authorized representative of what specific information is necessary to make the decision *within ten (10) business days* of the prior authorization request. Sioux Valley Health Plan must give the Member or the Member's authorized representative *forty-five (45) calendar days* to provide the specified information. In lieu of notifying the Member, the Plan can notify the practitioner of the information needed if the request for healthcare services came from the practitioner. The decision time period is suspended from the date of the notification to the Member or practitioner as applicable, until the earlier of the date on which the Plan receives any information from the Member or practitioner or *forty-five (45) days* after the notification to the Member or practitioner. If the information is not received by the end of *the forty-five (45) calendar day* extension Sioux Valley Health Plan will deny the request.

The prior authorization determination shall either be authorization of the requested service or additional review will be needed by the Plan Medical Director.

Sioux Valley Health Plan will deny any request if it does not receive the information to make a decision within this time frame. At this point, the Member can request an appeal. Refer to the "Member Complaint and Appeals Procedures" for details.

### **4. Prior Authorization for Urgent/Emergency Conditions**

Prior authorization (pre-service) 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 to you and your provider via telephone by the Health Services Department within *seventy-two (72) hours* of receipt of the request. You and your provider will receive written notification within *(one) 1 calendar day* of the decision.

If the Health Plan is unable to make a decision due to lack of necessary information it will extend the decision time frame once, for up to *forty-eight (48) hours*. Within *twenty-four (24) hours* of the Health Plan's request to extend the decision time frame, it will notify the Member or the Member's authorized representative of what specific information is necessary to make the decision. In lieu of notifying the Member, the Plan can notify the practitioner of the information needed if the request for healthcare services came from the practitioner.

#### **5. Authorization of Concurrent review**

Concurrent review (i.e. inpatient hospitalization or ambulatory care) 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. Sioux Valley Health Plan will follow the same time frame as for prior authorization of services for a concurrent review decision. 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. The Plan Medical Director or a psychiatrist reviews all cases that may lead to denial and those that are denied. If the request is *authorized* for urgent concurrent review, Sioux Valley Health Plan will make the decision and notify the practitioner and Member by oral, electronic or written notification *within twenty-four (24) hours* of the receipt of the request.

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 of treatments, Sioux Valley Health Plan will treat it as an urgent prior authorization decision and make the decision within *seventy-two (72) hours*. 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.

For urgent care concurrent review *denials*, the Plan gives electronic or written notification of the decision to practitioners and Members *within twenty-four (24) hours* of

the request. The Plan may provide an initial oral notification of the denial decision orally *within seventy-two (72) hours* of the request, provided that an electronic or written notification is given no later than *three (3) calendar days* after the oral notification.

#### **6. Authorization of Retrospective Review (Post-service)**

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.

If the Health Services Department is unable to make a decision *due to matters beyond its control*, it may extend the decision time frame once, for up to *fourteen (14) calendar days*. Within *thirty (30) calendar days* of the request for authorization, Sioux Valley Health Plan must notify the Member or Member's authorized representative of the need for an extension and the date by which it expects to make a decision.

For retrospective review *denial decisions*, Sioux Valley Health Plan will give electronic or written notification of the decision to practitioners and Members *within thirty (30) calendar days* of the request.

#### **C. 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 residence and for other Participating Providers it is within sixty (60) miles of a Member's 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.

#### D. Covered Services

The following Health Care Services are Covered Services:

1. **Acupuncture.** Covered as part of a comprehensive pain management program. Visits are limited to 12 sessions. Further prior-authorization from the Health Plan is required for any sessions beyond 12. Maintenance visits are not eligible for coverage. Treatment is generally limited to the following conditions: chronic pain syndromes; neuromusculoskeletal conditions (i.e. neck, back, extremity pain, plantar fasciitis, radicular syndromes, myofascial pain syndromes, fibromyalgia syndromes, chronic fatigue syndromes); headaches (chronic or recurrent, tension or migraine); and nausea.
2. **Ambulatory Surgical Center Services.** Health Care Services furnished in connection with a surgical procedure performed in a participating Ambulatory Surgical Center.
3. **Ancillary Diagnostic Services,** including diagnostic laboratory, x-rays, imaging services, and infertility testing.
4. **Anesthesia Services.** Services of an anesthesiologist or other certified anesthesia provider for the administration of anesthesia.
5. **Anesthesia and Hospital Charges for Dental Care** for a Member who is under age five (5), or is severely disabled, or who has a medical condition, and who requires hospitalization or general anesthesia for dental care treatment.
6. **Breast Cancer coverage** for treatment of breast cancer with high-dose chemotherapy with autologous bone marrow transplant. Coinsurance and copay amounts shall not be greater than that applicable to any other coverage provided by the Plan.

7. **Chemical Dependency Services**  
These are covered just like Health Care Services for any other condition. If the services are rendered on a group basis, two group sessions shall be the equivalent of one individual visit. Second opinions for Chemical Dependency Services that are provided by Non-Participating Providers when the Plan or Participating Provider determines that no type of structured treatment is necessary will be covered as In Network Coverage. The Plan or a Participating Provider is not obligated to accept the second opinion.
8. **Casts, Splints, Braces, Crutches, and Dressings,** that are part of treatment received in a physician's office, emergency room, or as part of an approved hospital treatment.
9. **Child Health Supervision Services,** including from birth to age six (6), pediatric preventive services, developmental assessments and appropriate laboratory services, as well as appropriate immunizations to age eighteen (18). Coverage shall be provided for five (5) child health supervision visits from birth to twelve (12) months, three (3) child health supervision visits from twelve (12) to twenty-four (24) months, and once a year from twenty-four (24) to seventy-two (72) months, or as recommended by the American Academy of Pediatrics. These services will not be subject to an annual deductible, copays, or coinsurance amounts.
10. **Chiropractic Services and Non-Surgical Spinal Treatments.**
11. **Dental Services** required because of injury, accident, or cancer that damages natural teeth (this does not include replacements including crowns, bridges or implants), as long as the patient was covered under the Plan during the time of the injury or illness causing the damage and receives care within six (6) months of the occurrence. Associated radiology services are included. "Injury" does not include injuries to natural teeth caused by biting or chewing. "Natural" teeth include teeth that are capped and filled.
12. **Diabetic** Coverage for type I or type II diabetes includes supplies, equipment, and outpatient self-management training and education. Coverage for medically Necessary equipment and supplies shall include:
  - a. Blood glucose monitors
  - b. Blood glucose monitors for the legally blind
  - c. Test strips for glucose monitors
  - d. Urine testing strips
  - e. Insulin injection aids
  - f. Lancets and lancet devices
  - g. Insulin pumps and all supplies for the pump
  - h. Syringes
  - i. Insulin infusion devices
  - j. Prescribed oral agents for controlling blood sugars

- k. Glucose agents
- l. Glucagon kits

Diabetes self management training and education shall be covered if:

- a. The service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator; and;
- b. The training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the State Department of Health.

Hours of instruction may vary based on individual needs. An average education program is about 12 hours. Medical nutrition therapy for diabetic care does NOT include food items or nonprescription drugs.

Coverage is limited to the closest available in-network qualified education program that provides the necessary management training to accomplish the prescribed treatment.

- 13. **Dialysis** for renal disease, unless or until the Member qualifies for funded hemodialysis services under ESRD. Services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit provisions apply, see Part X.

- 14. **Durable Medical Equipment**, covered equipment prescribed by an attending physician which is medically necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury.

15. **Emergency Services, Urgent Care Situations and Out of Area Services**

- a. **Emergency Services.** If an Emergency Condition arises, Members should proceed to the nearest emergency facility that is a Participating Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency facility, then the Member should seek care at the nearest emergency facility. If the Member is admitted to the hospital, the Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician, if one has been selected, as soon as reasonably possible, and no later than *forty-eight (48)* hours after physically or mentally able to do so. The Health Plan covers emergency services necessary to screen and stabilize Members without precertification in cases where a prudent layperson, acting reasonable,

believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

- b. **Urgent Care Situations.** An urgent care situation is a degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24)* hours, such as stitches for a cut finger. 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.

If a Member is admitted to the hospital, the Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician, if one has been selected, as soon as reasonably possible, and no later than *forty-eight (48)* hours after physically or mentally able to do so. If a Member is admitted to a Non-Participating facility, then the Plan will contact the admitting Physician to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Participating Hospital. With respect to care obtained from a nonparticipating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

- c. **Ambulance Service.** The Plan covers local ambulance services for the following:
  - i. emergency transfer to a Hospital or between Hospitals.
  - ii. approved planned transfer to a Hospital or between Hospitals.
  - iii. approved transfer from a Hospital to a skilled nursing facility.

Planned transfers to a Hospital or between Hospitals and transfers from a Hospital to a skilled nursing facility will be covered only when determined by the Plan to be Medically Necessary either before or after the ambulance is used. The Plan does not cover charges for an ambulance when used as transportation to a doctor's office for an appointment.

- d. **Out of Area Services.** If an Emergency occurs when traveling outside of the Plan's Service Area, Members should go to the nearest emergency facility to receive care. If the Member is admitted to the hospital, the Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician, if one has been selected, as soon as reasonably possible, and no later than *forty-eight (48)* hours after physically or mentally able to do so. Coverage will be provided for Emergency Conditions outside of the Service Area (at the In Network benefit level) unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

If an urgent care situation occurs when traveling outside of the Plan's Service Area, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. If a Primary Care Physician has not been selected, the Member should contact the Plan and follow the Plan's instructions. Coverage will be provided for urgent care situations outside the Service Area (at the In Network level) unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

Out of Network Coverage will be provided for non-emergency medical care or non-urgent care situations when traveling outside the Plan's Service Area unless care is available by a Participating Provider.

16. **Emotionally Handicapped Children** in a residential treatment facility licensed by the Commissioner of Human Services. These services shall be provided on the same basis as other Health Care Services.
17. **Eyeglasses or Contact Lenses**, for aphakic patients or soft contact lenses or scleral shells intended for the use in the treatment of a disease or injury (*one (1)* pair per Calendar Year).
18. **Family Planning Services**, including consultations, pre-pregnancy planning and outpatient contraceptive drugs and devices.
19. **Health Education Programs** approved by the Plan including, but not limited to, smoking cessation, and nutritional education.

20. **Hearing Aids, communication aids or devices** for members 18 years of age or younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures, effective August 1, 2003. Policy guidelines apply.

21. **Home Health Services**, if approved by the Plan. The Member must be home-bound to receive this care. The following Home Health Services are Covered Services:
- part-time or intermittent care by a RN or LPN/LVN.
  - part-time or intermittent home health aide services for direct patient care only.
  - physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable.
  - medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized.

22. **Hospice Services.** A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, under the following circumstances.
- the Member has been diagnosed with a terminal disease and a life expectancy of six (6) months or less;
  - The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);
  - The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Medical Director over the course of care; and
  - the hospice service has been approved by the Plan.

*The following Hospice Services are Covered Services:*

- admission to a hospice facility, hospital, or skilled nursing facility for room and board, supplies and services for pain management and other acute/chronic symptom management.
- part-time or intermittent nursing care by a RN, LPN/LVN, or home health aid for patient care up to eight (8) hours per day.
- social services under the direction of a Participating Practitioner.
- psychological and dietary counseling.
- physical or occupational therapy, as described under Treatment Therapies (see #41).
- consultation and case management services by a Participating Practitioner.
- medical supplies and drugs prescribed by a Participating Practitioner.
- expenses for Participating Practitioners for consultant or case management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of coverage for these services as listed under #41 "Treatment Therapies", but only where the hospice retains responsibility for the care of the Member.

**23. Hospital Services.**

The following Hospital Services are covered:

- a. room and board for a ward or semi-private room (room and board for a private room will be covered only when approved by the Plan).
- b. critical care services.
- c. use of the operating room and related facilities.
- d. general Nursing Services, including special duty Nursing Services if approved by the Plan. Coverage will be provided for one hundred twenty (120) hours of service provided by a private duty nurse or personal care assistant to a ventilator dependent Member for the purpose of acting as an interpreter or communicator for the ventilator dependent Member.
- e. the administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the United States Pharmacopoeia.
- f. special diets during Hospitalization, when specifically ordered.
- g. other services, supplies, biologicals, drugs and medicines prescribed by a Physician during Hospitalization.

NOTE: For inpatient hospital care out of the Plan's service area, coverage is limited to sixty (60) days of care in each contract year. Service area means the geographic locations in which the health maintenance organization is approved by the commissioner to sell its health products (see Part XIII). These provisions relate to the aggregate number of days of both acute care and convalescent care, both of which must be rendered to Members by the Plan, but which may be limited as indicated.

**24. Lyme Disease treatment.**

- 25. Maternity Care**, including prenatal through postnatal maternity care, delivery and care for complication of pregnancy of mother, and care for the newborn child from the moment of birth including care for illness, injury, congenital defects, including orthodontic and oral surgery treatment involved in the management of a congenital condition of cleft lip and cleft palate, birth abnormalities, and premature birth. The Plan shall not terminate inpatient benefits or require discharge of a mother or the newborn from the hospital following delivery earlier than determined to be medically appropriate by the attending Physician after consultation with the mother and in accordance with the Guidelines for Perinatal Care, Third Edition, 1992, by the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists. The minimum inpatient hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours following a vaginal delivery to a minimum of ninety-six (96) hours following a cesarean birth, excluding the day of delivery.

Such inpatient stays may be shortened if the treating physician, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Providers competent in postpartum care and newborn assessments. This visit is scheduled within forty-eight (48) hours after discharge. Coverage is provided for one home visit by a registered nurse within four days following an early discharge. Services provided by the nurse will include parent education, assistance and training in breast and bottle feeding and any appropriate and necessary clinical tests.

- 26. Medical Supplies**, such as ostomy and surgical supplies.

- 27. Mental Health Services.** These are covered just like Health Care Services for any other condition. Mental Health Services for minors include treatment for the family if a Participating Provider recommends family therapy. If the services are rendered on a group basis, two group sessions shall be the equivalent of one individual visit. Second opinions for Mental Health Services that are provided by Non-Participating Providers when the Plan or Participating Provider determines that no type of structured treatment is necessary will be covered as In Network Coverage. The Plan or a Participating Provider is not obligated to accept the second opinion.

Mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologists, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. Shall be covered provided that the health plan is given a copy of the court order and the behavioral care evaluation. Coverage for the evaluation will be provided if performed by a participating provider.

- 28. Nicotine addiction treatment** including smoking cessation medications, Physician counseling and treatment, Smoking Cessation Classes, or visit to a Certified Respiratory Therapist will be covered. Nicotine patches, nicotine gum and bupropion (Zyban) for the purpose of smoking/tobacco cessation, along with cessation classes to help you stop using tobacco, are generally eligible for coverage. Counseling for smoking cessation is covered under medical benefit for office copay amount or smoking cessation classes will be covered one time per calendar year under coinsurance and deductible benefit. Zyban is limited to a 180 day supply per calendar year and the patch and gum are limited to 90 days per calendar year. No more than a 30-day supply will be covered and dispensed at a time, a prescription is required from a licensed provider and

prescriptions must be filled at a network pharmacy using your ID card.

29. **Organ Transplants**, for human organs only, and only for the following:
- Cornea
  - Heart
  - Heart/Lung
  - Kidney
  - Liver
  - Lung (single and bilateral)
  - Pancreas
  - both allogenic (donor) and autologous (self) bone marrow transplants for:
    - Acute non-lymphocytic leukemia;
    - Advanced Hodgkin's lymphoma;
    - Advanced non-Hodgkin's lymphoma;
    - Advanced neuroblastomas; and
    - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.
  - Autologous bone marrow transplants for solid tumors such as breast cancer
  - high dose chemotherapy with bone marrow transplantation for the approved treatment of solid tumors, such as breast cancer.
  - prescribed post-transplant immunosuppressant outpatient drugs required as a result of a covered transplant.
  - coverage includes up to \$25,000 for acquisition fee.
  - medical expenses for the organ donor which are necessary for the transplant, and which are not covered by another group health plan or other coverage arrangement.
30. **Phenylketonuria Testing, Diagnosis and Treatment** including dietary management, formulas, case management, intake and screening, assessment, comprehensive care planning and service referral.
31. **Physician Services, including:**
- physician office visits;
  - physician inpatient visits;
  - consultations; and
  - surgical care
32. **Prescription Drug Services.** The Plan uses its drug *formulary* to determine which prescription drugs are covered. The formulary is a list of medications that are often the most effective for the treatment and diagnosis of disease and maintenance of health according to the clinical judgment of the physicians, pharmacists and other health care professionals who helped us develop the formulary. Not all drugs are covered, please also refer to Attachment II, *Drug Exclusion List*. For a copy of the Plan Formulary you can contact our Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863 (TTY: (605) 328-6869) or you can view the formulary online at [www.siouxvalley.org/HealthPlan](http://www.siouxvalley.org/HealthPlan).

The information about the formulary applies only to those drugs, including injectable drugs, that may be covered under this certificate. This formulary is subject to annual review and modifications.

Often there is more than one medication available to treat the same medical condition. For that reason, we have developed the formulary in cooperation with Express Scripts, Inc., our pharmacy benefits manager.

Following the formulary will save you money and help control the costs of health care. When your physician prescribes a drug for you, you can ask that he or she refer to the Plan formulary for prescription options. All participating physicians have received a copy of the Plan formulary on your behalf.

The Plan has options of Open, Closed and 3-Tier formulary systems for your employer's choice to best meet the needs of the company. Please refer to your Group *Summary of Plan Benefits* for your formulary benefit purchased.

**To be covered by the Plan, drugs must be:**

- Prescribed by or approved by a physician;
- Listed in the Plan formulary, unless prior authorization or a formulary exception is given by the plan;
- Provided by a Participating Pharmacy by utilizing their prescription drug card. Refer to your *Sioux Valley Health Plan Participating Pharmacy* brochure for a list of Participating Pharmacies. If Member does not utilize a Participating Pharmacy, except in an emergency, the Member is responsible for the full cost of the drug. If the Member fails to utilize their prescription drug card, except in an emergency, the Member is responsible for manually filing a paper claim with the Plan and must accept a reduced level of reimbursement. Reimbursement will be at the rate that would have been paid by the Health Plan had the Member used their ID card.
- Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

**The following types of drugs are covered. See your Drug Formulary for specific covered drug details.**

- Federal Legend Drugs. Any medicinal substance which bears the legend, "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to state law;
- An injectable drug prescribed to be self administered or administered by any healthcare professional. Covered injectable drugs include insulin.
- State restricted Drugs. Any medicinal substance which may only be dispensed by a prescription according to state law.
- Compounded Medications. Any medicinal substance which must be mixed, compounded, or otherwise

prepared by a registered pharmacist and has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.

- e. Diabetic needles and syringes and injectable insulin are covered. Each of the following shall constitute a separate prescription “supply” for copay purposes, and together they constitute the maximum amount of diabetic treatment that may be dispensed at one time:
- A 30-day supply of diabetic needles and syringes;
  - Either a 30-day supply or one 10-mL bottle, whichever is greater, of injectable insulin;
  - Diabetic testing strips are limited to 205 per month with doctor’s order.
- f. Contraceptive drugs and devices including but not limited to oral medications, IUDs, implantable and injectable birth control devices. This coverage rule is defined by the benefit package purchased by your employer group and State Insurance regulations for coverage.

**Exception to formulary.** The health plan will promptly grant an exception to the drug formulary, 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.

**Antipsychotic drugs** prescribed to treat emotional disturbance or mental illnesses is covered by the Plan regardless of whether the drug is in the Plan’s drug formulary, if the health care provider prescribing the drug certifies in writing to the health plan that the health care provider has considered all equivalent drugs in the health plan’s drug formulary and has determined that the drug prescribed will best treat the patient’s condition. The prescribing provider must indicate to the dispensing pharmacist, orally or in writing, that the prescription must be dispensed as communicated. The Plan will not provide coverage for drugs removed from the formulary for safety reasons. Antipsychotic drug exceptions to the formulary will not be subject to any special payment requirement different from drugs on the formulary and the Plan will not require written certification each time a prescription is refilled.

**Continuing care.** Members receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to *one (1) year* without the imposition of a special deductible, co-payment, coinsurance, or other special

payment requirements, when a health plan’s drug formulary changes or a Member changes health plans and the medication has been shown to effectively treat the patient’s condition.

In order to be eligible for this continuing care benefit:

- (1) the patient must have been treated with the drug for 90 days prior to a change in a health plan’s drug formulary or a change in the Member’s health plan;
- (2) the health care provider prescribing the drug indicates that the prescription must be dispensed as communicated; and
- (3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient’s condition.

The continuing care benefit shall be extended annually when the prescribing provider meets the criteria set forth above for **Antipsychotic Drugs**.

**Injectable Drug Program.** Sioux Valley Health Plan uses Express Scripts Specialty Care for your injectable medication needs. Specialty Care 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.

*Specialty Care* 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.

The following list of Injectable Medications require Prior Authorization by the Plan. Please call the Health Services Department at 1-800-805-7938 or (605) 328-6807. The medications listed will be applied to your medical benefit with coinsurance and deductible applying.

**Injectable Drugs that require Prior Authorization include:**

- Serostim
- Hemophiliac/Hemostatics
- Lupron (may be obtained from physicians office, pharmacy or Specialty Care program).
- Lupron Depo (may be obtained from physicians office, pharmacy or Specialty Care program).

If you are a woman currently receiving an injectable medication for infertility, another benefit has been offered to

you by *Express Scripts Specialty Care*. If you use the Specialty Care program you will receive a discount on all your injectable medications.

**To enroll in the *Express Scripts Specialty Care* program, call toll-free at 1-800-278-0980 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 *Express Scripts Specialty Care* 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.

Specialty Care will mail your physician a letter explaining the new program and how to send your prescriptions to *Express Scripts Specialty Care*. 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 refill 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.

33. **Prosthetic Devices** permanently implanted that are not Experimental or Investigational.

34. **Reconstructive Breast Surgery and Implants**, for those Members who had a mastectomy covered by this Plan, resultant from a disease, illness, or injury. This coverage extends to the non-affected side to make it similar in size to the affected breast post-surgical reconstruction. Includes *two (2)* bras per Calendar Year and replacements for external breast prosthesis or forms are limited to two (2) per affected side per Calendar Year.

35. **Reconstructive Surgery**, when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of a congenital or developmental abnormality, including treatment of port-wine stains, which has resulted in a functional defect as determined by the attending physician.

36. **Scalp Hair Prostheses**, worn for hair loss suffered as a result of alopecia areata up to a maximum of \$350 per contract year exclusive of any Deductible.

37. **Skilled Nursing Facility Services**, if approved by the Plan. The following Skilled Nursing Facility Services are covered:

- a. skilled nursing care, whether provided in an inpatient skilled nursing unit, a skilled nursing facility, or in a home health care program.
- b. room and board in a skilled nursing facility.
- c. special diets in a skilled nursing facility, if specifically ordered.

Skilled nursing care in a hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the hospital or in another hospital or health care facility within a *thirty-mile (30)* radius of the hospital.

38. **Sterilizations**, including voluntary tubal ligations and vasectomies.

39. **Temporomandibular Joint and Craniomandibular Disorders** including surgical and nonsurgical treatment by a physician or dentist. Coverage is the same as treatment for any other joint in the body.

40. **Transportation Services**. Transportation by professional ground ambulance, air ambulance, or on a regularly scheduled flight on a commercial airline when transportation is:

- a. Medically Necessary; and
- b. To the nearest Participating Hospital equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

41. **Treatment Therapies**

- a. Inhalation Therapy.
- b. Radiation Therapy.
- c. Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage.
- d. Outpatient Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitative services directed at improving physical functioning of the Member) which is expected to provide measurable improvement relative to established goals, as authorized on a prospective and timely basis by the Plan.
- e. Habilitative therapy includes services for congenital, developmental, or medical conditions that have delayed speech or motor development.

42. **Well Child Care Health Care Services**, Services provided to a healthy child as well as necessary care and treatment of medically diagnosed congenital defects and birth abnormalities up to age eighteen (18), including orthodontic and oral surgery treatment involved in the management of birth defects, such as a cleft lip and cleft palate. Periodic well child visits after age six (6) including: periodic examinations, diagnostic procedures, laboratory testing, X-rays, hearing and vision screening, and Plan-approved education services.

**43. Wellness Services.**

- a. periodic adult physical examinations including periodic diagnostic procedures, laboratory testing, diagnostic imaging, and eye and vision (chart) exams are covered. (as outlined in the Plan Preventative Health Guidelines), and Plan approved health education services for disease prevention and identification ordered or authorized by a Participating Provider.
- b. periodic preventative services visits including: periodic examinations (including hearing screening and eye and vision (chart) exam, diagnostic procedures, and laboratory testing, as outlined by the Plan Preventative Health Guidelines for children ages seven (7) to eighteen (18) and plan approved health education services.
- c. medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness, including administration of medically accepted pediatric and adult immunizations and injections (excluding self-injectable drugs). These services will not be subject to an annual deductible or copays.
- d. screening Mammography, as follows:
  - i. one (1) baseline mammography between the ages of thirty-five (35) and thirty-nine (39).
  - ii. annually after the fortieth (40<sup>th</sup>) birthday.
  - iii. Screenings may be more frequent if there is a family history of breast cancer or as approved by the Plan.
- e. annual gynecological examinations by a Participating Physician including a Pap smear test.
- f. prostate cancer screening for all men fifty (50) years and older, and for men forty (40) years and older who are symptomatic or in a high-risk category.

## PART IV LIMITED & NON-COVERED SERVICES

This section describes services that are NOT covered under this Contract, as well as limitations to some services that are covered. The Plan is not responsible for payment of these services.

### A. General Exclusions

1. Health Care Services provided either before the effective date of the Member's coverage with the Plan or after the Member's coverage is terminated.
2. The Member will not be responsible for services performed by a participating provider that are beyond the scope of practice authorized by law for the type of Practitioner performing them under the state law.
3. Health Care Services performed by any Provider who is a Member of the enrollee's immediate family, including any person normally residing in the member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the enrollee may go a Non-Participating Provider and receive In Network Coverage (Part III, Section C). If the immediate family member is not the only Participating Provider in the area, the enrollee must go to a Participating Provider in order to receive coverage (at the in network level).
4. Health certifications and services when required by third parties, including for the purpose of insurance, licensure and employment and when such services are not preventative care or otherwise medically necessary:
  - a. school physicals;
  - b. sports physicals;
  - c. pre-employment and employment physicals;
  - d. insurance physicals; or
  - e. government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses).
5. Health Care Services received for any disease or injury suffered as a result of or while in military service, provided that such services are available under another program of coverage.
6. Health Care Services ordered by a court or as a condition of parole or probation received from an Out of Network provider, except as described in this Certificate of Coverage.
7. Experimental and Investigational Services.
8. Complications from a non-covered procedure or service.
9. Charges for telephone calls to or from a physician, hospital, or other medical provider.
10. Health Care Services that the Plan determines are not medically necessary.
11. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.
12. Services, including transfers and admissions to *hospitals*, performed only for the convenience of the *member*, the *member's family* or the *member's physician* or other *provider*.
13. Services for, or related to, rehabilitation services, such as physical, occupational, and speech therapy, or such services provided in the *members' home* for convenience, that are not expected to make measurable or sustainable improvement within a reasonable period of time. Services that are primarily *educational* and provided for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal facility or clarity; voice training and voice therapy.
14. Cochlear implants.
15. Professional sign language and foreign language interpreter services in a *physician's office*.
16. Nutritional and electrolyte substances and infant formulas, except to treat PKU or otherwise required to sustain life.
17. Nutritional counseling, except when provided during a *confinement* or for the diagnosis and treatment of a medical condition affected by diet. Policy guidelines apply.
18. Services for, or related to, Methadone or Cyclazocine.
19. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *the Plan*.
20. Services primarily *educational* in nature; vocational and job rehabilitation; recreational therapy.
21. Mental or substance-related disorder services, including marital or family counseling, bereavement, pastoral, or custodial care counseling or other similar counseling or training services, treatment of mental health disorders or

- substance-related disorders that *the Plan* determines cannot be improved with treatment, except as stated in this *Certificate of Coverage*. However, this exclusion does not apply to outpatient family therapy that is recommended by a *provider* treating a minor *dependent* child.
22. Services for, or related to, mental retardation or mental disorders that, according to generally accepted professional standards, is not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention.
  23. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
  24. Any durable medical equipment or supplies not on *the Plan's* eligible list, as determined by *the Plan*. Except as specifically noted in this *Certificate of Coverage*, *the Plan* does not cover the following equipment and supplies:
    - Orthopedic shoes; over-the-counter orthotics and appliances;
    - Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage;
    - Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use;
    - Replacement or repair of items, if the items are damaged or destroyed by the *member's* misuse, abuse or carelessness, lost, or stolen;
    - Duplicate or similar items;
    - Service call charges, labor charges, charges for repair estimates;
    - Items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation;
    - Household equipment that primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools;
    - Household fixtures: fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas;
    - Home Modifications: modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment;
    - Vehicle/car or van modifications: modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier;
    - Other equipment and supplies that *the Plan* determines are not eligible for coverage.
  25. Charges for sales tax, mailing, interest and delivery.
  26. Financial or legal counseling services.
  27. Routine foot care including cutting, removal, or treatment of corns, calluses, or nails, except for *members* who have diabetes or peripheral vascular disease.
  28. Genetic testing, excluding testing for reproductive planning and testing that will direct patient care or treatment of a medical condition. Policy guidelines apply.
  29. Charges for services determined to be duplicate services by *the Plan* medical director or designee.
  30. Services payable by Medicare.
  31. Charges that exceeds the *usual and customary amount* for Non-Participating Providers.
  32. Telephone or electronic mail consultations.
  33. Any service not specifically described as covered services in this *Certificate of Coverage*.
  34. Organ Transplant:
    - a. expenses related to transplants of animal organs.
    - b. artificial organs.
    - c. expenses incurred by a Member as a donor, unless the recipient is also a Member and these services are not covered under another group health plan or Coverage Arrangement,
    - d. Services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
    - e. Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by *the Plan's* medical director or its designee.
    - f. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-contracted, non-LifeTrac Center of Excellence.
  35. Cosmetic Surgery including skin tag removal and other supplies and services used to repair or reshape a body structure primarily for the improvement of a covered person's appearance or psychological well-being or self-esteem. Excluding conditions that are not the result of disease, trauma, congenital, or developmental abnormalities, which are meant to improve appearances, including but not limited to breast augmentation, rhinoplasty, liposuction, scar revisions, and cosmetic dental services.
  36. Hypnotism, Hypnotherapy, Hypnotic Anesthesia, and Sleep Therapy (except for central or obstructive apnea when approved by the Plan).

37. Accupressure, Aquatic Therapy, Biofeedback, Massage Therapy, Fluidotherapy, Naturopathy, Homeopathy, Holistic Medicine or Therapeutic Touch.
  38. Diagnosis and Treatment of Weak, Strained, or Flat Feet, unless determined by the Plan to be Medically Necessary.
  39. Correction of Refractive Errors of the Eye, Purchase, Examination, or Fitting of Eyeglasses or Contact Lenses, except as specifically covered elsewhere.
  40. Radial Keratotomy, Myopic Keratomileusis, and any Surgery Involving Corneal Tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
  41. Sexual Re-assignment, including, but not limited to, surgery unless deemed medically necessary.
  42. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics.
  43. Non-Emergency Ambulance Services and/or Travel, unless approved and arranged by the Plan.
  44. Costs Associated with Private Rooms, above the semi-private room rate of the institution, except as specifically covered elsewhere.
  45. Private Duty Nursing, except as specifically covered elsewhere.
  46. Confinement in a Nursing Home, for custodial, convalescent, intermediate level, or domiciliary care, residential care, rest cures or care, or services to assist in activities of daily living.
  47. Medical nutrition therapy for diabetic care does NOT include food items or nonprescription drugs.
  48. Hot and cold packs provided by a physician, chiropractors, or other licensed providers.
  49. Sterilization of Dependent Children.
  50. The following Health Care Services Relating to the treatment of Infertility:
    - a. artificial means of conception:
      - i. Artificial insemination;
      - ii. In-vitro fertilization;
      - iii. Ovum or embryo placement or transfer;
      - iv. Gamete intra-fallopian tube transfer;
      - v. Cryogenic or other preservation techniques used in such or similar procedures;
      - vi. Infertility medication;
      - vii. Supplies related to artificial means of conception;
    - b. reversals of prior sterilization procedures; and
    - c. expenses related to surrogate parenting.
  51. Abortion Services.
  52. Wigs, Scalp Hair Protheses or Hair Transplants, except as specifically covered elsewhere.
  53. Dental Services, not specifically listed as a Covered Service, including dental x-rays, shortening of the mandible or maxillae for cosmetic purposes.
  54. Services and Supplies Related to Ridge Augmentation, Implantology, and Preventive Vestivuloplasty.
  55. Health Care Services Covered By Any Governmental Agency/Unit for military service-related injuries/ diseases, unless applicable law requires the Plan to provide primary coverage for the same.
- B. Drug Exclusions**
- Please review the following information concerning the drug exclusion and quantity limit listings. Additional drugs may be added throughout the year to any listing. Sioux Valley Health Plan will notify you of any changes. If you have any questions or concerns contact our Health Services Department at 800-805-7938.
- Excluded Drugs and Supplies**
- The following are specifically **EXCLUDED** from coverage under the plan unless mandated by State regulation:
1. Drugs not listed in the Sioux Valley Health Plan Formulary or without prior authorization or a formulary exception from the plan. See *Part III, B(2)* for a list of drugs that require prior authorization.
  2. Medications, equipment or supplies available over-the-counter (OTC) (except for insulin, insulin syringes or tobacco cessation products as covered elsewhere in this certificate) 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 Provider certifies off-label use with a letter of medical necessity).
  3. *Prescription drugs* for smoking cessation in excess of a 6-month supply per *calendar year*.
  4. Weight loss drugs except when *medically necessary* to treat morbid obesity.
  5. Prescriptions written by a *dentist* or *dental specialist*.
  6. Replacement of a *prescription drug* due to loss, damage, or theft.
  7. Outpatient Drugs Dispensed in a Provider's Office or non-retail pharmacy location.

8. Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multi-vitamins with iron and/or fluoride, and food supplements and baby formula.
9. Whole Blood and Blood Components Not Classified as Drugs, in the *United States Pharmacopoeia*.
10. Experimental or Investigational Drugs or Drug Usage that does not meet the criteria set forth in the definitions section of this certificate.
11. B-12 Injections, except for pernicious anemia.
12. Drug Efficacy Study Implementation (“DESI”) drugs.
13. Drugs that may be received without charge under a federal, state, or local program.
14. Drugs for cosmetic purposes, including baldness.
15. Refills of any prescription older than one year.
16. Compound medications with no legend medications.
17. Acne Medication for Members over ages thirty-five (35).

**C. Pre-Existing Conditions**

Health Care Services for Pre-Existing Conditions are excluded for a period of one (1) year (eighteen (18) months for late entrants) following the effective date of coverage or the first day of a waiting period if one applies. The one (1) year period shall be reduced by the aggregate number of days that a Member was covered under Creditable Coverage. This Pre-Existing Condition exclusion does not apply to newborn children, children placed for adoption, or adopted children under eighteen (18). The Plan will not count days of Creditable Coverage that occur before a significant break in coverage. A significant break in coverage is a period of sixty-three (63) consecutive days during all of which a Member does not have any Creditable Coverage, excluding any waiting periods and affiliation periods. Periods of Creditable Coverage shall be counted without regard to the specific benefits covered during the period.

Pre-Existing Condition limitations shall not be applied to Handicapped Dependents as defined in the Index to Term Definitions of this Certificate of Coverage.

Members shall have the right to provide the Plan with evidence of prior Creditable Coverage, including the right to secure a certificate of Creditable Coverage from a prior health plan or insurer and have the Plan assist in obtaining such a certificate. Prior to imposing a Pre-Existing Condition exclusion, the Plan shall inform the Member in writing of its determination of any Pre-Existing Condition exclusion period and the basis for the determination, provide an opportunity for the Member to submit additional materials regarding prior Creditable Coverage, provide an explanation

of any appeals procedures and provide a reasonable opportunity to submit additional evidence of Creditable Coverage.

**D. Services Covered by Other Payors**

1. Health Care Services for injury or sickness, which are job, employment or work related or for which benefits are provided or payable under any Worker’s Compensation or Occupational Disease Act or Law; or for which coverage was available under any Worker Compensation or Occupational Disease Act or Law, regardless of whether such coverage was actually applied for.

The Plan is not issued in lieu of nor does it affect any requirements for coverage by Worker’s Compensation. This Plan contains a limitation which states that health services for injuries or sickness which are job, employment or work related for which benefits are provided or payable under any Workers’ Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that Member is eligible to received Workers’ Compensation for the same incident, the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse the Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Workers’ Compensation Division Hearing. The plan reserves its right to recover against Member even though:

- (i) The Worker’s Compensation benefits are in dispute or are made by means of settlement or compromise; or
- (ii) No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
- (iii) The amount of Workers’ Compensation for medical or health care is not agreed upon or defined by Member or the Workers’ Compensation carrier; or
- (iv) The medical or health care benefits are specifically excluded from the Workers’ Compensation settlement or compromise.

Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Workers’ Compensation insurer, without the express written agreement of the Plan.

2. Health Care Services received directly from Providers employed by or directly under contract with the Member’s employer, mutual benefit association, labor union, trust, or any similar person or group.
3. Health Care Services for injury of sickness for which there is other non-group insurance providing medical

payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid, the Plan may exercise its Rights of Subrogation.

4. Health Care Services for conditions that under the laws of this State must be provided in a governmental institution.
5. Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and Tri-Care, unless applicable law requires the Plan to provide primary coverage for the same.

**E. Services and Payments That Are the Responsibility of Member**

1. Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Plan Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services.
2. Finance charges, charges for missed appointments and other administrative charges.
3. Services for which a Member is not legally, or as customary practice, required to pay in the absence of a group health plan or other coverage arrangement.

**F. Special Situations Affecting Coverage**

If the provision or approval of Covered Services is delayed or becomes impractical due to:

1. Complete or partial destruction of the Plan's facilities;
2. War;
3. Riot;
4. Civil insurrection;
5. Major disaster;
6. Disability of a significant portion of the Participating Providers;
7. Epidemic; or
8. A labor dispute not involving the Plan Participating Providers, the Plan will use its best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel.

However, neither the Plan, nor any Participating Provider, shall have any liability or obligation because of a delay or failure to provide such services under the circumstances enumerated above.

If provision or approval of Covered Services under this Contract is delayed due to a labor dispute involving the Plan or Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

## PART V CONTINUITY OF CARE

### A. Provider Contract Termination

In the event of provider contract termination (either non-renewal or without cause), the Health Plan shall notify all affected enrollees (as evidenced by past claims history) of such termination at least 30 days prior to the effective termination date. Such notification shall be sent to the last known address of the affected enrollee. This notice shall include information regarding what other participating providers are available to assume care of the enrollee and how an orderly transfer shall be accomplished in order to maintain continuity of care.

In situations where the Health Plan terminated the provider's contract without cause, the Health Plan shall provide, upon request, authorization to receive services that are otherwise covered under the terms of the Health Plan through the enrollee's current provider:

1. For up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:
  - a. An acute condition;
  - b. A life-threatening mental or physical illness;
  - c. Pregnancy beyond the first trimester of pregnancy;
  - d. A physical or mental disability defined as an inability to engage in one or more of life activities provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
  - e. A disabling or chronic condition that is in an acute phase.
2. For the rest of the enrollee's life if a physician certifies that the enrollee has a life expectancy of one hundred eighty (180) days or less.

### B. Provider Termination for Cause

In the event a provider is terminated for cause, the enrollees shall be notified of the termination and transferred to participating providers in a timely manner so that health care services remain available and accessible.

### C. Change of Provider

If the enrollee is required to change providers as a result of the decision made by the employer to change to a new health plan, the Health Plan shall provide, upon request, authorization to receive services that are otherwise covered under the terms of this contract through the enrollee's current provider:

1. For up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:
  - a. An acute condition;
  - b. A life-threatening mental or physical illness;
  - c. Pregnancy beyond the first trimester of pregnancy;

- d. A physical or mental disability defined as an inability to engage in one or more of life activities provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
    - e. A disabling or chronic condition that is in an acute phase; or
  2. For the rest of the enrollee's life if a physician certifies that the enrollee has a life expectancy of 180 days or less.

### D. Provider Agreement

Participating Providers in the Health Plan network agree to the following conditions:

1. Accept as payment in full the lesser of the health plan's reimbursement for in-network providers for the same or similar service or the enrollee's providers regular fee for that service;
2. Adhere to the Health Plan's prior authorization process; and
3. Provide the Health Plan with all necessary medical information related to the care of the enrollee.

### E. Coverage of Services

Nothing in this section requires the Plan to provide coverage for a service or treatment that is not covered services as outlined in Part V.

## PART VI

### HOW SERVICES ARE PAID FOR BY THE PLAN

#### A. The Process for Reimbursement of Charges by Participating Providers

When a Member receives Covered Services from a Participating Provider, the Plan will pay the Participating Provider directly, and the Member will not have to submit claims for payment. The Plan contracts with individual physicians, medical groups and hospitals to provide the benefits in this Certificate of Coverage. These Plan providers accept a negotiated payment from us. The Member's only payment responsibility, in this case, is to pay the Participating Provider, at the time of service, any copay, deductible or coinsurance which is required for that service.

as any Copay, Deductible, or Coinsurance which is required for the Covered Service.

**Time Limits.** Participating Providers must file claims to the Plan within *one hundred twenty (120)* days after the date that the cost was incurred.

In any event, the written proof required must be given to the Plan no later than *one hundred twenty (120)* days from the time stated, unless the claimant was legally incapacitated.

#### B. The Process for Reimbursement of Charges by Non-Participating Providers

1. **Written Notice of Claim.** The Member must give the Plan written notice of the costs to be reimbursed within *three hundred and sixty five (365)* days after the costs were incurred, or as soon as reasonably possible thereafter. The notice must be sent to the Plan or the Plan's agent, and must include:
  - a. name of the Subscriber;
  - b. group contract number; and
  - c. nature of the cost incurred.

Claim forms are available from the Plan's Member Services Department to aid in this process.

2. **Time Limits.** Claims must be given to the Plan within *three hundred and sixty five (365)* days after the date that the cost was incurred.
3. **Time of Payment of Claim.** The payment for reimbursement of the Member's costs will be made within *thirty (30)* days of when the Plan receives a complete written claim with all required supporting information.

When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to Plan guidelines, the Plan will arrange for direct payment to either the Non-Participating Provider or the Member, per plan policy. If the Provider refuses direct payment, the Member will be reimbursed for the reasonable costs of the services in accordance with the terms of this contract. The Member will be responsible for any expenses that exceed Reasonable Costs, as well

## PART VII COMPLAINT AND APPEAL PROCEDURES

### 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
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 and provider complaints. A process has been established for Members (or their designees) and providers to use when they are dissatisfied with the Plan, its 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.

Inquiry: A telephone call regarding, eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sioux Valley Health Plan to address Member and provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written complaint.

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 Member 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 certified; and the date of the service, procedure, or admission denial and reason for denial. If the Plan indicates certification by use of a number, the number must be called the "authorization number."

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.

#### **D. Complaint & Medical Review Determination Process**

##### **1. Informal Complaints:**

A complainant may submit a complaint to the Member Services Department either orally or in writing. 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 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) 282-5608, 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 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 10 business days that we received the written complaint, unless the complaint has been resolved to the complainant's satisfaction within those 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:

### **For Pre-Service Claims (services for which prior approval by us is a requirement for coverage)**

If the request concerns urgent care, you may request an expedited review either orally or in writing. Within 72 hours of such request, a decision on your complaint will be made.

If the request concerns non-urgent services, a decision on your request will be made within 30 calendar days from the date the Plan receives your request.

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

### **Pre-Service Authorizations requiring Utilization Review for Medical Determinations**

If the service request requires *utilization review* for a medical determination, you may request a review either orally or in writing.

### **Urgent Request**

If the service request is urgent, you may request an **expedited** review. Within 72 hours of such request, a decision will be made via telephone to you and your provider. You and your provider will receive written notification within 1 calendar day of the decision.

### **Non-Urgent Request**

If the service request concerns non-urgent services, a written decision will be made within 10 business days from the date the Plan receives your request. If the decision is not to certify your request, telephone notification will be made within 1 calendar day to you and your provider.

### **Post-Service Claims.**

A decision on your complaint will be made within 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 ongoing service, an appeal must be submitted to the Plan within 180 days following the written notice of initial determination.**

1. **Post-service appeal.** If after the first level of complaint review of a post-service claim, your request was denied, you or your authorized representative may submit a written request for appeal, including any relevant documents, and submit issues, comments and additional information as appropriate 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 phone. Hearings and written reconsideration shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary for a fair appraisal and resolution of the complaint. During your appeal, upon you request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

We will review your appeal and written notice of the decision and all key findings will be given to the complainant within 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 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 14 additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

2. **Pre-service and concurrent appeal (for utilization review for a medical determination).**

When an initial determination is to deny your request, you or your authorized representative may submit a request for appeal. You may request an expedited review either orally or in writing. Within 72 hours, or as expeditiously as the Member's medical condition requires, of such request, a decision on your complaint will be made via telephone to you and your provider. If the decision is to deny your request, you and your provider will receive written notification of the decision and your right to initiate the external appeals process as soon as practical.

If the complaint concerns non-urgent, services, a written decision on your complaint will be made within 30 calendar days from the date the Plan receives your request.

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

**F. 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 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. We 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 us. Within 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 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. We may seek judicial review of the decision under certain circumstances.

## PART VIII HOW COVERAGE ENDS

### A. Termination by the Subscriber

In accordance with your employer's Human Resources Policy, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. The Plan must receive a written request from the Group to end coverage. The Subscriber will be responsible for any Service Charges through the date of termination or the end of the calendar month in which termination occurs, whichever is later.

### B. Termination of Member Coverage

Plan may terminate, cancel, or refuse to renew a Member's coverage for any of the reasons listed below. Such action by the Plan is called "Disenrollment" of the Member.

1. **Payment.** Failure to make any required Service Charge payments, Copay, Deductibles or Coinsurance when due. A grace period of *thirty-one (31) days*, unless stated otherwise in this Certificate of Coverage, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period.
2. **Move Outside the Area.** A Member establishes permanent residence outside the Service Area and outside the state of Minnesota.
3. **Contract Termination.** This Contract terminates.
4. **Eligibility.** The Member is no longer eligible for coverage under this Contract.
5. **Use of ID Card by Another Individual.** A Member allows another individual to use his or her ID card to obtain services.

A Member may not be disenrolled due to the status of the Member's health or because the Member has exercised her or his rights under the Plan's Policy on Member Complaints and Grievances or the Policy on Appeal Procedures for Medical Review Determinations.

### C. Notice of Termination of Coverage

The Plan will notify the Group of the termination of coverage for any Member. The Group will then give written notice of the termination to the Member, at least thirty (30) days prior to the effective date of termination of coverage. For purposes of this contract, "give written notice," means to present the notice to the Member or mail it to the Member's last known address.

In situations where the Plan is canceling coverage for all enrollees of a group plan for nonpayment of the premium for coverage under the group plan, the Plan shall give all enrollees in the group thirty (30) days notice of termination.

The effective date of the notice shall not be less than thirty (30) days after the notice date and shall clearly state the cancellation date which shall be no more than sixty (60) days prior to the effective date of the notice. This notice shall include a statement of the enrollees' rights to convert to an individual policy without underwriting restrictions and shall include either an application for conversion coverage or a telephone number that the enrollees can call for further information about conversion to an individual plan.

*This notice will set forth at least the following:*

1. The effective date of termination or of the decision to not renew coverage;
2. The reason(s) for the termination or nonrenewal; and
3. The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
  - a. the right to appeal the termination or nonrenewal;
  - b. the availability of Continuation or Conversion of Coverage, if any; and
  - c. the fact that the Member may have rights to continue coverage under federal and state law, independent from any provisions of this contract, and should contact the Group for information regarding his or her Continuation of Coverage rights.

### D. Member Appeal of Termination

A Member may appeal the Plan's decision to terminate, cancel, or refuse to renew the Member's coverage. The appeal will be considered to be a Member Grievance and the Plan's Policy on Member Complaints and Grievances will govern the appeal procedure.

Pending the appeal decision, coverage will terminate on the date which was set by the Plan. However, the Member may continue coverage, if entitled to do so, by complying with the "Continuation of Coverage" provisions, below. If the Plan decides the appeal in favor of the Member, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

## PART IX OPTIONS AFTER COVERAGE ENDS

### Continuation of Coverage

If your eligibility for group coverage under this Contract ends because of one of the events shown below, called “qualifying events,” you may be eligible to continue group coverage, or to convert to non-group (individual) coverage. Each of these options is shown below.

#### A. Qualifying Events

Coverage under this contract may be continued by a Member, spouse and other dependents enrolled at the time coverage would otherwise end, or child born to or placed for adoption with the enrollee during the period of continuation coverage as a result of one of the following qualifying events:

- a. Termination of employment (except for gross misconduct) of the Member, or reduction in hours resulting in loss of group coverage.
- b. Death of the Member.
- c. Divorce or legal separation from the Member.
- d. Loss of eligibility as a dependent child.
- e. Initial enrollment of the Member for Medicare.
- f. For a retired Member, spouse and other dependents, the bankruptcy filing by a former employer, under Title XI, United States Code, on or after July 1, 1986.

The Member may continue coverage under the group medical coverage when qualifying events occur. If the Member chooses to continue coverage:

- the Member may also continue coverage for the same dependents enrolled when coverage would normally end;
- coverage will be the same as that for other Members;
- continuation coverage terminates when the group medical coverage terminates. The Member may however, be entitled to continuation coverage under another health plan offered by the employer. The Member should contact the employer for details about other continuation coverage.

#### What you must do to elect Continuation Coverage:

- notify the employer within 60 days of the divorce or legal separation;
- notify the employer within 60 days after a dependent is no longer eligible;
- elect continuation by notifying the Plan Administrator within 60 days after your coverage ends or the employer notifies you of continuation rights, whichever is later;
- pay premiums.

#### Premium Payments:

1. The premium to continue coverage is the rate charged under the group medical coverage for such period of coverage for other similarly situated Member, spouses and dependents. However, where a group has a separate premium charged for each dependent that is added to a Member’s enrollment, then a former spouse or

dependent could be required to pay 102% of the added premium in order to continue coverage.

2. The first premium must be paid within 45 days after choosing to continue the coverage. If coverage is terminated due to the Member’s death, payment is due 90 days after the dependents are notified of their right to continue coverage.
3. You must pay subsequent premiums by the premium due date.

#### What the Plan Administrator must do:

- determine if you are eligible to continue coverage according to state and federal laws;
- notify you of your right to continue coverage within 14 days of receiving notice of a qualifying event and furnish you with a Continuation of Coverage Declaration Form;
- inform you of the premium required to continue coverage and how to pay the premium.

**If this happens . . .****Coverage may be continued until...**

---

The Member's hours are reduced or employment with the employer ends for reasons other than gross misconduct.

A child born to or placed for adoption with the Member during this 18-month continuation will also be entitled to continuation coverage during this 18-month period.

The earliest of the following occurs:

1. 18 months after continuation began.
2. The Member and dependents become covered under another group health plan and any applicable preexisting condition limitation expires.
3. Coverage would otherwise end under the group medical coverage.

---

Death of the Member.

The earliest of the following occurs:

1. The dependents become covered under another group health plan or coverage would have ended if the Member had lived, whichever is later.
2. Coverage would otherwise end under the group medical coverage.

---

Divorce or legal separation from the Member.

The earliest of the following occurs:

1. You become covered under another group health plan.
2. You become enrolled for benefits under either or both Parts of Medicare.
3. Coverage would otherwise end under the group medical coverage.

---

Loss of eligibility by a dependent child.

The earliest of the following occurs:

1. 36 months\* after continuation coverage began.
2. The dependent child becomes covered under another group health plan.
3. You become enrolled for benefits under either or both Parts of Medicare.
4. Coverage would otherwise end under the group medical coverage.

\* Dependent coverage may be continued longer.

Contact the employer for information.

---

Enrollment of the Member for Medicare.

The earliest of the following occurs:

1. 36 months\* after continuation coverage began for the dependents.
2. The dependent becomes covered under another group health plan or Medicare.
3. Coverage would otherwise end under the group medical coverage.

\* Dependent coverage may be continued longer.

Contact the employer for information.

---

**If this happens . . .****Coverage may be continued until...**

---

The employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code. (This applies only to a retired Member and his or her dependents.)

The earliest of the following occurs:

1. You become covered under another group health plan.
2. Coverage would otherwise end under the group medical coverage.

---

**The Member's right to continue coverage because of total disability:****If this happens....**

The Member is absent from work due to total disability that occurred while the Member is employed by the employer and covered under the group medical coverage.

**Coverage may be continued until....**

Coverage would otherwise end under the group medical coverage.

---

**Your coverage may be continued longer under certain circumstances:****If this happens....**

You are disabled by the 60th day following that date the Member's hours are reduced or his/her employment with the employer ends for reasons other than gross misconduct.

A child born to or placed for adoption with the Member during this 29-month continuation will also be entitled to continuation coverage during this 29-month period.

**Coverage may be continued until...**

The earliest of the following occurs:

1. 29 months after continuation began or until the first month that begins more than 30 days after the date of any final determination that you are no longer disabled. Notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months in order to extend coverage beyond 18 months.
2. The dependents become covered under another group health plan.
3. The Member becomes covered under another group health plan and any applicable preexisting condition limitation expires.
4. Coverage would otherwise end under the group medical coverage.

---

You are currently continuing coverage because the Member's hours were reduced or employment with the employer ended for reasons other than gross misconduct, and any of the following occurs within the first 18 months of continuation:

1. Loss of dependent child eligibility;
2. Subscriber enrollment for Medicare;
3. the employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code. (This applies only to retired Members and his or her dependents.)

A child born to or placed for adoption with the Member during this 36-month continuation will also be entitled to continuation coverage during this 36-month period.

The earliest of the following occurs:

1. 36 months after continuation first began.
  2. You become covered under another group health plan.
  3. Coverage would otherwise end under the group medical coverage.
-

**If this happens....****Coverage may be continued until...**

---

The Member's spouse is currently continuing coverage because the Member's hours were reduced or employment with the employer ended for reasons other than gross misconduct, *and* they divorce or become legally separated during the first 18 months of continuation.

The earliest of the following occurs:

1. The Member's spouse or former spouse becomes covered under another group health plan.
  2. Coverage would otherwise end under the group medical coverage.
- 

Dependents are currently continuing coverage because the Member's hours were reduced or employment with the employer ended for reasons other than gross misconduct, and the Member dies during the continuation period.

The earliest of the following occurs:

1. The dependents become covered under another group health plan.
  2. Coverage would otherwise end under the group medical coverage.
- 

Dependents are currently continuing coverage because the employer files a voluntary or involuntary petition for protection under the bankruptcy laws found in Title XI of the United States Code and the retired Member dies during the continuation period.

The earliest of the following occurs:

1. 36 months after the Member's death.
  2. The dependents become covered under another group health plan.
  3. Coverage would otherwise end under the group medical coverage.
- 

A child born to or placed for adoption with the Member during this 36-month continuation will also be entitled to continuation coverage during this 36-month period.

## **B. Continuation of Coverage for Survivors**

The Plan will not terminate, suspend, or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy, contract, or plan to the survivor or survivors until the earlier of the following dates:

1. the date the surviving spouse becomes covered under another group health plan; or
2. the date coverage would have terminated under the policy, contract, or plan had the insured, subscriber, or enrollee lived.

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. The Plan, upon request, will provide the enrollee with written verification of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee.

Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium, written notice of cancellation will be mailed to the survivor's last known address at least 30 days before the cancellation. Any required premium for the coverage shall be paid by the survivor to the group policyholder for remittance to the Plan.

## **C. Disabled Member**

Pursuant to the provisions in Minnesota Statute 62A.148, the Plan agrees not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any Member who becomes totally disabled while employed by the group health plan sponsor and covered hereunder while this Contract is in force, solely due to absence caused by such total disability. The group health plan sponsor may require the Member to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the group health plan sponsor by that Member.

For the purpose of this section the term "total disability" means (a) the inability of an injured or ill Member to engage in or perform the duties of the Member's regular occupation or employment within the first two (2) years of such disability and (b) after the first two (2) years of such disability, the inability of the Member to engage in any paid employment or work for which the Member may, by education or training, including rehabilitative training, be or reasonable become qualified.

## **D. Replacement of Coverage and Confined Members**

When the group health plan sponsor replaces the Master Contract with that of another health plan offering similar benefits, coverage will be extended for a Member who is confined in an institution or institutions for medical care or treatment that would otherwise be covered under this Contract. Coverage will be extended only for services related to the condition for which the confinement is required. Coverage for these services will end on the earlier of the dates of discharge or the date benefits provided under the Contract are exhausted.

## **E. Conversion of Coverage**

Members who complete the Continuation of Coverage Period or at any time during the Continuation of Coverage Period are eligible for a conversion contract offered by the Plan, at the conversion contract rates then in effect. A Conversion Contract is an individual health care services plan (in contrast to a group plan) which may be purchased by a Member whose coverage under this contract is terminated, under certain circumstances.

### **1. Eligibility for Conversion of Coverage. A**

Subscriber and his or her Dependents are eligible for a Conversion Contract only if one of the following apply:

- a. the Subscriber is no longer eligible for coverage under this Contract and continuation of coverage has been exhausted;
- b. coverage is canceled or terminated by the Plan or Group; or
- c. the Member is the Spouse of a Subscriber who has become enrolled in Medicare or Social Security disability benefits and continuation of coverage has been exhausted.

### **2. Exceptions.** Conversion of Coverage is not available if any of the following apply:

- a. the required Service Charge payments are not made when due.
- b. the Member is covered under Medicare.
- c. the Member is covered by similar hospital, medical, or surgical benefits under state or federal law. Benefits or coverage shall be considered "similar" if coverage is provided for at least twelve (12) months under comprehensive type health coverage.
- d. the Member is covered by similar hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group whether on an insured or uninsured basis.
- e. the Member is covered for similar benefits through individual coverage.
- f. the Member has moved outside of the Service Area and outside the State of Minnesota.
- g. the cancellation of the Member's coverage occurred in relation to the Plan being placed in rehabilitation or liquidation proceedings.

- h. this Contract has been discontinued in its entirety, and there is a succeeding carrier providing coverage to the group in its entirety.
- i. the Member has committed fraud or made a material misrepresentation in applying for conversion coverage.
- j. the Plan has canceled all similar insurance policies in the State.

3. **Nature of the Conversion Contract.** The Conversion Contract will:

- a. not require evidence of insurability.
- b. not impose any Pre-Existing Condition limitations or exclusions other than those remaining unexpired under the contract from which the Member is converting.
- c. begin coverage for the Member on the date of termination of the former coverage.
- d. provide coverage that approximates the coverage provided to the Group and will be renewable at the option of the Member, unless one of the exceptions under section 2 above applies.

The Conversion Contract may require Copay and Deductibles and premiums that differ from the group contract.

4. **Out of Area Conversion Coverage.** Members who move outside of the Plan's service area but remain residents of the state of Minnesota, shall be given the option of a number 1, 2, or 3, or if Member is covered by Medicare, they shall be given the option of a Medicare Supplement Plan if available by the Plan. This option shall be made available at the Member's expense, without further evidence of insurability and without interruption of coverage. If conversion coverage cannot be arranged, the Plan shall notify Member of health plans available in other service areas.

5. **How to Obtain Conversion Coverage.** A Member who wishes to obtain Conversion Coverage must submit to the Plan:

- a. a written application within thirty-one (31) days after the date of termination;
- b. select a qualified 1, 2 or 3 conversion plan; and
- c. submit the required Service Charge payment, within thirty-one (31) days after the date of termination of the Member's coverage under this Contract.

## PART X COORDINATION OF BENEFITS

If a Member is covered by another health plan, insurance, or other coverage arrangement, the plans and/or insurance companies will share or allocate the costs of the Member's health care by a process called "Coordination of Benefits" so that the same care is not paid for twice (Minnesota Rule 4685.0950).

The Member has two obligations concerning Coordination of Benefits ("COB"):

1. The Member must tell the Plan about any other plans or insurance that cover health care for the Member, and
2. The Member must cooperate with the Plan by providing any information requested by the Plan.

The rest of the provisions under this section explain how COB works.

### A. Applicability

1. This Coordination of Benefits (COB) provision applies to this Plan when a Group Member or the Group Member's covered Dependent has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:
  - a. shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
  - b. may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section below entitled: "Effect of COB on the Benefits of this Plan."

### B. Definitions (for COB Purposes Only)

1. "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
  - a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.
  - b. "Plan" may include coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title MX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has *two* (2) parts and COB rules apply only to one of the two, each of the parts is a separate plan.

2. "This Plan" refers to this certificate, which provides benefits for health care expenses.
3. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than *two* (2) plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

4. "Allowable Expense" means a necessary, reasonable and customary health care service or expense including deductibles, coinsurance, or copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:
  - a. The difference between the cost of a private hospital room and the cost of a semi-private hospital room (unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
  - b. If a person is covered by two or more plans that compute the benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense;
  - c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;
  - d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and

customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be allowable expense for all plans; or

- e. When benefits are reduced under a Primary Plan because a Member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or because the person has a lower benefit because the person did not use a preferred provider.
3. **“Claim”** means a request that benefits of a plan be provided or paid in the form of services (including supplies), payment for all or portion of the expenses incurred, or an indemnification.
  4. **“Claim Determination Period”** means a calendar year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if overinsurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or similar provision takes effect.
  5. **“Closed Panel Plan”** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or Plan authorized referral by a Participating Provider.
  6. **“Custodial Parent”** means a parents awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

### C. Order of Benefit Determination Rules

1. **General.** When two or more plans pay benefits, the rules for determining the order of payment is as follows:
  - a. The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
  - b. A plan that does not contain a COB provision that is consistent with this regulation is always primary. The exception is coverage that is obtained by virtue of Membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contact holder. For example, major medical coverage that is superimposed over base plan hospital and surgical benefits, and insurance type coverage that is written in connection with a closed panel plan to provide Out of Network benefits

- c. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
  - a. **Non-Dependent/Dependent.** The plan which covers the person as a Group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:
    - i. secondary to the Plan covering the person as a Dependent; and
    - ii. primary to the Plan covering the person as other than a Dependent, for example a retired Group Member; then the order of benefits between the two plans is reversed so that the plan covering the person as a Group Member, Member, or Subscriber is secondary and the other plan is primary.
  - b. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
    - i. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or note they even have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
    - ii. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parents has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
    - iii. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the noncustodial parent; and then
      - The plan of the spouse of the noncustodial parent.
  - c. **Active/Inactive Group Member.** The benefit of a plan which covers a person as a Group Member who is neither laid off nor retired (or as that Group Member's dependent) is primary. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively

working spouse will be determined under Rule 2(a) above.

COB shall not apply between this plan and any other closed panel plans.

d. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

- i. primary, the benefits of a plan covering the person as a Group Member, Member or subscriber (or as that person's dependent);
- ii secondary, the benefits under the continuation coverage. If the other plan does not contain the order of benefits determination described within this subsection, and if as a result, the plans do not agree on the order of benefits, this requirement shall be ignored.

**Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered a Group Member, Member or subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

3. **Effect of COB on the Benefits of this Plan.**

a. **When This Section Applies.** This section applies when, in accordance with Section C "Order of Benefit Determination Rules," this Plan is a Secondary Plan as to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph "b(ii)" immediately below.

b. **Reduction in this Plan's Benefits.** The benefits of this Plan will be reduced when the sum of:

- i. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- ii. the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than 100% of those Allowable Expenses.
- iii. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a non-Participating Provider, benefits are not payable by one closed panel plan,

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

4. **Plan's Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

5. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. **Right of Recovery.** If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- a. the persons it has paid or for whom it has paid;
- b. insurance companies; or
- c. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**D. Calculation of Benefit's, Secondary Plan**

If Sioux Valley Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sioux Valley Health Plan, should the plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under the plan that is unpaid by the primary plan. Sioux Valley Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

**E. Coordination of Benefits With Medicare**

Medicare Benefits provisions apply when a covered person has health coverage under the Plan and is eligible for insurance under Medicare, Parts A and B, (whether or not the

covered person has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of the Plan.

**F. Members with End Stage Renal Disease (ESRD)**

1. The Plan has primary responsibility for the claims of a Member:
  - a) Who is eligible for Medicare secondary benefits solely because of ESRD, and;
  - b) During the Medicare coordination period of 30 months, which begins with the earlier of:
    - the month in which a regular course of renal dialysis is initiated, or
    - in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
2. The plan has secondary responsibility for the claims of a Member:
  - a) Who is eligible for Medicare primary benefits solely because of ESRD, and;
  - b) The Medicare coordination period of 30 months has expired.

## PART XI

### SUBROGATION AND RIGHT OF REIMBURSEMENT

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, the Health Plan may be able to “step into the shoes” of the Member to recover health care costs from the party responsible for the injury or illness. This is called “Subrogation,” and this part of this contract covers such situations.

If a Member has received or receives a recovery from the third party, the Health Plan has a right to reduce or be reimbursed for benefits it has provided and to be provided to the Member. This is called “Reimbursement” and this part of this contract covers such situations.

The Plan will provide Health Care services to the Member for the illness or injury, just as it would in any other case. However, if the Member accepts the services from the Plan, this acceptance constitutes the Member’s consent to the provisions discussed below.

#### **A. Plan’s Rights of Subrogation**

In the event of any payments for benefits provided to a Member under this Contract, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, his parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, under-insured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and workers compensation insurance or substitute coverage. The Plan shall be entitled to receive from any such recovery an amount up to the Reasonable Costs Charges for the services provided by the Plan.

Any such right of subrogation and recovery provided to the Plan under this Contract shall not apply or shall be limited to the extent that statutes or the courts of this State eliminate or restrict such rights.

In providing benefits to a Member, the Plan may obtain discounts from its healthcare providers, compensate providers on a capitated basis or enter into other arrangements under which it pays to another less than the Reasonable Costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under the Plan for an illness or injury, the Plan is subrogated to the Member’s right to recover the Reasonable Costs of the benefits it provides on account of such illness or injury, even if those Reasonable Costs exceed the amount paid by the Plan.

The Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. The Plan’s first priority right applies whether or not the Member has been made whole by any recovery. The Plan shall have a lien on all funds received by the Member, his parents, heirs,

guardians, executors, or other representatives up to the Reasonable Costs Charge for the Health Care Services provided and to be provided to the Member. The Plan may give notice of that lien to any party who may have contributed to the loss.

If the Plan so decides, it may be subrogated to the Member’s rights to the extent of the benefits provided or to be provided under this Contract. This includes the Plan’s right to bring suit against the third party in the Member’s name.

#### **B. Plan’s Right to Reduction and Reimbursement**

The Plan shall have the right to reduce or deny benefits otherwise payable by the Plan or to recover benefits previously paid by the Plan to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

Any such right of reduction or reimbursement provided to the Plan under this Contract shall not apply or shall be limited to the extent that statutes or the courts of this State eliminate or restrict such rights.

The Plan shall have a lien on all funds received by the Member, his parents, heirs, guardians, executors, or other representatives up to the Usual and Reasonable Charge for the Health Care Services provided and to be provided to the Member.

#### **C. Member’s Responsibilities**

The Member, his parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan may require to facilitate enforcement of its rights under this Part. The Member shall take no action prejudicing the rights and interests of the Plan under this provision. Neither a Member nor his attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan’s subrogation or reimbursement claim, or to release any right of recovery or reimbursement without the Plan’s express written consent. Any Member who fails to cooperate in the Plan’s administration of this Part shall be responsible for the Usual and Reasonable Charges for services subject to this Part and any legal costs incurred by the Plan to enforce its rights under this Part. Failure to comply with this Part will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

#### **D. Limitations**

The Plan shall not contain a subrogation, reimbursement, or similar clause that provides subrogation, reimbursement, or similar rights to the Plan, unless:

- (1) the clause provides that it applies only after the covered person has received a full recovery from another source, and;

- (2) the clause provides that the Plan's subrogation right is subject to subtraction for actual moneys paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the Plan is separately represented by an attorney.

If the Plan is separately represented by an attorney, the Plan and the covered person, by their attorneys, may enter into an agreement regarding allocation of the covered person's costs, disbursements, and reasonable attorney fees and other expenses. If the Plan and covered person cannot reach agreement on allocation, the Plan and covered person shall submit the matter to binding arbitration.

Nothing in this section shall limit a Plan's right to recovery from another source which may otherwise exist at law.

For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a covered person.

**E. Notice to Plan of subrogation claim required**

A Member covered by a health carrier who makes a claim against a collateral source for damages that include repayment for medical and medically related expenses incurred for the covered person's benefit shall provide timely notice, in writing, to the Plan of the pending or potential claim. Notwithstanding any other law to the contrary, the statute of limitations applicable to the rights with respect to reimbursement or subrogation by the Plan against the covered person does not commence to run until the notice has been given.

## **PART XII**

### **REIMBURSEMENT METHODOLOGY**

#### **A. Physician Reimbursement**

Physicians contracting with the Plan will be compensated under a fixed fee schedule that will be based initially on the Medicare Resource based Relative Value System (RBRVS). This fee schedule is based on reasonable and customary charges for procedures performed in the regional market. Physicians and other non-facility providers under contract to the Plan will agree to accept this fee schedule as reimbursement in full for services provided to the Plan's Members. Physicians and other providers not contracted with the Plan, accessed by the Out of Network provisions in the Plan will be paid according to a fee schedule based on the usual and customary reimbursement (UCR) levels. This level will be established at the median level of physician charges – the 50th percentile. Non-contracted providers will have the right to collect from the Members that portion of their fee not covered by the schedule.

#### **B. Hospital Reimbursement**

Hospitals and other facilities that provide service on an inpatient basis and who are under contract to the Plan will typically be paid on a per diem (per day) basis. These entities will agree to accept a maximum reimbursement per day based on the contract and will be prohibited from collecting additional reimbursement from the Member. There will be occasional situations when the Plan will sign contracts with reimbursement agreements that include a discount from charges. These relationships are expected to represent a very minor portion of facility utilization.

Hospitals and other facilities that provide services on an outpatient basis, especially ambulatory surgery, and are under contract to the Plan will typically be paid a fixed fee based on ambulatory surgery groupings and similar methods. These entities will agree to accept a maximum reimbursement per service based on the contract and will be prohibited from collecting additional reimbursement from the Member. There will be occasional situations when the Plan will sign contracts with reimbursement agreements that include a discount from charges. These relationships are expected to represent a very minor portion of this outpatient utilization.

## **PART XIII SERVICE AREA**

The service area for Sioux Valley Health Plan and Sioux Valley Health Plan of Minnesota, include the following counties in the following States.

### **SOUTH DAKOTA**

AURORA  
BEADLE  
BENNETT  
BON HOMME  
BROOKINGS  
BROWN  
BRULE  
BUFFALO  
BUTTE  
CAMPBELL  
CHARLES MIX  
CLARK  
CLAY  
CODINGTON  
CORSON  
CUSTER  
DAVISON  
DAY  
DEUEL  
DEWEY  
DOUGLAS  
EDMUNDS  
FALL RIVER  
FAULK  
GRANT  
GREGORY  
HAAKON  
HAMLIN  
HAND  
HANSON  
HARDING  
HUGHES  
HUTCHINSON  
HYDE  
JACKSON  
JERAULD  
JONES  
KINGSBURY  
LAKE  
LAWRENCE  
LINCOLN  
LYMAN

### **SOUTH DAKOTA**

MCCOOK  
MCPHERSON  
MARSHALL  
MEADE  
MELLETTE  
MINER  
MINNEHAHA  
MOODY  
PENNINGTON  
PERKINS  
POTTER  
ROBERTS  
SANBORN  
SHANNON  
SPINK  
STANLEY  
SULLY  
TODD  
TRIPP  
TURNER  
UNION  
WALWORTH  
WASHABAUGH  
YANKTON  
ZIEBACH

### **IOWA**

CLAY  
DICKINSON  
EMMET  
LYON  
O'BRIAN  
OCSEOLA  
SIOUX

### **MINNESOTA**

COTTONWOOD  
JACKSON  
LAC QUI PARLE  
LINCOLN  
LYON  
MARTIN  
MURRAY  
NOBLES  
PIPESTONE  
REDWOOD  
ROCK  
WATONWAN  
YELLOW MEDICINE

**ATTACHMENT I**  
**SUMMARY OF PLAN BENEFITS**

**ATTACHMENT II  
DRUG EXCLUSION LIST**

